STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	285218	A. Building B. Wing	04/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Cypress at Midtown	910 South 40th Street Omaha, NE 68105

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 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. Licensure Reference Number 175 NAC 12.006.11(E) Based on observation, interview, and record review, the facility failed to ensure all food stored in the facility's kitchen was labeled, dated, and/or sealed, ensure refrigerators (fridge) and freezers did not contain expired products to prevent foodborne illness, and ensure the interior bottom, bottom vents of refrigerators and freezer, top of the double door oven, and all dishes, plates, and serving containers were stored and maintained in a clean and sanitary manner to prevent cross contamination. This had the potential to affect all residents that consumed food prepared in the facility kitchen. The total facility census was 49. Findings are:A record review of the facility's Food Safety Requirements with a date reviewed/revised of 10/2025 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 record review of the facility's Sanitation Inspection policy with date reviewed/revised date of 10/2025 revealed all food service areas would be kept clean and sanitary. A.An observation on 04/27/2026 at 5:55 AM to 6:28 AM revealed:The Atosa 2 door reach-in fridge contained: - 1 pack of a white substance not labeled. - 1 large Zip Lock style bag that contained a white substance not sealed or labeled. - 1 pack of yellow slices wrapped in plastic wrap not labeled or dated. - 1 large Zip Lock style bag that contained a package labeled turkey breast that was opened, not dated. - 1 steam pan that contained a plastic and aluminum foil wrapped substance not labeled or dated. - 1 bag of a brown slices of a substance, not labeled. - 2 half pint containers of 1% chocolate milk with a use by date of 04/20/2026. - 1 gallon jug of 2% chocolate milk with an expiration date of 04/26/2026. - 3 bags of green items not labeled or dated.The Advantco 2 door reach-in freezer contained: - 1 open Zip Lock style bag that contained a brown substance that was not labeled. An observation on 04/27/2026 at 6:28 AM with the facility's Cook-D revealed:The Atosa 2 door reach-in fridge contained: - 1 pack of a white substance not labeled. - 1 large Zip Lock style bag that contained a white substance not sealed or labeled. - 1 pack of yellow slices wrapped in plastic wrap not labeled or dated. - 1 large Zip Lock style bag that contained a package labeled turkey breast that was opened, not dated. - 1 steam pan that contained a plastic and aluminum foil wrapped substance not labeled or dated. - 1 bag of a brown slices of a substance, not labeled. - 2 half pint containers of 1% chocolate milk with a use by date of 04/20/2026. - 1 gallon jug of 2% chocolate milk with an expiration date of 04/26/2026. - 3 bags of green items not labeled or dated.The Advantco 2 door reach-in freezer contained: - 1 open Zip Lock style bag that contained a brown substance that was not labeled. In an interview on 04/27/2026 at 6:28 AM, the facility's Cook-D confirmed that all the above items were not labeled, dated, and/or sealed and should have been. In an interview on 04/28/2026 at 6:46 AM, the facility's Certified Dietary Manager (CDM) confirmed the CDM observed all the listed items above on 04/27/2026 and the items were not labeled, dated, or sealed and should have been. B.An observation on 04/27/2026 at 5:55 AM to 6:28 AM revealed: - The Atosa 2 door reach-in fridge bottom vents contained lint, food debris, and food splatters. - The Advantco 2 door reach-in freezer bottom vents contained lint, food debris, and food splatters. - The True single door reach-in fridge interior bottom contained food debris and food splatters, and the bottom vent contained lint, food debris, and food (continued on next page)

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

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

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	splatters. - The top of the Sunfire double-door oven contained food debris. - The shelves on the North side of the kitchen by the dish machine contained small plates, bowls, and thermal plate containers all with the potential food contact surfaces facing up and uncovered. An observation on 04/27/2026 at 6:28 AM with Cook-D revealed: - The Atosa 2 door reach-in fridge bottom vents contained lint, food debris, and food splatters. - The Advantco 2 door reach-in freezer bottom vents contained lint, food debris, and food splatters. - The True single door reach-in fridge interior bottom contained food debris and food splatters, and the bottom vent contained lint, food debris, and food splatters. - The top of the Sunfire double-door oven contained food debris. - The shelves on the North side of the kitchen by the dish machine contained small plates, bowls, and thermal plate containers all with the potential food contact surfaces facing up and uncovered. In an interview on 04/27/2026 at 6:28 AM, the facility's Cook-D confirmed that all the above equipment contained lint, food debris, or food splatters and the food serving items on the shelves by the dish machine were stored upright and uncovered and should have been food-serving side down. In an interview on 04/28/2026 at 6:46 AM, the facility's Certified Dietary Manager (CDM) confirmed the CDM observed all the above equipment contained lint, food debris, or food splatters and the food serving items on the shelves by the dish machine were stored upright and uncovered and should have been food-serving side down.