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	12/16/2025

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to ensure all food stored in the facility's kitchen was labeled, sealed, and/or dated, ensure food was discarded that was past it's use-by date, and failed to ensure all kitchen equipment was clean and sanitized. This had the potential to affect all residents that consume food from the kitchen.A record review of the facility's Food Safety Requirements with a date reviewed/revised of 5/2025 revealed facility staff shall inspect all food, product, and beverages for proper storage to include labeling, dating, and monitoring food so it is used by its use by date. All equipment used shall be cleaned and sanitized. A.An observation on 12/10/2025 at 7:12 AM - 8:04 AM The True 2 door reach-in fridge contained a bag of a green leafy substance that was not labeled or dated. The true 2 door reach-in fridge by the double ovens had contained a plastic bag of brown patties that was not labeled and dated and 1 gallon container of Mayonnaise that had been opened with no open date. The walk-in refrigerator contained one personal can of Pepsi and one 5-pound container of low fat cottage cheese that had a best if used by date of 11/22/25. There were three 6.5-pound cans of [NAME] Country Style Gravy with a Best Buy date of September 14, 2025 on the can rack in the dry storage rack. The dry storage contained 1 large, opened bag of all-purpose flour sealed or dated. An observation on 12/10/2025 at 8:04 AM with the Dietary Manager (DM) revealed all of the above listed items were not labeled, dated, and/or sealed and there were items past their use-by date. In an interview on 12/10/2025 at 8:04 AM, the DM confirmed all of the above listed items were not labeled, dated, and/or sealed and should have been, or were past their use-by date and should have been discarded. B.An observation on 12/10/2025 at 7:12 AM - 8:04 AM revealed the bottoms of the [NAME] double oven contained a black crust. The True 2 door reach-in refrigerator's (fridge) by the back exit had vents on the bottom front that had food splatters throughout. The true 2 door reach-in fridge by the double ovens had vents on the bottom front that contained food splatters and debris. The large commercial mixer and stand had food debris and splatters on it. The walk-in refrigerator contained an internal thermometer that had a black slimy substance on it. The walk-in freezer floor had food debris and kernels of corn scatter throughout. Ther was a black cart by the walk-in freezer that contained food debris. The drawers on the prep table by the walk-in fridge and freezers contained food debris. The top and front of the milk cooler by the back door contained food splatters on the top and front. The ceiling vent by the back door and one in the dry storage area contained a thick gray fuzzy substance. There was 1 box of Grove Cranberry Juice Cocktail on the floor and 1 box of Marinara Sauce on the floor in the dry storage area. One opened large bag of all-purpose flour not labeled dated sealed. It was labeled. An observation on 12/10/2025 at 8:04 AM with the Dietary Manager (DM) revealed all of the above listed items were not clean. In an interview on 12/10/2025 at 8:04 AM, the DM confirmed all of the above listed items were not clean and should have been.

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 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. Licensure Reference Number 175 NAC 12.006.02(H) Based on observation, interview, and record review, the facility failed to ensure Adult Protective Services (APS) was notified within 2 hours of an allegation (a statement, made without giving proof, that someone has done something wrong) of potential abuse for 1 (Resident 51) of 3 sampled residents. The total facility census was 113. Findings are:A record review of the facility's Abuse, Neglect, and Exploitation policy with a Date Reviewed/Revised of 8/4/25 revealed an alleged violation is: A situation or occurrence that is observed or reported by staff, resident, relative, visitor, or others but has not yet been investigated and, if verified, could be noncompliance with the Federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property. Reporting of all alleged violations to the Administrator, state agency, adult protective services would be done immediately, but no later than 2 hours after the allegation was made if the allegation involves abuse, or result in serious bodily injury. A record review of Resident 51's Comprehensive Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 11/28/2025 revealed the resident was admitted to the facility 04/04/2023. The resident had a Brief Interview for Mental Status (BIMS)(a score of a resident's cognitive abilities) of 15 which indicated the resident was cognitively aware (able to think and comprehend). The resident required supervision or touching assistance with eating, oral and personal