

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>Licensure Reference Number 175 NAC 12-006.04(F)(i)(5)</p> <p>Based on record review and interview; the facility failed to notify the provider of unavailable medication for 1 (Resident 57) of 7 sampled residents. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of an undated facility policy entitled Unavailable Medications revealed:</p> <p>4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that the medication is unavailable:</p> <p>a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provide to obtain the medication.</p> <p>b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold.</p> <p>Record review of Resident 57's admission Record printed 6/25/25 identified Resident 57 as having diagnoses of bipolar disorder (a condition characterized by dramatic shifts in mood, energy, and activity levels that affect a person's ability to carry out day-to-day tasks. These shifts in mood and energy levels are more severe than the normal ups and downs that are experienced by everyone), schizoaffective disorder (a chronic mental health condition characterized primarily by symptoms of schizophrenia, such as hallucinations or delusions, and symptoms of a mood disorder, such as mania and depression), anxiety, and vascular dementia.</p> <p>Record review of resident 57's 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) revealed the facility admitted the resident on 02/21/25 and identified Resident 57 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 14. According to the MDS manual, a score of 13-15 indicated the resident was cognitively intact. Further review of the MDS identified resident 57 received antipsychotic, antianxiety, and anticonvulsant medications.</p> <p>(continued on next page)</p>

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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<p>F 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of resident 57's Physician's Orders active as of 04/12/25 revealed an order for tetrabenazine (given for tardive dyskinesia, a condition characterized by involuntary movements after prolonged use of antipsychotic medication), 25 milligrams three times daily ordered 03/20/25.</p> <p>Record review of Resident 57's Medication Administration Record (MAR) for April and May 2025 revealed the tetrabenazine was not received from 04/04/25 through 05/22/25 when the medication was discontinued. Further review of the April 2025 MAR revealed an order to hold tetrabenazine was entered on 04/05/25 through 04/12/25 and from 04/12/25 through 04/19/25.</p> <p>Record review of resident 57's Progress Notes (PN) showed the following:</p> <ul style="list-style-type: none"> -04/04/25 at 2:41 PM - Insurance is not covering the tetrabenazine and the pharmacy was notified. -04/04/25 at 8:24 PM - Waiting on pharmacy, insurance is not covering the cost. -04/12/25 at 2:36 PM - tetrabenazine is not available per pharmacy. <p>Further review of Resident 57's medical record revealed no further information about the hold order for tetrabenazine, or that Resident 57's provider was notified that the medication was not available.</p> <p>An interview on 06/30/25 at 12:05 PM with Assistant Director of Nursing (ADON-H) confirmed [gender] was aware of a hold order dated 04/05/25 through 04/12/25 but was unable to locate the order from the provider. ADON-H confirmed Resident 57's provider was not notified the tetrabenazine was not available until 04/12/25, 8 days after the last dose of medication was administered.</p> <p>The facility was unable to produce further documentation at the time of survey exit.</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Licensure Reference Number 175 NAC 12-006.19</p> <p>Based on observations and interviews, the facility failed to maintain the carpets in clean condition to prevent urine odors in 13 resident rooms (Rooms 103, 105, 106, 109, 203, 205, 207, 208, 311, 317, 407, 409) of 45 occupied resident rooms on the north side of the building and the carpets throughout the 100, 200, 300 and 400 hallways of the north side of the facility. This had the potential to affect 17 residents that resided in those rooms. The facility had a total of 81 occupied resident rooms in the facility. The facility census was 110.</p> <p>Findings are:</p> <p>Observation during the environmental tour 6/25/25 between 8:00 AM and 9:50 AM, with the facility Maintenance Director [MD], Housekeeping Director [HD] and Administrator [ADM], revealed the following environmental concerns in resident use areas in the facility:</p> <ul style="list-style-type: none"> - Carpets were stained in spots on the north side of the building on the 100, 200, 300 and 400 hallways. - A piece of carpet was pulled up and folded over itself beside the vending machine in the 400 hallway. - Carpets were stained in spots with a strong odor of urine present in resident rooms 103, 105, 106, 109, 203, 205, 207, 310, , 315, 317, 407, and 409. - Carpets were stained in spots in resident rooms 103, 105, 106, 109, 203, 208, and 311. - A strong odor of urine was present in the 100-unit hallway. - Handrails along the 100 hallway had a buildup of dust, dead bugs, food particles and trash in the space between the handrail and the wall. <p>Interview on 06/25/25 at 09:50 AM with the facility HD confirmed that the carpets are stained in several of the rooms and several areas of the hallways on the 100, 200, 300 and 400 hallways. The HD confirmed that several of the rooms had a strong odor of urine present. The HD confirmed the build up of dust, dead bugs, food particles and trash in the space between the handrails and the walls on the 100 hall of the facility and that the carpet had not been placed under the leg of the vending machine as intended.</p> <p>Observation on 06/30/25 between 11:00 AM and 11:38 AM with the Housekeeping Director revealed the following environmental concerns in resident use areas in the facility:</p> <ul style="list-style-type: none"> - Stained carpets in resident rooms 103, 105, 106, 109, 203, 208, and 311. - Stained carpets with strong odors of urine present in resident rooms 205, 207, 310, 315, 317, 407, and 409. <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 1-005.04</p> <p>Based on record reviews and interviews, the facility failed to resolve an ongoing grievance (a complaint or protest) and provide a written decision regarding grievance to the resident's representative. This had the potential to affect 1 (Resident 40) out of 1 resident sampled. The facility census was 110.</p> <p>Findings are:</p> <p>A record review of Resident 40's 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 05/22/2025 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 10. According to the MDS Manual a score of 8-12 indicates a person has moderately impaired cognition Section I of the MDS revealed the Resident was diagnosed with non-Alzheimer's dementia.</p> <p>Record review of the grievance form dated 03/16/2025 by the Director of Rehab (DOR) G on behalf of Resident's 40's Family Member (FM) revealed items listed as missing include a [NAME] shirt and 4 pairs of sleep bottoms. On 04/03/2025 the Grievance Official follow-up revealing the items were located and sent to laundry to be labeled with the family member being educated on ensure clothing was labeled prior to giving to resident. The Grievance form was signed as resolved by SSD-F on 04/03/2025.</p> <p>An interview was conducted on 06/23/2025 at 12:54 PM with Resident 40's FM revealing Resident 40 had 4 pajama pants missing specifically, with Cuddle Duds with the pants have never been found.</p> <p>On 06/26/2025 an observation was made of the Resident's room revealing a sign on the closet door that read Family will do laundry, with no pajama pants being observed hanging in the Resident's closet.</p> <p>On 06/30/2025 8:16 AM observed the Director of Nursing (DON) looking through clean clothing and the dirty laundry basket and no pajama pants found.</p> <p>On 06/30/2025 at 11:19 AM the DON confirmed that there were no Resident belongings in the laundry room.</p> <p>An interview was conducted with Resident 40's FM on 06/30/2025 at 11:28 AM. During the interview Resident 40's FM confirm the Resident 40's belongings were still missing. Resident 40's FM reported the pants in the Resident's room were not the Resident's pants and did not know where they came from. The FM revealed Social Services Director (SSD) F had called months ago regarding the missing items and revealed that all the Resident's clothes should be labeled before bringing them into the facility. Resident 40's FM reported not being satisfied with the resolution and was not provided with a written summary.</p> <p>A record review of the facility policy Resident and Family Grievances dated 4/2024 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>10. Procedure:</p> <p>g. In accordance with the resident's right to obtain a written decision regarding his or her grievance, the Grievance Official will issue a written decision on the grievance to the resident or representative at the conclusion of the investigation. The written decision will include at a minimum:</p> <ul style="list-style-type: none"> i. the date the grievance was received ii. the steps taken to investigate the grievance iii. a summary of the pertinent findings or conclusions regarding the resident's concern(s). iv. A statement as to whether the grievance was confirmed or not confirmed. v. any corrective action taken or to be taken by the facility as a result of the grievance. vi. The date the written decision was issued. <p>12. the facility will make prompt efforts to resolve grievances.</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.05(H)</p> <p>Based on interview and record review the facility failed to protect 1(Resident 3) of 2 resident's sampled from physical abuse. The facility census was 110.</p> <p>Findings are:</p> <p>A. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 05-09-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -had a cerebral infarction also known as a stroke with paralysis on one side of the body. -required limited assistance with bathing, transferring into or out of the tub or shower, and ambulation. <p>Record Review of Resident 3's Comprehensive Care Plan (CCP) dated 06-03-2025 revealed Resident 3 had been involved in a resident-to-resident altercation in June of 2025.</p> <p>An interview conducted with Resident 3 on 06-26-2025 at 9:53 AM revealed on 06-02-2025 Resident 3 and Resident 299 were waiting in the hallway to out for a cigarette; Resident 299 was angry about something and was yelling and acting erratically and then intentionally kicked me in the right shin. Resident 3 also revealed the kick did not result in pain, injury or mental anguish.</p> <p>B. Record review of Resident 299's MDS dated [DATE] revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored at a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -had verbal behaviors that were directed towards others for 1 to 3 days during the assessment period. -required extensive assistance with bathing. -required limited assistance with transfers and ambulation. -required supervision with bed mobility and hygiene. <p>Record review of Resident 299's CCP dated 03-31-2025 revealed the following:</p> <p>(continued on next page)</p>

