STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265564	A. Building B. Wing	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Medicalodges Butler	103 East Nursery Butler, MO 64730

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to administer the correct insulin Lantus (a long acting insulin)10 units but instead gave the resident Novalog (fast acting insulin) 10 units at 8:00 P.M., to one sampled resident (Resident # 1) out of three sampled residents. The facility census was 68 residents. On 6/5/25 the Administrator and acting Director of Nursing (DON) were notified of past non-compliance which occurred on 3/7/25. On 3/8/25 the facility administrator was notified of the incident by Licensed Practical Nurse (LPN) A and the investigation was started. LPN A was educated on 3/8/25 and was given a written warning on 3/10/25. Employee education started on 3/8/25 before the start of there shift and finished on 4/3/25. The deficiency was corrected on 3/8/25. Review of the facility's policy Medication Administration General Guidelines dated 1/25 showed: -Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles and practices and by persons legally authorized to do so. -Prior to administration, review and confirm medication orders for each individual resident on the Medication Administration Record (MAR). -Compare the medication and dosage schedule on the resident's MAR with the medication label. -Verify medication is correct three times before administering the medication. --When pulling medication package from the medication cart. --When the dose is prepared. --Before the dose is administered. 1. Review of the resident's admission Record showed the resident was admitted to the facility on [DATE] and readmitted on [DATE] with the following diagnosis of Type II Diabetes Mellitus (a deficiency or complete lack of insulin secretion in the pancreas or resistance to insulin). Review of the resident's Care Plan dated 9/15/22 showed: -Administer insulin per physician orders. (continued on next page)