hygiene (cleaning), and was dependent on staff for all other activities of daily living and mobility. The resident did not have behaviors, and it was very important to the resident to choose their own bedtime. A record review of the facility's un-named investigation form dated 12/10/25 at 12:20 PM revealed that was the date and time that APS was contacted and the Notification to Administrator/Director of Nursing (DON) was at 9:00 AM. An observation on 12/10/2025 at 9:33 AM revealed Resident 51 was lying in bed and appeared upset. An observation on 12/10/2025 at 9:42 AM revealed Registered Nurse (RN)-D was on the phone with the administration and overheard the RN-D tell the administration that the resident reported a nursing assistant (NA) bumped Resident 51's head against the side rail of the bed during cares last night. An observation on 12/10/2025 at 11:13 AM revealed staff just got Resident 51 up into the wheelchair. The resident pointed to an area on the right side of the forehead where the resident's head was bumped against the bed rail, and the resident did have a dime size diameter (round) raised area on the right side of the forehead 1 inch in front of a dark mole. In an interview on 12/10/2025 at 9:33 AM Resident 51 confirmed the resident felt afraid or humiliated by the staff because a staff member was rough during a brief change early that morning and rolled the resident toward the window and the resident hit the resident's forehead on the bedrail. The resident confirmed the resident reported the staff member being rough and hitting the resident's head on the bed rail to the nurse that was on during the interview, but the resident confirmed the resident was just trying to be peaceful. In an interview on 12/10/2025 at 9:36 AM, RN-D confirmed Resident 51 did report a staff member last night was rough and bumped the resident's face into the bed rail. RN-D confirmed the resident told RN-D the resident was hit on the right upper forehead. RN-D confirmed the resident did not know the staff member's name and that RN-D had not reported the incident to anyone. In an interview on 12/10/2025 at 9:46 AM, RN-D confirmed RN-D was on the phone with the Director of Nursing (DON) and told the DON about the situation. RN-D confirmed Resident 51 told RN-D what happened with the staff member during RN-D's medication pass which was at about 8:46 AM. In an interview on 12/10/2025 at 11:13 AM, Resident 51 confirmed that staff had not been in to talk to the resident about the incident with the staff member during the morning brief change. The resident confirmed the staff member came in and woke the resident up to change the resident's brief and that is when the staff member came in acting all ugly. The resident was not afraid to be in the facility but would not let that staff member help the resident again. He confirmed it seemed like (gender) was in a (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	rage. When the staff member got ready to change the resident diaper the staff member rolled the resident over, and the resident was trying to stop the staff member, but the staff member kept pushing. The resident confirmed he told the staff member to stop, the staff member was pushing the resident's head against the rail. The resident confirmed the resident still had a little knot on the resident's head. He confirmed the staff member was getting mad and the resident was getting mad, so told the staff member to stop. In an interview on 12/10/2025 at 11:37 AM, the DON confirmed the RN-D called the DON that morning and the DON thought RN-D told the DON that Resident 51 bumped the resident's hand on the bedside table and that RN-D did not see any injuries. RN-D was going to assess the resident and call the doctor. In an interview on 12/10/2025 at 11:48 AM, RN-D confirmed RN-D spoke to the DON on the phone that morning and told the DON that Resident 51 reported that the NA on the night shift bumped the resident's head on the siderail, on the upper forehead above the right eyebrow. The resident did not give RN-D a name or description of the NA. The resident said the NA turned the resident too far and hit the resident's head on the bedrail. In an interview with the facility's Administrator confirmed the Regional Director of Operations (RDO) was on the phone at the time of the interview and the RDO called APS about the allegation on 12/10/2025 at 12:20 PM. In an interview on 12/15/2025 at 2:35 PM, the DON confirmed that if there was an allegation of potential abuse, APS should be contacted within 2 hours of a person reporting it to a staff.