STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265246	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shady Oaks Healthcare Center	335 Business Route 63 Thayer, MO 65791

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observation, interview, and record review, the facility failed to maintain an error rate of less than five percent (%) during medication administration. There were 32 opportunities with two errors made, for an error rate of 6.25%, which affected two residents (Residents #41 and #53) out of 11 sampled residents. The facility census was 65. The facility did not provide a policy regarding insulin administration.Review of the Humalog/insulin lispro (a fast-acting insulin) Pen's Manufacturer Guidelines for Priming Before Each Injection and Administration, revised 02/2023, showed:- Turn the dose selector to select two units;- Hold the pen with the needle pointing up;- Tap the cartridge gently with your finger a few times to make any air bubbles collect at the top of the cartridge;- Keep the needle pointing upwards, press the push-button all the way in;- The dose selector returns to zero;- A drop of insulin should appear at the needle tip. If not, change the needle and repeat the procedure no more than six times;- Select your dose you want to give. 1. Review of Resident #41's December 2025 Physician Order Sheet (POS) showed:- An order for Humalog Kwikpen (type of insulin pen) 10 units subcutaneous (injection under the skin) with meals related to diabetes mellitus (a disorder where the body either doesn't produce enough insulin or can't effectively use the insulin it makes, leading to high blood sugar) after the resident had eaten each meal, dated 07/17/25.Observation on 12/03/25 at 4:08 P.M. of the resident's insulin administration showed:- Certified Medication Technician (CMT) B did not prime the Humalog Kwikpen and administered Humalog 10 units to the resident;- CMT B failed to prime the Humalog insulin pen before administering the medication to the resident.During an interview on 12/03/25 at 4:10 P.M., CMT B said the insulin pen primes itself when dialing the dose to give to the resident.2. Review of Resident #53's December 2025 POS showed:- An order for insulin lispro-aabc Pen subcutaneous as per sliding scale: if blood sugar 150-200 = 3 units; 201-250 = 5 units; 251-300 = 7 units; 301-350 = 9 units; 351-400 = 11 units before meals and at bedtime for diabetes mellitus, dated 07/14/25.Observation on 12/03/25 at 11:21 A.M., of the resident's insulin administration showed:- CMT A did not put a needle on the insulin pen and attempted to prime the insulin pen but the pen would not prime without the needle attached;- CMT A administered insulin lispro-aabc 7 units to the resident;- CMT A failed to prime the insulin lispro-aabc pen before administering the medication to the resident.During an interview on 12/04/25 at 1:15 P.M., CMT A said the process for priming an insulin pen was to attach a new needle to the insulin pen, dial 2 units, push the button on top of the pen for 10 seconds to prime it. Then he/she would administer the ordered dose of insulin to the resident. The process was repeated for each insulin administration.During an interview on 12/05/25 at 10:20 A.M., Registered Nurse (RN) C said the insulin pens were primed by pushing the button on top of the insulin pen without dialing up two units of insulin to waste.During an interview on 12/05/25 at 11:45 P.M., the Director of Nursing (DON) said she would expect medications to be given as ordered and for the medication error rate to be less than five percent. Insulin pen administration should be followed by using the manufacturer's box instructions.

