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	03/26/2024

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure Reference Number 175 NAC 12-006.04C3a(6) Based on record review and interview, the facility failed to ensure the responsible party was notified of a change of condition for 1 [Resident 32] of 4 sampled residents. The facility had a total census of 126. Findings are: A review of Resident 32's electronic medical record revealed Resident 32 was admitted to the facility on [DATE] with a diagnosis of unspecified dementia. A review of Resident 32's Progress Note dated 3/13/24 at 6:03 PM revealed Resident 32 was being sent to emergency room for evaluation and treatment of left sided weakness, facial drooping, and slurred speech since 3/8/24. Resident 32's Progress Note indicated Resident 32's physician was informed and a verbal order was received to send to emergency room via 911. A review of Resident 32's Progress Note dated 3/13/24 at 6:16 PM revealed Resident 32's family was notified of Resident 32's condition and transfer to the hospital. A review of Neurology Consult Note dated 3/14/24 identified a diagnosis of subacute CVA [Cerebral vascular accident]. In an interview on 3/18/24 at 2:03 PM, LPN C reported that Resident 32 was noted to have some left sided weakness. LPN C reported that PA [Physician Assistant] D had evaluated Resident 32 on the day that changes were noted and determined it was an exacerbation of an old stroke. LPN C had reported PA D had directed LPN C to monitor Resident 32 for any changes. A review of PA D's Progress Note for date of service 3/8/24 revealed Resident 32 was evaluated after nursing staff identified light weakness in left hand compared to right. Under Assessment and Plan section of Progress Note, Resident 32 was noted to be functioning at baseline neurological with no outright signs or symptoms of CVA or TIA [Transient ischemic attack]. The Progress Note identified the provider advised nursing staff verbally to continue to monitor resident and update the provider on any change of status and to update family of Resident 32's weakness. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 32's Progress Notes between 3/8/24-3/11/24 did not reveal the facility staff had notified Resident 32's family being notified of Resident 32's weakness. In an interview on 3/19/24 at 10:49 AM, Resident 32's family reported being notified Resident 32 was being sent to the hospital via 911 on 3/11/24. Resident 32's family member confirmed no notification had been received of Resident 32's change of condition until 3/11/24 when Resident 32 was sent to the hospital. In an interview on 3/19/24 at 11:01 AM, LPN C reported being uncertain if LPN C had notified Resident 32's family of change in condition. LPN C reported that normally family notification would be documented in the medical record. In an interview on 3/19/24 at 11:28 AM the Assistant Director of Nursing (ADON) F confirmed family should have been notified of Resident 32's change before 3/11/24. A review of facility policy titled Notification of Changes copyrighted in 2023 revealed the following: -The facility must inform the resident, consult with the resident's physician and/or notify the resident's -family member or legal representative when there is a change requiring such notification. -1. Accidents a. Resulting in injury b. Potential to require physician intervention. -2. Significant change in the resident's physical, mental or psychosocial condition such as deterioration in health, mental or psychosocial status. This may include: a. Life-threatening conditions, or b. Clinical complications -3. Circumstances that require a need to alter treatment This may include: a. New treatment b. Discontinuation of current treatment due to: i. Adverse consequences ii. A change or room or roommate assignment. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	iii. A change in resident rights

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12-00605(8) Based on observations, record review, and interview; the facility staff failed to evaluate the use of a seatbelt as a restraint for 1 (Resident 2) of 1 sampled resident. The facility identified a census of 126. Findings are: Record review of an undated facility policy entitled Restraint Free Environment revealed the following information: - It is this policy that each resident shall attain and maintain his / her highest practicable well being in an environment that prohibits the use of restrains for discipline or convenience and limits restrain use to circumstances in which the resident has a medical symptoms that warrant the use of restraints. - Physical Restraint: refers to any manual method or physical or chemical device adjacent to the residents body that the individual cannot easily remove which restricts freedom of movement. Physical restraints may include: Using devices in conjunction with a chair such as belts that the resident cannot easily remove and prevents the resident from rising. - Before a resident is restrained, the facility will determine the presence of a specific medical symptom that would require the use of the restraint and determine: a. how the restraint would treat the medical symptom. b. The length of time the restraint is anticipated to be used to treat the medical symptom, who may apply the restraint and the time and frequency that the restraint will be released. c. The type and direct monitoring and supervision that will be provided during the use of the restraint. d. How the resident will request staff assistance and how needs will be meet while the restraint is in place. - Medical symptoms warranting the use of the restraint should be documented in the medical record. The residents medical record needs to include documentation that less restrictive alternatives were attempted to treat the medical symptom but were ineffective, on going re-evaluation of the need for the restraint and the effectiveness of the restraint in treating the medical symptom. The care plan should be updated accordingly to include the development and implementation of interventions, to address any risks related to the use of the restraint. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of Resident 2's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 1/19/24 revealed an admitted [DATE] and diagnoses that included: aphasia (speech difficulty), quadriplegia, seizure disorder, traumatic brain injury, anxiety, depression and bipolar disorder (mood disorder). The MDS identified that Resident 2 had a Brief Interview for Mental Status (BIMS- a brief screener that aids in detecting cognitive impairment) score of 4 (severely cognitively impairment), exhibited no mood or behavior problems, used a manual wheelchair, required substantial / maximum assistance with sit to stand and chair / bed to chair transfers and no restraints were used. Observations on the following dates and times revealed the use of a seatbelt with a single clasp attached to Resident 2's wheelchair. The seatbelt was observed to be connected in the front of the resident during all the observations. - 03/18/24 12:47 PM Resident 2 was seated in a spot by the nurses station on Station 3 eating lunch. A seatbelt was positioned around the resident and was connected. - 03/19/24 12:40 PM Resident 2 was seated in a spot by the nurses station on Station 3 eating lunch. A seatbelt was positioned around the resident and was connected. - 03/19/24 2:00 PM Resident 2 was seated in the area by the nurses station on Station 3. A seatbelt was positioned around the resident and was connected. - 03/20/24 6:10 AM Resident 2 was seated in area by the nurses station on Station 3. The seatbelt was not buckled and the resident grabbed the ends and connected it without assistance. Record review of Resident 2's Electronic Medical Record [EMR] including doctor orders, progress notes, assessments and miscellaneous documents revealed no assessment or evaluation for the continued use of a seatbelt for Resident 2. Record review of Resident 2's Comprehensive Care Plan [CCP] dated 1/11/24 revealed no information related to the use of a seatbelt for Resident 2. Interview on 3/20/24 at 11:00 AM with the Director of Nursing [DON] confirmed that Resident 2 did use a seatbelt but was able to disconnect it without assistance. The DON confirmed that the use of the seatbelt had not been assessed as a potential restraint and medical reasons for the use of the seatbelt had not been evaluated or documented in the EMR. The DON confirmed that the EMR and the CCP did not contain any information related to the continued use of a seatbelt for Resident 2.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number 175 NAC 12.006.02(8) Based on observation, record review, and interview; the facility failed to report an allegation of staff to resident abuse within the required timeframe to the Department of Health and Human Services [DHHS] for 1(Residents 233) of 4 facility self report investigations reviewed. The facility census was 126. Findings are: Record review of an undated facility policy entitled Abuse , Neglect, Exploitation revealed the following information: A. The facility will have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, Adult Protective Services and to all other required agencies within specified timeframe's: - a. Immediately, but not later then 2 hours after the allegation is made, if the events that cause the allegation of abuse or result in serious bodily injury or: - b. Not later then 24 hours if the events that cause the allegation do not involve abuse and do not involve serious bodily injury. B. The Administrator will follow up with government agencies, during business hours, to confirm the initial report was received, and to report the results of the investigation when final within 5 working days of the incident, as required by state agencies. Record review of Resident 233's 5-day admission Minimum Data Set (MDS, a clinical assessment of the resident used to develop a comprehensive plan of care) revealed an admitted [DATE] with diagnoses that included cerebral vascular accident (stroke), diabetes mellitus and adjustment disorder with anxiety. The MDS identified Resident 233 had a BIMS (Brief interview Mental Status, a brief screener that aids in detecting cognitive impairment) score of 13 (cognition intact), used a walker and wheelchair, required substantial to maximum assistance from staff with toileting, showering, lower body dressing and putting on/taking off footwear. Record review of a facility investigation dated 11/22/23, related to an allegation of staff abuse that involved Resident 233, revealed that an investigation was initiated on 11/18/23 and was completed on 11/22/25. The incident occurred on 11/18/23 at 1:21 PM immediately after Resident 233 made an allegation of staff to resident abuse. Adult Protective Services was notified on 11/18/23 at 2:59 PM (within the required 2 hours). Two possible employees were identified and both were immediately suspended on 11/18/23 pending the results of the investigation. One of the staff members was terminated on 11/20/23. The facility report did not include verification that the investigation had been sent into DHHS within 5 working days. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Interview on 03/19/24 at 09:02 AM with the facility Administrator [ADM] confirmed that no report of the investigation had been sent into DHHS. The ADM confirmed that staff were not able to locate email or fax confirmation that the report had been sent in to DHHS.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 Licensure Reference Number 175 NAC 12-006.09D1c Based on record review, interview, and observation, the facility failed to provide bathing per resident preference for 2 (Resident 78 and 384) of 13 sampled residents. The facility identified a census of 126. Findings are: A. Record review of the facility policy Resident Showers and the policy is undated. The policy states: It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per the current standards of practice. Policy explanation and Compliance Guidelines: 1) Residents will be provided showers as per request or as per facility schedule protocols and based upon resident safety. B. Record review of Resident 78's Quarterly Minimum Data Set (MDS, a federally mandates assessment tool used for care planning) dated 1/5/24 revealed Resident 78's Brief Interview of Mental Status (BIMS) was a 5. According to the MDS [NAME] a score of 0 to 7 indicates a person has severe cognitive impairment. Review of section GG of the MDS revealed Resident 78 is dependent for shower/bath and is dependent for personal hygiene. Record review of Resident 78 Care Plan dated 11/23/23 revealed the following focus: -needs assist with activities of daily living (ADL). Care plan goal: resident will maintain a sense of dignity by being clean, dry, odor free, safe, and dressed appropriately on an ongoing basis for 90 days. Care plan interventions for bathing/showering and personal hygiene had no interventions identified. Record review revealed Resident 78 was admitted on Hospice services on 7/1/23. Record review of Resident 78 Bathing Preference sheet dated 8/16/23 revealed Resident 78 preferred a shower, two times per week. Record review of Resident 78 bathing record in Resident 78's Electronic Medical Record (EMR) keeping system for the last 30 days as of March 25th 2024 revealed there was no indications the facility staff had provided Resident 78 with shower/baths. Observation on 3/18/24 at 10:00 AM of Resident 78 revealed Resident 78's hair was uncombed and had a strong odor of urine. Observation on 3/19/24 at 7:00 AM revealed Resident 78 smelled of urine and Resident 78's hair was uncombed. Observation on 3/19/24 at 12:30 PM revealed Resident 78 remained in bed with a hospital gown on, hair uncombed, and smelled of urine. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observation on 3/20/24 at 6:00 AM revealed Resident 78 was in bed and had an odor of urine. A interview was conducted with Director of Nursing (DON) on 3/20/24 at 2:00 PM. During the interview DON reported Resident 78 receives showers/baths from the hospice aide. The DON confirmed no baths were given by the facility staff during the last 30 days. 17285 C. Record review of Resident 384's Clinical Census Report revealed an admitted [DATE] and a discharge date of [DATE]. Review of Resident 384's MDS dated [DATE] identified a BIMS, score of 11 (moderately cognitively impaired), had diagnoses that included hypertension, pneumonia, arthritis and chronic obstructive pulmonary disease. The assessment further indicated the resident required substantial to maximum assistance with shower/bathing and upper and lower body dressing. Record review of Resident 384's Baseline Care Plan dated 1/3/24 revealed that no information about bathing preferences had been identified on the baseline care plan. Record review of Resident 384's Bathing Preferences assessment dated [DATE] revealed Resident 384 preferred a shower to be given 3 times per week. The assessment was signed and dated 1/3/24 by the resident. Record review of a facility nurse aide task sheet ADL (activity of daily living) Bathing, that identified baths provided during Resident 384's stay at the facility, revealed that Resident 384 received a shower on 1/4/24 according to the provided bath records. On 1/7/24, the type of bath was marked not applicable. Interview on 03/21/24 at 8:44 AM with the DON confirmed that Resident 384 had received 1 shower throughout the residents stay at the facility and Resident 384 did not receive any type of bath on 1/7/24. The DON confirmed that Resident 384 did not get showers per the residents preference. The DON confirmed that Resident 384's bath preference was for 3 times per week for a shower. The DON confirmed that Resident 384 did not receive a shower after 1/4/24 and went a total of 8 days without a shower before the resident was discharged .

