DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RECEIVED
APR - 2 2012
Division of Health Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	355041	A. BUILDING ______ B. WING ______	03/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LUTHERAN HOME OF THE GOOD SHEPHERD	1226 1ST AVE N NEW ROCKFORD, ND 58356

(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 000	INITIAL COMMENTS For the standard Medicare/Medicaid recertification survey, started on 02/27/12 and completed on 03/01/12, the sample included 4 residents for complete review, 9 residents for focused review, and 2 closed records for review.	F 000		
F 240 SS=D	483.15 CARE AND ENVIRONMENT PROMOTES QUALITY OF LIFE A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and family and staff interview, the facility failed to ensure the environment promoted or enhanced the quality of life for 1 of 1 sampled resident (Resident #4) who utilized four one-half side rails while in bed. Use of the elevated side rails on Resident #4's bed limited the resident's visual field and may create a feeling of isolation. Findings include: Observations of Resident #4 included: *02/27/12 at 1:00 p.m. - Resident #4 lying awake in bed with four one-half side rails elevated and his television on. *02/28/12 at 8:15 a.m. - Resident #4's head of the bed elevated approximately 75-80 degrees, four one-half side rails in the up position while a certified nurse aide (CNA #1) fed the resident his breakfast meal.	F 240	1. Corrective action occurred on 2-28-12. Side rail consent reviewed with resident #4's mother. Explanation given in regards to side rails limiting the resident's visual field and possibly creating a feeling of isolation. Resident's mother insists on all side rails being up. Side rail consent signed and decision tree completed. 2. Upon admission, annually, and PRN the resident, resident family, or representative will be asked to sign a consent form stating if they want or do not want side rails up and reasons why. Decision tree reviewed on the form. 3. Policy will be developed in regards to side rail use. Education will be given in regards to this in a memo with appropriate forms attached. 4. A QA will be developed to monitor that side rail consents are being completed per side rail policy. DON will assign a nurse to perform QA on 2 random residents weekly x4, then monthly x3, then quarterly x3, and then as needed if problems are found.	via phone spoke with SS admin 04/03/12 adding an assessment of side rails JT 3/27/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]
TITLE: CEO/Administrator
(X6) DATE: 3-30-12

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F 240	Continued From page 1 *02/28/12 at 10:00 a.m. - Resident #4 asleep in bed with four one-half side rails elevated. *02/28/12 at 2:30 p.m. - Resident #4 lying in bed with four one-half side rails elevated and moving his head from side-to-side. Observation showed the top side rails (positioned on each side of the bed) impeded the resident's line of vision. *02/29/12 at 8:45 a.m. - Resident #4 positioned on his back with his eyes open, the television on, and four one-half side rails in the up position. *03/01/12 at 8:30 a.m. - Resident #4 positioned on his back with his eyes open, the television on, and four one-half side rails in the up position. Resident #4 moved his eyes and followed the movement of the surveyor as she entered his room. Review of Resident #4's record occurred on all days of survey. Medical diagnoses included quadriplegia, aphasia with a closed head injury, and multiple contractures. Resident #4's quarterly Minimum Data Set, dated 02/06/12, identified the resident is rarely/never capable of making himself understood or capable of understanding others, impaired vision, short and long term memory problems, severely impaired with daily decision making, and requires total two person physical assistance with all activities of daily living. During interview on on 02/29/12 at 4:00 p.m., a family member (A) stated Resident #4 has lived in this facility for over 30 years and the staff always raise the side rails on the bed. This family member stated initially after admission, the resident had "uncontrolled spastic movements," but has not had any problems for a "number of	F 240	5. Corrective action completed on 3-27-12.	3/27/2012