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

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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Observe for any signs/symptoms of hypo/hyperglycemia (excessive thirst, hunger, voiding, altered mental status, mood changes, excessive perspiration, weight changes, circulatory changes), and notify charge nurse/physician. -Monitor his/her blood sugars as ordered. -Notify physician of any unusual fluctuations. Review of the resident's annual Minimum Data Set (MDS - a federally mandated assessment tool completed by facility staff for care planning) dated 5/16/25 showed he/she: -Was cognitively intact. -Had a diagnosis of diabetes. -Received insulin injections. Review of the resident's Order Summary Report dated March 2025 showed: -Accucheck (blood sugar monitoring) four times a day related to Type II Diabetes. Follow diabetic protocol for blood sugar below 50 or above 450. -Lantus SoloStar 100 Unit/Milliliter (ml) Pen-Injector, inject 10 units subcutaneously (under the skin) at bedtime related to Type II Diabetes. -Novolog 100 Units/ml PenFill Cartridge, inject five units subcutaneously three times a day related to Type II Diabetes. Review of the resident's MAR dated March 2025 showed: -Accucheck four times a day on 3/7/25 were at 8:00 A.M. was 96, 12:00 P.M. was 149, 5:00 P.M. was 78, and 8:00 P.M. was 135. -Accucheck on 3/8/25 at 8:00 A.M. was 112. -Lantus SoloStar 100 Unit/ml Pen-Injector, 10 units was given to the resident on 3/7/25 at 7:47 P.M. -Novolog 100 Units/ml PenFill Cartridge, five units was given at 9:10 A.M., 12:21 P.M., and resident refused his/her 5:00 P.M. dose due to blood sugar being 78. Review of the resident's Nurse's Note dated 3/8/25 at 2:56 A.M. showed: -Humalog (rapid acting insulin) was given at 9:00 P.M. on 3/7/25. --NOTE: The resident did not have an order for Humalog. -At 1:30 A.M. on 3/8/25 LPN A realized what he/she had done. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A immediately took the resident's blood sugar and it was 34. -Resident immediately was awaken and able to speak with LPN A. -LPN A called the Nurse Practitioner (NP). -NP gave an order to give the resident two sugar tablets. -LPN A immediately gave the resident two sugar tablets, a glass of milk, and cookies. -LPN A rechecked the resident blood sugar at 2:00 A.M. and it was 65. -Resident's blood sugar was checked again at 2:49 A.M. and it was 115. Review of the resident's Physician's Telephone Order dated 3/8/25 showed: -Give two glucose tablets now. -Recheck blood sugar in 30 minutes. Review of the Medication Error Report dated 3/8/25 showed: -LPN A gave the resident 10 units of Humalog instead of 10 units of Lantus insulin as prescribed. -Resident unable to give description. -Humalog was given at 9:00 P.M. on 3/7/25. -At 1:30 A.M. on 3/8/25 LPN A realized what he/she had done. -LPN A immediately took the resident's blood sugar and it was 34. -Resident immediately was awaken and able to speak with LPN A. -LPN A called the Nurse Practitioner (NP). -NP gave an order to give the resident two sugar tablets. -LPN A immediately gave the resident two sugar tablets, a glass of milk, and cookies. -LPN A rechecked the resident blood sugar at 2:00 A.M. and it was 65. -Resident was oriented to person, place, time, and situation. -Resident was not sent to the hospital for evaluation and treatment. -LPN A did not follow rights of medication administration. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A's statement was the resident was out of Lantus insulin, so LPN A got Lantus from the E-kit and accidentally pulled Humalog and gave the resident 10 units at 9:00 P.M. At 1:30 A.M. he/she realized that he/she gave the wrong insulin. -The physician, Administrator, DON and family were notified of the incident. -Reviewed medication error of this resident's insulin. LPN A discovered his/her own mistake and called the NP for orders to correct the blood sugar. Orders were followed and resident was monitored. LPN A was educated on medication administration and written education was provided. All parties notified appropriately. Review of LPN A's Employee Warning Notice dated 3/10/25 showed: -LPN A obtained Humalog from the E-kit and administered that instead of Lantus 10 units. -LPN A did not follow proper procedure for removing E-kit medication. -LPN A failed to follow the rights of medication administration by not checking to ensure it was the correct drug. Review of the resident's Risk Progress Note dated 3/11/25 at 11:38 A.M. showed: -On 3/8/25 the resident was given 10 units of Humalog insulin at 9:00 P.M. -Order was for Lantus 10 units. -At 1:30 A.M. LPN A realized the medication error and immediately assessed the resident; blood sugar was 32. -LPN A notified NP. -Resident was given two sugar tablets, a glass of milk, and a cookie. -At 2:00 A.M. the resident's blood sugar was 65 and at 2:49 A.M. the resident's blood sugar was 115. -Root cause LPN A failed to follow right medication administration by not assessing it was the right drug. -Staff education provided immediately on right medication and administration. During an interview on 6/5/25 at 1:51 P.M., the NP said he/she: -Was notified on 3/8/25 that the resident was given Humalog 10 units instead of 10 units of Lantus. -The resident showed no other symptoms of low blood sugar that is why he/she only ordered two glucose tablets instead of the four. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-LPN A was educated right away and the rest of the staff was educated later on 3/8/25 thru 4/3/25. -The CMTs and nurses were educated before they worked their next shift. During an interview on 6/5/25 at 3:27 P.M., LPN A said he/she: -Was giving bedtime insulins and seen the resident was out of Lantus. -Went to the E-kit and took out an insulin pen and proceeded to give the resident 10 units of what he/she thought was Lantus insulin. -Did not check the insulin pen with the resident's MAR to make sure it was the right insulin and just gave the insulin pulled from the E-kit. -The medication error was found when he/she was going over the E-kit paperwork. -Resident was given 10 units of Humalog instead of 10 units of Lantus. -Went straight to the resident's room and woke the resident up and checked the resident's blood sugar. -The resident blood sugar was low at 34. -Called the NP and explained what had happened and followed the NP's orders. -Resident's blood sugar started to rise and was 65 15 minutes after giving the two glucose tablets as ordered. -Gave the resident a glass of milk and cookies to help raise the blood sugar level. -Notified the DON and Administrator of the medication error. -By 2:00 A.M., the resident's blood was 115. -Was educated by the DON while on the phone about medication administration rights to check the drug with the MAR before giving the medication. MO00250731