STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265874	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Nursing Center, Inc	400 Winchester Dr Bernie, MO 63822

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45872 Based on observation, interview, and record review, the facility failed to provide a safe, clean and comfortable homelike environment. This deficient practice had the potential to affect all residents in the facility. The facility census was 44. Review of the facility's policy titled, Homelike Environment, revised 2021, showed: - Residents are provided with a safe, clean, comfortable and homelike environment and encouraged to use their personal belongings to the extent possible; - Staff provides person-centered care that emphasizes the residents' comfort, independence and personal needs and preferences; - The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting which include a clean, sanitary and orderly environment. Observations made on 05/06/24 at 10:07 A.M., 05/07/24 at 3:13 P.M. and 05/08/24 at 12:17 P.M. , of the 100 Hall, showed: - A large stained area on the privacy curtain located next to bed 2 near the window in room [ROOM NUMBER]; - Several stained areas and markings on the privacy curtain located next to bed 1 near the door in room [ROOM NUMBER]. Observations made on 05/06/24 at 10:14 A.M., 05/07/24 at 3:42 P.M. and 05/08/24 at 12:25 P.M. , of the 200 Hall, showed: - A stained area and a thick liquid substance on the privacy curtain with areas of a thick liquid mucus substance on the wall located next to bed 1 near the door in room [ROOM NUMBER]; - Several stained areas on the privacy curtain located next to bed 2 near the window in room [ROOM NUMBER]; (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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Two large stained areas on the privacy curtain located next to bed 2 near the window in room [ROOM NUMBER]. During an interview on 05/06/24 at 10:22 A.M., Resident #1 said the privacy curtains have had stains for awhile. He/She did not remember when the last time his/her privacy curtain had been taken down and cleaned. During an interview on 05/08/24 at 12:26 P.M., Resident #34 said he/she had noticed his/her privacy curtain had stains. He/She did not remember the last time his/her privacy curtain had been taken down and cleaned. During an interview on 05/09/24 9:15 A.M., Housekeeper A said resident rooms are cleaned daily, but wasn't aware of a daily checklist. He/She notifies the nurse if a privacy curtain needs cleaned. He/She has not seen any privacy curtains that needed to be cleaned recently. During an interview on 05/09/24 9:22 A.M., Housekeeper B said there is a checklist posted on the housekeeping cart he/she follows when cleaning resident rooms. He/She notifies maintenance when privacy curtains need to be taken down and cleaned. He/She has not noticed any privacy curtains that needed cleaned, but has reported a couple in the past to maintenance. Review of the housekeeping cleaning schedule and the daily checklist posted on the cleaning cart showed privacy curtains not addressed. During an interview on 05/09/24 at 9:15 A.M., the maintenance supervisor said he/she would expect housekeeping to notify him/her of any privacy curtain that needed to be taken down and cleaned. During an interview on 05/09/24 9:39 A.M., the Administrator said she would expect housekeeping to check privacy curtains daily to ensure they are free of stains. She would expect housekeeping to notify maintenance if a privacy curtain needed to be taken down and cleaned as needed.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 26904 Based on interview and record review the facility failed to follow physician's orders for daily weights for one resident (Resident #40) out of 12 sampled residents. The facility census was 44. The facility did not provide a policy. 1. Review of Resident #40's Physician Order Sheet, dated May 2024, showed: - An order to obtain daily weight, one time a day, dated 03/21/24; - Diagnosis of congestive heart failure (when the heart does not pump like it should and fluid can build up around the heart). Review of the resident's medical chart showed: - March 21, 2024 through March 31, 2024 three missed out of 11 opportunities; - April 2024 12 missed out of 30 opportunities; - May 1, 2024 through May 8, 2024 five missed out of eight opportunities. During an interview on 05/29/24 at 1:55 P.M., Licensed Practical Nurse (LPN) D said if a resident has a weight ordered then it should be done and documented on the Treatment Administration Record (TAR). During an interview on 05/29/24 at 2:07 P.M., the Director of Nursing (DON) said if the resident has an order for daily weights, vitals or anything else it should be documented in the computer on the vital tab. He/She said if the residents refuse then it should also be documented in the progress note.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48532 Based on observation, interview and record review, the facility failed to follow standards of practice to have a physician's order for an indwelling catheter (a tube inserted into the urinary bladder to drain urine), failed to obtain orders to change catheter every 30 days and failed to ensure documentation of the catheter changes were maintained for one resident (Resident #6) out of three sampled residents. The facility census was 44. The facility did not provide a policy. Record review of Resident #6's Physician Order Sheet (POS), dated May 2024, showed: - An admitted [DATE]; - No order for Foley catheter. Observation made on 05/06/24 at 9:23 A.M., showed the resident resting in bed and catheter bag visible from doorway. Observation made on 05/07/24 at 8:44 A.M., showed the resident resting in bed and catheter bag visible from doorway. During an interview on 05/09/24 at 11:15 A.M., Registered Nurse (RN) E, said he/she would expect an order to change catheter (every 30 days or when needed) and an order with what size of catheter to use. He/She said hospice and the facility are responsible for providing catheter care for the resident. During an interview on 05/09/24 at 11:28 A.M., the Hospice Facility Case Manager said hospice will come to facility to change catheter if there is a problem with the catheter. There is no order for catheter change monthly or with what size to change it to, if the facility ever needs to change it at the facility.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 26904 Based on interview and record review, the facility failed to provide documentation of ongoing assessments, monitoring, and communication between the facility and the dialysis (a process for removing waste and excess water from the blood) center for two residents (Residents #40 and #42) out of two sampled residents. The facility census was 44. Review of the facility's policy titled, Hemodialysis Catheters-Access and Care Of, dated February 2023, showed: - Check patency (open/unobstructed) of the site at regular intervals. Palpate (examine by touch) the site to feel the thrill (a vibrating sensation) or use a stethoscope to hear the bruit (the sound of blood flowing through a narrowed blood vessel) through the dialysis access site; - The dressing change is done in the dialysis center after treatment; - The nurse should document in the resident's medical record every shift information such as: the location of the catheter (a flexible tube used for dialysis); the condition of the dressing; if dialysis was done during the shift, any part of report from the dialysis nurse about after dialysis care being given, and observations of after dialysis. 1. Review of Resident #40's Physician's Order Sheet (POS), dated May 2024, showed: - admitted [DATE]; - No order for dialysis with the specific days for dialysis; - An order to obtain weights on dialysis days, dated 01/25/24; - An order to obtain vital signs before and after dialysis; - An order to check the bruit and the thrill every shift, dated 01/25/24. Review of the resident's medical record showed: - Diagnoses of end stage renal disease (ESRD - when the kidneys are no longer able to work at a level needed for day-to-day life), high blood pressure, heart failure (when the heart does not pump blood as well as it should), and peripheral vascular disease (PVD - a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs); - March 2024 weights with four out of 13 opportunities missed; - April 2024 weights with three out of 13 opportunities missed; - Dialysis Communication logs, dated 02/01/24 through 05/07/24, with 17 out of 39 opportunities missed; (continued on next page)