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F 240	Continued From page 2 years." Record review identified the facility completed a "Side Rail Decision Tree" form in 1997. When asked for a more recent assessment indicating the reason for Resident #4's use of side rails, the facility provided a "Consent to Use Side Rails" form, dated 07/15/97, for review. During interview on 03/01/12 at 9:00 a.m., an administrative nurse (#7) stated the facility does not routinely assess residents who utilize side rails. This nurse confirmed Resident #4 is incapable of movement without total assistance of staff. Record review and observation identified Resident #4 as incapable of moving any of his limbs without staff assistance. Observations showed when facility staff raise the side rails attached to Resident #4's bed, the side rails have the potential to limit and impede the resident's line of vision and possibly create a feeling of isolation.	F 240		
F 278 SS=F	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the	F 278	1. Resident # 1 has since expired. Residents 5,6,8,9,10,11,12 and 13 will have their last MDS modified to correct HHO2OO, regarding individualized toileting plan. Section Z: Unable to correct this on previous assessments. Assessment Administration will now be signed off according to RAI Manual guidelines. Correction of signatures indicating sections completed will begin with any MDS with the ARD of 04/01/2012.	3/27/2012

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F 278	Continued From page 3 assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: 1. Based on observation, record review, review of the Long-Term Care Facility Resident Assessment Instrument (RAI) User's Manual (Version 3.0), policy review, and staff interview, the facility failed to ensure the Minimum Data Sets (MDSs) accurately reflected the resident's status for 8 of 8 sampled residents (Resident #5, #6, #8, #9, #10, #11, #12, and #13) identified on a toileting program (Section H: Bladder and Bowel). Failure to accurately code the MDS for these residents limited the facility's ability to develop and implement individualized care plans consistent with the residents' needs and functional status. Findings include: The Long-Term Care Facility RAI User's Manual	F 278	2. The Facility will identify other residents for the potential of being miscoded by re-education of all MDS nursing personnel. This was completed on 03/21/2012. In addition, all of the MDS team has been re-educated on the issue of signing the MDS form, section Z as per RAI manual instructions indicating the section completed. This was completed on 03/21/2012. 3. The Facility has completed an educational in-service for all MDS nursing personnel on 03/21/2012. A quality assurance monitoring program will be developed by 03/27/2012 to ensure this coding issue will not recur. 4. The Facility plans to monitor this correction of this practice by the institution of a quality assurance program to monitor the coding of HHO2OO and Section Z: Assessment Administration. The quality assurance program will monitor one(1) comprehensive MDS weekly, if one(1) is scheduled, and two(2) quarterly MDS assessments weekly, for four(4) weeks, then monthly times three(3) months, and then quarterly times three(3). 5. Corrective action completed on 03/27/2012.	3/27/2012

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F 278	Continued From page 4 stated on: *Page 2-1, ". . . The RAI process is the basis for the accurate assessment of each nursing home resident . . . " *Page H-5 identifies the medical record needs to include these three requirements for a current toileting program or trial, ". . . implementation of an individualized, resident-specific toileting program that was based on an assessment of the resident's unique voiding pattern; evidence that the individualized program was communicated to staff and the resident (as appropriate) verbally and through a care plan, flow records, and a written report; [and] notations of the resident's response to the toileting program and subsequent evaluations, as needed . . ." *Page H-6, ". . . Toileting (or trial toileting) programs refer to a specific approach that is organized, planned, documented, monitored, and evaluated . . . A toileting program does not refer to: -simple tracking continence status, -changing pads or wet garments, and -random assistance with toileting or hygiene." Review of a facility policy "Bowel & Bladder Assessment" occurred on 02/29/12. The policy, dated 04/01/08, stated: "It is the policy of Lutheran Home of the Good Shepherd that each resident that is incontinent of bladder . . . is identified and assessed . . . The program is based on current assessment and treatment concepts . . . Residents on toileting or retraining program will be reviewed at least quarterly and with a significant change in continence status. 4. Resident's continent status will be reviewed	F 278		

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quarterly with MDS [Minimum Data Set]."

- Review of Resident #6's medical record occurred February 27-March 1, 2012. The resident's current quarterly MDS, dated 01/03/12, identified moderately impaired cognition, extensive one person physical assistance with toileting, on a current urinary toileting program, and frequently incontinent of urine.

