STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265874	A. BUILDING _____ B. WING _____	03/13/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WINCHESTER NURSING CENTER, INC	400 WINCHESTER DR, PO BOX 760 BERNIE, MO 63822

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

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F 0582 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** Based on interview and record review, the facility failed to issue the Notice of Medicare Non-Coverage (NOMNC) and the Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) forms when a resident's Medicare covered services had ended for three residents (Resident #34, #35, and #36) out of three sampled residents. The facility census was 34. 1. Record review of Resident #34's medical record showed: - The resident discharged from Medicare skilled services on 12/3/19, and remained in the facility; - The facility failed to get a date of signature of patient or authorized representative on the SNF ABN form. 2. Record review of Resident #35's medical record showed: - The resident discharged from Medicare skilled services on 9/19/19, and discharged from the facility; - The facility failed to get a date of signature of patient or authorized representative on the SNF ABN and the NOMNC form. 3. Record review of Resident #36's medical record showed: - The resident discharged from Medicare skilled services on [DATE], and remained in the facility; - The facility failed to get a signature and date of patient or authorized representative on the NOMNC form. During an interview on 3/13/20 at 11:00 A.M. the Administrator said she knew when therapy notified staff of discharging the services for a resident, staff sends the necessary forms along with a self-stamped addressed envelope to the representative to be signed and dated, then returned. She said no one had been monitoring the forms for dates and signatures. The facility did not provide a policy for issuance of NOMNC and SNF ABN forms when a resident's Medicare covered services had ended.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interview, the facility staff failed to to follow their policy and procedure to complete a Criminal Background Check (CBC) for two of six sampled staff prior to hire and to check the Certified Nurses' Assistant (CNA) Registry for all staff to ensure they did not have a Federal Indicator (a marker given by the federal government to individuals who have committed abuse/neglect), for one of six sampled staff. The facility census was 34. Record review of the facility's policy and procedure for Applicant Background Screening Investigations, revised March 2019, showed: - The facility conducts employment background screening checks, reference checks and criminal conviction investigation checks on all applicants for positions with direct access to residents; - The Director of Personnel, or designee, conducts background checks, reference checks and criminal convection checks (including fingerprinting as may be required by state law) on all potential direct access employees and contractors; - Background and criminal checks are initiated within two days of an offer of employment or contract agreement, and completed prior to employment; - For any individual applying for a position as a Certified Nursing Assistant, the state nurse aide registry is contacted to determine if any findings of abuse, neglect, mistreatment of [REDACTED]. Review of the facility personnel records showed: - CNA B hired on 6/21/19, facility did not provide evidence of a CBC prior to hire; - CNA C hired on 1/3/19, facility did not provide evidence of a CBC prior to hire; facility did not provide CNA Registry check prior to hire. During an interview on 3/13/20 at 11:19 A.M., the Director of Nursing said he/she would expect that a background check and Nurse Aide Registry check be completed before an employee is hired.
F 0625 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide written notification regarding their bed-hold policy at the time of transfers for three residents (Resident #2, #7, and #16) of three sampled residents. The facility census was 34. Review of the facility's Bed-Hold and Returns Policy, dated March 2017, showed: - Prior to transfers and therapeutic leaves, residents or resident representatives will be informed in writing of the bed-hold and return policy. 1. Record review of Resident #2's nurse's notes showed: - Resident transferred to the hospital for medical evaluation on 2/17/20 and readmitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of the bed-hold policy provided to the resident or the resident's representative at the time of the transfer. 2. Record review of Resident #7's nurse's notes showed: - Resident transferred to the hospital for medical evaluation on 2/19/20 and readmitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of the bed-hold policy provided to the resident or the resident's representative at the time of the transfer. 3. Record review of Resident #16's nurse's notes showed: - Resident transferred to the hospital for medical evaluation on 11/28/19 and readmitted to the facility on [DATE]. Review of the resident's medical record showed no documentation of the bed-hold policy provided to the resident or the resident's representative at the time of the transfer. During an interview on 3/12/20 at 10:17 A.M., the Director of Nursing (DON) said the facility gives bed hold information on admission, no bed hold notification is given at time of transfer to the hospital.