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-Focus Resident 299 had a behavior problem as evidenced by making verbally inappropriate statements to staff and other residents.</p> <p>-The Goal for this focus area was Resident 299's behaviors will not interfere with the delivery of care or services or result in harm to self or others through the review date, and Resident 299 will be clean, well groomed and episodes of physical behaviors will decrease to less than weekly.</p> <p>-Interventions to achieve the goal were administer medications as ordered, monitor behavior episodes and attempt to determine the underlying cause, assess and anticipate residents needs, approach resident in a calm manner, when resident becomes agitated intervene before the agitation escalates by guiding away from the source of distress, engage resident in calm conversation, if the resident response is aggressive then approach at a later time after ensuring the safety of the resident and nearby residents.</p> <p>Record review of Resident 299's Progress Note (PN) dated 06-01-2025 at 5:45 PM revealed Resident 299 had a significant increase in agitation throughout the day, refusing medications, asking staff for scissors but would not say what the scissors were needed for, several other residents and staff have noticed an increase in agitation and negative behaviors, was yelling outside during smoke break and continued yelling into the dining room where resident transferred self into a regular chair and then shoved the wheelchair at the staff and began throwing items about.</p> <p>Record review of Resident 299's Electronic Health Record (EHR) revealed no change in interventions to manage Resident 299's escalating behavior on 06-01-2025 at 5:45 PM.</p> <p>Record review of Resident 299's PN dated 06-02-2025 at 1:14 AM revealed Resident 299 was found in room at 9:45 PM, had shredded papers all over the room and had taken everything off the bedside table and nightstand and threw it on the floor. This nurse cleaned up the room and went back 10 minutes later to find the resident had taken everything out of the closet and thrown on the floor. Resident refused skin assessments 4 times this shift and refused offers for medication, food, fluids and treatments. Resident was found in the hallway by staff wandering into other resident's rooms stating the British are going to kill me when questioned and threatened to pull the fire alarm and at 12:45 AM was observed by staff beating on the candy machine and when the nurse went to bring Resident 299 back to the nurse's station Resident 299 was not located for about 10 minutes when the resident was found in the conference room on 500 Hall. Resident was returned to the room, remains up in the wheelchair, refuses to go to bed.</p> <p>Record review of Resident 299's PN dated 06-02-2025 at 1:57 AM revealed Resident 299 was placed on 10-minute checks due to increased instability in gait and poor balance, as Resident 299 had gone to the toilet and placed a bottle of personal cleanser and an orange into the toilet and had turned her wheelchair upside down in the bathroom.</p> <p>Record review of Resident 299's PN dated 06-02-2025 at 2:31 AM revealed Resident 299 was sitting on the edge of the bed with staff assisting Resident 299 into a wheelchair and took Resident 299 to the nurse's station for closer observation.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 299's PN dated 06-02-2025 at 7:22 PM revealed nursing staff document Resident 299 had gotten into an altercation with another resident. According to Resident 299's PN dated 06-02-2025 the nurse asked Resident 299 if they wanted to go back to their room and come back later to smoke with the resident agreeing. While the nurse continued to pass the facility residents bedtime medications in the hallway, Resident 299 was observed half naked in the hallway. Resident 299 was redirected to their room where Resident 299 continued yelling out and using derogatory language towards staff. Resident PN dated 06-02-2025 further identified a CNA and Nurse went to help resident to the bathroom as Resident 299 was yelling out. After finishing using the bathroom a CNA gave a pullup brief to Resident 299 revealing Resident 299 slapped the CAN hand stating they gave (gender) a yeast infection with brief.</p> <p>Record review of Resident 299's PN dated 06-02-2025 at 9:51 PM reveals a resident informed the nurse that Resident 299 kicked Resident 3 in the right shin while waiting at the smoking entrance.</p> <p>Record review of Resident 299's EHR revealed no change in interventions to manage 299's escalating behavior after kicking Resident 3 in the shin.</p> <p>Record review of Resident 299's PN dated 06-03-2025 at 8:26 AM revealed Resident 299 was in dining room yelling at other staff and residents about Mexicans stealing Resident 299's things, Gettysburg, [NAME] King, [NAME] Obama, the English destruction of our land. (Gender) also was upset because they wanted a bathtub installed in Resident 299's room. Resident 299 demanded other residents be moved in the dining room because Resident 299 did not like where they were sitting. According to Resident 299's PN dated 06-03-2025 at 8:26 AM staff attempted to redirect Resident 299 without success.</p> <p>An interview conducted with the Director of Nursing on 06-30-2025 at 12:30 PM confirmed the facility did not increase supervision of Resident 299 due to escalating behaviors to prevent the behaviors.</p> <p>Record review of the facility policy dated 08-2024 titled Abuse, Neglect and Exploitation revealed:</p> <p>-It is the policy of this facility to provide protections for the health, welfare and rights of each resident by developing and implementing policies and procedures that prohibit and prevent abuse, neglect, exploitation and misappropriation of resident property.</p> <p>-abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting harm, pain or mental anguish, which can include staff to resident abuse and certain resident-to-resident altercations.</p> <p>-physical abuse includes, but is not limited to hitting, slapping, punching, biting and kicking.</p> <p>- the facility will implement policies and procedures to prevent and prohibit abuse of all types through identification, ongoing assessment, care planning of appropriate interventions, and monitoring residents with needs and behaviors which might lead to conflict.</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Licensure Reference Number 175 NAC 12-006.02(H)</p> <p>Based on record reviews and interviews, the facility failed to notify the required State Agency of a significant injury within the required time frame for 1 (Resident 70) of 1 sampled. The facility staff identified a census of 110.</p> <p>Findings are:</p> <p>A record review of Resident 70's admission Record revealed the facility admitted the Resident on 04/15/2024. Further review of Resident 70's admission Record revealed diagnoses of history of falling, schizoaffective disorder, bipolar type, violent behavior, traumatic subdural hemorrhage without loss of consciousness, and other chronic pain.</p> <p>A record review of Resident 70's 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 04/04/2025 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 5. The MDS manual states a score of 0-7 indicated the Resident had severe impairment.</p> <p>A record review of Resident 70's Progress Notes (PN) dated 03/11/2025 revealed the Resident had a fall that resulted in surgery and subsequent hospital stay.</p> <p>An interview was conducted on 06/25/25 at 1:32 PM with Licensed Practical Nurse (LPN)-E regarding the Resident's fall on 03/11/2025. During the interview LPN-E reported evaluating Resident 70 and felt an emergency room visit was needed. LPN-E reported Registered Nurse (RN)-K had notified the physician for order to send Resident to the emergency room. According to LPN-E, LPN-E felt the situation was more emergent and called 911. LPN-E reported the Director of Nursing (DON) and the Administrator had come to the area and were aware of the situation when it happened.</p> <p>Record review of Resident 70's PN dated 3/11/2025 at 4:26 Pm revealed revealed RN-K had been made aware of Resident 70's surgery and hospitalization.</p> <p>An interview was conducted on 06/25/25 at 1:43 PM with the DON and Regional Nurse Consultant (RNC) regarding Resident 70's fall on 03/11/2025. The DON confirmed knowledge of the situation with Resident 70 being sent to the emergency room but revealed no knowledge of Resident needing surgery and being admitted to the hospital until 03/12/2025. According to the DON when they were aware of the surgery and hospitalization, Adult Protective Services (APS) was called on 3/12/2025 at 9:00 AM.</p> <p>Facility Policy on Abuse, Neglect and Exploitation dated 8/2024 revealed the following:</p> <p>-Policy Explanation and Compliance Guidelines:</p> <p>1. The facility will develop and implement written policies and procedures that:</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>c. include training for new and existing staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property, reporting procedures, and dementia management and resident abuse prevention;</p> <p>VII. Reporting/Response</p> <p>A. The facility will have written procedures that include:</p> <p>1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframe's:</p> <p>a. immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or</p> <p>b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury.</p> <p>Review of facilities Fall Prevention Program dated 04/2024 revealed the following:</p> <p>9. When any resident experiences a fall, the facility will:</p> <p>a. Assess the resident</p> <p>b. complete a post fall assessment</p> <p>c. complete an incident report</p> <p>d. notify physician and family</p> <p>e. review the resident's care plan and update as indicated</p> <p>f. document all assessments and actions</p> <p>g. obtain witness statements in the case of injury.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 285054	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/30/2025
NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** D. Record review of Resident 16's admission Record revealed that Resident 16 was admitted to the facility on [DATE] with diagnoses that included secondary Parkinsonism, and Alzheimer's Disease early onset.</p> <p>Record review of Resident 16's Clinical Census revealed that Resident 16 was discharged to the hospital on [DATE].</p> <p>Record review of Resident 16's quarterly MDS dated [DATE] revealed that Resident 16 had a BIMS score of 15. The MDS manual identified that a score of 13-15 indicated the resident was cognitively intact. The MDS identified that Resident 16 had verbal behaviors exhibited toward others and rejection of care 1-3 days per week. The MDS identified that Resident 16 used a wheelchair for ambulation and required supervision with activities of daily living.</p> <p>Record review of a Health Status Note for Resident 16, dated 12/10/24, revealed the following information:</p> <p>- Note Text: Resident called 911 and stated [gender] couldn't breathe. However, resident was non-compliant with nursing staff, refused to be assessed by staff and told 911 [gender] just wanted to go to the hospital. Upon the ems's [Emergency Medical] assignment, resident's spo2 [oxygen level] was 94%, [gender] was very aggressive and telling staff [gender] does not want them in his room. Resident took all [gender] meds this morning, and [gender] refused to sign any paperwork. [gender] was transported via stretcher and taken to [hospital]. Pa [physician assistant] [name] notified.</p> <p>Record review of Resident 16's Electronic Medical Record, including scanned documents, revealed no written transfer / discharge notice with the reason for transfer and the required information had been provided to Resident 16 at the time of discharge to the hospital on [DATE].</p> <p>Interview on 06/26/25 at 10:58 AM with the RNC confirmed that no written transfer / discharge notice with the required information was provided to Resident 16 at the time of transfer to the hospital on [DATE].</p> <p>E. Record review of Resident 61's admission Record revealed that Resident 61 was admitted to the facility on [DATE] with diagnoses that included acute kidney failure and Type 2 Diabetes Mellitus.</p> <p>Record review of Resident 61's Clinical Census revealed that Resident 61 was discharged to the hospital on 4/27/25 and returned to the facility on 5/2/25. Resident 61 was discharged to the hospital again on 5/14/25 and returned to the facility on 5/29/25.</p> <p>Record review of Resident 61's 5 -day scheduled MDS assessment dated [DATE] revealed that Resident 61 had a BIMS score of 15. The MDS manual identified that a score of 13-15 indicated the resident was cognitively intact. The MDS identified that Resident 61 used a wheelchair for ambulation and required substantial to maximum assistance with activities of daily living.</p> <p>Record review of Resident 61's Health Status notes identified the following information:</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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)		
<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- 5/14/2025 10:19</p> <p>Health Status Note</p> <p>Note Text: This ADON [assistant director of nursing] received a call back from resident's nurse at [Name] hospital who stated that resident is going to be transferred and admitted to [Name] hospital for hypotension and abnormal labs.</p> <p>- 5/14/2025 05:45 Health Status Note:</p> <p>Note Text: [Name] PA notified altered labs, B/P 84/42, unable to manage pain, TO [telephone order] send to ER, resident transferred 4:10 am per squad</p> <p>- 5/14/2025 10:19 Health Status Note</p> <p>Note Text: This ADON received a call back from resident's nurse at [name] hospital who stated that resident is going to be transferred and admitted to [name] hospital for hypotension and abnormal labs.</p> <p>- 4/27/2025 12:28 Health Status Note</p> <p>Note Text: Resident continues on Fluconazole daily for Tinea Cruris. Bilateral legs are very red, swollen, and warm to the touch. Resident complains of itching but denies any pain. Vitals: BP-106/64, P-90, R-18, T-98.4, O2-93% room air. Called Dr [Name] and [Gender] said go ahead and send [gender] to the hospital (non-emergent). Nurse called [name] for transportation. They transported resident from bed to stretcher and took resident to [hospital name] ER.[emergency room].</p> <p>Record review of Resident 61's Electronic Medical Record, including scanned documents, revealed no written transfer / discharge notice with the reason for transfer and the required information had been provided to Resident 61 at the time of discharge to the hospital on 5/14/25 and 4/27/25.</p> <p>Interview on 06/26/25 at 10:58 AM with the RNC confirmed that no written transfer / discharge notice with the required information was provided to Resident 61 at the time of transfer to the hospital on 4/27/25 or 5/14/25.</p> <p>Licensure Reference Number 175 NAC 12-006.05</p> <p>Based on record reviews and interviews, the facility failed to notify the resident and resident representative in writing of the reason for hospital transfer for 5 residents (Resident 45, 75, 70, 61 and 16) of 5 sampled resident. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>A. Record review of the facility policy Transfer and discharge date d 4/2024:</p> <p>12. Emergency Transfers/Discharges - initiated by the facility for medical reasons to an acute care setting such as hospital, for the immediate safety and welfare of a resident (nursing responsibilities unless otherwise specified).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>a. obtain physicians' orders for emergency transfer or discharge, stating the reason the transfer or discharge is necessary on an emergency basis</p> <p>d. The original copies of the transfer form and Advance Directive accompany the resident. copies retained in the medical record.</p> <p>g. provide a notice of transfer and the facility's bed hold policy to the resident and representative as indicated.</p> <p>A. A record review of Resident 45's admission Record revealed the facility admitted the Resident on 01/14/2024. Further review of Resident 45's admission Record identified diagnoses of Alzheimer's disease, unspecified, paroxysmal atrial fibrillation, unspecified combined systolic and diastolic heart failure.</p> <p>A record review of Resident 45's Significant Change 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 05/22/2025 identified Resident 45 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 99. According to the MDS Manual, a score of 99 indicated that the Resident was unable to complete the interview.</p> <p>Record review of the Resident' 45's Progress Notes (PN) revealed Resident 45 was sent to the hospital on [DATE].</p> <p>Record review of Resident 45's medical record that included PN's, faxes. practitioner orders care plan revealed there was no indications information of the reason for transfer and no indications a written notification of the transfer had been completed.</p> <p>In an interview on 06/25/2025 at 3:45 PM the Regional Nurse Consultant (RNC) confirmed there was no transfer form for the incident which sent the resident to the hospital on [DATE] and no written notification to the Resident's representative.</p> <p>B. A record review of Resident 75's admission Record revealed the facility admitted the Resident on 01/08/2024. Further review of Resident 75's admission Record identified diagnoses of hyperlipidemia, Type 1 diabetes mellitus with other specified complications.</p> <p>A record review of Resident 75's MDS dated [DATE] identified Resident 75 had a BIMS score of 15. According to the MDS Manual, a score of 15 indicated the Resident was cognitively intact.</p> <p>Record review of Resident 75's PN dated 04/04/2025 revealed an emergency discharge to the hospital.</p> <p>Record review of Resident 75's medical record that included PN's, faxes. practitioner orders care plan revealed there was no indications information of the reason for transfer and no indications a written notification of the transfer had been completed.</p> <p>In an interview on 06/25/2025 at 3:45 PM the RNC confirmed there was no transfer form for the incident and no written notification to the Resident's representative.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0628</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>C. A record review of Resident 70's admission Record revealed the facility admitted the Resident on 04/15/2024. Further review of Resident 70's admission Record identified diagnoses of history of falling, schizoaffective disorder, bipolar type, violent behavior and other chronic pain.</p> <p>A record review of Resident 70's MDS dated [DATE] identified Resident 70 had a BIMS score of 5. According to the MDS Manual, a score of 0-7 indicated the Resident had severe impairment.</p> <p>Record review of Resident 70's PN dated 03/11/2025 revealed Resident 70 was discharged to the hospital.</p> <p>Record review of Resident 70's medical record that included PN's, faxes, practitioner orders care plan revealed there was no indications information of the reason for transfer and no indications a written notification of the transfer had been completed.</p> <p>In an interview on 06/25/2025 at 3:45 PM the Regional Nurse Consultant (RNC) confirmed there was no transfer form for the incident which sent the resident to the hospital on [DATE] and no written notification to the Resident's representative.</p>		