Resident #6's current care plan for "urinary freq [frequency]" identified an approach of "See bedside kardex [also known as the Activity of Daily Living (ADL) care plan]." Resident #6's ADL care plan, utilized by certified nurse aides (CNAs), identified the resident as "incontinent daily" of bladder and "Ind [individualized] toilet schedule" during the day and p.m. shift. Neither of the above care plans identified specific individualized times for staff to provide toileting assistance to the resident.

Resident #6's "Toileting Schedule" dated December 25-February 28, 2012, listed voiding times of "upon awakening, B/4 [before] dinner, after dinner, B/4 supper, and HS [before hour of sleep]." The "times" on the toileting schedule are "blocks of time," and this schedule failed to identify the specific times for staff to assist or toilet Resident #6.

During interview on 02/28/12 at 2:00 p.m., a CNA (#1) stated he assisted Resident #6 to toilet when he "got her up this morning" and "then again around 12:30 p.m." The CNA (#1) stated Resident #6 voided each time even though her incontinent brief was "wet."

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F 278	Continued From page 6 Observations on 02/29/12 showed facility staff toileted Resident #6 at 8:05 a.m., 10:30 a.m., and 11:00 a.m. The above observations and staff interview show facility staff toileted Resident #6 at random times rather than at established times, based on an individualized assessment. Resident #6's medical record lacked evidence the facility implemented, documented, monitored, and evaluated an individualized toileting program for this resident. - Review of Resident #5's medical record occurred February 27-March 1, 2012. The resident's current quarterly MDS, dated 01/07/12, identified intact cognition, limited one person physical assistance with toileting, on a current urinary toileting program, and continent of urine. Resident #5's current care plan for "incontinence" identified an approach of "Individualized Toileting schedule: May need to go more frequently after breakfast." Resident #5's ADL care plan, utilized by CNAs, identified the resident as continent of bladder during the day and p.m. shift. Neither of the above care plans identified specific individualized times for staff to provide toileting assistance to the resident. Observation on 02/28/12 at 9:00 a.m. showed a CNA (#2) pushed Resident #5's wheelchair into the bathroom. Resident #5 stood per self, and voided into a urinal held by CNA (#2). At 12:15 p.m., observation showed Resident #5 propelled his wheelchair to the doorway of his bathroom to use the toilet. Resident #5 stated he is capable of taking himself to the bathroom and "doesn't like to bother anyone . . ." and "I am pretty	F 278		

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independent [with toileting]."

The above observations identified Resident #5 utilized the toilet himself.

.- Review of Resident #11's medical record occurred February 29-March 1, 2012. The resident's current quarterly MDS, dated 01/03/12, identified intact cognition, extensive one person physical assistance with toileting, on a current urinary toileting program, and continent of urine.

Resident #11's current care plan for "incontinent" identified an approach of ". . . See bedside kardex [also known as the ADL care plan]." Resident #11's ADL care plan, utilized by CNAs, identified the resident as "never" incontinent of bladder during the day and p.m. shift and on an "Ind [individualized] toilet schedule" during the night. Neither of the above care plans identified specific individualized times for staff to provide toileting assistance to the resident.

Resident #11's "Toileting Schedule" dated December 29-February 29, 2012, listed voiding times of "upon awakening, B/4 dinner, after dinner, B/4 supper, and HS." The above "times" listed are blocks of time and this schedule failed to identify the specific times for staff to assist or toilet Resident #11. Review of the above toileting documentation identified Resident #11 remained continent of bladder on all days.

During interview on 02/29/12 at 3:00 p.m., a licensed nurse (#6) stated Resident #11 "takes herself to the bathroom" and "occasionally" staff will assist the resident with pulling up her pants as the resident requests.

