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F 000	INITIAL COMMENTS The following citation represents the finding of complaint investigation #KS00135641. This 2567 was electronically sent to the facility on 12/31/18.	F 000		
F 690 SS=E	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	F 690		

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

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comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.
This REQUIREMENT is not met as evidenced by:
The facility reported a census of 48 residents. The sample of 4 residents included 4 reviewed for urinary incontinence. Based on observation, interview, and record review the facility failed to implement individualized toileting plans to promote as much normal bladder function as possible for 4 of the 4 sampled residents.

Findings included:

- Resident #1's diagnoses included on the 10/23/18 physician order sheet, included Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) and behavioral disturbance.

An admission MDS (minimum data set), dated 10/19/18, identified the resident unable to conduct the BIMS (brief interview of memory status); staff identified the resident with long and short-term memory impairment and moderately impaired of decision making ability. The assessment further identified the resident exhibited inattention, had trouble with sleep and concentration and was short tempered/easily annoyed. The resident also exhibited hallucinations and delusions, experienced physical, verbal and other behavioral symptoms, with behaviors significantly interfering with the resident's care and participation in activities or social interactions, as well as putting others at significant risk for physical injury, intruding on the

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privacy of others and disrupting the care and living environment. The resident rejected care, wandered daily and the assessment identified these behaviors worsened since admission. The assessment identified the resident required limited assistance with all ADLs (activities of daily living) except dressing and toileting, which required extensive assistance from staff. The incontinence assessment identified the resident as incontinent of bowel and bladder and lacked a toileting program.

A 10/11/18 bowel and bladder assessment, lacked identification of review of a 3-day voiding diary and lacked any indication of a plan for toileting the incontinent resident. The assessment identified the resident as frequently incontinent of urine and bowel.

The baseline care plan, dated 10/11/18, instructed staff the resident was incontinent of bowel and bladder and required assistance with peri-care, wore incontinent briefs and had a toileting program. The care plan lacked direction to the staff related to requirements of the resident's toileting program.

A comprehensive care plan, dated 11/16/18, instructed staff the staff were to ask the resident yes or no questions due to severe impairment of cognition. Further instructions included the resident required limited assistance of staff with toileting. Wears incontinent briefs, toilet the resident before and after meals and at bedtime, and PRN (as needed). Do not leave alone in the restroom.

Observation on 12/27/18 from 3:10 PM to 3:50 PM, identified the staff providing one to one

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monitoring, with the resident who appeared restless, frequently moving around the dining room, sitting down, then arising, etc. Staff offered fluids, foods and attempted re-direction to the resident. During the observation time frame no toileting offers were given to the resident by staff.

On 12/28/18 at 7:55 AM, the resident sat in a wheelchair, at the dining table, eating breakfast. The resident consumed most of the meal, with staff redirecting one time to return to the table when he/she backed away from the table. At 8:10 AM, the resident began self-propelling the wheelchair with his/her feet, around the dining area. Staff offered the resident a magazine which the resident declined, with the resident continuing to move about the dining room. Occasionally, the staff or a resident re-directed the resident away when getting too close to bumping into another resident, with the wheelchair. At 8:25 AM, licensed nursing staff B re-directed the resident 3 times to remain seated in the wheelchair. The staff offered the resident a magazine, however, failed to offering toileting to the resident, as per the plan of care (after breakfast). At 8:35 AM, direct care staff D and licensed nursing staff B transferred the resident into a recliner in the living area, and staff B turned on the television for the resident. The staff failed to offer or provide a toileting opportunity at that time. At 9:00 AM, the resident remained in the recliner with staff providing re-direction to the resident when noting the resident attempting to rise from the recliner. The staff provided a tool box of various tools/items for the resident to tinker with. At 9:26 AM, the resident remained in the chair with the tool box in front of him/her. The resident attempted to stand again with staff redirecting the resident to continue working with the tools. At

