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F 000	INITIAL COMMENTS The following citations represent the findings of complaint investigations KS00140536 and KS00141417. The 2567 was electronically sent to the facility on 5/31/19.	F 000		
F 686 SS=G	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: The facility had a census of 36 residents with 4 residents selected for sample. The facility identified 3 of the 4 sampled residents with current or recently healed pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure or pressure in combination with shear and/or friction.) Based on observation, interview and record review, the facility failed to ensure 3 residents with current or recently healed pressure ulcers received appropriate care (completion of weekly skin assessments as per	F 686		

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

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.

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facility policy to monitor for alterations in skin integrity, consistent/thorough assessments of existing pressure ulcers to include wound measurements and staging information) to prevent the development of pressure ulcers and promote healing of existing ulcers.

Resident #2 developed two facility acquired pressure ulcers to the left foot in March 2019. Resident #3 developed two facility acquired pressure ulcers to the buttocks in March 2019. Those wounds resolved/healed and then reopened in late March 2019. Resident #4 developed two facility acquired pressure ulcers to the buttocks in March 2019. The staff failed to complete skin assessments per facility policy in the time period prior to the development of each resident's pressure ulcers. After development of the pressure ulcers, the facility staff failed to routinely/consistently assess the wounds to include measurements and staging information.

Findings included:

- Resident #2's clinical record included a comprehensive diagnoses list which identified the resident with multiple medical diagnoses, including type 2 diabetes mellitus (adult onset condition which occurs when the body cannot use glucose, not enough insulin is made or the boy cannot respond to the insulin), nutritional deficiencies, chronic kidney disease (disease of the kidneys which persists for a long period of time) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

The 2/20/19 significant change MDS (Minimum Data Set) identified the resident with no cognitive

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impairment (brief interview for mental status score of 13) and the need for extensive assistance of two staff for bed mobility and transfers. According to the assessment, the resident had a current unstageable pressure ulcer that was not present on admission. The resident also experienced frequent bowel and bladder incontinence.

The 2/13/19 care plan noted the resident's potential for development of pressure ulcers and/or skin breakdown. The care plan described education provided to the resident on the importance of repositioning every two hours and as needed and keeping the heels "offloaded" to prevent pressure. The care plan also directed staff to provide assistance of one for transfers and bed repositioning. On 5/15/19, care plan revisions included a change to a treatment to the pressure ulcer on the left foot.

A 12/1/18 Braden skin assessment (a standardized assessment tool used to identify risk for development of skin breakdown/pressure ulcers) identified the residents as "no risk" for skin breakdown. The clinical record lacked evidence of completion of additional assessments of skin breakdown risk since 12/1/18, a time period of more than 5 months.

Review of weekly skin assessments and/or wound assessment documentation found in the progress notes in the clinical record revealed the facility failure to complete weekly skin assessments as follows:

No evidence of skin assessments in the 18-day time-period from 1/7/19 to 1/25/19.

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No evidence of skin assessments in the 16-day time-period from 2/8/19 to 2/24/19.

A 3/5/19 progress note written at 10:59 AM described a "new area" of skin breakdown to the left great toe along a bony prominence which appeared red, non-blanchable with a dark purple center which measured 2.6 centimeters (cm) by 2.0 cm. The documentation lacked assessment information related to staging of the wound.

A 3/10/19 progress note written at 3:12 PM described a "new area" of skin breakdown to the left inner aspect of the foot which measured 0.5 cm by 1 cm. The documentation lacked assessment information related to staging of the wound.

No evidence of skin assessments in the 15-day time-period from 3/10/19 to 3/25/19.

No evidence of skin assessments in the 23-day time-period from 4/1/19 to 4/24/19.

No evidence of skin assessments in the 16-day time-period from 4/30/19 to 5/16/19.

A 5/16/19 progress note written at 11:20 AM described a continued area of skin breakdown/pressure ulcer to the left heel which measured 1 cm by 1.2 cm. The documentation lacked assessment information related to staging of the wound.