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<p>F 0638</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assure that each resident's assessment is updated at least once every 3 months.</p> <p>Licensure Reference Number 175 NAC 12-006.09(D)</p> <p>Based on record review and interview, the facility failed to complete the Quarterly Minimum Data Set (MDS, a federally mandated assessment tool used to determine a resident's functional capabilities and helps nursing home staff identify health problems) within the required time frames for 1 (Resident 72) of 29 sampled residents. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of the Centers for Medicare and (&) Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) Manual Version 1.18.11 dated 10/2023 revealed a quarterly MDS must be completed and signed not later than 14 days from the assessment reference date.</p> <p>Record review of Resident 72's quarterly MDS with a reference date of 6/10/25 revealed that as of 6/26/25 at 10:36 AM, the MDS had not been signed as completed, which is two days after the reference date.</p> <p>During an interview on 6/26/25 at 10:36 AM, the MDS Coordinator (MDSC-I) stated MDSC-I had begun the role in April and due to still learning, Regional MDS support was to sign the MDS as completed. MDSC-I confirmed that the quarterly MDS assessment for Resident 72 was not signed and should have been by 6/24/25.</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(B)</p> <p>Based on record reviews and interview, the facility failed to ensure the 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 04/25/25 reflected only medications received for 1 (Resident 49) of 6 sampled residents. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of the Centers for Medicare and (&) Medicaid Services Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, Version 1.8.11 dated 10/2023, Section N - Medications revealed: The intent of the items in this section is to record the number of days, during the last 7 days (or since admission/entry or reentry if less than 7 days) that any type of injection, insulin and/or select medications were received by the resident. N0415 Steps for Assessment instructed to review the resident's medical record for documentation that medications were received, including antipsychotics, in the 7-day look back period, and to review documentation from other health care settings where the resident may have received medications while a resident of the nursing home. Coding instructions included checking column one if the resident took medications during the 7-day look back period.</p> <p>A record review of Resident 49's admission Record printed 06/25/25 revealed the facility admitted the resident on 06/15/23 and identified Resident 49 had diagnoses of stroke, dementia, insomnia, and major depressive disorder.</p> <p>A record review of Resident 49's April 2025 Medication Administration Record (MAR) revealed Resident 49 did not receive any antipsychotic medications in the look back period.</p> <p>A record review of Resident 49's Annual MDS dated [DATE] revealed Section N0415A1 antipsychotics was checked. Section Z revealed Section N0415A1 was signed as complete and accurate on 05/08/25.</p> <p>In an interview on 06/26/25 at 10:36 AM, MDS Coordinator (MDSC-I) confirmed that Resident 49 did not receive antipsychotic medications during the look-back period and further confirmed that the Annual MDS dated [DATE] incorrectly identified that the resident had received an antipsychotic.</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0655</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)</p> <p>Based on record review and interview, the facility staff failed to ensure a Baseline Care Plan was completed for 1(Resident 255) of 1 residents within 48 hours of admission. The facility had a census of 110.</p> <p>Findings are:</p> <p>Record review of a Order summary Report sheet printed on 6-24-2025 revealed the facility staff admitted Resident 255 on 06-18-2025.</p> <p>A record review of the Resident 255's discharge orders from the hospital dated [DATE] revealed the following information: Renal Diet (a meal plan designed to support kidney health by carefully managing the intake of sodium, potassium, phosphorus, and protein along with fluid). 1500 milliliters (ml - a unit of measurement) a day fluid restriction. Dialysis (a mechanical treatment that performs the function of healthy kidneys to remove waste and excess fluid from the blood). Monday/Wednesday/Friday at 6:00 AM. Resident had a hemodialysis catheter (a soft flexible tube used to access a patient's blood for hemodialysis dual lumen (a catheter with two separate working channels) right internal jugular (a major vein that returns blood from the brain, face, and neck to the heart).</p> <p>A record review of Resident 255's Baseline Care Plan revealed on [DATE] at 3:30 PM revealed additional care areas were initiated by the MDSC J (Minimum Data Set Coordinator -a person responsible for overseeing the comprehensive assessment of resident's health and care needs for compliance with federal regulations and Medicare and Medicaid reimbursement). These areas were Activities of Daily Livings (self-care tasks necessary for independent living), falls, nutrition, and dialysis.</p> <p>An interview on [DATE] at 10:30 AM with Licensed Practical Nurse (LPN) E confirmed Resident 255's Baseline Care Plan, (a document created within 48 hours of a residents admission to a facility - which outlines the initial instructions for providing effective, person-centered care that meets professional standards) dated [DATE], contained Code information dated [DATE] (which indicates if a resident wants the facility to perform CPR (Cardiopulmonary resuscitation) in the event the residents heart stopped beating), Behavioral information (a focus on managing and preventing specific behaviors), and Pressure Ulcer information (a focus on managing and preventing pressure ulcers), dated [DATE].</p> <p>An interview on [DATE] at 2:30 PM with an MDSC J confirmed Resident 255's Baseline Care Plan contained information related to behavioral information, and Pressure Ulcer information. The MDS coordinator confirmed the Baseline Care Plan did not include dialysis information, medication information, target behaviors or behavioral monitoring. MDSC J confirmed they were unaware Resident 255 was a dialysis patient. MDSC J confirmed they added the additional areas to the Baseline Care Plan on [DATE].</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(F)(iii)</p> <p>Based on record reviews and interviews, the facility failed to revise the comprehensive care plan for 1 (Resident 70) of 1 sampled. The facility census was 110.</p> <p>The findings are:</p> <p>A record review of Resident 70's admission Record revealed the facility admitted the Resident on 04/15/2024. Further review of Resident 70's admission Record identified diagnoses of history of falling, schizoaffective disorder, bipolar type, violent behavior and other chronic pain.</p> <p>A record review of Resident 70's 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 04/07/2025 revealed a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 5. The MDS manual states a score of 0-7 is considered a score of 0-7 indicated the Resident had severe impairment.</p> <p>A record review of progress notes revealed the Resident had a fall that resulted in surgery and subsequent hospital stay with Resident 70 returning to the facility on [DATE].</p> <p>A record review of the Resident's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) dated 04/16/2024 revealed independence with eating, toileting, ambulation, dressing, and personal hygiene.</p> <p>An MDS Section GG was completed on 03/23/2025 and revealed the Resident had declined in ADL's. The Resident required assistance with oral hygiene, supervision or touching assistance with toileting hygiene, setup or cleanup assistance with upper body dressing, partial/moderate assistance with lower body dressing and setup or cleanup assistance with personal hygiene.</p> <p>Observation on 6/24/25 12:20 PM revealed Resident 70 was in their room trying to put a hoodie. Further observations revealed Nursing Assistant (NA)-C came to assist Resident with getting hoodie on correctly.</p> <p>On 06/26/25 at 12:58 PM a interview was conducted with NA-C. During the interview NA-C reported staff assist Resident 70 to the restroom to avoid falls.</p> <p>An interview was conducted with Minimum Data Set Coordinator (MDSC)-I on 6/26/2025 at 10:00 AM. During the interview MDSC-I confirmed Resident 70's CCP had not been updated to reflect Resident 70 required assistance with oral hygiene, supervision or touching assistance with toileting hygiene, setup or cleanup assistance with upper body dressing, partial/moderate assistance with lower body dressing and setup or cleanup assistance with personal hygiene.</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09 (H)</p> <p>Based on record review and interview the facility failed to establish a restorative nursing program with frequency of modalities for 3 (Resident 3, 37 and 72) of 5 residents sampled. The facility census was 110.</p> <p>Findings are:</p> <p>A. Record review of Resident 3's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 05-09-2025 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -Brief Interview of Mental Status (BIMS) was scored as a 15. According to the MDS Manual a score of 13-15 indicates a person is cognitively intact. -had a cerebral infarction also known as a stroke with paralysis on one side of the body. -required limited assistance with bathing, transferring into or out of the tub or shower, and ambulation. -was receiving restorative range of motion, and ambulation. <p>Record review of Resident 3's Comprehensive Care Plan (CCP) dated 07-16-2024 revealed the following:</p> <ul style="list-style-type: none"> -Focus Resident 3 was working with restorative for bilateral lower extremity strengthening and ambulation. -Goal Resident 3 will participate in a restorative program dated 07-16-2024 revised on 09-16-2024. -Interventions listed were Active Range of Motion (AROM) to bilateral lower extremities (BLE) in all plains and joints. <p>Record review of Therapy to Nursing, Restorative Nursing Program Communication (TNRNPC) dated 03-20-2025 for Resident 3 revealed physical therapy had recommended the following modalities for Resident 3:</p> <ul style="list-style-type: none"> -AROM to BLE for 2 sets of 10 in each motion. -ambulate with 2 staff members plus wheelchair to follow closely for safety for 100 to 125 feet with a front wheeled walker. -use the Nustep (a recumbent cross training machine) for 15 minutes. <p>(continued on next page)</p>		