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 04577 Licensure Reference Number 175 NAC 12-006.09 Based on record review and interview, the facility failed to ensure monitoring was completed for change of resident condition for 1 [Resident 32] of 4 sampled residents. The facility has a total census of 126 residents. Findings are: A review of Resident 32's electronic medical record revealed Resident 32 was admitted to the facility on [DATE] with a diagnosis of unspecified Dementia. A review of Resident 32's Progress Note dated 3/13/24 at 6:03 PM revealed Resident 32 was being sent to emergency room for evaluation and treatment of left sided weakness, facial drooping, and slurred speech since 3/8/24. Resident 32's Progress Note dated 3/13/24 indicated Resident 32's physician was informed and verbal order was received to send to emergency room via 911. A review of Neurology Consult Note dated 3/14/24 identified a diagnosis of subacute CVA [Cerebral vascular accident]. In an interview on 3/18/24 at 12:14 PM, LPN [Licensed Practical Nurse] A reported that Medication Aide B had alerted LPN A that Resident 32 was having left sided weakness and slurred speech. LPN A had checked the tablet used to communicate with the health care provider group and found a note to the providers that had not been sent. LPN A reported calling the provider and receiving orders to send Resident 32 to the hospital. LPN A reported that LPN A's assessment indicated that Resident 32 had an obvious change in condition. LPN A reported that information is not being passed along to the next shift for follow up. In an interview on 3/18/24 1:14 PM, Medication Aide B reported on 3/13/24 Medication Aide B had been cleaning Resident 32's fingernails and Resident 32 would not use Resident 32's left hand. In an interview on 3/18/24 at 2:03 PM, LPN C reported that Resident 32 was noted to have some left sided weakness. LPN C reported that PA [Physician Assistant] D had evaluated Resident 32 on the day that changes were noted and determined it was an exacerbation of an old stroke. LPN C had reported PA D had directed LPN C to monitor Resident 32 for any changes. In an interview on 3/18/24 at 2:15 PM, PA D reported evaluating Resident 32 and finding no evidence of acute cardio or neurological changes. Resident 32's vital signs were ok and Resident 32 had no slurring of words. PA D reported that PA D did not hear any more about Resident 32 between the assessment and when Resident 32 was sent to the hospital. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of PA D's Progress Note for date of service on 3/8/24 revealed Resident 32 was evaluated after nursing staff identified light weakness in left hand compared to right. Under Assessment and Plan section of Progress Note, Resident 32 was noted to be functioning at baseline neurological with no outright signs or symptoms of CVA or TIA [Transient ischemic attack]. The Progress Note by the provider advised nursing staff verbally to continue to monitor Resident 32 and update provider on any change of status. In an interview on 3/19/24 at 6:37 AM, Medication Aide E reported being alerted to Resident 32 talking gibberish and left arm was not the same over the weekend of 3/9/24 to 3/10/24. Medication Aide E had been on the phone with ADON [Assistant Director of Nursing] F at the time and had informed ADON F of Resident 32's condition. ADON F directed Medication Aide E to notify nurse on duty of Resident 32's condition and have nurse evaluate Resident 32. In an interview on 3/19/24 at 6:52 AM, Nurse Aide G reported working the weekend of 3/9/24-3/10/24 and that Resident 32 wouldn't move left arm, left side of face was drooping and had slurred speech. Nurse Aide G reported alerting the nurse of Resident 32's change. In an interview on 3/19/24 at 7:55 AM, ADON F confirmed getting a call from Medication Aide E on the weekend of 3/9-24-3-10/24 regarding Resident 32. ADON F had directed Medication Aide E to inform the nurse to assess Resident 32 and contact the provider for any orders. ADON F reported that ADON F didn't hear any more about Resident 32 condition. A review of Resident 32's electronic medical record including assessments and progress notes between 3/8/24-3/11/24 did not reveal any documentation of an assessment being completed of Resident 32's condition. In a follow up interview on 3/19/24 at 11:01 AM, LPN C reported that PA D had directed LPN C to monitor Resident 32 and let PA D know of any changes. LPN C reported that LPN C had checked Resident 32 and there were no changes from when Resident 32 was evaluated by PA D. LPN C confirmed that LPN C did not document any assessment of Resident 32 in the electronic medical record. In a follow-up interview on 3/19/24 at 11:24 AM, ADON G reported an expectation that the assessment of Resident 32 should have been documented in Resident 32's medical record. In an interview on 3/19/24 at 3:32 PM, Regional RN [Registered Nurse] Consultant H reported an evaluation can be completed in the electronic medical record for a change in resident condition. This will result in an alert being generated for the 24 hour report in the electronic medical record that will alert the next shift that resident has had a change of condition. In an interview on 3/19/24 at 8:35 AM, the Director of Nursing confirmed an expectation that either a progress note or a change of condition evaluation should have been completed on Resident 32 when changes in condition were observed on 3/8/24.