During an observation on 5/28/19 at 10:30 AM, resident #2's left heel had a scabbed over area that was without drainage. The resident reported he/she experienced pain in the left heel which was "throbbing" in nature. The resident required

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staff assistance with transfer from the bed to the chair and with positioning him/herself comfortably in the recliner.

During an interview on 5/28/19 at 1:20 PM, administrative nurse B reported licensed nurses should complete skin assessments for all residents on a weekly basis. Upon review of resident #2's clinical record, Nurse B confirmed staff failed to complete and/or document weekly skin assessments repeatedly from 1/1/19 - 5/16/19. Administrative Nurse B also confirmed resident #2 developed pressure ulcers to the foot after admission/readmission to the facility.

During an interview on 5/29/19 at 3:55 PM., Medical Director F denied knowledge facility staff failed to complete weekly skin assessments for residents as per facility policy. Medical Director F also lacked knowledge licensed nursing staff failed to consistently measure and stage existing pressure ulcers with each assessment. According to Medical Director F, the facility needed to develop a more "proactive" approach to pressure ulcer prevention.

The facility's April 29, 2008 policy for "Wound Measurements" included, "A complete skin assessment is to be completed upon admission, with a weekly assessment thereafter. Skin assessments are to be documented in the resident chart on all intermediate care residents.... Wounds are to be measured weekly and documented in resident's chart....Site, stage, size (specific measurements) depth, color, drainage and odor...."

The facility failed to provide resident #2 with appropriate care (completion of weekly skin

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assessments as per facility policy to monitor for alterations in skin integrity, consistent/thorough assessments of existing pressure ulcers to include wound measurements and staging information) to prevent development of facility acquired pressure ulcers and promote healing of existing ulcers. The staff failed to complete skin assessments per facility policy in the time-period prior to the development of the pressure ulcers, and after development of the pressure ulcers, the staff failed to routinely/consistently assess the wounds to include measurements and staging information.

- Resident #3's clinical record included a comprehensive diagnoses list which identified the resident with multiple medical diagnoses, including chronic kidney disease (kidney disease which persisted for a long period of time) and dementia (progressive mental disorder characterized by failing memory and confusion).

The 4/10/19 quarterly minimum data set (MDS) identified the resident with moderate cognitive impairment (brief interview for mental status score of 8), dependence on extensive assistance of one staff for bed mobility and transfers, and functional limitations in range of motion on one side of the lower extremities. According to the MDS, the resident did not have any current pressure ulcers.

The 5/8/19 significant change MDS identified the resident with severe cognitive impairment (brief interview for mental status score of 7) and the need for extensive assistance of two staff for bed mobility/transfers/ambulation. According to the MDS, the resident had a current Stage 2 (partial-thickness skin loss with exposed dermis)

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pressure ulcer that was not present on admission.

The 5/13/19 pressure ulcer care area assessment (CAA) noted the presence of a Stage 2 pressure ulcer to the left inner buttock.

The 5/14/19 care plan identified the resident's potential for pressure ulcer development and noted the history of opening and closing wounds on the right buttock. According to the care plan, the resident required monitoring/reminding/assistance to turn and/or reposition at least every 2 hours and more often as needed or requested.

The Braden skin assessments (a standardized assessment tool used to identify risk for development of skin breakdown/pressure ulcers) completed on 1/29/19 and 4/22/19 identified the resident as "low risk" for skin breakdown.

Review of the weekly skin assessments and/or wound assessment documentation found in the progress notes in the clinical record revealed the facility failure to complete weekly skin assessments as follows:

No evidence of skin assessments in the 37-day time period from 1/21/19 to 2/27/19.

A progress note written on 3/10/19 noted the presence of two "new" open areas on the right buttock which measured 0.8 centimeters (cm) by 0.6 cm (upper buttock wound) and 0.4 cm by 0.6 cm. (lower buttock wound). The documentation lacked assessment information related to the staging of the wounds.