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	265874	A. Building B. Wing	05/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- March 2024 vital signs with four out of 13 opportunities missed; - April 2024 vital signs with four out of 13 opportunities missed; - March 2024 bruit and thrill checked with seven out of 93 opportunities missed; - April 2024 bruit and thrill checked with five out of 90 opportunities missed; - May 1, 2024 through May 7, 2024, bruit and thrill checked with three out of 21 opportunities missed; -The facility failed to provide and obtain consistent pre-and post-dialysis communication with the dialysis center; - The facility failed to obtain weights, vital signs, and check bruit and thrill as ordered. Review of the resident's care plan, reviewed on 05/01/24, showed: - The resident needed dialysis related to hypertensive chronic kidney disease (high blood pressure causes damage to the kidneys); - The resident was at risk for complications related to renal failure (the kidneys lose the ability to remove waste and balance fluids); - Auscultate (examine by listening with a stethoscope) and palpate the fistula as ordered for a pulse and a bruit; - Dialysis communication form be completed on dialysis days; - Resident received dialysis every Tuesday, Thursday and Saturday. 2. Review of Resident #42's POS, dated May 2024, showed: - admitted [DATE]; - No order for dialysis with the specific days for dialysis; - An order for weights on dialysis days, dated 03/11/24; - An order to obtain vital signs before and after dialysis, dated 03/11/24; - An order to check the bruit and thrill every shift, dated 03/03/24; - An order to remove the dialysis dressing four hours after dialysis, dated 03/11/24. Review of the resident's medical record showed: (continued on next page)