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F 0686 Level of Harm - 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** 49164 Licensure Reference Number 175 NAC 12-006.09D2a Based on observation, record reviews and interview; the facility staff failed to implement interventions to prevent and treat pressure ulcer for 1 (Resident 87) of 5 sampled residents. The facility staff identified a census of 126. The findings are: A. Record review of Resident 87's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated 2-08-2024 revealed Resident 87 admitted to the facility on [DATE] with the diagnoses of Anemia, Atrial fibrillation, Hypertension, Gastroesophageal reflux Disease (GERD), thyroid disorder, Cerebrovascular Accident (stroke), Malnutrition, Hemiplegia (paralysis on one side of the body). Further review of Resident 87's MDS dated [DATE] revealed Resident 87 required Substantial/Maximal assistance with toileting, shower/baths, upper body dressing, lower body dressing, rolling left and right and go from a sitting to lying position. Resident 87 was dependent on staff form sitting to standing and chair to bed transfer. The facility staff identified Resident 87 was frequently incontinent of bladder. Resident 87's MDS dated [DATE] identified the resident as at risk for developing pressure ulcers and did not currently have a pressure ulcer. Record review of a Skin Only Evaluation ([NAME]) sheet dated 2-05-2024 revealed the facility staff had identified Resident 87 did not have any skin issues. Record review of Resident 87's Comprehensive Care Plan (CCP) printed on 3-19-2024 revealed the facility staff identified Resident 87 was at risk for skin impairment related to decreased mobility, muscle weakness, malnutrition, cancer and anemia. The goal identified for Resident 87 was to be free from pressure ulcers revised on 3-08-2024. Intervention identified on Resident 87's CCP printed on 3-19-2024 was to have the resident wear edema wear, encourage good nutrition and hydration, encourage the resident to wear Pravalon boots (a type of heel protection boots that lift the heel to help prevent the development of heel pressure injuries), Braden scale (a nursing assessment used to accurately identify pressure injury risk) upon admission, re-admission, weekly, quarterly, annually, and as needed. In addition, staff was to complete weekly skin inspections. Record review of Resident 87's Comprehensive Skin Sheet Evaluation (CSE) sheet dated 2-12-2024 revealed the facility staff evaluated Resident 87 with no skin issues. Record review of Resident 87's CSE sheet dated 2-19-2024 revealed the facility staff evaluated Resident 87 with no sin issues. Record review of a Skin Observation-Shower sheet for Resident 87 dated 2-28-2024 revealed Resident 87 was identified as having red areas and open area to Resident 87's left buttocks. (continued on next page)

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	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of Resident 87's practitioner orders, CCP, Progress notes, faxes, assessments revealed there were no additional CSE weekly skin evaluations completed. In addition, there was no indications the facility staff had followed up on the Skin Observation-Shower sheet dated 2-28-2024 that had identified Resident 87 had red and open areas to the left buttocks. Record review of Resident 87's medical record revealed the a Braden scale completed was on 2-5-2024. An observation on 3-25-2024 at 3:10 PM of Resident 87's skin during a dressing change being performed by LPN (Licensed Practical Nurse) -O revealed a dressing was observed on Resident 87's right buttock. LPN-O removed the soiled dressing revealing a moderate amount of red and brown drainage on it. The wound to the right buttock was approximately 2.5 centimeters in length and 1.5 centimeters in width, with an approximate depth of 0.1-0.2 centimeters. The wound edges were pink in color and the wound bed was beefy red with a drop of blood noted in the center of the wound bed. Skin to left buttock was intact and free of the presence of a wound dressing. LPN-O irrigated the wound with wound wash and patted the wound dry with a clean dry gauze sponge. LPN-O then applied hydrogel gauze to the wound bed and covered the area with a bordered foam dressing. During this observation on 3-25-2024 at 3:10 PM the wound nurse LPN-I was present and confirmed the correct dressing was applied to the pressure ulcer on the right buttock and did not have a pressure ulcer on the left buttock. Record review of Resident 87's order summary printed on 3-19-2024 revealed the facility received an order for wound care plus service to evaluate and treat Resident 87 on 3-6-2024. In addition, orders for wound care was to right buttock as follows: -cleanse wound with wound wash -apply hydrogel gauze -cover with bordered foam dressing daily at bedtime and as needed if the dressing was soiled dated 3-12-2024. Record review of Wound Care Plus's progress notes dated 03-07-2024 indicated that Resident 87 had a pressure ulcer to the right buttock that was a stage 3 (a full thickness tissue loss through the epidermis and dermis). Wound care orders were written on 03-07-2024 to cleanse wound with wound cleanser of facility choice, apply hydrogel sheet/gauze preferred, cover with bordered gauze change daily and as needed for soiling, saturation, or unscheduled removal. An interview with the DON on 3-26-2024 at 11:45 AM revealed that no other skin checks were performed by the facility staff between 02-28-2024 and 03-07-2024 when the Wound Care Plus practitioner evaluated Resident 87. The DON confirmed there was no follow up by nursing staff for the Skin Observation-Shower Sheet completed on 2-28-2024 and the one Braden Scale evaluation had been completed for Resident 87 was done on admission on 02-05-2024. (continued on next page)

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	285054	A. Building B. Wing	03/26/2024

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F 0686 Level of Harm - Actual harm Residents Affected - Few	Record review of an undated policy Pressure Injury Prevention and Management revealed the facility shall establish and utilize a systematic approach for the pressure injury prevention and management including prompt assessment and treatment; intervening to stabilize, reduce or remove underlying risk factors, monitoring the impact of the interventions and modifying interventions as appropriate. Licensed nurses will conduct a pressure injury assessment using the Braden Scale on all residents upon admission/readmission, then weekly for 4 weeks, then quarterly or whenever the resident's condition changes significantly. Licensed nurses will conduct a full body skin assessment on all residents upon admission/readmission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49164 Licensure Reference Number 175 NAC 12-006.09 Based on observation, record review and interview the facility staff failed to develop and implement a pain management program for 1 (Resident 134) of 2 residents sampled. The facility census was 129. Findings are: Record review of Resident 134's Progress Notes (PN) revealed Resident 134 admitted to the facility on [DATE] following hospitalization for spine surgery. According to Resident 134's PN dated 3-13-2024 revealed direct skilled nursing was required for inherent complexity of the care of surgical wounds or open lesions from spinal surgery. In addition, overall management and evaluation of the care plan required due to pain management with the resident receiving an as needed Oxycodone (a semi-synthetic narcotic pain medication). Record Review of Resident 134's admission Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) revealed a Brief Interview for Mental Status (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) score of 13 indicating indicating Resident 134 was cognitively intact. Record Review of Resident 134's order summary report of active orders as of 03-19-2024 revealed Resident 134 had a diagnosis of Scoliosis, Fusion of the Spine-Lumbar region, Athrodesis Status (surgical immobilization of a joint by fusion of the adjacent bones), Hypertension, hypothyroidism, neuralgia and neuritis, chronic kidney disease and pain. Active orders included an order for buprenorphine HCl (a synthetic opioid used to treat pain) 750 micrograms in the cheek every morning and bedtime for pain, pregabalin 150 mg (a medication used to treat nerve pain) by mouth 3 times a day for pain, Oxycodone 10 mg every 4 hours as needed for chronic pain, extra strength Tylenol 1000 mg 3 times a day as needed for pain/discomfort, and cyclobenzaprine 10 mg (a muscle relaxant) every 8 hours as needed for pain related to muscle spasms. Record review of Resident 134's Pain Evaluation (PE) sheet on 03-13-2024 revealed Resident 134 had pain rated at a 7, the location of the pain was the spine associated with the surgical incision on the back. Resident 134's PE sheet dated 3-13-2024 revealed the pain began after surgery with the pain described as dull, the pain had an effect on the resident's mood, repositioning and pain medication alleviated the pain. Resident 134 PE sheet dated 3-13-2024 revealed lying in the same position for a long time aggravates the pain. Treatment for pain was identified as Oxycodone 10 mg by mouth every 4 hours and as needed. Record Review of Resident 134's baseline care plan did not identify pain as a concern and did not identify an acceptable pain level or pain goal for Resident 134. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of Resident 134's Medication Administration Record (MAR) revealed the as needed Oxycodone was used 2-4 times a day prior to 03-20-2024 and non-pharmacological interventions were not used. Record Review of a handwritten note with Comprehensive Pain and Infusion Center letterhead dated 03-20-2024 revealed Resident 134 was able to be treated by a medical professional using their best clinical judgement for acute pain. This includes narcotics. Further review of the note dated 3-20-2024 revealed using the narcotic would not be a violation of the pain contract that Resident 134 was currently in. An observation of Resident 134 on 03-20-2024 at 8:50 AM revealed Resident 134 lying in bed, moaning. Resident 134 was grimacing and (gender) face was red. An interview was conducted with Resident 134 during this observation with Resident 134 reporting being up all night in pain and the staff told (gender) they were out of Oxycodone. Resident 134 rated the pain at a 7 on a 0-10 scale, 1-being the least amount of pain and 10-being the highest amount of pain. An interview with Licensed Practical Nurse (LPN) A on 03-20-2024 at 9:40 AM confirmed that there was no Oxycodone available for Resident 134 on the medication cart or in the facility Pyxis machine (an automated medication dispensing system that provides secure medication storage including narcotic medications). An interview with LPN A on 03-20-2024 at 11:00 AM revealed that Resident 134 had a pain contract with a pain specialist. LPN A stated not knowing what the pain contract entails or what Resident 134's acceptable pain level was. An interview conducted with Resident 134 on 03-20-2024 at 11:10 AM revealing Resident 134's acceptable pain level was a 5 and current Resident 134's pain level was a 8.5. An interview conducted with LPN A on 03-20-2024 at 1:15 PM revealed that the pharmacy called and said it would be a couple of hours before the Oxycodone arrived. LPN A confirmed that it was taking too long to get pain medication and Resident 134 did not have a pain management program that identified an acceptable pain level. An observation on 03-20-2024 at 3:15 PM revealed Resident 134 lying on their left side in bed revealing an approximated incision from the shoulder blades to the sacrum, with staples present. An interview with Resident 134 was conducted during this observation which revealed that (gender)refused to have the staples removed from the incision today due to the pain. An interview on 03-25-2024 at 11:42 AM with LPN N revealed LPN N did not know what Resident 134's acceptable pain level was, what the pain contract was for or what the interventions were to alleviate Resident 134's pain. An interview conducted on 03-25-2024 at 11:59 PM with the Director of Nursing (DON) confirmed the facility did not know about a pain contract with a pain specialist until 03-20-2024 when Resident 134 was out of the pain medication, Oxycodone. (continued on next page)