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(G) Based on interview and record review, the facility failed to ensure a gradual dose reduction (GDR),tapering of a dose of medication) was completed in the required timeframe for 1 (Resident 1) of 4 sampled residents' duloxetine (a medication used to treat depression), monitor for behaviors and adverse consequences (negative outcomes), and document non-pharmalogical interventions related to 1 (Resident 1) of 4 sampled residents' duloxetine and trazodone (a medication used to treat depression that can be used to treat insomnia) medications. The facility census was 49. Findings are:A.A record review of the facility's Gradual Dose Reduction of Psychotropic Drugs policy with a date reviewed/revised of 10/2026 revealed that a resident's psychotropic (medication that alters one's mind) medications would receive a GDR and behavioral interventions unless clinically contraindicated (cause a return of behavioral symptoms). A GDR should be completed after the first year of use unless it was clinically contraindicated or the physician provided a rational (reason) why it should not be attempted. A record review of Resident 1's Clinical Census dated 04/28/2026 revealed the resident was admitted to the facility on [DATE]. A record review of Resident 1's Medical Diagnosis dated 02/12/2026 reveled the resident had diagnoses of Adjustment Disorder With Mixed Anxiety And Depression and Insomnia (a sleep disorder). A record review of Resident 1's Minimum Data Set (MDS)(a comprehensive assessment used to develop a resident's care plan) dated 03/23/2026 revealed 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 understand). The resident was independent with person and oral hygiene (cleaning) and upper body dressing, required setup or clean-up assistance with eating, partial/moderate assistance with bathing. Substantial/maximal assistance with lower body dressing, and dependent on staff for toileting hygiene and footwear. The resident required substantial/maximal assistance with bed mobility and was dependent on staff for transfers. The resident did not have behavior symptoms. A record review of Resident 1's Care Plan Report with an admission date of 04/22/2025 revealed the resident demonstrated behavioral concerns with a revision date of 03/31/2026, and staff was to monitor and document behavior episodes and interventions. The resident used Black Box (warnings issued highlighting serious risks of the drug) medications and staff was to monitor for adverse reactions and report. The resident used psychotropic medications related to the mood disorder with anxiety and depression and had interventions to review the GDR as needed, the pharmacist would review the medications and forward suggestions to the physician, and the facility would monitor and document target behaviors, mood, or nursing staff problems. A record review of Resident 1's Clinical Physician Orders dated 04/28/2026 revealed the resident had orders for duloxetine, one 60 milligram (mg) delayed release capsule, with a start date of 05/28/2024. The original start date for the duloxetine was 03/20/2026 at one 20 mg capsule, on 05/20/2024 the dose was increased to one 30 mg capsule, then the dose was increased to 60 mg on 05/28/2024. A record review of the facility pharmacy's Study of Psychoactive by Resident dated 11/05/2025 revealed Resident 1 was on 20 mg duloxetine(an antidepressant medication), on 05/28/2024 it was increased to 60 mg for pain, and the last GDR was 05/01/2025. A record review of the facility pharmacy's Consultant Recommendation to Physician printed 05/06/2025 revealed Resident 1 had been using duloxetine 60 mg once a day for pain since 05/28/2024 and a trial dose reduction may be reasonable at that time. The physician/prescriber was crossed out and a different physician was written in. Neither physician provided a response or signed the Consultant Recommendation to Physician printed 05/06/2025. A record review of the facility pharmacy's Consultant Pharmacist MRR (medication regimen review) Recommendation to Prescriber with a MRR dated of 04/08/2026 revealed Resident 1 was receiving psychotropic medications duloxetine 60 mg once a day, trazadone 25 mg at hours of sleep, and Buspar (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	(a medication used to treat anxiety) 10 mg two times per day. GDR was required twice in the first year of therapy and annually thereafter unless clinically contraindicated. Clinical contraindication is defined as previous failure of reduction AND documentation by the MD (medical doctor) detailing medical