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F 278	Continued From page 8 The above staff interview identified Resident #11 toilets herself and facility staff do not routinely take or prompt the resident to toilet. Resident #11's medical record lacked evidence the facility implemented, documented, monitored, and evaluated an individualized toileting program for this resident. During interview on the morning of 03/01/11 an administrative nurse (#7) confirmed the facility failed to identify specific individualized toileting times for staff to assist Resident #5, #6, and #11. - Review of Resident #8's medical record occurred on all days of survey. Diagnoses included cerebral vascular accident (CVA) with right sided hemiplegia (weakness/paralysis), hemarthrosis (bleeding into) of the right knee, and aphasia (difficulty speaking). Resident #8's admission MDS, dated 10/18/11, identified the resident on a trial or current toileting program, unable to determine the effectiveness, and frequently incontinent. A quarterly MDS, dated 01/09/12, identified the resident on a toileting program and frequently incontinent. Resident #8's current care plan identified a problem of "Incontinent of urine several times daily . . . Related To: Dx [diagnosis] of CVA and pain in right knee and ankle. Evidenced By: frequent urinary incontinence" with approaches of "Individualized Toileting schedule: May need to go more frequently after breakfast. Incontinence protection products --see bedside care kardex . . ." Resident #8's care kardex identified the resident as incontinent daily during the morning,	F 278		

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F 278	Continued From page 9 evening, and night shift; on an individualized toileting program; on a check and change each shift; and required assist of one or two for toileting. The "Elimination" section identified the resident as toileted in the bathroom only on the evening shift and wearing an incontinent product each shift. Neither of the above care plans identified resident-specific toileting schedules. On 02/28/12 at 10:15 a.m., observation showed two CNAs (#9 and #10) toileted Resident #8, and the resident began to void as soon as one of the CNAs removed the resident's incontinent brief. Observation showed the resident's brief dry. At 3:00 p.m., a CNA reported taking the resident to the toilet, the resident was incontinent, and also voided. During interview on 01/29/12 at 10:50 a.m., an administrative staff member (#7) stated no assessment and individualized toileting schedule occurred for Resident #8, and the 01/09/12 MDS inaccurately showed the resident on a toileting schedule. During interview on 03/01/12 at 10:40 a.m., an administrative staff member (#7) stated Resident #8 has never been on a toileting schedule. - Review of Resident #9, #10, #12, and #13's medical records also showed (within the resident's care plan) each resident on a toileting program and/or schedule. The records also identified the residents' toileting schedules as upon awakening, before dinner, after dinner, before supper, and at HS. The care plans included blocks of time and failed to identify the specific times for staff to provide toileting	F 278		

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F 278	Continued From page 10 assistance for each resident. Each resident's most current MDS identified the resident(s) with frequent bladder incontinence. The following MDSs identified toileting schedules: * Resident #9's annual MDS, dated 01/07/12. * Resident #10's quarterly MDS, dated 11/30/11. * Resident #12's significant change MDS, dated 12/19/11. * Resident #13's quarterly MDS, dated 02/12/12. The resident's medical records lacked evidence the facility assessed each resident for an individualized toileting program, clearly communicated and made the plan available (via the care plan and CNA care kardex), identified the resident's response to the toileting program, and documented each evaluation in the medical record. During interview on the morning of 03/01/12, an administrative staff member (#7) stated the facility does not document each resident's response to their toileting programs on a quarterly basis. 2. Based on record review, policy and procedure review, review of the Long-Term Care Facility RAI User's Manual (Version 3.0), and staff interview, the facility failed to identify which staff member completed each section or portion of the section for each MDS item (Section Z: Assessment Administration) for 13 of 13 sampled residents (Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, and #13) and 2 closed records (Resident #14 and #15). Failure to identify the section(s) completed by each staff member does not ensure the staff member attests to the accuracy of the response for the information	F 278		

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collected on a specific section of the MDS.

Findings include:

The Long-Term Care Facility RAI User's Manual stated on:

*Page Z-6, "To obtain the signature of all persons who completed any part of the MDS. Legally, it is an attestation of accuracy with the primary responsibility for its accuracy with the person selecting the MDS item response . . . The importance of accurately completing and submitting the MDS cannot be over-emphasized. The MDS is the basis for the development of: -an individualized care plan; -the Medicare Prospective Payment System; -Medicaid reimbursement programs . . ."

Review of a facility policy "MDS Assessment Completion" occurred on 02/28/12. This policy, dated 10/01/10, stated, "Purpose: To ensure completion of the MDS assessment include the Care Area Assessment [CAA] areas in a timely and appropriate manner. Procedure: Sections of the MDS Assessment and CAAs are to be completed by the designated discipline, or designee . . . NOTE: All ares may be completed by an area's designee or by an RN [registered nurse]." This policy listed every section of the MDS (A-Z) and assigned a specific department or discipline to complete the item set or section.