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	285054	A. Building B. Wing	03/26/2024

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record Review of an undated facility policy for Pain Management revealed the facility will use a systematic approach for recognition, assessment, treatment and monitoring of pain. For pain management and treatment, the facility in collaboration with the attending physician/prescriber, other health care professionals and the resident will develop, implement, monitor and revise as necessary interventions to prevent or manage each individual resident's pain beginning at admission. The interdisciplinary team and the resident will collaborate to arrive at a pertinent, realistic and measurable goal for pain.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 17285 Licensure Reference Number: 175 NAC 12-006.09D7a Based on observations, record review, and interview: the facility failed to assess the need for and resident safety regarding the continued use of a half sized side rail for 2 (Resident 2 and 20) of 2 residents reviewed for the use of side rails. This failure could potentially result in resident injury related to the gaps between the side rail and the mattress. The facility census was 126. Findings are: A. Record review of an undated facility policy entitled Proper use of bed rails revealed the following information: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. Definitions: - Bed Rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes and sizes ranging from full to one half, one quarter or one eighth lengths. - Entrapment is an event in which a resident is caught, trapped or entangled in the space in or about the bed rail. 1. As part of the residents comprehensive assessment, the following components will be considered when determining the need and whether or not the use of bed rails meets those needs: - a. Medical Diagnoses - b. size and weight - c. sleep habits - d. medications - e. Acute medical or underlying or surgical interventions - f. underlying medical conditions - g. Existence of delirium (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- h. Ability to toilet safely - i. Cognition - j. Communication - k. Mobility (in and out of bed) - l. Risk of falling 2. The resident assessment must also include an evaluation of the alternatives that were attempted prior to the installation or use of a bed rail and how these alternatives failed to meet the residents assessed need. 3. The resident assessment must also assess the residents risk from using bed rails. 4. The resident assessment should assess the residents risk of entrapment between the mattress and bed rail or in the bed rail itself. B. Record review of Resident 2's significant change MDS (Minimum Data Set, a federally mandated comprehensive assessment tool utilized to develop resident care plans) dated 1/19/24 revealed an admitted [DATE]. The MDS revealed Resident 2 had a Brief Interview for Mental Status (BIMS, a brief screener used to detect cognitive impairment) score of 04 (severe cognitive impairment), exhibited no mood or behavior problems and required substantial to maximum assistance with rolling right to left in bed and sit to stand in wheelchair. In the section of the MDS for Physical Restraints, the facility coded the resident had not used a bed rail during the assessment reference period (prior 7 days). The resident was identified as on Hospice (end of life care) while a resident. Record review of Resident 2's Clinical Census Report identifed that Resident 2 was admitted to Hospice on 1/9/24. Observations on 03/18/24 at 11:52 AM and 3/20/24 at 11:00 AM revealed the presence of a side rail that extended half the length of the bed that was attached to Resident 2's bed frame. There was a gap between the side rail and the mattress which measured 3 inches in width. The side rail was loose and was able to be moved back and forth while on the bed. Record review of Resident 2's Electronic Medical Record [EMR] including doctor orders, progress notes, assessments and miscellaneous documents revealed no assessment for the need for or the safety of the use of side rails for Resident 2. C. Record review of Resident 20's significant change MDS dated [DATE] revealed an admitted [DATE]. The MDS revealed Resident 20 was moderately cognitively impaired, exhibited no mood or behavior problems, required substantial to maximum assistance with rolling right to left in bed. In the section of the MDS for Physical Restraints, the facility coded the resident had not used a bed rail during the assessment reference period (prior 7 days). Record review of Resident 20's Clinical Census Report identifed that Resident 20 was admitted to Hospice on 10/19/23. (continued on next page)

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Observations on 03/19/24 at 12:32 PM and 3/20/24 at 6:15 AM revealed the presence of a side rail that extended half the length of the bed that was attached to Resident 20's bed frame. There was a gap between the side rail and the mattress which measured 3 inches in width. The side rail was loose and was able to be moved back and forth while on the bed. Record review of Resident 20's EMR including doctor orders, progress notes, assessments and miscellaneous documents revealed no assessment for the need for or the safety of the use of side rails for Resident 20. D. Interview on 3/20/24 at 11:00 AM with the Director of Nursing [DON] confirmed the presence of a half size bed rail on Resident 2 and 20's beds,. The DON confirmed that there was a 3 inch gap between the mattress and the bed rail on both beds and that this could pose a risk for entrapment if the residents were caught in the gap. The DON confirmed that no bed rail safety assessment had been completed for Resident 2 or 20 and that Hospice had brought out the beds for the residents with the bed rail attached when they were admitted to Hospice.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. 17285 Licensure Reference Number 175 NAC 12-006.04B2 Based on record review and interview, the facility failed to complete competencies for 7 (staff members C, T, U, V, W, X and Y) of 34 Licensed Practical Nurse [LPN] employees files, 2 (staff members Z, and AA) of 36 Registered Nurse [RN] employee files and 6 (staff members J, K, L, BB, CC and DD) of 122 Nurse Aide [NA] employee files. The files reviewed included both facility and agency staff. This had the potential to affect 126 residents that resided in the facility. The facility census was 126. Findings are: A. Record review of the Facility Assessment Tool dated 12/20/23 revealed the following information related to competencies: Staff are provided ongoing education utilizing online education, staff in services, conferences and competency/skills fair. Consider the following competencies (this is not an inclusive list): - Activities of daily living: Bathing (tub, shower, sitz), bed making (occupied and unoccupied), bedpan, dressing, feeding, nail and hair care, Perineal care (female and male), mouth care (brushing teeth or dentures), providing resident privacy, range of motion (upper and lower extremity), transfers, using gait belt, using mechanical lifts. - Infection control: Hand hygiene, isolation, standard universal precautions including use of personal protective equipment, MRSA / VRE / CDI precautions, environmental cleaning. - Medication administration: injectable, oral, subcutaneous, topical. - Resident assessment and examinations-admission assessment, skin assessment, pressure injury assessment, neurological check, lung sounds, nutritional check, observation of response to treatment, pain assessment. - Caring for persons with Alzheimers/Dementia - Specialized care -Catheterization insertion/care, colostomy care, diabetic blood glucose, testing, oxygen administration, suctioning, pre-op and post-op care, trachea care/suctioning, ventilator care, tube feedings, wound care/dressings. B. Record review of 4 LPN employee files of staff who had been here over a year and 3 agency employee LPN's revealed no competencies for care and services provided to residents had been completed or documented for 2023. There was no information related to competencies completed in the employee files. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Facility staff reviewed: - Staff Member U was hired on 4/11/17. - Staff member V was hired on 12/2/19. - Staff Member W was hired on 9/20/21. - Staff member X was hired on 4/4/16. Agency staff reviewed: - Staff Member C: see F 880 related to Hand Hygiene during medication administration. - Staff member Y - Staff member T : see F 880 related to wound care treatments. C. Record review of 2 RN employee files who had been here over a year revealed no competencies for care and services provided to residents had been completed or documented for 2023. There was no information related to competencies completed in the employee files. Facility staff reviewed: - Staff member Z was hired on 12/23/19. - Staff Member AA was hired on 12/22/20 D. Record review of 3 NA employee files who had been here over a year and 3 agency staff members revealed no competencies for care and services provided to residents had been completed or documented for 2023. There was no information related to competencies completed in the employee files. Facility staff reviewed: - Staff member BB was hired on 11/15/18. - Staff member CC was hired on 2/3/21. - Staff member DD was hired on 6/25/21. Agency staff reviewed: - Staff member K: see F 880 related to hand washing during pericare. - Staff member J: see F 880 related to hand washing during pericare. - Staff member L: see F 880 related to hand washing during pericare. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview on 3/19/20 at 1:48 PM with the Director of Nursing [DON] confirmed that the facility was unable to locate any competency checks that had been completed for their facility staff. The DON stated they had called the various agencies that the facility utilizes and none were able to provide competency checks for the agency staff. The DON confirmed that no competency checks were done with agency staff prior to entering and working in the building. Interview on 03/25/24 at 09:43 AM with the DON confirmed that Staff Members T, Y, C, K, J and L are agency staff. Cross reference 880