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<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Furthermore, there was not a frequency on how often to perform the AROM or the ambulation.</p> <p>Record review of restorative nursing documentation in Resident 3's Electronic Health Record (EHR) for 06-01-2025 to 06-30-2025 revealed Resident 3 received AROM and ambulation on 06-28-2025.</p> <p>An interview conducted on 06-25-2025 at 9:15 AM with Resident 3 revealed the staff had provided range of motion and restorative ambulation but did not know how often it was to be done.</p> <p>An interview conducted on 06-30-2025 at 1:37 PM with the Director of Nursing (DON) confirmed restorative modalities did not have a frequency and should have.</p> <p>B. Record review of Resident 37's MDS dated [DATE] revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -had a diagnosis of Dementia. -was rarely understood. -BIMS was not conducted. -Required total assistance with eating, hygiene, toileting, bathing, transfers and bed mobility. -was receiving restorative modalities of Range of Motion (ROM) and transfer training. <p>Record review of TNRNPC for Resident 37 dated 01-27-2025 revealed physical therapy had recommended the following modalities for Resident 37:</p> <ul style="list-style-type: none"> -BLE ROM exercise in all planes for 2 sets of 10 in each motion. -transfer training- stand at the side railing in the therapy gym for 20 to 30 seconds with one person assist and gait belt (a belt used to provide stability with transfers and ambulation). <p>There was no directions TNRNPC on how often to perform ROM or standing in the therapy gym.</p> <p>Record review of Resident 37's EHR revealed from 06-01-2025 to 06-30-2025 Resident 37 received assistance with standing on 06-15-2025, 06-25-2025 and 06-28-2025 and the ROM program was provided on 06-04-2025, 06-11-2025, 06-15-2025, 06-25-2025, and 06-28-2025.</p> <p>An interview conducted on 06-25-2025 at 8:00 AM with Resident 37's family member revealed the only restorative they were aware of was that Resident 37 goes to a group exercise where the residents toss a balloon around for 5 minutes.</p> <p>An interview conducted on 06-30-2025 at 1:37 PM with the DON confirmed restorative modalities did not have a frequency and should have.</p> <p>C. Record review of Resident 72's admission Record revealed the facility admitted the resident on 11/07/23 and identified diagnoses of bilateral osteoarthritis of the knee, need for assistance with personal care, and pain.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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)		
<p>F 0688</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Record review of Resident 72's Quarterly MDS dated [DATE] identified Resident 72 had a BIMS score of 10. According to the MDS Manual, a score of 10 indicated the resident had a moderate cognitive impairment. Further review of the MDS revealed one day of restorative nursing for AROM at 15 minutes or more in the 7-day look back period.</p> <p>Record review of Resident 72's CCP dated 01/01/25 revealed the following:</p> <ul style="list-style-type: none"> -Focus: Resident 72 was on a restorative nursing program. -Goal: Resident 72 will participate in restorative nursing program to maintain or improve ROM dated 10/10/2024. -Intervention: BLE ROM all joints/planes. <p>The CCP did not include a frequency on how often to perform AROM exercises.</p> <p>Record review of TNRNPC dated 02/10/25 revealed for Resident 72 revealed physical therapy had recommended the following modality for Resident 72:</p> <ul style="list-style-type: none"> -AROM to BLE in all planes for 2 sets of 15 repetitions (reps). <p>The TNRNPC did not include a frequency on how often to perform AROM exercises.</p> <p>Record review of Resident 72's restorative nursing program documentation over the past 30 days revealed the resident received restorative on the following days: 05/25/25, 05/28/25, 06/04/25, 06/12/25, 06/13/25, 06/18/25, 06/23/25, 06/25/25.</p> <p>An interview on 06/23/25 at 3:25 PM with Resident 72 revealed Resident 72 believe [gender] was to receive restorative nursing at least twice weekly but was unsure of the last time that restorative was received twice weekly.</p> <p>An interview on 06/30/2025 at 8:48 AM with the DON confirmed that Resident 72's restorative program did not specify a frequency for exercises and should.</p> <p>Record review of a facility policy entitled Restorative Nursing Programs dated revised 1/14/25 revealed:</p> <ul style="list-style-type: none"> - Policy: It is the policy of this facility to provide maintenance and restorative services designed to maintain or improve a resident's abilities to the highest practicable level. - 9. The DON/Restorative nurse is responsible for maintaining a current list of residents who require restorative nursing services, and for ensuring that all elements of each resident's program are implemented. -10. A resident's restorative nursing plan will include: <ul style="list-style-type: none"> -a. The problem, need, or strength the restorative tasks are to address. <p>(continued on next page)</p>		

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	<ul style="list-style-type: none"> -b. The type of activities to be performed. -c. Frequency of activities -d. Duration of activities -e. Measurable goal and target date.

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on observation, interview and record review the facility failed to assess the ability to smoke safely, which resulted in physical injury for 1 (Resident 50) of 1 smoking residents sampled and failed to implement a fall mat for 1 (Resident 99) of 2 residents sampled. The facility census was 110.</p> <p>The findings are:</p> <p>A. Record review of Resident 50's Minimum Data Set (MDS: a federally mandated assessment tool used for care planning) dated 12-23-2024 revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -had admitted to the facility on [DATE]. -Brief Interview of Mental Status (BIMS) was scored at a 5. According the MDS Manual a score of 0-7 indicates a person has severe cognitive impairment. -had a previous cerebrovascular accident (stroke) with hemiplegia (paralysis to one side of the body) and aphasia (a brain disorder that affects how you speak and understand language). -had limited range of motion to the right arm and leg. - was non ambulatory. <p>Record review of Resident 50's progress note dated 03-24-2025 revealed Resident 50 was out in the courtyard smoking and set (gender) beard and hair on fire, resulting in burns to the anterior neck, right chest and left fingertips.</p> <p>Record review of Resident 50's Electronic Health Record revealed a safe smoking evaluation had not been conducted for Resident 50 prior to 03-24-2025.</p> <p>Record review of the facility reported incident and self-identified plan of correction, revealed the following:</p> <ul style="list-style-type: none"> -all current smokers were evaluated to determine their capability for safe smoking. -smoking aprons enforced for resident's deemed to require it. -staff to light all resident cigarettes moving forward using 1 lighter -the new procedure was reviewed and discussed with all smokers. -training to staff was provided on 03-24-2025 and 3-28-2025. <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview conducted on 06-30-2025 at 7:07 AM with the Director of Nursing (DON) confirmed a safe smoking evaluation had not been conducted for Resident 50 prior to smoking on 03-24-2025, a safe smoking evaluation was conducted after Resident 50 had been burned.</p> <p>An observation conducted on 06-30-2025 from 9:00AM to 9:40 AM revealed the Activity Director (AD) was present to supervise resident's smoking. The staff member had a toolbox with each resident's cigarettes individually contained inside. The toolbox also contained a list of smokers with designation of which person is required to wear an apron and 1 lighter. During this continuous observation the AD was present for the entire smoking session and the AD was the only person who had a lighter and was lighting the cigarettes for the residents.</p> <p>On 06-30-2025 at 12:30 PM implementation of the self-identified plan of correction was verified on-site, specifically evaluations for all smokers to determine their capability for safe smoking, signed copies of the smoking policy that was reviewed with each smoker, and now staff are to light all resident's cigarettes revealing the facility staff had correct the past non-compliance related to smoking.</p> <p>B. Record review of Resident 99's MDS dated [DATE] revealed the facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -had osteoporosis (brittle bones), epilepsy (a seizure disorder) and a left hip fracture. -BIMS was scored as a 7. According to the MDS Manual a score of 0-7 indicate a person has severe cognitive impairment. -required extensive assistance with eating and hygiene. -required total assistance with transfers, bed mobility, dressing and toileting. -was non ambulatory. <p>Record review of Resident 99's Comprehensive Care Plan dated 01-26-2025 revealed the following:</p> <ul style="list-style-type: none"> -Focus Resident is at risk for falls related to gait and balance problems and a history of falls. -Goal Resident will be free from falls and subsequent injuries through the review date. -interventions were bed in low position, complete fall risk assessment upon admission, quarterly and with any change of condition, encourage socialization and activity attendance, fall mat at bedside when occupied, non-skid footwear (socks and shoes) as Resident allows, offer toileting assistance when rounding, provide verbal cues for safety and sequencing when needed. <p>An observation on 06-25-2025 at 7:20 AM revealed Resident 99 was lying in bed without a fall mat at bedside.