- Record review for Resident #1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #11, #12, #13, #14, and #15 occurred between February 28 and March 01, 2012. Review of the above residents' current MDS Section Z - Assessment Administration

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F 278	Continued From page 12 (Z0400) item set lacked identification of which specific section each individual staff member completed. On 02/29/12 at 10:25 a.m., an administrative nurse (#8) stated the facility established a policy designating who can complete which section(s) of the MDS and stated the facility's computer program will not allow them to list each individual section at Z0400 due to a lack of space in that field.	F 278		
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, review of facility policy, and staff interview, the facility failed to complete a comprehensive assessment, develop care plan interventions specific to an assessment, implement a scheduled toileting program specific for each resident, and evaluate the effectiveness of the toileting schedule for 4 of 6 sampled residents (Resident #6, #9, #12, #13) on a scheduled toileting program for frequent bladder incontinence. Failure of staff to implement	F 315	1. Resident # 1 has since expired. Resident # 6, 9, 12, 13 will be re-evaluated using the Potential for Bowel and Bladder retraining tool and the bowel and bladder tracking. The results of each resident will be reviewed and indicated toileting plan instituted. 2. All residents have the right to have the highest level of continence possible. 3. All resident's will have their continence status reviewed using the potential for Bowel and Bladder retraining tool quarterly and prn in conjunction with the MDS schedule. Bowel and Bladder/toileting Policy has been revised and a Policy on Potential for Bowel and Bladder retraining was developed 3-22-12. Education was given to the Nurses and CNAs on 3-27-12.	3/27/2012

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F 315	Continued From page 13 scheduled toileting plans, at times consistent with the residents' voiding habits/patterns, placed these residents at risk for avoidable increased bladder incontinence, falls, urinary tract infections, and also has the potential to compromise residents' individual dignity. Findings include: Review of a facility policy "Bowel & Bladder Assessment" occurred on 02/29/12. The policy, dated 04/01/08, stated: "It is the policy of Lutheran Home of the Good Shepherd that each resident that is incontinent of bladder . . . is identified and assessed, given the opportunity to achieve continence or restore as much normal bladder . . . as possible and to maintain the resident's skin integrity. Appropriate treatment and services will be offered to restore as much function as possible. The continence program utilized is a structured Bladder and Bowel Rehabilitation Program designed to help resident' [sic] progress from incontinence to continence . . . through guided nursing management. The program is based on current assessment and treatment concepts combined with the newest theoretical and practical knowledge about rehabilitating the incontinent elderly. PROCEDURE: 1. Implement and record bladder . . . patterns as documented in CNA [Certified Nursing Assistants] sheets. I & O [intake and output] record will be obtained for 72 hours. 2. If deemed appropriate, scheduled toileting or bladder retraining program . . . will be	F 315	4. A QA will be developed to ensure that residents incontinent of bladder receives appropriate plan to restore as much normal bladder function as possible. DON will assign a nurse to perform QA on 2 random incontinent residents weekly x4, than monthly x3, than quarterly x3, and than as needed if problems are found. 5. Corrective action completed on 3-27-12	3/27/2012

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F 315	Continued From page 14 implemented. 3. Residents on toileting or retraining program will be reviewed at least quarterly and with a significant change in continence status. 4. Resident's continent status will be reviewed quarterly with MDS [Minimum Data Set]." The facility policy and procedure lacked how the facility determined a resident is "deemed appropriate" for a scheduled toileting or bladder retraining program. The procedure lacked a key aspect of the assessment to determine the nature of the incontinence, including functional, urge, overflow, stress, mixed, or transient incontinence in order to understand the cause to address the incontinence to the extent possible and provide individualized interventions. The policy/procedure also failed to define interventions consistent with each residents' 72 hour bladder record; consistent with prior history of urinary incontinence, consistent with the residents' determined voiding habits/patterns, and as determined by each residents' cognitive and functional capabilities. Review of Resident #6, #9, #12 and #13's care plan identified each resident on an "Individualized Toileting schedule." The toileting schedule form included documentation of each time the facility found the resident incontinent, voided or continent: upon awakening, before dinner, after dinner, before supper and at bedtime (HS). The toileting schedule showed when staff found the resident incontinent, voided or continent and times between the standardized toileting schedule. The night shift documentation never identified the specific times of incontinence, toileting or continence (with voiding). The toileting	F 315		