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

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure drugs and biologicals were labeled in accordance with currently accepted practices. This had the potential to affect all residents. The facility's census was 65.Review of the facility policy titled, Medication Labeling and Storage, revised February 2023, showed:- The nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner;- If the facility has discontinued, outdated, or deteriorated medications or biologicals, the dispensing pharmacy is contacted for instructions regarding returning or destroying these items;- Labeling of medications and biologicals dispensed by the pharmacy is consistent with applicable federal and state requirements and currently accepted pharmaceutical practices;- The medication label includes, at a minimum, the medication name (generic and/or brand), prescribed dose, strength, expiration date - when applicable, resident's name, route of administration, and appropriate instructions and precautions;- Multi-dose vials that have been opened or accessed (e.g., needle punctured) are dated and discarded within 28 days unless the manufacturer specifies a shorter or longer date for the open vial.Review of the manufacturer's information for insulin aspart (a rapid-acting insulin) pen, Lantus (a long-acting insulin) Pen, Humalog (a fast-acting insulin) Kwikpen, Basaglar (a long-acting insulin) Kwikpen, and insulin lispro (a rapid-acting insulin) Kwikpen, updated May 2024, showed:- When opened or left at room temperature, the insulin aspart Pen, Lantus Pen, Humalog Kwikpen, Basaglar Kwikpen, and insulin lispro Kwikpen expires after 28 days.1. Observation on 12/04/25 at 10:40 A.M., of the Wing 1/Wing 2 medication storage room showed: - An opened tuberculin purified protein derivative (medication to check exposure of tuberculosis (a serious bacterial infection primarily affecting the lungs)) one milliliter (ml) multidose vial, dated 9/20/25. Observation on 12/04/25 at 10:55 A.M., of the Wing 1 medication cart showed: - One opened insulin aspart (a rapid-acting insulin) Pen, dated 8/20/25 (79 days past expiration date);- One opened Lantus Pen not dated;- One opened Humalog Kwikpen not dated;- One opened Basaglar Kwikpen not dated;- One opened insulin lispro Kwikpen labeled with a room number and not a resident name, dated 09/03/25 (65 days past expiration date);- One opened insulin glargine (a long-acting insulin) Pen not dated.During an interview on 12/04/25 at 11:05 A.M., Registered Nurse (RN) D said opened insulin pens and turberculin vials should be labeled with the resident's name and dated when opened. Insulin pens and tuberculin vials were good for 28 days after opened.During an interview on 12/05/25 at 11:39 A.M., the Director of Nursing (DON) said opened insulin medications and tuberculin vials should be discarded 28 days after opened.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to provide enhanced barrier precautions (EBP) when staff failed to implement EBP for one resident (Resident #56) and failed to wear a gown during wound care for one resident (Resident #71) with a chronic wound out of five sampled residents. The facility census was 65.Review of the facility policy titled, Enhanced Barrier Precautions, dated 2024, showed:- All staff receive training on EBP upon hire and at least annually and are expected to comply with all designated precautions;- All staff receive training in high-risk activities and common organisms that require EBP;- The facility will have the discretion on how to communicate to staff which residents require the use of EBP, as long as staff are aware of which residents require the use of EBP prior to providing high-contact care activities;- EBP will be initiated for residents with wounds, and/or indwelling/implanted medical devices even if the resident is not known to be infected or colonized with a multidrug resistant organism (MDRO), and infection or colonization with a Centers for Disease Control and Prevention (CDC) targeted MDRO with contact precautions (gloves and gown are used for infectious agents that may be transmitted by direct or indirect contact with the person or the person's environment) do not otherwise apply;- Personal protective equipment (PPE) for EBP is only necessary when preforming high-contact care activities and may not need to be donned prior to entering the resident's room;- Place a yellow sticker or magnet on the name plate of the resident's door to identify the need of EBP;- High-contact resident care activities include dressing, bathing, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, and wound care;- 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 a higher risk.1. Review of Resident #56's medical record showed:- An admission date of 02/25/13;- Diagnoses of rheumatoid arthritis (an ongoing condition that causes pain, swelling and irritation in the joints), morbid obesity, moisture associated skin damage (MASD- occurs when skin is repeatedly exposed to various sources of bodily fluids) to right inner thigh, and pressure ulcer (localized injuries to the skin and/or the underlying tissue) to the right inner thigh;- No documentation the resident required EBP;- An order for wound care to the right medial (inner) thigh to cleanse with Vashe (wound cleanser), apply skin prep (a treatment that creates a protective film) to the peri wound (skin and tissue immediately surrounding a wound), apply collagen