</p> <p>An observation on 06-26-2025 at 5:45 AM revealed Resident 99 was lying in bed without a fall mat at bedside.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview with conducted with Nursing Assistant (NA) U on 06-26-2025 at 6:30 AM which confirmed there was no fall mat in Resident 99's room because Resident 99 is independent with everything and did not need one.</p> <p>An interview with the Director of Nursing on 06-30-2025 at 7:06 AM revealed Resident 99 had been in a different room and when Resident 99 moved to the current room the fall mat was not moved with the resident and should have been.</p> <p>Record review of the facility policy dated 04-2024 titled Fall Risk/Prevention revealed the following:</p> <ul style="list-style-type: none"> -it is the policy of this facility to provide an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. -the risk assessment will be completed upon admission, quarterly and when a significant change has been identified. -the risk assessment will identify environmental hazards and individual risks, including the need for supervision. -each residents risk factors and environmental hazards will be evaluated when developing the resident's comprehensive care plan, and the care plan will be revised as needed. -the care plan will include interventions, including adequate supervision, consistent with the needs, goals, and current standards of practice. -monitor the effectiveness of the care plan interventions and modify the interventions as necessary, in accordance with the current standards of practice. 		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>Licensure Reference Number 175 NAC 12-006.09(H)(iv)(2)</p> <p>Based on observation, interview, and record review; the facility staff failed to evaluate and implement a toileting program for 1 (Resident 72) of 1 sampled resident. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of a facility policy entitled Incontinence dated 8/2024 revealed:</p> <ul style="list-style-type: none"> -Based on the resident's comprehensive assessment, all residents that are incontinent will receive appropriate treatment and services. - 4. Residents that are incontinent of bladder or bowel will receive appropriate treatment to prevent infections and to restore continence to the extent possible. <p>Record review of Resident 72's admission Record (AR) printed on 06/25/25 revealed the facility admitted the resident on 11/07/23. Further review of the AR identified that Resident 72 had diagnoses of type 2 diabetes mellitus, chronic constipation, benign prostatic hyperplasia (a condition where the prostate gland enlarges, potentially causing urinary problems), polyuria (increased urine production), and bilateral osteoarthritis of the knee.</p> <p>Record review of Resident 72's 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 06/10/25 identified facility staff assessed the following about the resident:</p> <ul style="list-style-type: none"> -The resident had adequate hearing and the ability to understand others. -The resident had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 10. According to the MDS manual, a score of 10 indicated the resident had a moderate cognitive impairment. -The resident required substantial/maximal assistance with transfers and toileting. -The resident was frequently incontinent of bowel and bladder and was not on a toileting program. <p>Record review of Resident 72's Quarterly Evaluation, Bowel and Bladder dated 10/16/24 revealed the resident was not continent of bowel and bladder. The evaluation further identified the resident's urinary and bowel incontinence was improved. The program potential evaluated the resident as aware of the urge to void, the urge to defecate, appropriate places to pass urine or stool, and was able to find the toilet. The evaluation revealed the resident understood reminders and prompts, was motivated to be continent, and is aware when wet or soiled from incontinence.</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Further review of the electronic health record (EHR) revealed a past due quarterly evaluation which included bowel and bowel assessments. The EHR showed the assessment was due to be completed on 06/09/25. No new evaluation of Resident 72's bowel and bladder retraining ability since 10/16/2024 was available.</p> <p>Record review of Resident 72's POC Response History for bladder continence revealed the resident was continent of bladder 7 out of 28 responses from 05/27/25 to 06/24/25.</p> <p>Record review of Resident 72's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed the following incontinence interventions:</p> <ul style="list-style-type: none"> -Resident 72 transfers with substantial assistance and gait belt dated revised 06/24/25. -Apply appropriate disposable undergarments as accepted by resident dated 08/02/24. -Observe for redness and skin breakdown daily dated 08/02/24. -Provide peri care and apply protective skin barrier after each incontinent episode dated 08/02/24. <p>An observation on 06/25/25 at 1:28 PM revealed Resident 72 activated his call light for toileting assistance. Nurse Aide (NA-R) assisted Resident 72 to the toilet, the resident was continent of bowel and bladder at this time.</p> <p>During an interview on 06/23/25 at 3:27 PM, Resident 72 reported that [gender] is aware of the need to use the toilet and that [gender] was not on a toilet program.</p> <p>An interview on 06/25/25 at 1:28 PM with NA-R revealed Resident 72 was not on a toileting program and confirmed that the resident activated the call light for toileting assistance.</p> <p>An interview on 06/26/25 at 10:20 AM with the Administrator (ADM) with the Director of Nursing (DON) and Regional Director of Operations (RDO) present revealed in the past the bowel and bladder evaluations were auto-triggered, but the facility discovered on this date that the bowel and bladder evaluations were no longer auto-triggered.</p> <p>An interview on 06/30/2025 at 11:10 AM with the DON confirmed Resident 72 did not have a bladder and bowel re-evaluation completed since October 2024 and should be completed quarterly with the MDS.</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Licensure Reference Number 175 NAC 12-006.09(I)</p> <p>Based on observations, record reviews, and interviews; the facility failed to assess for bed assist bar (a bar affixed to the bed used to assist the resident in bed mobility and positioning) use for 1 (Resident 49) of 1 sampled resident. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of Resident 49's admission Record printed 06/25/25 revealed the facility admitted the resident on 06/25/23 and identified Resident 49 had diagnoses that included stroke, dementia, epilepsy, weakness, other abnormalities of gait and mobility, and reduced mobility.</p> <p>Record review of Resident 49's 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) revealed Resident 49 had a Brief Interview for Mental Status (BIMS, a brief screener that aids in detecting cognitive impairment) score of 11. According to the MDS manual, a score of 11 indicated the resident had a moderate cognitive impairment. Further review of the MDS revealed Resident 49 required substantial assistance for bed mobility and transfers. The MDS did not identify use of bed assist bars.</p> <p>Record review of Resident 49's Quarterly Evaluation, Section 7 Alarming Devices/Bed Rails/Restraints dated 01/29/25 revealed the resident did not use bed assist bars.</p> <p>Record review of Resident 49's Physician's Orders revealed the following:</p> <ul style="list-style-type: none"> -Ok for assist bars on bed dated 04/22/24. -Apply assist bars to bed bilaterally for assistance with repositioning and mobility dated 06/17/25. <p>Record review of Resident 49's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed:</p> <ul style="list-style-type: none"> -Resident 49 requires assistance with ADL's which included bed mobility and transfers. -Assist bars on bed offload feet when in bed initiated on 04/23/24 and revised on 06/23/25. <p>An observation on 06/23/25 at 12:02 PM revealed Resident 49 in bed leaned to the left with the resident's head resting on the left bed assist bar.</p> <p>An observation on 06/24/25 at 1:47 PM revealed Resident 49 in bed with body in alignment and bilateral bed assist bars in place on the bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An observation on 06/26/25 at 10:27 AM with Assistant Director of Nursing (ADON-H) revealed Resident 49 in bed with proper body alignment and bilateral bed assist bars in place.</p> <p>An interview on 06/26/25 at 10:27 AM with ADON-H confirmed the placement of bilateral bed assist bars. ADON-H further confirmed that the bed assist portion of the Quarterly Evaluation dated 01/29/25 showed that the resident did not use a bed rail/handrail/grab bar, restraint, or alarm. ADON-H stated that bed rail assessment should be completed quarterly to verify that the bed assist bars were an appropriate intervention for the resident.</p> <p>An interview on 06/26/25 at 10:36 AM was conducted with MDS Coordinator (MDSC-I). During the interview MDSC-I confirmed Resident 49 had not been evaluated for the bed assist bars since 01/29/25 and should be completed quarterly with the MDS assessment.</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure medication error rates are not 5 percent or greater.</p> <p>Licensure Reference Number 175 NAC 12-006.10(D)</p> <p>Based on observation, record review, and interview; the facility staff failed to ensure a medication error rate of less than 5 percent (%). Observation of 35 medications revealed 3 errors with a resulting error rate of 8.57%. The medication errors are related to 1 (Resident 91) of 6 sampled residents. The facility staff identified a census of 110.