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F 315	Continued From page 15 schedules failed to identify each resident's individualized toileting schedules/plan via the resident care plan, certified nursing assistant's (CNA) care kardex, and toileting forms. The medical record of each resident failed to identify the resident's response to the toileting program and document subsequent evaluations in the clinical record, including when staff made changes depending on the resident's response. - Record review for Resident #12 occurred on February 28-March 1, 2012. The admission Minimum Data Set (MDS), dated 09/15/11, identified extensive assistance with toilet use, on a scheduled toileting plan, and occasional urinary incontinence. The current MDS, dated 12/19/11, identified extensive assistance with toilet use, on a scheduled toileting program, and frequently incontinent (a decline in toileting ability since the admission MDS). The resident's Urinary Incontinence/Catheter Care Area Assessment (CAA), dated 09/21/11, stated, "The team has determined that a Urinary Incontinence problem is present demonstrated by this resident's inability to consistently maintain continence. . . .Expected prognosis of urinary incontinence problem is that we will see improvement in continence . . ." An admission toileting assessment, dated 09/08/11, stated "Denies incontinence; ? [question] if dribbles; toileting schedule to start. . . ." Review of the interdisciplinary progress notes, dated 09/27/11, stated, ". . . 22:42 [10:42 p.m.]. . . . Staff heard noise. . . . saw resident on the floor	F 315		

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F 315	Continued From page 16 in the hallway . . . states she was looking for the bathroom. . . . Checked for injuries. slight abrasion to [right] shoulder 3 x 5 cm [centimeter], bruise near [right] elbow. 2 x 3 cm. . . . Assisted to bathroom then to bed. Will monitor." Follow up documentation, dated 09/30/11, related to the fall identified the following: ". . . Isolated incident. Res. [resident] had been toileted at 9:30 p.m. Will monitor for further problems. Cont. [continue] on toileting schedule." The documentation did not identify re-assessment of the appropriateness of the resident's toileting plan to address the resident's risk for falls and attempt at self toileting during the night. The current comprehensive care plan stated, "Toileting schedule: May need to go more frequently after breakfast." The care plan did not specifically address toileting during the night or the resident's attempt to self toilet which resulted in her fall. Resident #12 toileting records for December 2011 identified more incontinence at night and upon awakening, during the assessment look back period. Review of the resident's medical record failed to identify specific assessment information addressing the resident's incontinence at night and early morning or implementation of an individualized toileting program to address the resident's increased incontinence, or history of her attempt to self toilet which resulted in a fall with injury.	F 315		

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F 315	Continued From page 17 The facility failed to accurately assess, care plan, implement and evaluate the effectiveness of the interventions, and revise as necessary, as appropriate, to determine progress, changes, or decline in bladder function. - Record review for Resident #9 occurred on all days of survey. Diagnoses included: chronic renal failure, prolapsed bladder, and dementia. Resident #9's admission MDS, dated 02/17/11, identified the resident required extensive assistance with toilet use, occasionally incontinent of bladder, and decreased wetness on a scheduled toileting plan. The most recent annual MDS, dated 01/07/12, identified the resident required extensive assistance with toileting, on a scheduled toileting program, and frequently incontinent (a decline in incontinence since the admission MDS). The current care plan identified the resident as incontinent of urine at times, related to "has had problems for years (per family) with approaches of "Individualized Toileting schedule: May need to go more frequently after breakfast. Incontinence protection products -- see bedside care kardex. Encourage fluids. Offer with cares. Verbal/physical cues and or assist as needed. . . . " The CNA kardex identified the resident as utilizing the bathroom and wearing an incontinence brief on each shift. The care kardex identified the resident with daily incontinence on each shift; on an individualized toilet schedule each shift, toileting self on the day shift, requiring assist of one with toileting on the evening shift and by self and assist of one to two on the night shift. The care kardex and care plan failed to	F 315		