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Licensure Reference Number 12-006.09(H)(vi)(3)g Based on observation, interview and record review the facility failed to ensure oxygen and BiPap orders were obtained and followed for 1 (Resident 73) of 4 residents sampled. The facility census was 113. The findings are:Record review of the facility policy titled Noninvasive Ventilation (CPAP, BiPAP, AVAPS, Trilogy) dated 05-20-2025 revealed it is the policy of this facility to provide noninvasive ventilation as per physician's orders and current standards of practice. BiPAP or bi-level positive airway pressure, is a respiratory therapy intervention that delivers an inhale pressure and an exhale pressure to provide a patent airway. It requires a machine that generates the separate pressures through a tube into a mask that fits over the nose or mouth. A personal BiPAP device may be brought into the facility for the resident's use. If brought in, the nurse/respiratory therapist will verify the settings on the machine prior to use. Record review of Resident 73's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 10-30-2025 revealed the facility staff assessed the following about the resident:-had a diagnosis of morbid obesity with alveolar hypoventilation (a condition where excess weight impairs breathing and requires a treatment of positive airway pressure).-Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicated a person is cognitively intact. -had a noninvasive mechanical ventilator.-had shortness of breath while lying flat.-required extensive assistance with bathing and lower body dressing.-required total assistance with toileting, bed mobility and transfers. Record review of Resident 73's After Visit Summary (AVS) dated 10-24-2025 revealed an order for BIPAP AUTO, use every night as directed. Settings 14/6 and back up rate 16. Record review of Resident 73's Comprehensive Care Plan (CCP: a document describing agreed goals of care, and outlining planned medical, nursing and allied health activities for the resident.) dated 10-24-2025 revealed Resident 73 had impaired respiratory status and was at risk of shortness of breath, respiratory distress, increased anxiety and hypoxia. Interventions the staff were to use included the BiPAP per order and to ensure settings and supplementary oxygen are correct each time the device is applied. An observation conducted on 12-10-2025 at 8:15 AM revealed Resident 73 had a BiPAP machine on the bedside table next to the bed. An interview conducted with Resident 73 on 12-16-2025 at 9:20 AM revealed the facility staff attach supplementary oxygen to the BiPAP when the machine is used. An interview conducted on 12-16-2025 with Registered Nurse (RN) F at 10:05 am revealed Resident 73's BiPAP machine was brought from home and the staff at the facility do not program or adjust the settings on BiPAP machines. The machine is either brought from home with the settings already programmed or the facility has their respiratory company come to the facility and set up the machine. An observation on 12-16-2025 at 10:10 am of RN F checking Resident 73's BiPap revealed the inability to verify BiPAP machines settings. An interview with the Regional Nurse Consultant (RNC) on 12-16-2025 confirmed Resident 73's BiPAP machine had not had the settings verified by facility's respiratory company and the facility had not obtained orders for supplementary oxygen to be used with the BiPAP. The RNC confirmed this should have been done and wasn't.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. .Based on record review and interview, the facility failed to evaluate and identify situational triggers for post -traumatic stress disorder [PTSD, a psychological reaction occurring after experiencing a highly stressing event (such as wartime combat, physical violence, or a natural disaster) that is usually characterized by depression, anxiety, flashbacks, recurrent nightmares, and avoidance of reminders of the event] for 1 (Resident 12) of 2 residents reviewed. The facility census was 113. Findings are:Record review of a facility policy entitled Trauma Informed Care dated 3/25/25 revealed the following information: It is the policy of this facility to provide care and services which, in addition to meeting professional standards, are delivered using approaches which are culturally competent, account for experiences and preferences, and address the needs of trauma survivors by minimizing triggers and / or re-traumatization. Trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual wellbeing. Common sources of trauma may include but are not limited to: Natural and human caused disasters, accidents, rape, violent crime, physical, sexual, mental and /or emotional abuse past or present, war, history of imprisonment, history of homelessness, traumatic life events (death of a loved one. Personal illness etc). Trauma informed care is an approach to delivering care that involves understanding, recognizing and responding to the effect of all types of trauma. A trauma informed approach to care delivery recognizes the widespread impact and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures and practices to avoid re-traumatization. 