rationale for continued use of the current dose. The Consultant Pharmacist MRR Recommendation to Prescriber had not been responded to or signed. In an interview on 04/29/2026 at 2:33 PM, the facility's Regional Nurse Consultant (RNC) firmed it was the RNC's expectation that the physician would respond to a GDR within a few days to a week, but it may sit on a physician's desk a little longer. In an interview on 04/29/2026 at 11:23 AM, the facility's Administrator confirmed the facility did not have a GDR for Resident 1's duloxetine. B.A record review of the of the facility's undated Psychotropic Medication(s) policy revealed psychotropic medications are to be used only when the physician determines the medication is appropriate to treat the resident's specific, diagnosed condition and is beneficial as demonstrated by monitoring and documenting the response to the medication. Non-pharmalogical approaches must be attempted, unless clinically contraindicated, to minimize the need for psychotropics medications. A record review of Resident 1's Order Summary Report dated 04/28/2026 revealed the resident had orders for duloxetine - one 60 milligram (mg) delayed release capsule once per day and trazadone - 50 mg, 0.5 tablet at bedtime related to insomnia. The Order Summary Report revealed the only psychotropic monitoring for behaviors, side effects, and interventions was for the buspirone (a antianxiety medication, same as Buspar). A record review of Resident 1's Medication Administration Record and Treatment Administration Record (MAR & TAR) dated February - April 2026 revealed the psychotropic monitoring for behaviors, side effects, and interventions was for use of the buspirone. A record review of Resident 1's Electronic Medical Records (EMR) did not reveal that behaviors were being monitored in the Tasks, or that behaviors, side effects, or non-pharmalogical interventions were completed on paper and scanned into the EMR. In an interview on 04/29/2026 at 9:15 AM, the Director of Nursing (DON) confirmed the only medication monitoring for behaviors, side effects, and interventions was for the buspirone on the MAR & TAR.

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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. Based on observation, intervention and record review, the facility failed to maintain a Medication Error rate of less than 5%. Observation of 26 medications revealed 2 errors with a resulting rate of 7.69%. The medication errors are related to 1 (Resident 8) of 4 sampled residents. The facility staff identified a census of 49. Findings are:A record review of the facilities Medication Administration policy with a revision date of 10/25 revealed the following:?Ensure that the six rights of medication administration are followed:a. Right residentb. Right drugc. Right dosaged. Right routee. Right timef. Right documentation Record review of a facility policy titled ?Insulin Pen Policy' with an implemented date of 8/2025 and a date reviewed/revised as 10/2025 revealed the following: Policy: It is the policy of this facility to use insulin pens (an injection device that allows you to deliver preloaded insulin into your subcutaneous tissue) in order to improve the accuracy of insulin dosing, provide increased resident comfort and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge.Policy Explanation guide and Compliance Guidelines:6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir.11. Procedure:h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise.ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Record review of Resident 8's treatment administration record (TAR) dated 4/2026 revealed the following:-Fiasp FlexTouch 100 unit/milliliter [ml] solution pen-injector, inject 8 units subcutaneously before meals related to type 2 diabetes mellitus with hyperglycemia.-Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine) Inject 75 units subcutaneously two times a day related to type two diabetes mellitus with chronic kidney disease. Hold if blood sugar is less than 100. Call Dr for blood sugars less than 100 or greater than 450.Observation of a medication administration on 4/28/26 at 8:15 A.M. to 8:30 A.M. revealed Licensed Practical Nurse (LPN) A gathered supplies to give insulin to Resident 8, entered the room, and obtained blood sugar with a reading of 143. LPN A obtained an Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) pen, cleansed the hub with an alcohol wipe, applied the needle, turned the dose selector to 75 units, and without priming the pen injected the insulin into Resident 8's lower abdomen. LPN A obtained a Fiasp FlexTouch 100 unit/ml Solution pen-injector pen, cleansed the hub with an alcohol wipe, turned the does selector to 8 units, and without priming the pen injected the insulin into the lower abdomen. In an interview with LPN A on 4/28/26 at 8:30 A.M. confirmed the insulin pen was not primed prior to administering the insulin. In an interview with the Director of Nursing on 4/28/26 at 1:15 P.M. it was confirmed the insulin pen should have been primed prior to selecting the dose and it would be considered a medication error.