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F 315	Continued From page 18 identify individualized toileting times for Resident #9. Resident #9's "toileting schedule," a facility form, identified Resident #9's elimination patterns for the three days prior to the assessment reference period for the 01/07/12 MDS. The toileting schedule showed no documentation of toileting on two of the three days on the day shift with the resident incontinent of bladder upon awakening on the third day (01/06/12), always incontinent once between the before supper toileting and HS toileting. The record showed the resident incontinent of urine at all times on the night shift, with inconsistent toileting on the night shift (between one to four times on the night shift). Review of Resident #9's toileting schedule between 02/01/12 and 02/14/12 identified Resident #9 frequently incontinent upon awakening, always continent before dinner, frequently incontinent after dinner, mostly continent before supper (one episode of incontinence), mostly incontinent between supper and HS, mostly continent at HS, and incontinent on the night shift (generally three times). The facility failed to individualize Resident #9's toileting schedule, and adapt it to Resident #9's routine incontinent episodes to prevent a decline in incontinence. Review of nursing assessments, dated 02/10/11 (admission), 11/07/11 and 01/06/12 failed to include a comprehensive assessment of Resident#9's urinary incontinence, include an individualized toileting schedule, and include an evaluation and/or re-assessment of the appropriateness of the resident's toileting plan on	F 315		

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F 315	Continued From page 19 a quarterly basis as identified in facility policy. The facility failed to individualize and address Resident #9's increase in frequency of incontinence, the resident's frequent incontinence between supper and HS,and consistent incontinence on the night shift with the standardized toileting schedule. - Record review for Resident #13 occurred on February 29-March 1, 2012. Resident #13's admission MDS, dated 05/30/11; quarterly MDS, dated 11/22/11; and quarterly MDS, dated 02/21/12, identified the resident required extensive assistance of one to two persons with toilet use, and on a scheduled toileting plan. The admission MDS identified the resident having occasional incontinence and the two quarterly MDSs identified the resident as frequently incontinent (a decline in incontinence since the admission MDS). The current care plan identified the resident as incontinent of urine at times, related to "Confusion/dementia" with approaches of "Individualized Toileting schedule: May need to go more frequently after breakfast. Incontinence protection products -- see bedside care kardex. Encourage fluids. Offer with cares. Verbal/physical cues and or assist as needed. . . . Report s/s [signs or symptoms] of UTI's [urinary tract infections] to nursing. . . ." The care kardex for the day and evening shift identified the resident incontinent daily, required assist of one to two staff, and on a individual scheduled toileting plan. The kardex identified on the night shift the resident incontinent less than daily and a check and change. The elimination care plan identified the resident utilizing the bathroom and	F 315		

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F 315	Continued From page 20 wearing an incontinence brief on each shift. The care kardex and care plan failed to identify toileting times individualized for Resident #13. Resident #13's "Care Area Assessment," for urinary incontinence, dated 01/07/12 stated, "The Team has determined that a Urinary Incontinence problem is present demonstrated by this resident's inability to consistently maintain continence. . . . Cause: dementia; Onset: she had had this problem when at the previous nursing home. Expected prognosis of urinary incontinence problem: Our goal is to see improvement with toileting schedule . . . Consideration of: (1) Conclusions regarding delirium; (2) Cognitive decline over the last 90 days . . ." Resident #13's "toileting schedule," identified elimination patterns for the three days prior to the assessment reference period for the 02/21/12 MDS. The toileting schedule showed Resident #13 always incontinent upon awakening, incontinent once before dinner, always continent after dinner, never toileted before supper, incontinent at least once daily after supper, always continent at HS, and incontinent at least once each night. Review of nursing assessments completed on the following dates identified the following: * 08/21/11, showed the resident usually continent, wears incontinent brief, and toilets herself at night. * 11/23/11, identified Resident #13 as usually continent of bladder, incontinent at least one to two times a day, toilets self at night, wears an incontinent brief, and on a toileting schedule.	F 315		