2. The facility will use a multi-pronged approach to identifying a resident's history of trauma, as well as his/her cultural preferences. This will include asking the resident about triggers that may be stressors or may prompt recall of a previous traumatic event, as well as screening and assessment tools, such as the RAI [Resident assessment instrument, a document published by the Centers for Medicare & Medicaid Services (CMS) to facilitate accurate and effective resident assessment practices in long-term care facilities], admission assessment, the history and physical, the social history / assessment and others. 4. The facility collaborates with resident trauma survivors, and as appropriate the family and physician and other health professionals such as mental health professionals to develop and implement individualized care plan interventions. 6. The facility will identify triggers which may re-traumatize residents with history of trauma. Trigger specific interventions will identify ways to decrease the resident's exposure to triggers which re-traumatize the resident, as well as identify ways to mitigate or decrease the effect of the trigger on the resident and will be added to the residents' care plan. 7. Trauma specific care plan interventions will recognize the interrelation between trauma and symptoms of trauma such as substance abuse, eating disorders, depression and anxiety. These interactions will also recognize the survivors need to be respected, informed, connected and hopeful regarding their own recovery. 8. The facility will evaluate whether the interventions have been able to mitigate or reduce the impact of identified triggers on the residents that may cause re-traumatization. The resident and/or his or her family or representative will be included in this evaluation to ensure clear and open discussion and better understand if interventions must be modified. 10. In situations where a trauma survivor is reluctant to share their history, the facility will still try to identify triggers which may re-traumatize the resident and develop care plan interventions which minimize or eliminate the effect of the trigger on the resident. Record review of Resident 12's Face Sheet dated 12/11/25 revealed an admission date of 9/30/16 with diagnoses that included PTSD chronic, unspecified Dementia unspecified severity without behavioral disturbance, psychotic disturbance mood disturbance and anxiety, Bipolar Disorder[mental illness characterized by mood changes], Schizoaffective Disorder [mental health condition that combines symptoms of schizophrenia such as hallucination with mood disorder symptoms like depression or mania [elevated or irritable mood], Major Depressive Disorder and (continued on next page)

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Anxiety Disorder. Record review of Resident 12's most recent quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 10/30/25 identified that Resident 12 exhibited short- and long-term memory problems and modified independence with decision making with some difficulty in new situations only. The resident exhibited no mood concerns, and no behaviors were exhibited. Diagnoses identified on the MDS included PTSD, anxiety, Depression, Bipolar Disorder and Schizophrenia. The MDS identified that Resident 12 took antipsychotic [a class of medications used to manage psychosis in Schizophrenia], antidepressant and antianxiety medications daily. Record review of Resident 12's Electronic Medical Record [EMR], including progress notes, clinical assessments and the Comprehensive Care Plan {a document that includes measurable objectives and timetables to meet a resident's medical, nursing and mental and psychosocial needs] dated 10/27/25 revealed no evaluation for PTSD had been completed for Resident 12. The EMR and CCP did not identify situational triggers or specific interventions that would identify ways to decrease Resident 12's exposure to triggers which could re-traumatize the resident. Interview on 12/15/25 at 3:27 PM with the Regional Nurse Consultant [RNC] confirmed that Resident 12 had a diagnosis of PTSD. The RNC confirmed there was no history of trauma identified in the EMR and PTSD had not been evaluated and should have been. The RNC confirmed that Resident 12's CCP did not identify situational triggers or specific interventions that would identify ways to decrease Resident 12's exposure to triggers.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. Licensure Reference Number 175 NAC 12-006. 