F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** Based on interview and record review, the facility failed to electronically transmit all Minimum Data Sets (MDS); a federally mandated assessment instrument to be completed by facility staff in a timely manner and in accordance to guidelines for one resident (Resident #1) outside the sample. The facility's census was 34. Record review of the facility's policy on MDS Completion and Submission and Timeframe's, dated July 2017 showed: - The facility will conduct and submit assessments in accordance with current federal and state submission timeframes; - Timeframes for completion and submission of assessments is based on the current requirements published in the Resident Assessment Instrument Manual (RAI) manual. 1. Record review of Resident #1's medical record showed: - Last MDS completed on 10/31/19; - discharged from facility on 1/01/20; - Submitted on 3/13/20 (73 days late), over 120 days from 10/31/19. During an interview on 3/13/20 at 9:15 A.M., the MDS coordinator said she thought the MDS for this resident had been submitted. During an interview on 3/13/20 at 11:30 A.M., the Corporate MDS coordinator said the discharge MDS for this resident had been missed, but was submitted today. Record review of the facility's policy on Resident Assessments, dated November 2019 showed a discharge assessment is

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

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F 0640 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) conducted when a resident is discharged from the facility.
F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to provide adequate incontinent care of three residents (Resident #12, #25, and #27) out of six sampled residents. The facility census was 34. 1. Record review of Resident #12's annual Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 1/2/20 showed: - Frequently incontinent of bowel and bladder; - Extensive assistance of two staff for toileting. Observation on 3/11/20 showed: - At 11:39 A.M. Certified Nurse Aide (CNA) D and CNA E entered Resident #12's room; - CNA D removed the resident's urine soaked brief; - CNA D cleaned the resident's front periarea; - CNA E rolled the resident to his/her side; - CNA D cleaned the resident's right hip; - CNA E placed a clean brief under the resident; - CNA D and CNA E fastened the clean brief; - CNA D or CNA E did not clean the resident's left hip or rectal area. 2. Record review of Resident #25's MDS, dated [DATE], showed: - Occasionally incontinent of bowel and bladder; - Limited assistance of one staff for toileting; Observation on 3/11/20 showed: - At 11:27 A.M. CNA D and CNA E entered Resident #25's room; - CNA D and CNA E donned gloves; - CNA D removed the resident's urine soaked brief, cleansed the resident's front periarea; - CNA E rolled the resident to his/her side; - CNA D placed a clean brief under the resident; - CNA E rolled the resident to his/her back, fastened the brief; - CNA D did not clean the resident's hips, buttocks, or rectal area. 3. Record review of Resident #27's MDS, dated [DATE], showed: - Occasionally incontinent of bowel and bladder; - Limited assistance of one staff for toileting; Observation on 3/12/20 showed: - At 10:05 A.M. CNA E assisted Resident #27 to the bathroom; - CNA E removed the resident's urine soaked brief as he/she stood next to the commode; - From behind the resident, CNA E reached between resident's legs with a cleansing wipe and made one swipe towards the residents rectal area; - CNA E placed a clean brief on resident, pulled his/her pants up, and sat him/her back in the wheelchair; - CNA E did not clean the resident's front peri area, buttocks, or hip areas. During an interview on 03/13/20 at 10:56 AM CNA E said when providing peri-care for a resident with a urine soaked brief, all of the peri areas, front and back, and hips should be cleaned. During an interview on 3/13/20 at 10:58 A.M. Licensed Practical Nurse (LPN) F said when staff is providing peri-care for a resident, all areas should be cleaned. Record review of the facility's policy on Perineal Care, date February 2018, showed: - For a male resident, retract foreskin of the uncircumcised male; - Wash and rinse urethral area using a circular motion; - Continue to wash the perineal area including the penis, scrotum and inner thighs; - Thoroughly rinse perineal area in same order, using fresh water and clean washcloth; - Ask the resident to turn on his side with his upper leg slightly bent, if able; - Wash and rinse the rectal area thoroughly, including the area under the scrotum, the anus, and the buttocks.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow a physician's orders for two residents (Resident #2 and #31) out of 12 sampled residents by not reporting weight gain as ordered. The facility census was 34. 