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	265874	A. Building B. Wing	05/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Diagnoses of ESRD, high blood pressure, heart failure, PVD and diabetes mellitus (DM - a disease that occurs when your blood sugar is too high); - March 2024 weights with five out of nine opportunities missed; - April 2024 weights with eight out of 13 opportunities missed; - May 2024 weights with three out of four opportunities missed; - Dialysis Communication logs, dated 03/11/24 through 05/07/24, with 17 out of 26 opportunities missed; - March 2024 vital signs with nine out of 18 opportunities missed; - April 2024 vital signs with seven out of 26 opportunities missed; - March 2024 bruit and thrill checked with eleven out of 28 opportunities missed; - April 2024 bruit and thrill checked with five out of 39 opportunities missed; -The facility failed to provide and obtain consistent pre-and post-dialysis communication with the dialysis center; - The facility failed to obtain weights, vital signs, and check bruit and thrill as ordered. Review of the resident's care plan, reviewed on 03/29/24, showed: - The resident needed dialysis related to renal failure; - The resident was at risk for complications related to renal failure; - Auscultate and palpate the fistula as ordered for a pulse and bruit; - Obtain weight on dialysis days; - Dialysis communication form to be completed on dialysis days; - Resident received dialysis every Monday, Wednesday and Friday. During an interview on 05/29/24 at 1:54 P.M., Licensed Practical Nurse (LPN) D said if a resident had a weight ordered, then it should be done and documented on the Treatment Administration Record (TAR). Staff should be checking the resident's fistula for a thrill and bruit. If the weights were not obtained before the resident left the facility for dialysis, then the dialysis center did pre- and post- dialysis weights and they could use those weights and document it on the TAR. (continued on next page)

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	265874	A. Building B. Wing	05/09/2024

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 2:06 P.M., the Director of Nursing (DON) said if the resident had an order for weights, vitals signs, or anything else, it should be documented. If the resident had refused, then it should also be documented in the progress notes She expected staff to check the bruit and thrill, assess the dressing as ordered, get weights on dialysis days, and get vital signs before and after dialysis, and all of it should be documented. 48532

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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. 48532 Based on observation, interview and record review, the facility failed to maintain a medication error rate of less than five percent (%). There were 25 opportunities with three errors made, resulting in an error rate of 12% for five residents (Residents #9, #25, #28, #34 and #42) out of five sampled residents. The facility's census was 44. Review of the facility's policy titled, Administering Medications, dated April 2019, showed: - Medications are administered in accordance with prescriber orders, including any required time frame; - The policy did not address insulin pen administration technique. Review of the Humalog/lispro (a rapid insulin injected just below the skin that helps lower mealtime blood sugar spikes) Kwik Pen (Insulin in a pen-type device) instructions, revised, July 2023, showed: - Pull the Kwik Pen cap straight off; - Wipe the rubber seal with an alcohol swab; - Check the liquid in the Pen which should be clear and colorless; - Place the new capped needle straight onto the Pen and twist the needle on until it is tight; - Pull off the outer needle shield. Do not throw away; - Pull off the inner needle shield and throw it away; - Prime the pen by turning the dose knob to two units; - Hold the pen with the needle pointing up; - Tap the cartridge holder gently to collect air bubbles at the top; - Push the dose knob in until it stops, and 0 is seen in the dose window, count to five slowly, insulin will be visible at the tip of the needle; - Select the dose; - Give the injection after selecting the area and cleaning the site with an alcohol swab. Review of the Novolog/aspart (fast-acting insulin injected just below the skin that helps lower mealtime blood sugar spikes) Flex Pen administration instructions, dated September 2021, showed: (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Check label to make sure that the FlexPen contains the correct type of insulin; - Pull off the pen cap; - Remove paper tab from cap needle; attach needle to pen so that it is straight and secure; - Pull off outer needle cap, pull off inner needle cap and discard; - Turn the dose selector to two units; - Keep the needle upwards and press the push-button until the dose selector reads 0; - Turn the dose selector to select the number of prescribed units; - Push the needle into the skin, then press the dose button until dose selector indicates 0; - Keep the push-button fully pushed in after injection; - Leave the needle under the skin for 6 seconds and then remove it. 1. Review of Resident #9's POS, dated May 2024, showed: - An order for lispro insulin pen 100 units per milliliter (ml) subcutaneous (an injection just below the skin) with meals per a sliding scale of blood sugar of if 151 - 200 = 2 Units, 201 - 300 = 4 Units, 301-400 = 6 Units, 401 - 500 = 8 Units, if blood sugar is greater than 500, call MD (medical doctor), dated 12/14/23. Observation of Resident #9's medication administration on 05/08/24 at 11:00 A.M., showed: - Licensed Practical Nurse (LPN) D administered 2 units of lispro subcutaneously per order of the sliding scale for a blood sugar of 177 with the resident's lispro Kwik Pen; - LPN D failed to prime the lispro Kwik Pen per the manufacturer's instructions prior to the administration to the resident. 2. Review of Resident #25's POS, dated May 2024, showed: - An order for Novolog insulin pen 100 units per ml subcutaneous with meals per a sliding scale of blood sugar of if 0-100= 0 Units, 101-150=4 Units, 151 - 200 = 5 Units, 201 - 250 = 6 Units, 251 - 300 = 7 Units, 301 - 350 = 8 Units, 351 - 400 = 9 Units, dated 2/26/24. Observation of Resident #25's medication administration on 05/08/24 at 11:21 A.M., showed: - LPN D administered 6 units of Novolog subcutaneously per order of the sliding scale for a blood sugar of 248 with the resident's Novolog Flex Pen; - LPN D failed to prime the Novolog Flex Pen per the manufacturer's instructions prior to the administration to the resident. (continued on next page)