09(H)Based on record review and interview, the facility failed to hold blood pressure medications according to prescribed blood pressure parameters for 2 (residents 1 and 3) of 5 sampled residents. The facility census was 113. Findings are: A. A record review of the facilities Medication Administration policy with a revision date of 10/15/25 revealed the following: Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. A record review of the facilities Unnecessary Drugs-Without Adequate Indication for Use policy with a revision date of 11/4/24 revealed the following: Information gathered during the initial and ongoing evaluations will be incorporated into the resident's comprehensive care plan that reflects person-centered medication related goals and parameters for monitoring the residents condition, including the likely medication effects and potentials for adverse consequences. A record review of Resident 3's quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and help nursing home staff identify health problems) dated 11/28/25 revealed the Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 15. According to the MDS manual, a BIMS score of 15 indicated that the residents had intact cognition. Further review of the MDS revealed a diagnosis of coronary artery disease, heart failure, and hypertension. A record review of Resident 3's Medication Administration Record (MAR) dated 11/2025 and 12/2025 revealed an order for Metoprolol Tartrate 25 milligram (mg) Give 0.5 tablet by mouth two times a day related to essential hypertension. Hold medication if pulse (p) is below 60 and/or Systolic Blood Pressure (SBP, the top number in a blood pressure reading) is below 110 and or Diastolic Blood Pressure (DBP, the bottom number in a blood pressure reading) is below 60. Further review of Resident 3's MAR revealed the following medication administration outside of parameters: -11/2/25 AM bp 106/63, p50, -11/4/25 PM bp 105/66, p84, -11/9/25 AM bp 101/59, p55, -11/9/25 PM bp 101/59, p55, -11/11/25 AM bp 109/71, p54, -11/17/25 PM bp 108/57, p50, -11/21/25 PM bp 111/62, p50, -12/1/25 PM bp 104/62, p66, (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-12/13/25 PM bp 95/80, p71. In an interview on 12/16/25 at 7:13 AM the Director of Nursing (DON) confirmed that the administration of Metoprolol on 11/2/25 AM, 11/4/25 PM, 11/9/25 AM & PM, 11/11/25 AM, 11/17/25 PM, 11/21/25 PM, 12/1/25 PM, and 12/13/25 was given outside of parameters and should not have been administered. B. Record review of Resident 1's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 11-20-2025 revealed the facility staff assessed the following about the resident: -Had a diagnosis of orthostatic hypotension (a sudden drop in blood pressure when moving from sitting to standing). -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13 to 15 indicated a person was cognitively intact. -Required supervision with eating, bathing, toileting and transfers. Record review of Resident 1's Comprehensive Care Plan (CCP) dated 08-07-2024 revealed Resident 1 had hypotension. The interventions the staff were to use included giving medications as ordered, monitor for side effects and effectiveness, and obtain vital signs (blood pressure, pulse, respiration rate, temperature) as ordered. Record review of Resident 1's Medication Administration Record (MAR) for November 2025 printed on 12-11-2025 revealed an order dated 03-24-2025 for hydralazine (a blood pressure medication) 25 milligram (mg) tablet, give 1 tablet 3 times a day for a Systolic Blood Pressure (SBP: the top number of a blood pressure reading) of greater than 160 or a Diastolic Blood Pressure (DBP: the bottom number of a blood pressure reading) greater than 90. Further review of the November 2025 MAR revealed on the following dates hydralazine was administered outside of the prescribed parameters: -11-03-2025 at 9 AM Blood Pressure (BP) was 125/83. -11-03-2025 at 9 PM BP was 112/66. -11-06-2025 at 9 PM BP was 119/86. -11-07-2025 at 9 PM BP was 132/76. -11-08-2025 at 9 AM BP was 125/78. -11-09-2025 at 9 AM BP was 98/53. -11-12-2025 at 2 PM BP was 128/87. -11-14-2025 at 9 PM BP was 105/65. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-11-15-2025 at 9 PM BP was 130/79. -11-16-2025 at 9 PM BP was 125/79. -11-17-2025 at 9 AM BP was 120/62. -11-17-2025 at 2 PM BP was 120/62. -11-19-2025 at 9 PM BP was 82/48. Record review of Resident 1's November 2025 MAR revealed an order dated 11-25-2025 for Midodrine 5 mg tablet give 1 tablet 3 times a day for hypotension hold if SBP is greater than 120 while sitting. Further review of the November 2025 MAR revealed on the following dates Midodrine was administered outside of the prescribed parameters: -11-26-2025 at 8 PM BP was 134/96. -11-28-2025 at 8 PM BP was 145/89. -11-29-2025 at 2 PM BP was 145/82. An interview conducted with the Regional Nurse Consultant on 12-16-2025 at 10:55 AM confirmed the midodrine and the hydralazine medications were administered outside of the prescribed parameters, should have been held and wasn't.