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9:45 AM, staff B responded and re-directed the resident to remain seated and changed the television channel for the resident. At that time, staff B asked the resident about toileting, with the resident responding "Yes." The staff member indicated a plan to get some assistance and left the resident in the recliner, while the staff member continued passing medications to other residents. The resident continued to attempt to arise from the chair at frequent intervals. Staff B continued monitoring the resident. At 9:57 AM, staff B instructed staff D to toilet the resident. Direct care staff D sat with the resident for several minutes while waiting for the resident to state he/she was ready to get up. When the resident did not respond to staff D, staff D left the area, without providing toileting to the resident. At 10:10 AM, the resident stood up from the chair, walked around the table and a dietary staff member re-directed the resident to sit back down into the recliner. At 10:40 AM, direct care staff D and E assisted the resident into the wheelchair and took the resident to the bathroom for toileting, 55 minutes after the resident indicated to the nurse of his/her need to toilet. Staff E completed the toileting care for the resident, with the resident urinating in the toilet. The resident's incontinent brief was wet with a small amount of incontinent urine. Following toileting staff E returned the resident to the living room area and left the resident in the wheelchair, where the resident sat until lunchtime. At 12:30 PM, a staff member assisted the resident to the dining room table for lunch, without a toileting opportunity offered or provided, as per direction in the plan of care. The resident appeared to sleep off and on during the time from 1:30 PM to 3:00 PM. At 3:09 PM, direct care staff F and G toileted the resident, with the resident urinating in the toilet with a dry

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incontinent brief. Direct care staff E reported the resident was frequently incontinent of urine and later indicated that the staff member toileted the resident one time this shift.

Direct care staff D reported, on 12/28/18 at 8:46 AM, the resident required frequent one to one monitoring with frequent re-direction. The staff further noted that sometimes when the resident became restless he/she needed to toilet, or sometimes wanted to go for a walk. The staff reported the resident was incontinent and required toileting every couple of hours.

On 12/28/18 at 1:40 PM, direct care staff I reported the resident required close supervision and assistance with ambulation. The staff further noted the resident was incontinent of urine and required frequent checking for incontinence and toileting. The staff did not recall ever doing a 3-day voiding diary for the residents of the facility and when asked indicated he/she did not provide any toileting tasks for the resident during this shift.

On 12/28/18 at 2:08 PM, direct care staff D reported assisting the resident with arising cares this AM, and toileting the resident at that time, however, had not completed any other toileting opportunities for the resident. The staff additionally reported he/she did not recall doing a 3-day voiding diary for this resident upon admission.

On 12/28/18 at 2:52 PM, direct care staff G reported the resident required 1 to 2 staff assistance with cares including toileting every 2-3 hours, usually before and after meals and then at bedtime. The staff did not recall completing a

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3-day voiding diary for the resident.

A policy for the facility toileting policy was not available.

The facility failed to ensure this incontinent resident received toileting opportunities, as planned, before and after meals. Additionally, the facility failed to provide the resident with an individualized toileting plan to promote as much normal bladder function as possible.

- Resident #2's diagnoses from the physician's order sheet, dated 8/2/18, included Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure), behavioral disturbance, and urinary incontinence (involuntary passage of urine).

The annual MDS (minimum data set), dated 11/11/18, identified the resident scored 7/15 on the BIMS (brief interview for mental status) assessment, identifying the resident as severely impaired of cognition. The staff identified the resident required limited to extensive assistance for most ADLs (activities of daily living).

A bowel and bladder assessment, dated 8/19/18, identified the resident was occasionally incontinent of urine and required assistance of staff for toileting. Review of the document lacked evidence of an analysis of the residents 3-day voiding diary to determine the most effective toileting plan for this incontinent resident.

The comprehensive care plan, dated 11/20/18, instructed staff in toileting needs, including: Required stand by assistance of 1 staff with

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toileting.
Required use of grab bars for toileting.
Wears incontinent products (pullups).
The care plan lacked an individualized toileting plan, instructing staff in the residents individualized toileting needs.