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50106 Licensure Reference Number 175 NAC 12-006.09D Based on record review, observations, and interviews, the facility staff failed to identify and monitor specific target behaviors for the use of an antipsychotic [a class of medications used to treat psychosis] medication for 2 (Resident 96 and 78) and failed to discontinue an antipsychotic medication per gradual dose reduction order for 1 (Resident 78) of 5 residents reviewed for unnecessary medications. The facility census was 126. Findings are: A. Review of the facility's Use of Psychotropic Medication Policy (with a copyright date of 2023 from The Compliance Store) revealed residents are not given psychotropic drugs unless the medication is necessary to treat a specific condition, as diagnosed and documented in the clinical record, and the medication is beneficial to the resident, as demonstrated by monitoring and documentation of the resident's response to the medication(s). Psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. Psychotropic drugs include but are not limited to the following categories: antipsychotics, antidepressants, anti-anxiety, and hypnotics. Residents who use psychotropic drugs shall receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. Review of the facility's Gradual Dose Reduction (GDR) of Psychotropic Drugs (with a copyright date of 2023 from the Compliance Store) revealed residents who use psychotropic drugs receive (GDR) and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. Definition of GDR is the stepwise tapering of a dose to determine if symptoms, conditions, or risks can be managed by a lower dose or if the dose or medication can be discontinued. B. Record review of Resident 78's Quarterly Minimum Data Set (MDS) (a federally mandated comprehensive assessment tool used to develop resident care plans) dated 1/5/24 revealed Resident 78's Brief Interview of Mental Status (BIMS) (a test to reveal a resident's cognitive status) revealed a score of 5. A score of 5 indicated the resident is severely cognitively impaired. Section D of the MDS revealed the resident had no mood or behavior issues identified. Section I revealed the following diagnoses: medically complex conditions, Anemia, Coronary Artery Disease, Heart Failure, Hypertension, Diabetes Mellitus, Hyperlipidemia, non-Alzheimer's Dementia. Record review of Resident 78's census tab in Resident 78's Electronic Management System (EMS) revealed Resident 78 was admitted to Hospice on 7/1/23. (continued on next page)

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	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	2525 South 135th Avenue Omaha, NE 68144

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 78's Care Plan (CP) dated 7/25/2023 indicated Resident 78 had Mood Distress-Depression. According to Resident 78's CP dated 7/25/2024, Resident 78 demonstrated a significant mood distress and a difficult time adjusting to placement and changes in roles/status. in addition, Resident 78 had a diagnosis of adjustment disorder with mixed anxiety and depressed mood. The goal identified for Resident 78 was to remain free of signs and symptoms. The interventions identified on Resident 78's CP to manage mood and anxiety were as follows: -will verbalize the thoughts and feelings that contribute to remaining depressed - administer medications as ordered -monitor and document side effects and effectiveness, monitor/document/report to Nurse/MD signs and symptoms of depression, including hopelessness, anxiety, sadness, negative statements, repetitive anxious or health-related complaints, tearfulness,. -provide Resident #78 time to talk as needed and encourage Resident 78 to express feelings. Further review of Resident 78's CP dated 7/25/2023 revealed there were not any targeted behaviors for the antipsychotic medication (Quetiapine). Record review of Resident 78's Physician's Order Summary as of 3/20/24 revealed Resident 78 is on the following antipsychotic medication: Quetiapine tab 25 milligrams (mg), take 1/2 TAB (12.5 mg) by mouth at bedtime for unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety. Record review of Resident 78's Gradual Dose Reduction dated 6/16/23 revealed Quetiapine was to be discontinued on 6/20/2023 when the GDR was signed by the physician. Record review of Resident 78's Medication Administration Records (MAR) from June 2023 through March 2024 revealed Resident 78 received Quetiapine 12.5 mg at bedtime every day. Observations of Resident 78 on 3/18/24 at 10:00 AM, 3/19/24 at 7:00 AM, 3/20/24 at 6:00 AM, 8:00 AM and 11:30 AM revealed Resident 78, no disruptive or negative behaviors were noted. A interview with Director of Nursing (DON) was conducted on 3/20/24 at 11:40 AM. During the interview the DON reported there was no behavior charting currently done for residents on psychotropic medications. DON confirmed there was a discontinue order for the quetiapine 12.5 mg at bedtime for Resident 78 signed by the physician on 6/20/23 that was not implemented. 17285 C. Record review of Resident 96's Clinical Census report revealed Resident 98 was admitted to the facility on [DATE] and resided on the secured unit of the facility. Record review of Resident 96's quarterly MDS dated [DATE] revealed that Resident 96 had diagnose of: Alzheimer's disease, Non-Alzheimer's dementia, depression, psychotic disorder and unspecified dementia with other behavioral disturbance. The MDS indicated Resident 96 was severely cognitively impaired, exhibited wandering behaviors 1 to 3 days during the look back period of the MDS (past 7 days) and used an anti-psychotic medication daily. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident 96's Physician Orders revealed Resident 96 was prescribed Seroquel (Quetiapine Fumarate) (an antipsychotic medication) Oral Tablet 50 mg, give 1 tablet by mouth three times a day for psychosis on 11/13/23. Record review of Resident 96's Physician Orders revealed Resident 96 was prescribed Seroquel Oral Tablet 25 mg 1 tablet 3 times per day on 11/20/23, give together with 50 mg to equal 75 mg total. Observations of Resident 96 on 03/18/24 at 12:40 PM, 03/19/24 at 12:50 PM and 03/20/24 at 11:47 AM revealed the resident was in the activity/dining area on the secured unit of the facility. No negative behaviors were observed at the time of the observations. Record review of Resident 96's most recent Medication Administration record [MAR] dated February and March 2024 showed that the Seroquel was provided in accordance with the physician orders. Record review of resident 96's Electronic Medical Record [EMR] including physician orders, progress notes, nurse aide task documentation and progress notes revealed no target behaviors had been identified and no monitoring for behaviors had been completed for the use of the antipsychotic medication. Record review of Resident 96's Physician Orders dated 3/21/24 revealed the following: - Monitor for the following targeted behaviors r/t (related to) the use of anti-psychotic medication.- fear/paranoia - hallucinations. -Document: yes if any of the above are observed and add a progress note including intervention used Document no if monitored and none of the above was observed every shift for Medication Management. Interview on 03/20/24 at 11:47 AM with the DON confirmed that specific target behaviors had not been identified and there was no behavior monitoring completed for the continued use of the Seroquel prior to 3/20/24 for Resident 96.