powder (a type of treatment), apply calcium alginate (a type of treatment) cut to fit inside the wound edges, secure with an island dressing (an adhesive bordered gauze dressing), cleanse with Vashe, apply skin prep to peri wound, apply collagen powder (aids in healing) to wound bed, apply calcium alginate (manage wound drainage and promote healing) cut to fit inside wound edges, secure with island dressing (adhesive bordered gauze dressing for wounds) daily and as needed for soiling or displacement, dated 11/20/25;- A Provider Note, dated 11/11/25, showed the wounds would heal and then open back up for the past two years.Observation on 12/03/25 at 11:25 A.M. of the resident's incontinent care showed:- No EBP signage outside of the resident's room;- Certified Nurse Assistant (CNA) J did not put on a gown before entering the resident room and performed incontinent care for the resident.2. Review of Resident #71's medical record showed:- An admission date of 11/25/25;- Diagnoses of acquired absence of the right leg above the knee, acquired absence of the left leg above the knee, rectal abscess (a pocket of infection) , type 2 diabetes mellitus (a disorder in which the body doesn't produce enough or respond normally to insulin which causes blood sugar levels to be abnormally high), morbid obesity, stage three (full thickness tissue loss) pressure ulcer of the coccygeal (the area surrounding the tailbone) region, and chronic ulcer of the sacral (pressure that develops over the at the base of the spine above the tailbone) region;- The resident required EBP;- An order to clean the bilateral (both left and right) above the knee amputation incisions with wound cleanser, apply bacitracin (a topical antibiotic) and Xeroform (a sterile protective dressing that will not stick to the wound), apply skin prep to the peri wound, and cover (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with 6x6 gauze, dated 12/04/25;- An order to cleanse the sacrum (a shield-shaped bony structure that is located at the base of the spine) with Vashe (a wound cleanser), apply skin prep to the peri wound, pack the wound with wet-to-wet gauze moistened with normal saline (a mixture of water and salt), and secure with gauze, an abdominal pad (a thick gauze pad used to absorb discharges from heavily draining wounds), and paper tape daily and as needed for soiling or displacement, dated 12/03/25;- An order for the coccyx (the tailbone) and left ischium (the curved bone forming the base of each half of the pelvis) wound to apply a nickel-thick layer of Triad (paste that helps maintain a moist wound healing environment) two times a day and as needed to maintain a thick layer, dated 11/25/25.Observation on 12/04/25 at 4:04 P.M. of the resident's wound care showed:- An EBP sticker above the name plate on the resident's room;- An 8 inch (in.) by 10 (in.) EBP sign taped to the resident's door;- CNA H brought two gowns into the room;- CNA H put on one gown and lay the other gown on the bedside table;- Licensed Practical Nurse (LPN) G did not put on a gown and performed the resident's wound care to the right and left surgical incisions to the above the knee amputations;- LPN G leaned over the right side of the bed and cleaned the wound to the left leg;- LPN G leaned over the right side of the bed to dress the wound to the left leg;- LPN G leaned over the right side of the bed to clean the wound to the right leg;- LPN G leaned over the right side of the bed to dress the wound to the right leg.During an interview on 12/04/25 at 4:53 P.M., LPN G said he/she forgot to put a gown on before doing the resident's wound care.During an interview on 12/05/25 at 8:30 A.M., CNA E said he/she knew residents were on EBP by the EBP signage on the nameplate. If a resident had lines, implanted devices, and/or wounds, they would be on EBP. A gown should be worn when performing high-contact care on those residents. The linen closets on each hall had PPE supplies.During an interview on 12/05/25 at 8:32 A.M., the Minimum Data Set (MDS - a federally mandated assessment to be completed by the facility staff) Coordinator said EBP was documented on a resident's Kardex (a nursing system for quick resident information) and their care plan when they were on EBP. A magnet was placed outside the door and an EBP sign was put on the door. Residents on EBP were those with chronic wounds, indwelling catheters, or tubes. Staff were to wear a gown and gloves during hands-on care which included dressing a resident or performing personal hygiene. The Infection Preventionist (IP) implemented EBP.During an interview on 12/05/25 at 8:38 A.M., CNA F said he/she knew a resident was on EBP by the EBP signage. He/she wore a gown when doing high-contact care on residents with lines, wounds, and implanted devices. PPE supplies were in the linen room on each hall.During an interview on 12/05/25 at 8:40 A.M. the Infection Preventionist (IP) said EBP was implemented on residents with any kind of line or tube and pressure ulcers. He/she did not implement EBP on Resident #56 because the wound was classified as MASD. He/she was not aware of the wound having a secondary diagnosis of a pressure ulcer.During an interview on 12/05/25 AT 11:39 A.M., the Director of Nursing (DON) and Administrator said they would expect residents with pressure ulcers or a chronic wound to be on EBP. They would expect staff to wear a gown and gloves during high-contact care of a resident on EBP or with a chronic wound.