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A progress note written on 3/13/19 described the buttock pressure ulcers as "resolved."

A progress note written on 4/2/19 referred to an "open area on buttocks." The note lacked information related to wound measurements or staging.

A progress note written on 4/11/19 referred to two open areas on the right and left buttocks with measurements of each wound recorded at 2 cm by 1.5 cm. The documentation lacked assessment information related to staging of the wounds.

No evidence of skin assessments in the 13-day time-period from 4/11/19 to 4/24/19.

A progress note written on 4/24/19 described the presence of one pressure ulcer to the left inner buttock which measured 0.9 cm by 0.2 cm with a "red wound base." The documentation lacked assessment information related to staging of the wounds.

A progress noted dated 4/30/19 described no open areas to the buttocks.

No evidence of skin assessments in the 15-day time-period from 4/30/19 to 5/15/19.

During an observation on 5/28/19 at 12:20 PM, resident #3 lacked the ability to respond to simple verbal commands. The resident required the assistance of one staff to stand up from the wheelchair and ambulate to the toilet. At the time of the observation, the resident had no areas of skin breakdown on the buttocks or other pressure areas.

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During an interview on 5/28/19 at 1:20 p.m., administrative nurse B reported licensed nurses should complete skin assessments for all residents on a weekly basis. Upon review of resident #3's clinical record, Nurse B confirmed staff failed to complete and/or document weekly skin assessments repeatedly in the time-period from 1/1/19 - 5/16/19. Administrative Nurse B also confirmed resident #3 developed pressure ulcers to the buttocks after admission to the facility.

During an interview on 5/29/19 at 3:55 p.m., Medical Director F denied knowledge facility staff failed to complete weekly skin assessments for residents as per facility policy. Medical Director F also lacked knowledge licensed nursing staff failed to consistently measure and stage existing pressure ulcers with each assessment. According to Medical Director F, the facility needed to develop a more "proactive" approach to pressure ulcer prevention.

The facility's April 29, 2008 policy for "Wound Measurements" included, "A complete skin assessment is to be completed upon admission, with a weekly assessment thereafter. Skin assessments are to be documented in the resident chart on all intermediate care residents....Wounds are to be measured weekly and documented in resident's chart....Site, stage, size (specific measurements) depth, color, drainage and odor...."

The facility failed to provide resident #3 with appropriate care (completion of weekly skin assessments as per facility policy to monitor for

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alterations in skin integrity, consistent/thorough assessments of existing pressure ulcers to include wound measurements and staging information) to prevent development of facility acquired pressure ulcers and promote healing of existing ulcers. The staff failed to complete skin assessments per facility policy in the time-period prior to the development of the pressure ulcers, and after development of the pressure ulcers, the staff failed to routinely/consistently assess the wounds to include measurements and staging information.

- Resident #4's clinical record included a comprehensive diagnoses list which identified the resident with multiple medical diagnoses, including a Stage 3 (full thickness skin loss) pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence as a result of pressure or pressure in combination with shear and/or friction which has gone through the second layer of skin into the fat tissue) to the right buttock, dementia (progressive mental disorder characterized by failing memory/confusion), muscle weakness and cancer of the lung.

The 3/27/19 significant change minimum data set (MDS) identified the resident with no cognitive impairment (brief interview for mental status score of 15), the need for extensive assistance of one staff for bed mobility and transfers and the presence of functional limitations in range of motion on both sides of the upper and lower extremities. According to the MDS, the resident was "always" incontinent of bladder and experienced occasional bowel incontinence. The assessment also identified the presence of a current Stage 3 pressure ulcer which was not

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present on admission.

The 4/2/19 care plan identified the resident with limited physical mobility due to general weakness. The care plan also noted the resident's potential for pressure ulcer development and skin breakdown related to incontinence and decreased mobility. The care plan directed staff to provide encouragement and reminders to turn and reposition at least every two hours and more often as needed or requested. The care plan described the resident as "frequently incontinent."