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	265874	A. Building B. Wing	05/09/2024

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Review of Resident #28's POS, dated May 2024, showed: - An order for Novolog insulin pen 100 units per ml subcutaneous with meals per a sliding scale of blood sugar of if 0-149=0 Units, 150 - 200 = 3 Units, 201 - 250 = 5 Units, 251 - 300 = 7 Units, 301 - 450 = 10 Units, 451 or greater call MD, dated 10/20/22. Observation of Resident #28's medication administration on 05/07/24 at 12:09 P.M., showed: - LPN G administered 3 units of Novolog subcutaneously per order of the sliding scale for a blood sugar of 156 with the resident's Novolog Flex Pen; - LPN G failed to prime the Novolog Flex Pen per the manufacturer's instructions prior to the administration to the resident. 4. Review of Resident #34's POS, dated May 2024, showed: - An order for lispro insulin pen 100 units per ml subcutaneous with meals per a sliding scale of blood sugar of if 131-180=4 Units, 181-240= 6 Units, 241-300=10 Units, 301-350=12 Units, 351-400=14 Units, 401-600=16 Units, If blood sugar is over 400 give 16 Units and call MD, dated 11/08/23. Observation of Resident #34 medication administration on 05/08/24 at 11:15 A.M., showed: - LPN D administered 6 units of lispro subcutaneously per order of the sliding scale for a blood sugar of 234 with the resident's lispro Kwik Pen; - LPN D failed to prime the lispro Kwik Pen per the manufacturer's instructions prior to the administration to the resident. 5. Review of Resident #42's POS, dated May 2024, showed: - An order for lispro insulin pen 100 units per ml subcutaneous with meals per a sliding scale of blood sugar of if 151 - 200 = 2 Units, 201 - 250 = 4 Units, 251 - 300 = 6 Units, 301 - 350 = 8 Units, 351 - 400 = 10 Units, 401 - 999 = 12 Units, dated 03/08/24. Observation of Resident #42 medication administration on 05/07/24 at 12:14 P.M., showed: - LPN G administered 12 units of lispro subcutaneously per order of the sliding scale for a blood sugar of 404 with the resident's lispro Kwik Pen; - LPN G failed to prime the lispro Kwik Pen per the manufacturer's instructions prior to the administration to the resident. During an interview on 05/08/24 at 04:09 P.M., LPN C said when administering insulin, he/she would dial up 1-2 units to prime needle of the insulin pen a, clean injection site with alcohol swab and administer insulin. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 05/09/24 at 10:00 A.M., LPN G, said the only time he/she primes the insulin pen when it is new, once used the pens do not need to be primed. He/she said the purpose is to prime the pen, not the needle. LPN G said when administering insulin, the pen should be held to the skin from a few seconds, if a safety needle is used, he/she would hold for longer. During an interview on 05/09/24 at 11:58 A.M., the Administrator said the expectation is to dial up 2 units of insulin to prime the pen needle, then dial the prescribed dose and administer. She would expect staff to hold the insulin pen for 3-5 seconds. During an interview on 05/09/24 at 2:18 P.M., Director of Nursing (DON) said he/she would expect staff to prime the pen needle with 1 unit of insulin prior to administering the prescribed dose. He/she would expect staff to hold the insulin pen for a few seconds after administering the insulin.