1. Record review of Resident #2's Physician's Order Sheet (POS) dated March 2020, showed: - A [DIAGNOSES REDACTED].) in a day or more than 5 lbs. in a week. Record review of the facility's weights and vitals summary for the resident showed: - From 2/9/20 to 2/10/20 -181 lbs. to 182.2 lbs. (2.2 lb. weight gain) - From 2/13/20 to 2/14/20 -180 lbs. to 182.6 lbs. (2.6 lb. weight gain); - From 2/29/20 to [DATE] -180.4 lbs. to 185.2 lbs. (4.8 lb. weight gain); - From 3/3/20 to 3/4/20 -185.2 lbs. to 189.2 lbs. (4 lb. weight gain). Review of the resident's medical record showed no documentation of the physician being notified of the weight gains. Record review of the resident's care plan, last updated 3/2/20 showed: - On daily weights; - Notify my physician of a 2 lb. weight gain in a day or 5 lb. in a week; - Monitor for any significant weight gain caused by fluid; - Monitor for signs and symptoms of [MEDICAL CONDITION]/difficulty breathing. 2. Record review of Residents #31's POS, dated March 2020 showed: - An order to weigh the resident daily; - An order to notify the physician of a weight gain or more than 2 lbs. in a day or more than 5 lbs. in a week; - an order for [REDACTED]. to 194.2 lbs. (8 lb. weight gain); - From 3/7/20 to 3/8/20 - 189.6 lbs. to 192 lbs. (2.4 lb. weight gain); - From [DATE] to [DATE] - 191.2 lbs. to 193.2 lbs. (2 lb. weight gain). Record review of the resident's care plan, last updated 12/20/19 showed: - On daily weights; - Notify physician of weight gain of 2 lbs. in a day or more than 5 lbs. in a week; - Monitor for signs and symptoms of [MEDICAL CONDITION] or difficulty breathing; - Administer diuretic (a fluid tablet) as ordered. During an interview on 3/12/20 at 2:13 P.M. Licensed Practical Nurse (LPN) F said the restorative aide is responsible to weigh each resident, however if he/she is not here than another staff member weighs the residents. LPN F said if there is ever a discrepancy in weight then the wheelchair weight needs to be verified. Someone could have removed a foot pedal or added one and the weight would be incorrect. He/she said if the weight is truly a weight gain then the physician's order should be followed and the physician should be notified. During an interview on 3/12/20 at 2:45 P.M. the Family Nurse Practitioner (FNP) said he/she did not have any calls in regards to these resident. The FNP said the facility should be following the physician's orders and contacting the office of resident's weight gain. If the facility thought it was inaccurate the resident should be re-weighed. He/She said especially a resident with a [DIAGNOSES REDACTED]. Record review of the facility's policy on Weighing and Measuring the Resident, dated March 2011, showed: - The purpose of this procedure are to determine the resident's weight and height, to provide a baseline and ongoing record of the resident's body weight as an indicator of the nutritional status and medical condition of the resident. - When weighing the resident the following guidelines will promote accurate weight assessment across time; - Weigh at the same time of day each time; - Use the same scale for weighing the resident each time; - If possible, weigh the resident with approximately the same amount of clothing on the resident each time; - Be sure the weight scale is calibrated. - Report significant weight loss/weight gain to the nurse supervisor.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide restorative services for two residents (Resident #10 and #21) out of four sampled residents. The facility census was 34. Review of the facility's Restorative Nursing Services Policy, dated July 2017, showed: - Residents will receive restorative nursing care as needed to help promote optimal safety and independence; - Residents may be started on a restorative nursing program upon admission, during the course of stay or when discharged from rehabilitative care; - The resident or representative will be included in determining goals and the plan of care; - Restorative goals may include, but are not limited to supporting and assisting the resident in; - Adjusting or adapting to changing abilities; - Developing, maintaining or strengthening his/her physiological and psychological resources; - Maintaining his/her dignity, independence and self-esteem. 1. Record review of Resident #10's quarterly Minimum Data Set (MDS), a federally mandated assessment instrument, completed by facility staff, dated 12/26/19, showed: - Resident has a BI[CONDITION] (Brief Interview for Mental Status) score of 15 (indicating full cognitive ability); - Extensive assistance of two staff members for transfers between surfaces including to and from bed, chair, and wheelchair; - To walk in the room or the corridor did not occur; - Use of a wheelchair for mobility; - Impairment on both sides of the upper and lower extremities. Record review of Resident #10's medical chart, showed: - [DIAGNOSES REDACTED]. Observation of Resident #10 on [DATE] at 2:59 P.M., showed: - Resident lay in bed, unable to move his/her legs and arms; - An adaptive call bell device attached to bedside table, located near resident's mouth, that resident must blow into to get assistance from staff. During an interview on [DATE] at 2:59 P.M., the resident said he/she did receive some occupational therapy, but that ended in October 2019, and thought he/she was supposed to be on restorative services after that, but no one has provided that to him/her. During an interview on 3/12/20 at 1:57 P.M., the Restorative