The Braden skin assessments (a standardized assessment tool used to identify risk for development of skin breakdown/pressure ulcers) completed on 1/1/19 and 3/31/19 identified the resident as "low risk" for skin breakdown. A Braden assessment completed on 4/1/9 identified the resident as "moderate risk" for skin breakdown.

The physician's orders included a 2/9/18 order for "Skin assessment in the morning every Wednesday" and a 3/29/19 physician's order for placement of a pressure relieving cushion due to a wound.

Review of weekly skin assessments and/or wound assessment documentation found in the progress notes in the clinical record revealed facility failure to complete weekly skin assessments as follows:

No evidence of skin assessments in the 22-day time-period from 1/1/19 - 1/23/19.

A progress note written on 1/23/19 at 12:24 p.m. described a purple discoloration to the resident's

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inner buttocks.

No evidence of skin assessments in the 21-day time-period from 1/30/19 - 2/20/19.

A progress note written on 1/30/19 at 11:26 AM described a purple discoloration to the inner buttocks and the resident's refusal of the application of cream to those areas.

A progress note written on 2/27/19 at 11:34 AM described a purple discoloration to the resident's buttocks.

No evidence of skin assessments in the 17-day time-period from 3/6/19 - 3/23/19.

A progress note written on 3/6/19 at 11:28 AM described a purple discoloration to the resident's "inner buttock cheeks."

A progress note written on 3/23/19 at 8:39 AM described the presence of "an open area" on the right inner buttock which included a white colored wound base, surrounded by dark red granulation tissue (tissue formed during wound healing). The wound measurements recorded were 1.3 centimeters (cm) by 3 cm. The documentation lacked assessment information related to staging of the wound.

A progress note written on 3/27/19 at 9:40 p.m. described the presence of two open areas on the resident's buttocks. The documentation lacked wound measurements or information related to staging of the wounds.

No evidence of skin assessments in the 23-day time-period from 3/31/19 - 4/23/19.

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A progress note written on 3/31/19 at 9:02 AM described the presence of one wound to the right buttock which measured 2 cm by 3.5 cm. The documentation lacked information related to staging of the wound. According to the note, the wound base was covered with "white slough" (dead tissue) surrounded by dark red granulation tissue. The documentation lacked information related to staging of the wound.

A progress note written on 4/23/19 at 12:06 PM described the presence of an open wound on the right buttock which measured 0.4 cm by 0.3 cm with a small amount of dry yellow slough tissue present. The documentation lacked information related to staging of the wound.

No evidence of skin assessments in the 26-day time-period from 4/24/19 - 5/20/19.

A progress note written on 5/20/19 at 7:07 AM described no open areas/skin breakdown on the resident's body.

During an observation on 5/28/19 at 11:00 AM, resident #4 required staff assistance of one to stand from a sitting position next to his/her recliner. At the time of the observation, the resident had no areas of skin breakdown on the buttocks or other pressure areas.

During an interview on 5/28/19 at 1:20 PM, administrative nurse B reported licensed nurses should complete skin assessments for all residents on a weekly basis. Upon review of resident #4's clinical record, Nurse B confirmed staff failed to complete and/or document weekly skin assessments repeatedly in the time-period

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from 1/1/19 - 5/16/19. Administrative Nurse B also confirmed resident #4 developed pressure ulcers to the buttocks after admission to the facility.

During an interview on 5/29/19 at 3:55 p.m., Medical Director F denied knowledge facility staff failed to complete weekly skin assessments for residents as per facility policy. Medical Director F also lacked knowledge licensed nursing staff failed to consistently measure and stage existing pressure ulcers with each assessment. According to Medical Director F, the facility needed to develop a more "proactive" approach to pressure ulcer prevention.