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	285054	A. Building B. Wing	03/26/2024

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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** 49164 Licensure Reference Number 175 12-006.10D Based on observation, interview, and record review the facility failed to ensure residents were free of significant medication errors for 1 (Resident 137) of 8 sampled residents. The facility census was 126. Findings are: Record review of Resident 137's Minimum Data Set (MDS, a federally mandated assessment tool used for care planning) dated -3-11-2024 revealed Resident 137 admitted to the facility on [DATE] with diagnoses of Seizure Disorder-Epilepsy, Anemia, Arthritis, Cerebrovascular Accident, Depression, and Asthma. The MDS also revealed Resident 137 had a Brief Interview of Mental Status score (BIMS, an assessment that aids in detecting cognitive impairment. A score of 0-7 equals severe impairment, 8-12 indicates moderate impairment and 13-15 indicates cognitively intact) of 15 indicating Resident 137 was cognitively intact. An interview with Resident 137 on 03-18-2024 at 2:17 PM revealed Resident 137 was concerned that (gender) was not getting all the medications ordered for seizures. During the interview with Resident 137 on 3-18-2024 at 2:17 PM Physician's Assistant (PA) D entered Resident 137 room and discussed the benefit of going to the hospital to see Resident 137's neurologist today for seizures rather than wait for the scheduled appointment on 04-02-2024. Record Review of Resident 137's Medication Administration Record (MAR, a tool for tracking administration of medications and missed doses for whatever reason) for the month of March 2024 revealed active orders for the following medications: -Clobazam 10 milligram (mg), give 1.5 tablet by mouth 2 times a day for Epilepsy -Lamotrigine 250 mg by mouth 2 times a day for Epilepsy -Levetiracetam 1000 mg give 2 tablets by mouth 2 times a day for Epilepsy -Gabapentin give 400 mg by mouth 4 times a day for neuralgia -Midazolam Nasal Solution 5 mg per 0.1 milliliter (ml) give 1 spray in alternating nostrils as needed for seizures related to Epilepsy. Additionally, Resident 137's MAR indicated that there was a missed dose of Clobazam in the morning on 03-16-2024 as staff were waiting for the pharmacy to deliver the medication. Record Review of a Progress Note by PA D with a date of service of 03-18-2024 revealed Resident 137 was on a significant anti-seizure regimen that includes 5 different medications. The medications identified in this regimen are as follows: (continued on next page)

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	285054	A. Building B. Wing	03/26/2024

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Lamotrigine 250 mg 2 times a day (an anti-epileptic medication). -Levetiracetam 2000 mg 2 times a day (an anticonvulsant medication). -Clobazam 15 mg 2 times a day (sedative medication). -Gabapentin 400 mg 4 times a day (anticonvulsant medication). -Midazolam nasal spray 5 mg/0.1 ml give 1 spray in alternating nostrils for seizure activity as needed. In addition, the Progress note by PA D dated 03-18-2024 revealed that Resident 137 did not receive the scheduled morning dose of Clobazam on 03-16-2024 due to awaiting delivery of the medication from the pharmacy. PA-D discussed with Resident 137's neurologist and the medical director and both agreed that hospitalization was appropriate at the time. Record Review of an Order Administration note dated 03-19-2024 revealed Resident 137 was sent to the hospital for recurrent seizures to be immediately (STAT) evaluated by Resident 137's neurologist. Record review of the facility's undated policy titled Medication Errors identified a Significant Medication Error as an error which causes the resident discomfort or jeopardizes the resident's health and safety. The factors indicating errors in medication administration include medication administration not in accordance with the Prescribers' order such as omission of the medication. Record review of the facility's undated policy title Unavailable Medications revealed staff shall take immediate action when it is known that a medication is not available to notify the physician to obtain alternative treatment and/or specific orders for monitoring the resident while the medication is on hold An interview with LPN A on 03-20-2024 at 12:00 PM confirmed that the morning dose of Clobazam was missed on 03-16-2024, and the physician should have been notified to provide an alternative treatment for Resident 137. LPN A further confirmed missing a dose of seizure medication was a significant medication error for Resident 137.

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	285054	A. Building B. Wing	03/26/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 17285 Licensure Reference Number 175 NAC 12-006.11E Based on observations, record review and interview; the facility kitchen staff failed to utilize handwashing and gloving techniques during food preparation to prevent potential food borne illness and failed to maintain the kitchen equipment/floors in clean manor and in good repair. This had the potential to effect 126 residents who ate food from the kitchen. The facility staff identified a census of 126. Findings are: A. Observation on 03/20/24 between 7:10 AM and 7:30 AM during preparation of breakfast revealed the following hand washing concerns: -Cook II cooked eggs, stopped and went to the walk-in refrigerator for more eggs, performed hand hygiene for 7 seconds, donned new gloves then returned to the prep area and continued cooking eggs. -Dietary Aide JJ took soiled dishes into the dish room, performed hand hygiene for 8 seconds, donned new gloves and returned to the food preparation area. Interview on 03/20/24 at 8:50 AM with the Dietary Manager confirmed the expectation of 20 second hand wash between tasks and prior to performing any type of food preparation, and after returning from the soiled dish area. The DM confirmed that the expectation is that hands are to be washed before applying gloves. The DM confirmed that the Cook II and Dietary Aide JJ did not wash their hands for a long enough period of time in accordance with the expectations and the facility policy. Observations on 3/20/24 between 10:15 AM and 10:30 AM during preparation of puree foods revealed the following hand washing concerns: -Cook II prepared puree Salisbury steak. Cook II placed 3 portions of steak into the Robo coup with gloved hands and pureed the meat. Cook II stopped, removed the soiled gloves, went to the sink for hot water for broth, performed hand hygiene for 7 seconds, donned new gloves then returned to the prep area and finished making the puree meat. Observation on 3/20/24 at 10:50 AM revealed Dietary Aide KK poured drinks with gloves on. Dietary Aide KK took the pitchers to the soiled dish area, returned to prep area and started rolling clean silverware with no hand hygiene performed. Interview on 3/20/24 at 11:00 AM with the DM confirmed that Cook II did not perform hand hygiene for a long enough period of time and Dietary Aide KK did not wash hands after returning from the soiled dish area and prior to touching clean silverware. Observation on 03/20/24 between 7:10 AM and 7:30 AM with the DM, District Manager for Dietary and the Registered Dietician revealed the following concerns with the sanitation in the kitchen: (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Walk in freezer: floor tiles stained brown, broken and missing, several particles of food on the floor. -Walk in refrigerator: Shelves were corroded with a rust colored substance and portions of the metal coating were peeled away. -Burnt, black food spatters were present on the back splash of the stove, front of stove and side of the steamer next to the stove. -Grease and food particles were present on the attached shelf above the stove. -The pan drying rack was corroded with a rust colored substance and portions of the metal coating were peeled away. -Two green food transport carts had food and liquid spatters present on the interior of the carts. Interview on 3/20/24 at 7:50 AM with the DM confirmed the observed concerns with the sanitation in the kitchen: -Walk in freezer: floor tiles stained brown, broken and missing, several particles of food on the floor. -Walk in refrigerator: Shelves were corroded with a rust colored substance and portions of the metal coating were peeled away. -Burnt, black food spatters were present on the back splash of the stove, front of stove and side of the steamer next to the stove. -Grease and food particles were present on the attached shelf above the stove. -The pan drying rack was corroded with a rust colored substance and portions of the metal coating were peeled away. -Two green food transport carts had food and liquid spatters present on the interior of the carts. Record review of weekly cleaning schedules between 3/11/24 and 3/17/24 identified that ovens/ stove tops were signed off as cleaned last on 3/17/24 and back splash polished was signed off as cleaned daily with the last time being documented on 3/17/24. Interview on 03/21/24 at 08:36 AM with the facility Administrator revealed that all 126 that resided in the facility ate foods prepared in the facility kitchen. Record review of the undated facility policy Tilted Policy and Procedure Manual Hand Washing. Policy: Employees will wash hands as frequently as needed throughout the day using proper hand washing procedures (and surrogate prosthetic device washing procedures as appropriate). Hand washing facilities will be readily accessible and equipped with hot and cold running water, paper towels, and/or automatic hand dryer, soap trash cans and signage outlining hand washing procedures. If chemical sanitizing gels are used, staff must first wash hands as outlined hand as outlined below. (continued on next page)

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	285054	A. Building B. Wing	03/26/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	-Procedure: Hands and exposed portions of arms (or surrogate prosthetic devices) should be washed immediately before engaging in food preparation. -2. How to wash hands: --C) Scrub well with soap and additional water as needed, scrubbing all areas thoroughly. Pay close attention to the fingernails using a brush as needed. Scrub for a minimum of 10 to 15 seconds within the 20 second-hand washing procedure. Apply vigorous friction between fingers and fingertips. Rinse with clean, running warm water.