On 12/28/18 at 7:54 AM, the resident slept in his/her bed. At 8:42 AM, direct care staff I checked on the resident and inquired if the resident was ready to get up. The resident declined to get up at that time and the staff indicated they would return later to check on him/her. At 10:00 AM, direct care staff E staff ambulated with the resident to the dining room, where the resident sat down in a chair and ate breakfast. The resident remained at the table with tablemates and a visitor until 11:20 AM, when staff offered toileting to the resident, who indicated he/she had no need. The staff encouraged the resident to get up from the table and walk to a chair in the outer walkway, where the resident sat for a short while. Staff got a sweater for the resident and then staff I ambulated with the resident to the recliners in the living area, where the resident remained until 4:10 PM, with on-going monitoring, with the exception from 12:30 PM to 1:15 PM. At 3:35 PM, a request for a skin check was made to licensed nursing staff C. At 4:10 PM, direct care staff H ambulated with the resident to his/her room for toileting. The resident sat onto the toilet, after staff H lowered the resident's slacks and incontinent brief. Staff removed the slightly wet incontinent brief and placed a clean brief on the resident. The resident voided in the toilet, as well.

On 12/28/18 at 8:51 AM, direct care staff D

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reported the resident liked to sleep late and that staff check and change him/her to ensure the resident remained dry and comfortable. After arising and while awake the resident could usually tell the staff when needing to toilet. The resident was usually continent when awake. The staff later verified he/she did not provide any cares to the resident that shift.

On 12/28/18 at 1:40 PM, direct care staff I reported the resident was a late sleeper. Staff indicated the resident began having more behaviors and often yelled at the staff when they attempted to get the resident to awaken. Staff I reported the resident was often incontinent when asleep, and staff checked and changed the resident when in bed. When awake the resident usually told staff when needing to toilet. The staff further indicated he/she had not provided any toileting care to the resident this shift.

On 12/28/18 at 2:03 PM, direct care staff E reported assisting the resident with arising cares this AM. Staff E reported the resident toileted at that time, however, was incontinent with the use of an incontinent product in place and indicated he/she did not provide any further toileting opportunity to the resident this shift.

On 12/28/18 at 2:56 PM, direct care staff G reported the resident required assistance with toileting and ambulation, however, did at times get up unassisted. The staff identified the staff check and change the resident when in bed and offered toileting when awake. Staff reported he/she offered toileting to the resident at 2:15 PM, when providing snacks, which the resident declined.

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A policy for the facility toileting policy was not available.

The facility failed to thoroughly assess and determine the resident's toileting needs, and then use the data to implement and individualized toileting plan for this incontinent resident.

- Resident #3's diagnoses from the Physician's Order Sheet, dated 9/28/18, Alzheimer's Disease (progressive mental deterioration characterized by confusion and memory failure) and stress incontinence (an involuntary release of urine with coughing, sneezing, or other unexpected actions).

The admission MDS (minimum data set), dated 9/17/18, identified a score of 11 on a BIMS (brief interview of mental status) score, indicating moderately impaired cognition. The assessment further identified the resident required supervision for occasional incontinence of urine.

A significant change MDS (minimum data set), dated 10/22/18, identified the resident with a BIMS (brief interview of mental status) score of 8/15, indicating moderately impaired cognition. The assessment identified the resident required extensive assistance for most ADLs (activities of daily living), lacked a toileting program and was frequently incontinent of bowel and bladder.

A 9/26/18 bowel and bladder assessment, lacked identification of an individualized toileting plan, identified the resident as always continent and required set-up supervision for toileting. The assessment further lacked any evidence of a 3-day voiding diary. The facility failed to complete

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another assessment when the resident declined and became frequently incontinent of bowel and bladder as identified in the significant change MDS, on 10/22/18.

The resident's care plan, dated 11/4/18, instructed staff to provide set-up assistance with toileting.
Some (urinary) dribbling, therefore wears pads.
Provide supervision assistance of 1 staff for toileting at request of the resident.

Observation of the resident on 12/27/18 at 3:05 PM and 4:00 PM, identified the resident up and ambulating independently, in his/her room.

On 12/28/18 at 7:55 AM, the resident sat at the dining room table eating breakfast. When the resident finished breakfast, he/she left the area independently and returned to his/her room. At 8:40 AM, the resident rested in bed, appearing to sleep. The resident remained independent throughout the day and at 2:15 PM, toileted him/herself prior to going to the dining room for an afternoon snack.

On 12/28/18 at 8:54 AM, direct care staff D reported the resident only needed supervision and some set-up assistance. Staff D reported the staff cued the resident for toileting and was usually continent of bowel and bladder. Staff indicated the resident's level of confusion seemed to be increasing as sometimes the resident believed his/her adult child was his/her mother.

