

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 676259	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/11/2025
NAME OF PROVIDER OR SUPPLIER Shinnery Oaks Community		STREET ADDRESS, CITY, STATE, ZIP CODE 711 West Broadway Denver City, TX 79323	
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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews and record review, the facility failed to ensure the assessment accurately reflected the resident's status for 2 of 6 (Resident #9 and #46) residents reviewed for accuracy of assessments. The facility failed to ensure Resident #9 and #46 were coded in the MDS for wander alarm. This failure could place residents at risk for receiving inadequate care and services based on an inaccurate assessment. The findings included: Resident #9 Record review of Resident #9's face sheet dated 12/10/25 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Dementia (cognitive decline), Hypertension (high blood pressure), anxiety (feeling of fear and worry) and muscle weakness. Record review of Resident #9's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 00 indicating Resident #9's cognition was severely impaired. The MDS also indicated Section P - Restraints and Alarms - section P0200 - Alarms E. Wander/Elopement alarm was marked not used. Record review of Resident #9's care plan, dated 11/05/2025, revealed a care plan for dementia/Alzheimer's and required a secure unit related to elopement risk and wanders aimlessly. Interventions revealed implement appropriate security measures, such as alarms, coded doors, and surveillance systems. Wander guard in place and functioning properly. Intervention initiated date 6/28/24 and revised date 7/2/24. Record review of Resident #9's physician orders revealed an order to check wander guard placement every shift for wander guard placement dated 05/22/2024. The physician orders further revealed an order for wander guard functioning properly, every night shift for elopement risk dated 05/22/2024. During an observation on 12/09/2025 at 11:45 AM observed Resident #9 sitting in wheelchair with wander guard bracelet on right ankle. Resident #46 Record review of Resident #46's face sheet dated 12/10/25 reflected the resident was an [AGE] year-old female who was admitted to the facility on [DATE] with the following diagnoses: Alzheimer's Dementia (cognitive decline), Hypertension (high blood pressure), Cerebral infarction (blood flow was block from part of the brain) and muscle weakness. Record review of Resident #46's Quarterly MDS assessment dated [DATE] revealed she had a BIMS score of 04 indicating Resident #46 cognition was severely impaired. Section P - Restraints and Alarms - section P0200 - Alarms E. Wander/Elopement alarm was marked not used. Record review of Resident #46's care plan, dated 11/05/2025, revealed a care plan for resident elopement related to residents wanting to go to the store. Interventions revealed wander guard in place on left lower extremity dated 11/13/2025. Record review of Resident #46's physician orders revealed an order to check wander guard placement every day and night shift for elopement risk dated 11/13/2025. The physician orders further revealed an order for wander guard placement related to exit seeking behaviors dated 11/13/2025 and an order for wander guard functioning properly, every night shift for elopement risk dated 11/13/2025. During an observation on 12/09/2025 at 11:10 AM observed resident #46 in room sitting in recliner with wander guard bracelet on left ankle. During an interview on 12/10/2025 at 03:00 PM with the MDS nurse, she reviewed Resident #9 and #46's quarterly MDS and stated they both should be marked as use daily. During an interview on 12/11/2025 at 08:50 AM with the MDS Nurse, the MDS nurse stated the purpose of the MDS was to accurately put all resident information. The MDS nurse stated she was not aware the MDS's was not (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections for 2 of 3 residents (Residents #13 and #28) reviewed for infection control. 1. RN A failed to wear proper PPE (a gown) when providing wound care for Resident #13 who was on EBP. 2. LVN B failed to wear proper PPE (a gown) when providing wound care for Resident #28 who was on EBP. These failures could place residents at risk for the spread of infection and cross contamination. 1. Record review of Resident #13's face sheet, dated 12/10/25, reflected a [AGE] year-old female who was admitted to the facility on [DATE]. Resident #13 had diagnoses which included: Alzheimer's Disease (a progressive brain disorder leading to severe cognitive decline), peripheral vascular disease (a circulatory problem resulting in reduced blood flow, and pressure ulcer of the left ankle. Record review of Resident #13's annual MDS, dated [DATE], reflected an unscored BIMS, due to the resident was rarely or never understood. Section - M - Skin Conditions reflected the resident was at risk of developing pressure ulcers. Section - G - Functional Abilities reflected the resident was dependent on staff for transfers, bathing, and toileting and required substantial/maximal assistance for eating. Record review of Resident #13's Comprehensive Care Plan, dated 10/29/25, reflected the resident had a pressure ulcer to the left ankle. Interventions included: Administer treatments as ordered and monitor effectiveness. EBP in place. Record review of Resident #13's current Physician's Orders, dated 12/10/25, reflected an order with a start date of 11/21/25 to treat the pressure injury to left ankle and apply a dressing. Further review reflected an order for Enhanced Barrier Precautions related to wounds which stated staff members will wear a clean gown and gloves while performing