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	285054	A. Building B. Wing	03/26/2024

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 17285 Licensure Reference Number 175 NAC 12-006.07 Based on record review and interview, the facility failed to ensure the Quality Assurance Performance Improvement Program [QAPI, a facility process that identifies problems in the facility and works to correct the concerns] identified and addressed concerns related to deficient practice cited on the current annual survey 2024 (F 580, 604, 609, 677, 684, 686, 697, 700, 726, 758, 760, 812, 867, 880 and 909) and repeat deficient practice from previous surveys (684 x 1 year, 812 x 4 years and 880 x 2 surveys). This had the potential to affect all 126 residents that resided in the facility. The facility census was 126. Findings are: A. Record review of a facility policy entitled Quality Assurance and Performance Improvement Plan revised February 2020 revealed the following information: The facility shall develop, implement and maintain ongoing, facility wide, data driven QAPI program that is focused on indicators of the outcomes of care and quality of life for our residents. The objectives of the QAPI Program are to: - 1. Provide a means to measure current and potential indicators for outcomes of care and quality of life. - 2. Provide a means to establish and implement performance improvement projects to correct identified negative or problematic indicators. - 3. Reinforce and build upon effective systems and processes related to the delivery of care and services. - 4. Establish systems through which to monitor and evaluate corrective actions. Implementation: 2. The QAPI plan describes the process for identifying and correcting quality deficiencies. Key components of the process include: - a. Tracking and measuring performances - b. Establishing goals and thresholds for performance - c. identifying and prioritizing quality deficiencies - d. Systematically analyzing underlying causes of systemic improvement activities (continued on next page)

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	285054	A. Building B. Wing	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	- e. Developing and implementing corrective actions and performance improvement activities and - f. Monitoring or evaluating the effectiveness of corrective actions / performance improvement activities and revising as needed. The committee meets monthly to review reports, evaluate data and monitor QAPI activities and make adjustments to the plan. B. Observations, record reviews and interviews during the current annual survey of the facility between 3/14/24 and 3/26/24 revealed the following identified deficient practice: - F 580 Notify family of changes in resident condition. - F 604: Physical restraints related to seatbelts. - F 609: Abuse allegation reporting to state agency. - F 677: ADL bathing assist. - F 684: Monitoring for change in condition (repeat x 1 year). - F 686: Pressure ulcer treatments, monitoring. - F 697: Pain management. - F 700: Bed rails no assessment. - F 726: Staff competencies. - F 758: Behavior monitoring for use of Antipsychotic medication. - F 760: Significant medication error. - F 812: Kitchen: sanitary conditions / hand hygiene (repeat x 4 years). - F 867 Quality Assurance (repeat x 2 years). - F 880: Hand Hygiene / gloving during cares, treatments, medication pass (repeat x 2 years). - F 909: Bed rail maintenance. Interview on 03/25/24 12:42 PM interview with the facility Administrator revealed the facility had no active Performance Improvement Programs [PIP, a program designed to identified concerns in the facility with ongoing monitoring to correct] right now in the building. Interview on 03/26/24 at 07:44 AM with the facility Administrator confirmed that the QAPI process had not identified the current deficient practices and had not maintained correction for repeated tags.

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	285054	A. Building B. Wing	03/26/2024

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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** 04577 Licensure Reference Number: 175 NAC 12-006.17B Based on observations, record review and interview; the facility staff failed to implement infection control precaution to prevent the spread of infectious disease for 1 (Resident 100) and failed to utilized handwashing and gloving techniques during the provision of care and treatments for 3 (Resident 120, 41 and 80). The total sample size was 12. The facility staff identified a census of 126. Findings are: A. Review of Resident 100's electronic medical record revealed Resident 100 was admitted on [DATE]. Diagnoses list in electronic medical records identified a diagnosis of Extended Spectrum Beta Lactamase Resistance [an enzyme found in some strains of bacteria that is antibiotic resistant] during stay dated 3/11/24. A review of Resident 100's Urinalysis result dated 12/27/23 showed moderate Leukocyte Esterase [white blood cells] with specimen forwarded for culture and sensitivity. A review of Resident 100's Urine Culture Result dated 12/29/23 revealed microbiology results of Escherichia coli ESBL [Extended Spectrum Beta Lactamase] greater than 100,000 cfu/ml [colony-forming unit per milliliter]. A review of 12/23 Monthly Infection Surveillance log revealed Resident 100's urinary tract infection from 12/28/23 was noted on the log with a notation that no culture was completed. In an interview on 3/18/24 at 10:35 AM, RN [Registered Nurse] Infection Preventionist reported being unaware that Resident 100 had tested positive for ESBL in 12/23. RN Infection Preventionist reported that Resident 100 was not placed in isolation at the time. In an interview on 3/18/24 at 11:07 AM, the DON [Director of Nursing] confirmed Resident 100's Urine Culture was positive for ESBL in 12/23. In further interview on 3/20/24 at 8:32 AM, the DON reported that the procedure for an ESCL infection would be to place resident an individual room. If an individual room is not available, resident could be placed with someone that doesn't use the restroom or cohorted with another resident with ESBL. 49164 B. Record Review of the facility's undated policy titled Transmission-Based (Isolation) Precautions defines contact isolation as measures that intended to prevent transmission of infectious agents which are spread by direct or indirect contact with the resident's environment. Included in the policy was Type and Duration of Transmission-Based Precautions Recommended for Selected Infections and Conditions that indicated for Clostridium Difficile use contact precautions for the duration of the illness and that Hand hygiene was to be done with soap and water. (continued on next page)

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	03/26/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record Review of Resident 120's Order Summary Report printed on 03-20-2024 revealed Resident 120 was admitted to the facility on [DATE] with active diagnoses of Enterocolitis due to Clostridium Difficile, (C-Diff, a gram positive bacteria that creates spores that are hard to get rid of and causes diarrhea and inflammation of the colon) Wedge Compression Fracture of Thoracic-11 and Thoracic-12 vertebra, Wedge Compression Fracture of the First Lumbar Vertebra, Unspecified Fracture of the Sacrum, Unspecified Fracture of Pubis, Celiac Disease, Anemia, Gastro-Esophageal Reflux Disease (GERD). The report also revealed Resident 137 has difficulty walking and needs assistance with personal care. Included in Resident 137's active orders was an order for Isolation-Contact Precautions, every shift. Reason for isolation: C. Diff. An observation of the signs outside of Resident 120's room revealed on the sign was: CONTACT PRECAUTIONS revealed the following information: - Everyone must clean their hands including before entering and when leaving the room. Included was a picture of a bottle with the abbreviation ABHR (Alcohol-Based Hand Rub). - Providers and staff must also put on gloves before entering the room and to discard the gloves before room exit the room. - Put on gown before room entry and to discard gown before room exit. The posted information also instructed staff/providers not to wear the same gown and gloves for the care of more than 1 person. Continuous observation on 3-20-2024 from 6:05 AM to 6:25 AM revealed Nursing Assistant (NA) S applies PPE outside of Resident 120 door after using ABHR. NA S enterer Resident 120's room revealing Resident 120 was lying in bed. NA S explains that it was time to check Resident 120's brief and preceded to remove brief and confirmed that Resident 137 was having a bowel movement. After cleaning Resident 120 and applying a new brief, NA S went to the bathroom and removed the soiled gloves and applied clean gloves. NA S went to Resident 120's bedside and assisted in placing a pillow under Resident 120's legs and covering (gender) with blankets. NA S went to Resident 120's the door, removed gloves and gown and placed them in the trash then used ABHR from the dispenser in the room located right next to the door. An observation on 03-20-2024 at 8:02 AM revealed Occupational Therapist (OT) M used ABHR, applied gloves and gown and entered Resident 120's room. OT M assisted Resident 120 to the bathroom with a walker and assisted Resident 120 with personal hygiene while Resident 120 was standing at the sink. Once completed OT M assisted Resident 120 with walker back to a wheelchair in the room. OT M removed the gloves and gown and placed them in the trash and used ABHR from the dispenser located right next to Resident 120's door. A interview was conducted on 03-20-2024 at 8:02 AM with OT M. During the interview OT M confirmed using ABHR to performed hand hygiene after leaving Resident 120's room. An interview with conducted LPN (Licensed Practical Nurse) A on 03-20-2024 at 8:20 AM. During the interview LPN A confirmed the sign outside the door directed staff to use ABHR. LPN A also stated Resident 120 was on contact precautions for C. Diff and ABHR was not effective to prevent the transmission of C. Diff and hand washing with soap and water must be used. (continued on next page)