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Licensure Reference Number 175 NAC 12-006.10(D)Based on observation, record review, and interview, the facility failed to ensure a medication error rate of less than 5%. Observation of 25 medications revealed 4 errors with a resulting error rate of 16%. The medication errors are related to 1 (Resident 100) of 4 sampled residents. The facility census was 113.Findings are:A record review of the facilities Medication Administration policy with a revision date of 10/15/25 revealed the following: Obtain and record vital signs, when applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation A record review of the facilities Medication Errors policy with a revision date of 8/16/25 revealed the following: The facility must ensure that it is free of medication error rates of 5% or greater as well as significant medication error events. A record review of Resident 100's medication administration record (MAR) dated 12/2025 revealed the following:-Tylenol Extra Strength Oral Tablet 500 milligrams (mg) (Acetaminophen) Give 2 tablet via Percutaneous Endoscopic Gastrostomy (PEG)-Tube (a feeding tube in the stomach that can be accessed outside the body) three times a day for pain with scheduled administration times of 8:00 AM, 2:00 PM, and 10:00 PM.-Clonidine HCl Oral Tablet 0.2 mg (Clonidine HCl) Give 1 tablet via PEG-Tube two times a day for hypertension (HTN). Hold for Systolic Blood Pressure (SBP, the top number in a blood pressure reading) less than (<)100.-Amlodipine Besylate Oral Tablet 5 mg (Amlodipine Besylate) Give 1 tablet via PEG-Tube one time a day for HTN. Hold for SBP<130-Valproic Acid Oral Solution 250 mg/5 milliliter (ml) (Valproate Sodium) Give 5 ml via PEG-Tube two times a day related to adjustment disorder with depressed mood. An observation on 12/16/25 at 9:22 AM revealed Licensed Practical Nurse (LPN)-G dispensed two tablets of Tylenol, one tablet of clonidine, one tablet of amlodipine and placed each medication into a clear pouch. LPN-G crushed each medication and dumped the pouch into a medication cup. LPN-G grabbed a bottle of valproic acid with another resident's name on it and poured it into a medication cup. LPN-G entered the resident's room and mixed each medication cup with water and administered the medications through the PEG-tube. LPN-G did not obtain a blood pressure for the amlodipine or clonidine. LPN-G administered the Tylenol 1 hour and 22 minutes after the scheduled administration time. LPN-G administered the valproic acid to Resident 100 after LPN-G obtained the medication from another resident's pharmacy dispensed medication bottle.In an interview on 12/16/25 at 10:40 AM, LPN-G confirmed that valproic acid of another resident was administered to Resident 100. LPN-G confirmed that Tylenol was administered outside of the administration window. LPN-G further confirmed a blood pressure was not obtained with the Amlodipine and Clonidine and should have been.

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	12/16/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure reference: 175 NAC 006.11 Based on observation, interview and record review, the facility failed to ensure to physician's ordered diet was followed for 1 [Resident 122] of 1 sampled resident with orders for a renal diet. The facility had a total census of 113. Findings are:A review of Resident 122's admission Record revealed Resident 1 was admitted to the facility on [DATE] with a diagnosis of dependence on renal dialysis and end stage renal disease [a stage of impairment that appears irreversible and permanent]. A review of Resident 122's order summary revealed an order dated 12/3/25 of a renal diet with regular texture and thin liquid consistency. A review of Resident 122's care plan revealed an intervention of providing and serving diet as ordered. Observations on 12/11/25 at 12:22 PM revealed Resident 122 with lunch tray. Resident 122's lunch included chicken, cornbread, macaroni and cheese, Brussel sprouts, and pumpkin pie. A review of facility menu for 12/11/25 and Resident 122's 12/11/25 tray ticket revealed residents on a renal diet were to be served buttered macaroni noodles in place of macaroni and cheese and butterscotch pudding in place of pumpkin pie. Observations on 12/15/25 at 8:37 AM revealed Resident 122 with breakfast tray. Resident 122's breakfast included French toast casserole, bacon, oatmeal, and chocolate milk. A review of facility menu for 12/15/25 and Resident 122's 12/15/25 tray ticket revealed residents on a renal diet were to be served 2 slices of French toast in place of French toast casserole and 1/4 cup scrambled eggs in place of the bacon. In an interview 12/15/25 at 2:11 PM, Registered Dietitian I reported that menu modifications from the regular diet automatically print out on the resident's tray ticket. In an interview on 12/15/25 at 2:31 PM, the Dietary Manager confirmed that Resident 122 should have received the menu items for the renal diet and the renal diet needed to be followed. A review of facility Diet and Nutrition Care Manual dated 2021 revealed the following regarding the Renal Dialysis Diet:- Individuals placed on this diet are often limited in the amount of sodium, fluid, potassium and phosphorus they can consume. Protein and calorie needs may be increased depending on the individual's health, weight, laboratory parameters and dialysis therapy.