On 12/28/18 at 1:40 PM, direct care staff I reported the resident was mostly independent with cares and preferred to spend most of his/her time in his/her room. The staff reported the

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resident toileted him/herself most of the time independently, and that the resident displayed more confusion recently, requiring increased monitoring. The staff indicated he/she was not aware of any 3-day voiding diary done with the resident and the resident had incontinence at times. The staff verified he/she had not provided any cares this shift.

On 12/28/18 at 2:04 PM, direct care staff E reported the resident only required supervision and he/she had not provided cares to the resident this day.

On 12/28/18 at 2:07 PM, direct care staff D reported he/she had not provided any cares to the resident this shift.

On 12/28/18 at 3:02 PM, direct care staff G reported the resident was usually continent and used the bathroom independently. Staff reported he/she usually checked the resident at bedtime to ensure the resident was clean and dry.

A policy for the facility toileting policy was not available.

The facility failed to complete a thorough assessment of this resident for his/her bladder needs. The most recent significant change MDS identified the resident with frequent bladder incontinence, however, the previously completed bladder assessment identified the resident continent of bladder.

- Resident #4's quarterly MDS (minimum data set), dated 12/16/18, included a BIMS (brief interview of 7/15, indicating severely impaired

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cognition, and identified the resident required extensive assistance for toileting, without a toileting program and frequently incontinent of bladder and bowel.

The bowel and bladder assessment, dated 9/17/18, lacked evidence of review of a 3-day voiding diary to determine the resident's individualized toileting needs.

The resident's care plan, dated 12/20/18, instructed the staff:
Provide limited assistance of 1 staff with toileting, at my request.
Used incontinent products, please ensure they are on appropriately; wears a med pull-up.
Keep my skin well lubricated with use of a moisture barrier to protect from incontinence.
Monitor urine for odor and color and signs and symptoms of UTI (urinary tract infection).
Offer fluids of choice at meals and at bedside.
Usually liked to go to the bathroom when choosing (upon request), usually before and after meals.

Observation of the resident, on 12/28/18 at 8:30 AM, identified the resident in the dining room eating breakfast. The resident ate very slowly and at 10:30 AM, self-propelled in his/her wheelchair to another table in the dining room. The resident remained at that table, visiting and watching another resident and his/her guest playing cards, until lunch began being served, at which time the resident moved to a different table. At that time, direct care staff I asked the resident about toileting and the resident denied the need. The resident remained at the table eating lunch from 11:20 AM to 1:30 PM. At 1:30 PM, another resident entered the dining room and inquired

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why the resident sat at "her spot." The resident then left the table and self-propelled to his/her room and sat looking at some papers and dozing in his/her wheelchair.

On 12/28/18 at 3:30 PM, direct care staff G toileted the resident, removing an incontinent brief, with urine and feces present. The resident stood independently from the toilet when finished with the staff providing perineal hygiene care.

On 12/28/18 at 11:20 AM, licensed nursing staff B, reported the resident needed assistance for all cares and was unaware of care needs or the need to ask for assistance.

On 12/28/18 at 1:40 PM, direct care staff I reported the resident was sometimes incontinent. The staff reported he/she asked the resident 3 times today, about toileting and the resident refused each time, indicating no need. The staff noted the resident does at times take him/herself to the toilet, although staff needed to assist him/her due to a high risk of falling. Staff I reported assisting the resident with arising cares this AM and toileted the resident at that time. The staff indicated he/she offered toileting again after breakfast, before lunchtime and the resident refused. The staff reported not aware of any 3-day voiding assessments for the resident.

On 12/28/18 at 3:08 PM, direct care staff G reported the resident at times self-toileted; was sometimes continent of urine and usually incontinent of bowel. The staff noted the resident usually told staff when he/she needed toileting or other needs.

A policy for the facility toileting policy was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175304	A. BUILDING _____ B. WING _____	C 12/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EMPORIA PRESBYTERIAN MANOR	**2300 INDUSTRIAL ROAD EMPORIA, KS 66801**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 690	Continued From page 14 available. The facility failed to ensure a thorough assessment of the resident's individualized toileting needs, including an analysis of the resident's toileting habits to develop and implement an individualized toileting plan for this incontinent and confused resident.	F 690		