</p> <p>The findings are:</p> <p>Record review of Resident 91's Medication Administration Record (MAR) dated 06/2025 revealed Resident 91's practitioner had ordered medications that included:</p> <ul style="list-style-type: none"> -potassium 20 milliequivalents (mEq) to be given in the morning; -divalproex tablet delayed release 500 mg to be given twice a day; and -artificial tears one drop in both eyes to be given twice a day. <p>Observation on 06/25/25 at 7:57 AM revealed Medication Aide (MA-S) prepared Resident 91's medications for administration. The potassium and divalproex medication cards from which medications are dispensed and compared to the MAR read Do Not Crush. MA-S crushed all the resident's medications prior to mixing with applesauce. The resident consumed all the medications. MA-S proceeded to administer the eye drops by using the thumb to pull Resident 91's upper eyelid up, then dropped the eye drop directly on the eye.</p> <p>During an interview on 06/25/25 at 8:19 AM, MA-S confirmed that the potassium and divalproex medication cards read Do Not Crush and that all oral medications were crushed. MA-S revealed that instruction was provided to always crush Resident 91's medications. MA-S further confirmed that the proper way to administer an eye drop was to form a pouch in the lower eyelid and administer the drop into the pouch.</p> <p>During an interview on 06/25/25 at 8:47 AM Registered Nurse (RN-T) confirmed that if the medication card says do not crush and the medication was crushed, that would constitute a medication error.</p> <p>Record review of an undated facility policy entitled Medication Administration revealed:</p> <ul style="list-style-type: none"> -10. Ensure that the six rights of medication administration are followed: <ul style="list-style-type: none"> -a. Right resident -b. Right drug -c. Right dosage -d. Right route <p>(continued on next page)</p>		

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<p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>-e. Right time</p> <p>-f. Right documentation</p> <p>-11. Review MAR to identify medication to be administered.</p> <p>-12. Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.</p> <p>-c. If other than PO route, administer in accordance with facility policy for the relevant route of administration (i.e. injection, eye, ear, rectal, etc.).</p> <p>-17. Administer medication as ordered in accordance with manufacturer specifications.</p> <p>-c. Crush medications as ordered. Do not crush medications with do not crush instructions.</p> <p>Record review of an undated facility policy entitled Administration of Eye Drops or Ointments revealed:</p> <p>-5. Administration:</p> <p>-b. steady hand holding the medication, as needed, on resident's forehead.</p> <p>-c. with other hand, pull down lower eyelid to form a pouch of the conjunctival sac, instructing resident to look up.</p> <p>-d. For eye drops: squeeze the prescribed number of drops into the conjunctival sac, avoiding placement of the drops directly on the eyeball.</p>		

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NAME OF PROVIDER OR SUPPLIER The Banyan at Montclair		STREET ADDRESS, CITY, STATE, ZIP CODE 2525 South 135th Avenue Omaha, NE 68144	
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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Licensure Reference Number 175 NAC 12-006.11E</p> <p>Nebraska Food Code 2017 4-904.11(A)</p> <p>Based on observation, record review and interviews; the facility failed to handle dishware in a manner to prevent the potential for food borne illness while serving foods in the facility dining room. This had the potential to affect 7 (Residents 3, 44, 53, 72, 99, 105, and 250) residents that received foods during the meal service and failed to ensure a refrigerators were maintained below 41 degrees in 1 (Resident 75) of 15 resident refrigerators. The facility census was 110.</p> <p>Findings are:</p> <p>A. Record review of an undated facility Policy entitled Proper Handling of Tableware revealed the following information:</p> <p>Handling of clean tableware:</p> <ul style="list-style-type: none"> - Do not touch eating surfaces of forks, spoons, knives, rims of glasses, or the inside of bowls and plates. - Glasses, cups and bowls should be handled by the base or out edge only. <p>Observation during dining services on 06/23/25 between 12:00 PM and 12:28 PM revealed Dietary Aide (DA) A served a drink to Resident 72. Observation revealed that DA-A handled the glass of juice by the rim of the glass to hand it to the resident. DA-A continued to serve drinks to several other residents in the dining room and touched the rim of the glasses as the drinks were being poured. No hand sanitizer was observed to be used during the meal service.</p> <p>Observation during dining services on 06/23/25 at 12:10 PM revealed DA-A served a drink to Resident 3. Observation revealed that DA-B handled the glass of milk by the rim of the glass to hand it to the resident.</p> <p>Observation during dining services on 06/23/25 at 12:13 PM revealed the Dietary Manager (DM) served a salad to Resident 44. The DM held the salad bowl by the rim and touched the interior surface of the salad bowl with a bare finger.</p> <p>Observation during dining services on 06/23/25 at 12:15 PM revealed DA-A served a salad to Resident 72. DA-A held the salad bowl by the rim and touched the interior surface of the salad bowl with a bare finger.</p> <p>Observation during dining services on 06/23/25 at 12:18 PM revealed DA-A served a salad to Resident 250. DA-A held the salad bowl by the rim and touched the interior surface of the salad bowl with a bare finger.</p> <p>(continued on next page)</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Observation during dining services on 06/23/25 at 12:20 PM revealed DA-B served a drink to Resident 99. Observation revealed that DA-B handled the glass of milk by the rim of the glass to hand it to the resident. DA-B continued to serve drinks to other residents (Residents 105 and 53) in the dining room and touched the rim of the glasses as the drinks were being poured.</p> <p>Interview on 06/25/25 at 11:30 AM with the DM confirmed that staff should not touch the rim of glasses and should not touch the inside surface of bowls when serving foods.</p> <p>Interview on 06/30/25 at 07:45 AM with the facility Administrator revealed that the average number of residents that eat in the facility dining area is 30.</p> <p>Record review of the facility policy for Resident in room Refrigerators dated 5/01/2025 revealed the following:</p> <ul style="list-style-type: none"> -2. The resident is responsible for recording refrigerator temps weekly on a temperature log attached to the refrigerator. -b. Temperatures will be at or below 41 degrees(Fahrenheit) F and freezers will be cold enough to keep foods frozen solid to the touch (or in accordance with state regulations) -c. if Temps are out of range, the resident shall discard any food that requires refrigeration. <p>An observation was conducted on 06/25/2025 at 8:30 AM of refrigerator temperatures for Resident 75's personal refrigerator revealed a temperature of 47.3 degrees Fahrenheit (F). According to the temperature log on Resident 75's refrigerator door revealed the temps should be between 36-46 degrees F.</p> <p>Record review of the temperature log for Resident 75's refrigerator revealed the following temperatures above 41 degrees:</p> <ul style="list-style-type: none"> 6/25/25 44 degrees F 6/24/25 43 degrees F 6/20/25 43 degrees F 6/16/25 51 degrees F 6/15/25 43 degrees F 6/14/25 45 degrees F <p>On 6-25-2025 at 8:30 AM the Maintenance Director (MD) confirmed the temperature log had readings above 46 and the information was relayed to the maintenance department. The MD confirmed the refrigerator temperature reading was 47.3</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>D. An observation on 6/23/2025 at 10:48 AM revealed a nebulizer machine (a machine that changes liquid medicine into fine droplets inhaled through a mouthpiece or a mask) and tubing and a room telephone placed directly on the carpeted floor beside the bed of Resident 64.</p> <p>An observation on 6/24/2025 at 5:00 PM revealed a nebulizer machine and tubing and room telephone on the floor beside the bed of Resident 64.</p> <p>An observation on 6/24/2025 at 7:10 AM revealed a nebulizer machine and tubing and room telephone on the floor beside the bed of Resident 64.</p> <p>An interview on 6/23/2025 at 10:50 AM with Resident 64 confirmed the nebulizer machine and tubing and the room telephone are always kept on the floor of the resident's room.</p> <p>An interview on 6/24/25 at 5:10 PM with Licensed Practical Nurse (LPN) O confirmed having the nebulizer machine, tubing and telephone on the floor is an infection control risk.</p> <p>An interview on 6/24/25 at 5:15 PM with Medication Aide (MA) P confirmed the placement of the nebulizer machine, tubing and telephone on the floor is an infection control risk.</p> <p>An interview on 6/24/2025 at 5:20 PM with the Consultant Infection Preventionist (CIP) confirmed that having the nebulizer machine, tubing, and the telephone on the floor of the room created an infection control risk.</p> <p>E. An observation on 6/26/2025 at 9:55 AM revealed Resident 14 was reclined on their bed and received a breathing treatment from a nebulizer machine. The nebulizer machine was positioned on the floor and the nebulizer tubing was resting partly on the floor.</p> <p>An interview on 6/26/2025 at 9:55 AM with Licensed Practical Nurse E confirmed that a nebulizer machine on the floor of the resident's room created an infection control risk.