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	285054	A. Building B. Wing	12/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12.006.18(B)Licensure Reference Number 175 NAC 12.006.19(A)(i) Based on observation, interview, and record review, the facility failed to ensure staff transported clean linen in a manner to prevent potential cross contamination, ensure clean sheets were utilized for Resident 70, and failed to ensure Resident 1's nebulizer (neb)(a machine used to deliver aerosolized medications to the lungs) administration kit was cleaned after each use. The facility census was 113. Findings are: A. An observation on 12/15/2025 at 7:29 AM revealed Medication Aide-A exited the laundry room and walked down the 100 hallway to Resident 11's room with unbagged, clean, bedding draped over MA-A's left arm and against MA-A's hand and clothing. An observation on 12/15/2025 at 2:55 PM revealed NA-B exited the dining room and walked to the South side of building into the resident care areas with unbagged, clean, linens being carried between NA-B's left arm and chest against NA-B's clothing. In an interview on 12/15/2025 at 2:56 AM, the facility's Regional Director of Operations (RDO) confirmed the staff should not have carried clean linens against the staff member's body or clothing. D. A record review of the facility's Nebulizer Therapy policy with a Date Reviewed/Revised of 8/24/25 revealed that the neb equipment should be cleaned after each use. When the medication delivery was complete, the staff should disassemble and rinse the neb kit with sterile or distilled water and allow it to air dry. Once it was completely dry, it should have been stored in a zip lock bag. A record review of Resident 1's Clinical Physician's Orders dated 12/11/2025 revealed Resident 1 had an order for Sodium Chloride Inhalation Nebulization Solution 3 percent (%) four times per day. A record review of Resident 1's Medication Administration Record (MAR) dated [DATE] revealed the Sodium Chloride Inhalation Nebulization Solution 3 percent (%) was administered four times per day on 12/09/2025 – 12/15/2025 during the morning (AM) medication pass, 2:00 PM, 4:00 PM, and HS (hours of sleep). An observation on 12/10/2025 at 2:07 PM revealed Resident 1 had a nebulizer on the table between the bed and recliner that had the neb kit draped over it and the kit had a residual (small, leftover) amount of medication in the kit, and the mask had facial oils on it. An observation on 12/11/2025 at 3:15 PM revealed Resident 1's neb kit was draped over the nebulizer on a table in front of the resident's window and it had a residual amount of medication in the kit, and the mask had facial oils on it. An observation on 12/15/2025 at 9:12 AM revealed Resident 1's neb kit was laying on the ledge below the window, and it had a residual amount of medication in the kit, and the mask had facial oils on it. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 12/15/2025 at 3:17 PM, Registered Nurse (RN)-F confirmed Resident 1's neb kit was supposed to be cleaned after each treatment and it had not been. C. Observation on 12/15/2025 at 9:08 AM with NA [Nurse Aide] E on the secured unit of the facility revealed NA-A carried a set of clean sheets and towels to room [ROOM NUMBER]. The clean sheets and towels were draped across NA-E's bare forearm. Interview on 12/15/25 at 9:15 AM with NA-E confirmed that clean linens should not be carried in contact with the staff member's arm. D. Record review of Resident 70's most recent quarterly Minimum Data Set (MDS, a federally mandated comprehensive assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) dated 12/3/25 revealed an admission date of 4/18/24 with Diagnoses that included Non-Alzheimer's Dementia and Psychotic Disorder [severe mental illnesses characterized by disconnection from reality]. The MDS identified that Resident 70 was independent with transfers and ambulation and was occasionally incontinent of urine. Observation on 12/10/2025 at 8:02 AM revealed sheets on the bed in room [ROOM NUMBER]-B for Resident 70 were heavily soiled with a large, circular yellow brown substance that resembled a dry urine ring. Observation on 12/10/2025 at 12:25 PM revealed sheets on the bed in room [ROOM NUMBER]-B for Resident 70 were heavily soiled with a large, circular yellow brown substance that resembled a dry urine ring. Observation on 12/11/2025 at 2:36 PM revealed sheets on the bed in room [ROOM NUMBER]-B for Resident 70 were heavily soiled with a large, circular yellow brown substance that resembled a dry urine ring. Observation on 12/15/2025 at 7:05 AM revealed sheets on the bed in room [ROOM NUMBER]-B for Resident 70 were heavily soiled with a large, circular yellow brown substance that resembled a dry urine ring. Observation on 12/15/2025 at 9:08 AM with NA-E observed and confirmed that the sheets in Resident 70's were soiled with a large, dried urine ring and needed to be changed. NA-E confirmed that the sheet smelled of urine when the comforter was pulled back. Interview on 12/15/25 at 9:15 AM with NA-E confirmed that Resident 70's sheets were soiled with a large, dried urine ring and needed to be changed. NA-A confirmed the sheet smelled of urine when the comforter was pulled back.