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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. 48532 Based on observation, interview, and record review, the facility failed to provide a safe and sanitary environment by failing to perform hand hygiene during medication administration for five residents (Resident #9, #25, #28, #34, and #42) and to disinfect the glucometer (a device used to measure blood sugar) per the manufacturer's instructions for three residents (Resident #9, #25, and #34) out of five sampled residents. The facility's census was 44. Review of the facility's policy titled, Blood Sampling-Capillary (fine-branching blood vessels) (Finger Sticks), revised 09/2014, showed: - Always ensure blood glucose meters intended for reuse are cleaned and disinfected between resident uses; - The steps in the this procedure include: wash hands; put on gloves; follow the manufacturer's instructions to clean and disinfect the reusable equipment, parts and/or devices after each use; wash hands; and replace blood glucose monitoring device in the storage area after cleaning. Review of the facility's policy titled, Infection Control-Policies and Practices, revised 10/2018, showed the policy did not address glucometer disinfecting techniques or recommendations. Review of the Blood Glucose Monitoring System (glucometer) user instruction manual showed: - The glucometer should be cleaned and disinfected between each resident; - To disinfect the glucometer, clean the meter surface with one of the approved disinfecting wipes; - Allow the surface of the meter to remain wet at room temperature for the contact time listed on the wipe's directions for use; - Wipe all external areas of the meter including both front and back surfaces until visibly wet; - Avoid wetting the meter test strip port; - Wipe dry or allow to air dry. Review of the Super Sani-Cloth Germicidal Disposable wipes label showed to allow the treated surfaces to remain visibly wet for two minutes. 1. Observation of Resident #9 on 05/08/24 at 11:00 A.M., showed: - Licensed Practical Nurse (LPN) D obtained the glucometer from the medication cart drawer; - LPN D failed to perform hand hygiene, put on gloves, performed the resident's blood glucose testing, removed the gloves, and failed to perform hand hygiene; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 265874	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Nursing Center, Inc	400 Winchester Dr 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN D lay the glucometer on the medication cart and failed to sanitize the glucometer after the resident use; - LPN D failed to perform hand hygiene and put on gloves; - LPN D administered the insulin injection to the resident; - LPN D removed the gloves and failed to perform hand hygiene. 2. Observation of Resident #25 on 05/08/24 at 11:21 A.M., showed: - LPN D failed to sanitize the glucometer prior to use; - LPN D failed to perform hand hygiene, put on gloves, performed the resident's blood glucose testing, removed the gloves, and failed to perform hand hygiene; - LPN D lay the glucometer on the medication cart and failed to sanitize the glucometer after the resident use; - LPN D failed to perform hand hygiene and put on gloves; - LPN D administered the insulin injection to the resident; - LPN D removed the gloves and failed to perform hand hygiene. 3. Observation of Resident #28 on 05/07/24 at 12:09 P.M., showed: - LPN G obtained the glucometer from the medication cart drawer; - LPN G failed to perform hand hygiene, put on gloves, performed the resident's blood glucose testing, removed the gloves, and failed to perform hand hygiene; - LPN G put on gloves; - LPN G administered the insulin injection to the resident; - LPN G removed the gloves and failed to perform hand hygiene. 4. Observation of Resident #34 on 05/08/24 at 11:15 A.M., showed: - LPN D failed to perform hand hygiene, put on gloves, performed the resident's blood glucose testing, removed the gloves, and failed to perform hand hygiene; - LPN D lay the glucometer on the medication cart and failed to sanitize the glucometer after the resident use; - LPN D failed to perform hand hygiene and put on gloves; (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265874	A. Building B. Wing	05/09/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Winchester Nursing Center, Inc	400 Winchester Dr Bernie, MO 63822

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- LPN D administered the insulin injection to the resident; - LPN D removed the gloves and failed to perform hand hygiene. 5. Observation of Resident #42 on 05/07/24 at 12:21 P.M., showed: - LPN G failed to perform hand hygiene, put on gloves, performed the resident's blood glucose testing, removed the gloves, and failed to perform hand hygiene; - LPN G put on gloves and administered the insulin injection to the resident; - LPN G removed the gloves and failed to perform hand hygiene. During an interview on 05/08/24 at 04:09 P.M., LPN C said when taking a resident's blood sugar, he/she would perform hand hygiene, put on gloves, collect the resident's blood sample, remove the gloves, perform hand hygiene, wipe the glucometer and wrap the it in a disinfectant wipe. When administering insulin, he/she would perform hand hygiene, put on gloves, administer the insulin, remove the gloves, and perform hand hygiene before moving to the next resident. During an interview on 05/09/24 at 10:05 A.M., the Assistant Director of Nursing (ADON) said he/she would expect hand hygiene to be done between the glucometer use and moving to the next resident. During an interview on 05/09/24 at 11:58 A.M., the Administrator said she would expect staff to perform hand hygiene, whether that be soap and water or hand sanitizer, anytime gloves were changed or between tasks with residents. She said the expectation was for staff to disinfect the glucometers between residents by wrapping the it in a Sani-Cloth wipe and left wrapped for two minutes. During an interview on 05/09/24 at 2:18 P.M., the Director of Nursing (DON) said she would expect staff to change gloves and perform hand hygiene after having obtained a blood sugar and disinfect the glucometer by wrapping it in a Sani-Cloth and left visibly wet for two minutes.