The facility's April 29, 2008 policy for "Wound Measurements" included, "A complete skin assessment is to be completed upon admission, with a weekly assessment thereafter. Skin assessments are to be documented in the resident chart on all intermediate care residents.... Wounds are to be measured weekly and documented in resident's chart....Site, stage, size (specific measurements) depth, color, drainage and odor...."

The facility failed to provide resident #4 with appropriate care (completion of weekly skin assessments as per facility policy to monitor for alterations in skin integrity, consistent/thorough assessments of existing pressure ulcers to include wound measurements and staging information) to prevent development of facility acquired pressure ulcers and promote healing of existing ulcers. The staff failed to complete skin assessments per facility policy in the time-period prior to the development of the pressure ulcers, and after development of the pressure ulcers, the

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F 686	Continued From page 14 staff failed to routinely/consistently assess the wounds to include measurements and staging information.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to	F 690		

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restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility had a census of 36 residents, with 4 residents selected for sample. Three of four sampled residents experienced urinary incontinence. Based on observation, interview and record review, the facility failed to ensure 3 sampled residents with urinary incontinence received services and assistance to maintain and/or restore continence to the extent possible. (#1, #2, #4)

Findings included:

- Resident #1's clinical record included a comprehensive diagnoses list which identified the resident with multiple medical diagnoses, including cerebral infarction (sudden death of brain cells due to lack of oxygen caused by impaired blood flow to brain by blockage or rupture of an artery to the brain), heart failure, hemiplegia (paralysis of one side of the body), hemiparesis (muscular weakness of one side of the body), and mild cognitive impairment.

The 4/3/19 quarterly minimum data set (MDS) identified the resident with severe cognitive impairment (Brief Interview for Mental Status score of 3), the need for extensive assistance of 2 staff for transfers and toilet use and he/she experienced functional limitations in range of motion on one side of his/her lower extremities. According to the MDS, the resident experienced frequent bladder incontinence and did not have a toileting program. The resident utilized diuretic medication (medication used to promote the formation and excretion of urine) daily.

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The 4/9/19 care plan noted the resident's self care performance deficit and directed staff to provide assistance of 1-2 for toileting. The care plan lacked measurable goals or resident specific interventions related to urinary incontinence.

The facility completed a "Bowel and Bladder Program Screener" evaluation on 11/1/18 and determined the resident was "a good candidate for retraining." A 4/1/19 "Bowel and Bladder Program Screener" identified the resident as a "candidate for scheduled toileting."

Review of the clinical record revealed no evidence staff completed a thorough assessment of resident #1's urinary incontinence to include the type of incontinence experienced. The record also lacked evidence of staff completion of a voiding diary for the resident in an attempt to determine specific, individualized voiding patterns experienced by the resident. Additionally, the clinical record lacked evidence staff attempted a bladder retraining program based on the results of the 11/1/18 bladder assessment screening, or attempted scheduled toileting as indicated by the 4/1/9 bladder assessment screening.

During an observation on 5/15/19 at 10:50 AM, resident #1 required assistance of two staff to transfer from the wheelchair to the toilet. The resident had the ability to follow staff commands and to verbalize his/her needs. Prior to toileting, the resident's incontinence brief was dry. The resident voided on the toilet after being assisted there by staff.

During an interview on 5/28/19 at 9:00 AM, a person involved in resident #1's day to day

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activities at the facility reported he/she wished staff would toilet the resident more often in the morning after the resident takes 'large doses" of diuretics. According to this person, resident #1 "gets real antsy and uncomfortable" when he/she needs to urinate and staff aren't available to assist.

During an interview on 5/15/19 at 10:50 AM, Direct Care Staff E reported resident #1 tells staff when he/she needs to toilet. According to Staff E, the resident experiences occasional urinary incontinence and is not on a specific toileting plan.

During an interview on 5/28/19 at 1:00 PM, Administrative Nurse B confirmed resident #1's clinical record lacked evidence of staff completion of a voiding diary for the resident. Nurse B also confirmed the clinical record lacked evidence of attempts to develop/implement bladder retraining and/or scheduled toileting as directed as a result of bladder screening assessments completed in November 2018 and April 2019.