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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. Based on observation, interview and record review the facility staff failed to prime an insulin pen prior to administering insulin on 2 of 2 observations for 1 (Resident 8) of 1 sampled resident who received insulin, resulting in a significant medication error. The facility identified a census of 49. Findings are:Record review of a facility policy titled ?Insulin Pen Policy' with an implemented date of 8/2025 and a date reviewed/revised as 10/2025 revealed the following:?Policy: It is the policy of this facility to use insulin pens in order to improve the accuracy of insulin dosing, provide increased resident comfort and serve as a teaching aid to prepare residents for self-administration of insulin therapy upon discharge.Policy Explanation guide and Compliance Guidelines:6. Insulin pens will be primed prior to each use to avoid collection of air in the insulin reservoir.11. Procedure:h. Prime the insulin pen: i. Dial 2 units by turning the dose selector clockwise.ii. With the needle pointing up, push the plunger, and watch to see that at least one drop of insulin appears on the tip of the needle. If not, repeat until at least one drop appears. Record review of Resident 8's treatment administration record (TAR) dated 4/2026 revealed the following:-Fiasp FlexTouch 100 unit/milliliter[ml] solution pen-injector, inject 8 units subcutaneously before meals related to type 2 diabetes mellitus with hyperglycemia.-Insulin Glargine Solostar Subcutaneous Solution Pen-Injector 100 unit/ml (Insulin Glargine) Inject 75 units subcutaneously two times a day related to type two diabetes mellitus with chronic kidney disease. Hold if blood sugar is less than 100. Call Dr for blood sugars less than 100 or greater than 450.Observation of a medication administration on 4/28/26 at 8:15 A.M. to 8:30 A.M. revealed Licensed Practical Nurse (LPN) A gathered supplies to give insulin to Resident 8, entered the room, and obtained blood sugar with a reading of 143. LPN A obtained an Insulin Glargine Solostar Subcutaneous Solution Pen-injector 100 unit/ml (Insulin Glargine) pen, cleansed the hub with an alcohol wipe, applied the needle, turned the dose selector to 75 units, and without priming the pen injected the insulin into Resident 8's lower abdomen. LPN A obtained a Fiasp FlexTouch 100 unit/ml Solution pen-injector pen, cleansed the hub with an alcohol wipe, turned the does selector to 8 units, and without priming the pen injected the insulin into the lower abdomen. In an interview with LPN A on 4/28/26 at 8:30 A.M. confirmed the insulin pen was not primed prior to administering the insulin. In an interview with the Director of Nursing on 4/28/26 at 1:15 P.M. it was confirmed the insulin pen should have been primed prior to selecting the dose and it would be considered a medication error.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Licensure Reference Number 175 NAC 12.006.18(B) Based on observation, interview, and record review, the facility failed to ensure hospice staff donned (put on) personal protective equipment (PPE) during wound care in a manner to prevent cross contamination for 1 (Resident 45) of 2 sampled residents. The facility census was 49. Findings are:A record review of the facility's Enhanced Barrier Precautions (EBP) policy with a date reviewed/revised of 04/01/2026 revealed EBP was an infection control intervention designed to reduce transmission of multidrug-resistance organisms (MDRO) that employ targeted gown and glove use during high contact cares such as wound care. A record review of the undated Enhanced Barrier Precautions sign revealed providers and staff must wear gloves and a gown for high-contact resident care activities such as wound care. A record review of Resident 45's Order Summary Report dated 04/27/2026 revealed the resident had wound care orders for wounds on the left inner heel and open area above the left heel, skin tear to the left shin, and scabs on the left shin. A record review of Resident 45's Clinical Physician Orders dated 04/27/2026 revealed the resident was in EBP due to wounds and ensure appropriate PPE was used during resident care activities. An observation on 04/28/2026 at 8:57 AM revealed there was an EBP sign to the left of the door to Resident 45's room. The Hospice Registered Nurse (HRN)-B was in the room and had removed the dressing on the ankle. The HRN-B did not have a gown on. Licensed Practical Nurse (LPN)-C entered the room to complete wound care on Resident 45's left lower extremity (LLE)(left lower leg and foot). HRN-B touched the resident's LLE wounds twice and lifted the LLE five times, without a gown on, while LPN-C applied dressings to the resident's wounds. In an interview on 04/28/2026 at 9:30 AM, HRN-B confirmed HRN-B did not have a gown on during wound care on Resident 45 and should have had a gown on.