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>F. An observation on 6/26/2025 at 6:15 AM of tube feed administration for Resident 90 by Licensed Practical Nurse Q revealed LPN Q entered Resident 90's room after knocking and informed them they were there to set up the tube feed. LPN Q washed their hands did not don a gown and returned to Resident 90's bedside. LPN Q donned gloves and removed a stethoscope from a drawer and a 60 cc (cubic centimeters) syringe to determine tube placement in the abdomen using air forced through the syringe. LPN Q discarded their gloves, cleaned the stethoscope with an alcohol wipe, replaced it in the drawer, and placed the syringe on a paper towel on Resident 90's table. LPN Q did not use hand sanitizer or wash their hands. LPN Q then unpacked the kangaroo delivery system (a double bag and tube system intended to deliver nutrition, hydration, and formula through a tube directly into the stomach via an entry point in the abdomen) and used the bathroom faucet to fill the water pouch portion of the delivery system. LPN Q donned gloves without washing hands or using hand sanitizer and filled the tube feed pouch of the kangaroo set with 4 containers of Jevity 1.5 containing 8 oz each. LPN Q hung the set from a pole and threaded the tubing through the feeding pump (a machine used to provide patients with the essential nutrients and hydration needed in order to survive). LPN Q ran the tube feed through the tubing until it reached the exit site. LPN Q changed their gloves and did not hand sanitize. LPN Q attached the tubing to the residents G-tube (a feeding tube inserted through the abdominal wall directly into the stomach) entry site and began the tube feeding. LPN Q removed their gloves and wrote the date, time and their initials on a label and placed it on the tube feed bag. LPN Q donned gloves gathered their trash and left the room.</p> <p>An interview with LPN Q on 6/26/25 at 6:45 AM confirmed Resident 90 is on EBP. LPN Q confirmed they did not use hand sanitizer between donning and doffing of gloves, before touching the faucet to fill the kangaroo set and locating and replacing the stethoscope from the drawer. LPN Q confirmed they did not don a gown before working on the tube feeding and did not think they were supposed to. LPN Q agreed that according to the EBP sign outside the resident's room, a gown should have been worn. LPN Q confirmed that not wearing a gown and not using hand sanitizer between glove changes created a break in infection prevention practice.</p> <p>Licensure Reference Number 175 NAC 12-006.18</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure Enhanced Barrier Precautions (EBP - an infection control intervention designed to reduce transmission of multidrug resistance organisms (MDRO's) in nursing homes), were utilized during a peripherally inserted central catheter (PICC - a long thin tube that is inserted into an arm vein and threaded into a larger vein near the heart) dressing change for 1 (Resident 82) of 1 resident sampled for PICC line dressing changes, failed to observe hand hygiene between glove changes and when changing the routes of medication administration for 1 (Resident 91) of 6 sampled residents sampled for medication administration, failed to ensure that a gown was worn and hand hygiene was completed between glove changes when providing tube feeding to 1 (Resident 90) of 2 residents samples for Gastrointestinal tubes (a feeding tube inserted through the abdominal wall into the stomach) and failed to ensure that nebulizer machines (a machine that changes liquid medication into fine droplets that are administered via an oral device of a face mask) were not placed on the floor for 2 residents (Resident 14 and 64) of 2 residents sampled. The facility staff identified a census of 110.</p> <p>Findings are:</p> <p>A. Record review of a facility policy entitled PICC/Midline/CVAD Dressing Change dated revised 4/2024 revealed:</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>-2. Establish area for soiled products to be placed.</p> <p>-3. g. Open the sterile dressing change kit, lay out the sterile drape and place supplies on the sterile field being careful not to contaminate them.</p> <p>Record review of Resident 82's admission Record printed 06/25/25 revealed the facility admitted the resident on 12/26/24 and identified Resident 82 had diagnoses of acute osteomyelitis (infectious inflammation of bone marrow), extended spectrum beta lactamase (ESBL, an enzyme produced by some bacteria that allows them to become resistant to certain antibiotics), local infection of the skin and subcutaneous tissue, and type 2 diabetes mellitus.</p> <p>Record review of Resident 82's 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 05/27/25 identified facility staff assessed the following about the resident:</p> <p>-Resident 82 had a MDRO, wound infection, and diabetes mellitus.</p> <p>-Resident 82 received intravenous (IV) antibiotics while a resident.</p> <p>Record Review of Resident 82's Physician's Orders revealed the following orders:</p> <p>- Central Line Dressing Change with transparent semi-permeable membrane (TSM, a type of dressing used to cover catheter insertion sites, allowing observation of the site while protecting it from contamination) dressing every 7 days and PRN (as needed). Located on Right Upper Chest dated 05/21/25.</p> <p>- Enhanced Barrier Precautions due to central line IV access. Ensure appropriate PPE is used during resident care activities dated 05/22/25.</p> <p>-Daptomycin-Sodium Chloride IV Solution (antibiotic medication) Use 250 mg IV one time a day related to local infection of the skin and subcutaneous tissue, dated 05/21/25. Administer at 50 milliliters (mL) per hour (hr) over 30 minutes into the vein one time a day at the same time every day.</p> <p>Record Review of Resident 82's Comprehensive Care Plan (CCP, a document that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment) revealed staff were to use EBP due to wound on scalp and central line in place dated revised 05/28/25.</p> <p>An observation on 06/24/25 at 12:12 PM of Resident 82's PICC line dressing changed revealed MDS Coordinator (MDSC)-I performed hand hygiene and provided the resident with a mask to wear. MDSC-I prepared a sterile field, arranged supplies, then removed the old PICC line dressing. MDSC-I removed the soiled gloves, placed the soiled gloves in the sterile field where the chlorhexidine swab was exposed, performed hand hygiene, and completed the remainder of the dressing change.</p> <p>An interview on 06/24/25 at 12:30 PM with MDSC-I confirmed that soiled gloves were placed in the sterile field during the dressing change and should have been discarded elsewhere.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>B. Record review of a facility policy entitled Enhanced Barrier Precautions dated revised 03/20/24 revealed:</p> <p>-1. Prompt recognition of need.</p> <p>-a. All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions.</p> <p>-b. All staff receive training on high-risk activities and common organisms that require enhanced barrier precautions.</p> <p>2. Initiation of Enhanced barrier precautions:</p> <p>b. An order for enhanced barrier precautions will be obtained for residents with any of the following:</p> <p>i. wounds (e.g., chronic wounds such as pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers) and/or indwelling medical devices (e.g. central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes) even if the resident is not known to be infected or colonized with a MDRO.</p> <p>ii. Infection or colonization with a CDC-targeted MDRO when contact precautions do not otherwise apply.</p> <p>3. Implementation of Enhanced Barrier Precautions:</p> <p>b. PPE for EBP is only necessary when performing high-contact care activities and may not need to be donned prior to entering the resident's room.</p> <p>4. High-contact resident care activities include:</p> <p>a. Dressing</p> <p>b. bathing</p> <p>c. transferring</p> <p>d. providing hygiene</p> <p>e. changing linens</p> <p>f. Changing briefs or assisting with toileting</p> <p>g. Device care or use: central lines, urinary catheters, feeding tubes, tracheostomy/ventilator tubes.</p> <p>h. Wound care: any skin opening requiring a dressing.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6. MDROs for which EBP applies are based on local epidemiology. At a minimum, they should include resistant organisms targeted by CDC but can also include other epidemiologically important MDROs.</p> <p>9. EBP should be used for the duration of the affected resident's stay in the facility or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk.</p> <p>Record review of the facility's EBP roster dated 06/23/25 included Resident 82 for central line and wound.</p> <p>An observation on 06/24/25 at 12:12 PM of Resident 82's PICC line dressing change revealed MDS Coordinator (MDSC-I) performed the PICC line dressing change without the use of a gown.</p> <p>An interview on 06/24/25 at 12:30 PM with MDSC-I confirmed that a gown was part of EBP, was not utilized during the PICC line dressing change, and should have.</p> <p>C. Record review of a facility policy entitled Hand Hygiene dated revised 4/1/25 revealed:</p> <p>-1. Staff will perform hand hygiene when indicated, using proper technique consistent with accepted standards of practice.</p> <p>-6. The use of gloves does not replace hand hygiene. If your task requires gloves, perform hand hygiene prior to donning (applying) gloves, and immediately after removing gloves.</p> <p>An observation on 06/25/25 at 7:57 AM revealed Medication Aide (MA-S) prepared Resident 91's medications. After returning oral medication packages to the medication cart and without the benefit of hand hygiene, MA-S donned gloves, locked the computer, and locked the medication cart. MA-S administered oral medications to Resident 91 and when finished, dropped the spoon on the floor. MA-S picked up the spoon and discarded it, doffed gloves, and without the benefit of hand hygiene donned new gloves. MA-S applied a cream medication and when completed, doffed gloves. Without the benefit of hand hygiene, MA-S assisted Resident 91 with administration of a nasal spray. Without hand hygiene, MA-S lifted Resident 91's right upper eye lid, administered an eye drop and repeated the process with the resident's left eye. Without performing hand hygiene, MA-S returned to the medication cart, returned medications to the drawers, and documented the medications administered.</p> <p>An interview on 06/25/25 at 8:19 AM with MA-S confirmed that hand hygiene was not performed between glove changes or when changing from nasal spray to eye drops and should have.</p>		