high contact resident care activities. During an observation on 12/10/25 at 9:40 AM, RN A performed wound care to Resident #13's left ankle wound, per physician's orders. RN A put on gloves but failed to put on a gown prior to performing wound care for Resident #13. Enhanced Barrier Precaution signage was noted to the door of Resident #13's room and a supply of PPE was noted inside Resident #13's room. During an interview on 12/10/25 at 2:48 PM, RN A stated she did not put on a gown prior to performing wound care for Resident #13 who was on EBP. She stated she did not think to put on a gown due to being nervous during the observation of wound care. She stated she had been trained on EBP through in-services conducted by nursing administration. RN A stated a gown should be worn when conducting direct care, including wound care, on any resident who was on EBP. She stated a potential negative outcome for failure to utilize proper PPE during direct care of a resident on EBP was infection. 2. Record review of Resident #28's face sheet, dated 12/10/25, reflected an [AGE] year-old male who was admitted to the facility on [DATE]. Resident #28 had diagnoses which included: atrial fibrillation (a type of irregular heartbeat which makes the heart less efficient at pumping blood), pressure-induced deep tissue damage of other site (a pressure sore), and unspecified dementia. Record review of Resident #28's quarterly MDS, dated [DATE], reflected a BIMS score of 02, which indicated the resident had severe cognitive impairment. Section - M - Skin Conditions reflected the resident was at risk of developing pressure ulcers. Record review of Resident #28's Comprehensive Care Plan, revised 11/25/25, reflected the resident had a DTI to the 3rd digit on the right foot. Interventions included: Administer treatments as ordered and monitor effectiveness. Enhanced Barrier Precautions; staff members will wear a clean gown and gloves while performing high contact resident care activities. Record review of Resident #28's current Physician's Orders, dated 12/10/25, reflected an order with a start date of 11/26/25 to treat deep tissue injury to the 3rd digit of the right foot and apply a dressing daily. Further review reflected an order for Enhanced Barrier Precautions related to wounds and stated staff members will wear a clean gown and gloves while performing high contact resident care activities. An order with a start date of 12/09/25 (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reflected, Enhanced Barrier Precautions related to wounds. During an observation on 12/10/25 at 9:49 AM, LVN B performed wound care to Resident #28's right foot wound, per physician's orders. LVN B put on gloves but failed to put on a gown prior to performing wound care for Resident #28. Enhanced Barrier Precaution signage was noted to the foot of Resident #28's bed and a supply of PPE was noted inside Resident #28's room. During an interview on 12/10/25 at 2:52 PM, LVN B stated she did not put on a gown prior to performing wound care for Resident #28 who was on EBP. She stated she was unsure why she did not put a gown on before performing wound care. She stated, I guess I was just nervous because I normally put a gown on before doing wound care. LVN B stated she had been trained on EBP approximately quarterly through in-services conducted by nursing administration. LVN B stated a gown should be worn when conducting direct care, including wound care, on any resident who was on EBP. She stated a potential negative outcome for failure to utilize proper PPE during direct care of a resident on EBP was infection and cross-contamination. During an interview on 12/11/25 at 3:43 PM, the ADM stated he was not aware staff were performing wound care on EBP residents without utilizing proper PPE. He stated a gown should be worn during wound care of a resident on EBP. The ADM stated the nurse performing wound care was responsible for utilizing proper PPE. He stated nursing administration was responsible for monitoring staff to assure EBP guidelines and standards of care were followed. The ADM was asked to state a potential negative outcome for failure to utilize proper PPE during direct care of a resident on EBP and he stated, I cannot assume what the negative outcome would be. During an interview on 12/11/25 at 3:50 PM, the DON stated the direct care nurse was responsible for utilizing proper PPE during care of an EBP resident. She stated nursing administration was responsible for monitoring, training and assuring staff adhere to EBP guidelines. The DON stated the ADON conducted rounds in the facility to monitor and ensure staff were following EBP guidelines. She stated staff were trained on EBP through in-services conducted by nursing administration. The DON stated a potential negative outcome for failure to utilize proper PPE during direct care of a resident on EBP was the transfer of diseases. Record review of the facility's undated sign posted outside Resident #13's door and on the foot of Resident #28's bed, titled, Enhanced Barrier Precautions, reflected: PROVIDERS AND STAFF MUST ALSO: Wear gloves and a gown for the following High-Contact Resident Care Activities .Wound Care; any skin opening requiring a dressing Record review of the facility-provided policy titled, Modified Isolation or Enhanced Barrier Precautions; Based on guidance recommendation from the Centers for Disease Prevention and Control 07/2022, reflected: Enhanced Barrier Precautions expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for the transfer of MDROs to staff hands and clothing. Examples of high-contact resident care activities requiring gown and glove use for Enhanced Barrier: .Wound care: any skin opening requiring a dressing.		