During an interview on 5/28/19 at 1:57 PM, Direct Care Staff C reported staff assist residents to the toilet when the resident's tell staff they need to use the bathroom. According to Staff C, if a resident is unable to verbalize their toileting needs, staff just toilet the residents based on what they know about the residents. Direct Care Staff C could not verbalize any facility residents with specific, individualized toileting plans used to manage urinary incontinence.

During an interview on 5/28/19 at 2:07 PM, Direct Care Staff D reported staff assist residents to the toilet on "an every two hour rotation or when they

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ask for help." Direct Care Staff D could not verbalize any facility residents with specific, individualized toileting plans used to manage their urinary incontinence.

The facility's undated "Policy and Procedure for Bowel and Bladder Incontinence" included, "It is the policy of Prairie Sunset Home to promptly and accurately identify, through comprehensive assessment, residents who are incontinent to ensure that all residents receive appropriate treatment and services to achieve or maintain as much normal urinary function as possible while maximizing quality of life and dignity." The policy directed staff to complete a Bowel and Bladder Assessment upon admission and quarterly and then, based on the score of the assessment, start the resident on a specific toileting program. An addendum to the policy included a "Bowel and Bladder Assessment Record" which directed staff to record bowel and bladder information hourly for 3 days in an attempt to identify bowel and bladder patterns/habits.

The facility failed to to ensure resident #1 received services and assistance to maintain and/or restore urinary continence to the extent possible.

- Resident #2's clinical record included a comprehensive diagnoses list which identified the resident with multiple medical diagnoses, including generalized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), repeated falls, chronic kidney disease (disease of the kidneys which persisted for a long period of time) and congestive heart failure (a condition with low heart output and the body becomes congested with fluid).

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The 2/20/19 Significant Change MDS (Minimum Data Set) identified the resident with no cognitive impairment (Brief Interview for Mental Status score of 13), the need for extensive assistance of two staff for transfers and toileting, frequent bladder incontinence and no toileting plan.

The 2/13/19 Care Plan noted the resident's bladder incontinence and directed staff to "change pullups as needed and "check the resident as required for incontinence."According to the care plan, the resident incontinence "varies with [his/her] willingness to get up and participate in ADL [activity of daily living] needs."

The facility completed a "Bowel and Bladder Program Screener" evaluation on 12/8/18 and determined the resident was "a candidate for scheduled toileting." The clinical record lacked evidence of completion of additional bladder assessments in the 5 months since the December 2018 assessment.

Review of the clinical record revealed no evidence staff completed a thorough assessment of resident #2's urinary incontinence to include the type of incontinence experienced. The record also lacked evidence of staff completion of a voiding diary for the resident in an attempt to determine specific, individualized voiding patterns experienced by the resident. Additionally, the clinical record lacked evidence staff attempted a scheduled toileting program based on the results of the 12/8/18 bladder assessment screening.

During an observation on 5/28/19 at 10:30 a.m., resident #2 required staff assistance to transfer from the bed to the recliner. According to the

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resident, he/she wore incontinence briefs at the time of the observation.

During an interview on 5/28/19 at 1:00 p.m., Administrative Nurse B confirmed resident #2's clinical record lacked evidence of staff completion of a voiding diary for the resident. Nurse B also confirmed the clinical record lacked evidence of attempts to develop/implement scheduled toileting as directed as a result of bladder screening assessment completed in December, 2018.

During an interview on 5/28/19 at 1:57 p.m, Direct Care Staff C reported staff assist residents to the toilet when the resident's tell staff they need to use the bathroom. According to Staff C, if a resident is unable to verbalize their toileting needs, staff just toilet the residents based on what they know about the residents. Direct Care Staff C could not verbalize any facility residents with specific, individualized toileting plans used to manage urinary incontinence.