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) Nurse Aide (RNA) A said he/she has never received a restorative care plan for the resident and has not provided any restorative services to him/her since he/she has been here. During an interview on 3/12/20 at 2:10 P.M., the Director of Nursing (DON) said he/she can not locate a restorative service recommendation plan from the therapy department, but he/she will check with the resident and get him/her on restorative services if he/she wishes to do so. 2. Record review of Resident #21's Quarterly MDS, dated [DATE], showed: - Extensive assistance of two staff members for be mobility; - Total assistance of two staff members for transfers between surfaces including to and from bed, chair, and wheelchair; - To walk in the room or the corridor did not occur; - Use of a wheelchair for mobility; - Impairment on one side of the upper and lower extremities. Record review of Resident #21's Physician order [REDACTED]. Review of Occupational Therapy progress and discharge summary showed: - On 10/2[DATE]9 the resident was discharged from therapy services; - A recommendation to start restorative services, focusing on increasing and maintaining range of motion to right upper extremity (RUE). - Nursing staff instructed to position patient with RUE sling, and right lower extremity (RLE) foot positioner. Observations of the resident showed: - On [DATE] at 10:04 A.M., the resident sat in his/her room wearing a sling to RUE and RLE on a foot positioner; - On [DATE] at 12:19 P.M., the resident sat in dining room eating lunch wearing a sling to RUE and RLE on foot positioner; - On 3/12/20 at 11:45 A.M., the resident sat at dining room table wearing a sling to RUE and RLE on foot positioner; During an interview on 3/13/20 at 11:20 P.M., the RNA A said this resident was not on her restorative list and has not been receiving any restorative services. During an interview on 3/13/20 at 9:03 A.M., the DON said she has talked with the Therapy Department, and they have worked out a communication plan to make sure the Restorative recommendations from them does not get over looked in the future.
F 0756 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility pharmacist failed to identify and/or report the use of an as needed (PRN) [MEDICAL CONDITION] (a drug that affects mood, thoughts, behavior and or perception) medication prescribed and/or administered for excessive duration greater than 14 days during the pharmacist's monthly Medication Regimen Review (MRR) for one resident (Resident #2) out of 12 sampled residents. The facility census was 34. Review of the facility's Antipsychotic medication Use policy, dated December 2016, showed: - The need to continue PRN orders for [MEDICAL CONDITION] medications beyond 14 days requires the practitioner to document the rational for the extender order; - The duration of the PRN order will be indicated in the order. 1. Record review of Resident #2's Physician order [REDACTED]. Record review of the Pharmacist's Monthly Medication Review log, dated 2/21/20, showed no recommendations from the Pharmacist. During an interview on 3/12/20 at 2:05 P.M., the Pharmacist said, the PRN [MEDICATION NAME] should have had a 14 day stop, the resident was in the hospital when I was there. The Pharmacist said she could have documented the resident was in the hospital and on his/her return the medication needed the 14 day stop date.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility staff failed to ensure that as needed (PRN) orders for anti-anxiety medications were limited to 14 days for one resident (Resident #2) of 12 sampled residents. The facility census was 34. 1. Review of Resident #2's Physician order [REDACTED]. - The prescribing practitioner did not document that it was appropriate for the PRN anti-anxiety medication to be extended beyond 14 days and did not document the rationale in the medical record and indicate the duration for the PRN order. Record review of the Medication Administration Record [REDACTED]. During an interview on 03/12/20 at 2:05 P.M., the Pharmacist said the medication should have had a stop date. During an interview on 03/12/20 at 1:10 P.M. the Director of Nursing (DON) said the medication should have had a duration with justification or a 14 day stop date. Review of the facility's Antipsychotic Medication Use policy, dated December 2016, showed: - The resident will not receive PRN doses of [MEDICAL CONDITION] medications unless that medication is necessary to treat a specific condition that is documented in the clinical record; - The need to continue PRN orders for [MEDICAL CONDITION] medications beyond 14 days requires the practitioner to document the rationale for the extender order; - The duration of the PRN order will be indicated in the order.