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F 315	Continued From page 21 * 02/20/12, stated Resident #13 "Doesn't take product off as much as she used to;" as incontinent of bladder, dribbles, toilets self at night, and on a toileting schedule. The facility failed to individualize Resident #13's toileting schedule, according to identified incontinent episodes to attempt to improve her continence level. Resident #13's assessments did not include a comprehensive assessment of Resident#13's urinary incontinence, an individualized toileting schedule, and or an evaluation and/or re-assessment of the appropriateness of the resident's toileting plan on a quarterly basis. The facility failed to individualize and address Resident #13's frequent incontinence upon awakening, failure of staff to toilet the resident before supper, incontinence after supper, and incontinence at night. - Review of Resident #6's medical record occurred on February 28-March 1, 2012. Resident #6's quarterly MDS, dated 01/03/12, identified the resident required extensive assistance of one person with toilet use, on a scheduled toileting program, and frequently incontinent of urine. Resident #6's current care plan for "urinary freq [frequency]" identified the resident experienced "urinary frequency with some dribbling and incontinent episodes related to CHF and daily diuretic use evidenced by frequency and urgency and dribbling" and approaches of " . . . supply incontinent pads for resident to use and control dribbling problem. See bedside kardex [also	F 315		

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F 315	Continued From page 22	F 315		

known as the Activity of Daily Living (ADL) care plan]."

Resident #6's ADL care plan, utilized by certified nurse aides, identified the resident as "incontinent daily" of bladder and "Ind [individualized] toilet schedule" during the day and p.m. shift. Neither of the above care plans identified specific individualized times for staff to provide toileting assistance to the resident.

Resident #6's "Toileting Schedule" dated December 25-February 28, 2012, listed voiding times of "upon awakening, B/4 [before] dinner, after dinner, B/4 supper, and HS [before hour of sleep]. The "times" on the toileting schedule are "blocks of time" and this schedule failed to identified the specific times for when staff need to assist or toilet the resident. Review of Resident #6's "Toileting Schedule," for the seven days prior to the assessment reference date for the 01/03/12 MDS, showed one to six incontinent episodes (which occurred upon awakening, before dinner, after dinner, before supper, HS, and during the night) and one to four continent episodes (which occurred before dinner, before supper, sometime after supper but before HS, and during the night).

Resident #6's comprehensive nursing assessment (an assessment of all body systems), dated 01/01/12, identified the resident as "continent" of bladder, uses the bathroom during the day, and on a toileting schedule. This information contradicts with the above voiding episodes as documented on Resident #6's toileting schedule form. Documentation revealed Resident #6 exhibited more episodes of

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F 315	Continued From page 23 incontinence rather than continent episodes. The facility failed to individualize Resident #6's toileting schedule, according to identified incontinent episodes to attempt to improve her incontinence level. During interview on the morning of 02/29/12, a supervisory staff member (#8) stated the toileting schedules for residents did not include specific toileting times, but rather are standardized (upon awakening, before and after dinner, before supper, and HS) for all residents, and stated occasionally a resident may need toileting at night only. The staff member stated the toileting schedules lacked the time staff toilet residents at night. The staff member stated if an increase in breakdown (skin integrity alteration) would occur, a resident not on a toileting schedule would be put on a program. The staff member also stated staff observe resident behaviors to determine if a resident needs toileting at other than the standardized times. The lack of an adequate assessment of each resident's routine voiding habits/patterns fails to ensure how each resident could benefit from a scheduled toileting plan developed in response to each residents' identified individual needs. During interview on the morning of 03/01/12, an administrative staff member (#7) lacked awareness of what the "Bowel and Bladder Rehabilitation Program" in the facility policy consisted of. The staff member could not identify what "deemed appropriate" meant in the facility policy. The staff member agreed the facilities current (standardized) toileting program did not address other times of the day when a resident's	F 315		

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F 315	Continued From page 24 incontinence occurs.	F 315		