During an interview on 5/28/19 at 2:07 p.m., Direct Care Staff D reported staff assist residents to the toilet on "an every two hour rotation or when they ask for help." Direct Care Staff D could not verbalize any facility residents with specific, individualized toileting plans used to manage their urinary incontinence.

The facility's undated "Policy and Procedure for Bowel and Bladder Incontinence" included, "It is the policy of Prairie Sunset Home to promptly and accurately identify, through comprehensive assessment, residents who are incontinent to ensure that all residents receive appropriate treatment and services to achieve or maintain as

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much normal urinary function as possible while maximizing quality of life and dignity." The policy directed staff to complete a Bowel and Bladder Assessment upon admission and quarterly and then, based on the score of the assessment, start the resident on a specific toileting program. An addendum to the policy included a "Bowel and Bladder Assessment Record" which directed staff to record bowel and bladder information hourly for 3 days in an attempt to identify bowel and bladder patterns/habits.

The facility failed to to ensure resident #2 received services and assistance to maintain and/or restore urinary continence to the extent possible.

- Resident #4's clinical record included a 3/27/19 Significant Change MDS (Minimum Data Set which identified the resident with no cognitive impairment (Brief Interview for Mental Status score of 15), the need for extensive assistance of 2 staff for transfers/ambulation/toileting, functional limitations in range of motion on both sides of the upper and lower extremities, "always" incontinent of bladder, and no participation in a toileting program.

The 4/2/19 Care Plan noted the resident's frequent urinary incontinence and use of incontinence "pullups" to maintain dignity. The care plan lacked measurable goals or resident specific interventions based on the residents individual bladder habits/patterns.

Bowel and Bladder Program Screener:
12/30/18: Good candidate for retraining (score of 16)
3/30/19: Candidate for scheduled timed toileting

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F 690	Continued From page 22 (score of 10)	F 690		

The facility completed a "Bowel and Bladder Program Screener" evaluation on 12/30/18 and determined the resident was "a good candidate for retraining." The facility completed an additional Bowel and Bladder Program Screener assessment on 3/30/19 and determined the resident was a "candidate for scheduled timed toileting.

Review of the clinical record revealed no evidence staff completed a thorough assessment of resident #4's urinary incontinence to include the type of incontinence experienced. The record also lacked evidence of staff completion of a voiding diary for the resident in an attempt to determine specific, individualized voiding patterns experienced by the resident. Additionally, the clinical record lacked evidence staff attempted a retraining program or scheduled timed toileting program as indicated by the results of the 12/30/18 and 3/30/19 bladder assessments.

During an observation on 5/28/19 at 10:30 a.m., resident #4 required staff assistance to transfer from a sitting position in the recliner to a standing position. The resident had the ability to verbalize his/her needs. The resident reported he/she wore "special undergarments" to help control urinary incontinence.

During an interview on 5/28/19 at 1:00 p.m., Administrative Nurse B confirmed resident #4's clinical record lacked evidence of staff completion of a voiding diary for the resident. Nurse B also confirmed the clinical record lacked evidence of attempts to develop/implement retraining and/or scheduled toileting as directed as a result of

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bladder screening assessments completed in December, 2018 and March, 2019.

During an interview on 5/28/19 at 1:57 p.m, Direct Care Staff C reported staff assist residents to the toilet when the resident's tell staff they need to use the bathroom. According to Staff C, if a resident is unable to verbalize their toileting needs, staff just toilet the residents based on what they know about the residents. Direct Care Staff C could not verbalize any facility residents with specific, individualized toileting plans used to manage urinary incontinence.

During an interview on 5/28/19 at 2:07 p.m., Direct Care Staff D reported staff assist residents to the toilet on "an every two hour rotation or when they ask for help." Direct Care Staff D could not verbalize any facility residents with specific, individualized toileting plans used to manage their urinary incontinence.

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F 690	Continued From page 24 patterns/habits. The facility failed to to ensure resident #4 received services and assistance to maintain and/or restore urinary continence to the extent possible.	F 690		