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 staff failed to ensure proper infection control practices were followed for three residents (Resident #2, #16 and #25) out of six sampled residents. The facility census was 34. 1. Record review of Resident #2's significant change Minimum Data Set (MDS), a federally mandated assessment instrument completed by staff, dated 3/4/20 showed: - Always incontinent of bowel and bladder; - Extensive assistance of two staff for toileting. Observation on 03/11/20 at 11:45 AM showed; - The resident lay in bed; - CNA A and CNA G donned gloves; - CNA A rolled the resident to the right side, CNA G placed a bedpan under resident; - CNA A rolled the resident to the right side, CNA G removed the bedpan containing stool; - CNA G cleaned the resident's front periarea; - CNA A rolled the resident to his/her side; - CNA G wearing the same soiled gloves, cleaned the residents back periarea; - Wearing the same soiled gloves, CNA G moved the residents wheelchair, opened the dresser drawer, got a brief and placed it under the resident; - Wearing the same soiled gloves CNA G, placed the brief under the resident, and assisted CNA A with putting the residents pants on; - CNA G did not change gloves between dirty and clean. 2. Record review of Resident #16's annual MDS, dated [DATE], showed: - Always incontinent of bowel and bladder; - Total dependence of two staff members for toileting. Observation on 03/11/20 at 1:42 P.M., showed: - The resident lay in bed wearing a urine soiled brief; - CNA A and CNA G donned gloves; - CNA G removed the tabs on brief, removed the urine soiled brief from the resident; - CNA G cleaned the resident's front periarea; - CNA A rolled the resident to his/her side; - CNA G cleaned the resident's backside; - CNA A rolled the resident to his/her back; - CNA G wearing the same soiled gloves, placed a clean brief under the resident; - CNA A and CNA G repositioned the resident up in the bed and covered the resident; - CNA G placed the residents call light within reach wearing the same soiled gloves; - CNA G did not change gloves between dirty and clean. During an interview on 3/13/20 at 11:25 A.M., CNA A said gloves should be changed between dirty and clean areas, before covering and positioning the resident, before touching resident belongings, and getting supplies. During an interview on 3/13/20 at 11:43 A.M., CNA G said glove should be changed between areas, when dirty, before touching resident clothing, bedding, furniture, and getting supplies. 3. Record review of Resident #25's quarterly MDS, dated [DATE] showed: - Occasionally incontinent of bowel and bladder; - Limited assistance of one staff member for toileting. Observation on 3/11/20 at 11:27 A.M. showed;- The resident lay in bed wearing a urine soaked brief; - CNA D and CNA E donned gloves; - CNA D removed the tabs on brief, removed the urine soaked brief from the resident; - CNA D cleaned the resident's front periarea; - CNA E rolled the resident to his/her side; - CNA E wearing the same soiled gloves, placed a clean brief under the resident; - CNA E did not change gloves between dirty and clean. During an interview on 3/13/20 at 11:23 A.M. Licensed Practical Nurse (LPN) F said anytime the gloves are soiled they need to be changed. He/she said the gloves should be changed between dirty and clean. During an interview on 3/13/20 at 11:55 A.M., the Director of Nursing (DON) said she would expect staff to change gloves anytime they are soiled, between dirty and clean and before touching the residents belongings. The facility did not provide a policy on glove changing.