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	03/26/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Banyan at Montclair	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	An interview conducted on 3-20-2024 at 3:45 PM with Regional Registered Nurse H confirmed that hand hygiene must be done with soap and water for C. Diff. 47733 C. Record review of Resident 41's Treatment Administration Record (TAR) for March 2024 revealed Resident 41 readmitted to the facility on [DATE]. Further review of Resident 41's TAR for March 2024 revealed Resident 41 had pressure ulcers to the left Ischium with treatment orders to cleanse the wound with wound wash. Apply collagen pad to wound and apply Medi honey alginate to wound bed. Staff were then to apply fluff gauze to wound and cover with super absorbent pad. The order further instructed staff to secure the pad with tape. Record review on 3/20/24 of Resident 41's treatment orders revealed: 1) Left Ischium- Cleanse wound with wound wash. Apply collagen pad to wound. Apply Medi honey alginate (medication used to aid in wound healing) to wound bed, honey side to wound bed. Apply fluff gauze to wound. Cover with super absorbent pad, secure with tape. one time a day for Wound care, and as needed for Accidental removal. 2) Sacrum- Cleanse with wound wash. Pat dry. use skin prep on peri wound. Apply collagen pad to wound bed. Apply Medi honey alginate to wound bed, honey side to wound. Apply fluff gauze packed into wound. Cover with super absorbent dressing. Secure with tape. One time a day for Wound care, and as needed for Accidental removal. Observation on 3/20/24 at 6:54 AM with Assistant Director of Nursing (ADON)-F revealed LPN T entered Resident 41's room to perform a wound treatment to 2 pressure ulcers on the resident's sacral area and left ischium. LPN-T grabbed dressing packages without hand hygiene and opened the packages onto Resident 41's bed. LPN-T proceed to put one glove on without hand hygiene walked over to Resident 41's bed and touched a soiled pad with the gloved hand. LPN-T then removed the glove and balled it up in LPN-T's hand. LPN-T left Resident 41's room to locate another pad and did not complete hand hygiene. LPN-T returned to Resident 41's room and put on gloves without completing hand hygiene ,removed a soiled dressing and applied wound cleanser to the sacral wound. LPN-T did not change gloves between removing the soiled dressing and applying wound cleanser to the sacral wound. LPN-T returned to opening clean dressing packages onto the resident's sheets after reaching into the pocket with the soiled gloves. LPN-T then touched Resident 41's pad, grabbed clean gauze, with the same soiled gloved hands, cut a dressings with the same soiled gloved hands. LPN-T wiped the sacral wound with a gauze pad, without changing the soiled gloves or completing hand hygiene. LPN-T without changing the soiled gloves and completing hand hygiene opened a dressing package and another package of collagen filler powder with the same soiled gloves. LPN-T after cutting dressing to size, placed the collagen filler powder on the dressing LPN-N then with the same soiled gloves placed the dressing with the collagen filler to the outside of Resident 41's wound. A interview on 3/20/24 at 8:00 AM was conducted with ADON-F. During the interview ADON-F confirmed LPN did not change gloves and perform hand hygiene during the treatment for Resident 41. A interview with LPN-T was conducted on 3/20/24 at 8:30 AM. During the interview LPN-T confirmed no hand hygiene was completed before and during the treatment for Resident 41. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	50106 D. Record review of Resident 80's Minimum data set (MDS, a federally mandated assessment tool used for care planning) dated 2/1/24 revealed a Brief Interview of Mental status (BIMS) score of 12. according to the MDS [NAME] a score of 8 to 12 indicates a person is moderately cognitively impaired. Section GG of the MDS revealed resident is dependent for toileting hygiene and is dependent for bed mobility. Section H revealed resident is occasionally incontinent of urine and is always continent of bowel. Section I revealed the following diagnoses: hypertension, diabetes mellitus, aphasia, non-Alzheimer's dementia, and depression. Observation on 3/20/2024 at 1:09 PM with ADON-F revealed NA K and ADON-F completed hand hygiene and donned gloves. NA-K pulled down Resident 80's adult brief in preparation for personal care. NA-K removed 2 wipes from the container and cleansed Resident 80's left groin with one of the wipes and used the second wipe to cleanse Resident 80's right groin area. NA-K without changing the soiled gloves obtained a cleaning wipe retracted Resident 80's foreskin and cleansed the area. NA-K without changing the soiled gloves and completing hand hygiene obtained a cleaning wipe and cleansed Resident 80's scrotum. NA-K removed the soiled gloves completed hand hygiene for 6 seconds and donned a pair of gloves. NA-K and ADON-F assisted Resident 80 into a right laying position. NA-K obtained a wiped and cleansed buttocks and rectal area. NA-K removed the soiled gloves and completed hand hygiene for 8 seconds. NA-K donned gloves, obtained a cream an applied it to Resident 80's buttock and without changing the soiled gloves applied an adult brief to Resident 80 buttocks and rolled the resident onto a back laying position. NA-K removed the soiled gloves and without hand hygiene donned a pair of gloves and applied cream to Resident 80's scrotum. NA-K removed the soiled gloves and completed handwashing for 3 seconds. A interview with NA-K was conducted on 3/20-2024 at 1:40 PM. during the interview NA-K confirmed hand hygiene should be performed for 20 seconds when using soap and water. NA-K confirmed the wipe's package did become contaminated with removal of the wipes with dirty gloves and further confirmed hand hygiene should be done with each glove change.

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Regularly inspect all bed frames, mattresses, and bed rails (if any) for safety; and all bed rails and mattresses must attach safely to the bed frame. 17285 Licensure Reference Number 175 NAC 12-006.18B3 Based on observation and interview, the facility failed to routinely check bed rails [a bar that is attached to the bed frame and is used to provide assistance with pulling oneself up in bed] for security and maintain documentation of preventative maintenance for 10 (Beds in resident rooms 104 A, 107 B, 109 B, 111 A 309 B, 310 A, 317 B, 403 A, 403 B, 803) of 134 occupied resident beds in the facility. The facility census was 126. Findings are: A. Record review of an undated facility policy entitled Proper use of bed rails revealed the following information: It is the policy of this facility to utilize a person-centered approach when determining the use of bed rails. Appropriate alternative approaches are attempted prior to installing or using bed rails. If bed rails are used, the facility ensures correct installation, use and maintenance of the rails. Definitions: Bed Rails are adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes and sizes ranging from full to one half, one quarter or one eighth lengths. Installation and Maintenance of bed rails: 12. The facility will assure the correct installation and maintenance of the bed rails prior to use. This includes: - a. Checking with the manufacturer to make sure the bed rails, mattress and bed frame are compatible. - b. Ensuring the beds dimensions are appropriate for the resident by: i. Confirming that the bed rails are the appropriate for the size and weight of the resident. ii. Installing bed rails using manufacturers instructions and specifications to ensure a proper fit. iii. Inspecting and regularly checking the mattress and bed rail for possible entrapment. iv. Ensuring the bed frame, bed rail and mattress do not leave a gap wide enough to entrap a residents head or body, regardless of mattress width, length and / or depth. (continued on next page)

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F 0909 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	v. Checking the bed rails regularly to make sure they are installed correctly and have not shifted or loosened over time. - d. Conducting routine preventative maintenance of beds and rails to ensure they meet safety standards and are not in need of repair. B. Observations on 03/18/24 at 11:52 AM and 3/20/24 at 11:00 AM revealed the presence of a bed rail that extended half the length of the bed that was attached to Resident 2's bed frame. There was a gap between the side rail and the mattress which measured 3 inches in width. The bed rail was loose and was able to be moved back and forth while on the bed. C. Observations on 03/19/24 at 12:32 PM and 3/20/24 at 6:15 AM revealed the presence of a bed rail that extended half the length of the bed that was attached to Resident 20's bed frame. There was a gap between the side rail and the mattress which measured 3 inches in width. The bed rail was loose and was able to be moved back and forth while on the bed. D. Interview on 3/20/24 at 11:00 AM with the Director of Nursing [DON] confirmed the presence of a half size bed rail on Resident 2 and 20's beds,. The DON confirmed that there was a 3 inch gap between the mattress and the bed rail on both beds. The DON confirmed that Hospice had brought out the beds for the residents with the bed rail attached when they were admitted to Hospice. The DON confirmed that the bed rails could easily be moved back and forth and were loose. E. Record review of a list of residents that had bed rails present on their beds was provided by the Director of Maintenance [DOM]. The list included the following resident beds: 104 A, 107 B, 109 B, 111 A 309 B, 310 A, 317 B, 403 A, 403 B and 803. F. Interview on 3/20/24 at 01:20 PM with the Director of Maintenance [DOM] confirmed that the bed rails on the beds in resident rooms 104 A, 107 B, 109 B, 111 A 309 B, 310 A, 317 B, 403 A, 403 B and 803 were present on the beds and that routine checks on the beds and the rails had not been completed.