STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035189	A. BUILDING _____ B. WING _____	07/18/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LA CANADA CARE CENTER	7970 NORTH LA CANADA DRIVE TUCSON, AZ 85704

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0636 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, policy review, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the admission Minimum Data Set (MDS) assessment for 2 of 20 sampled residents (#17 and #63) included resident interviews. The deficient practice could delay the ongoing process of identifying residents' preferences and goals of care and strengths and needs. Findings include: -Resident #17 was admitted on (MONTH) 20, 2019, with [DIAGNOSES REDACTED]. Review of the admission Social Services Assessment/Evaluation dated (MONTH) 23, 2019, revealed the Brief Interview for Mental Status (BIMS) and the Resident Mood Interview was conducted. Review of the admission MDS assessment dated (MONTH) 27, 2019 revealed the BIMS, the Resident Mood Interview, and the Interview for Daily and Activity Preferences were coded yes the interviews should be conducted with the resident. However, further review of the MDS assessment revealed no evidence the interviews were conducted with the resident. The areas were coded with a dash (-). -Resident #63 was admitted to the facility on (MONTH) 14, 2019, with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 21, 2019, revealed the BIMS, the Resident Mood Interview, and the Interview for Daily and Activity Preferences should be conducted with the resident. However, further review of the MDS assessment revealed no evidence that these three interviews were conducted with the resident. The areas were coded with a dash (-). An interview was conducted on (MONTH) 18, 2019 at 8:35 a.m. with the MDS coordinator (staff #74). She stated that she follows the RAI manual to ensure the MDS assessments are completed accurately. She stated that other departments, including social services and activities were responsible for completing some sections of the MDS assessment. The MDS Coordinator further stated that she was responsible for reviewing each section of the MDS assessment to ensure all of the questions are answered. She also stated that for missing information, she would investigate with the appropriate department to find the missing information. She stated that if the MDS assessment indicated interviews should be conducted with the resident for the BIMS, the Resident Mood interview, and the Daily and Activity Preferences, she would expect to see answers to the interview questions in the MDS assessment. The MDS Coordinator stated that if the MDS assessment did not contain the resident interview answers, it would be considered incomplete. Review of the facility's policy regarding Resident Assessment reviewed (MONTH) (YEAR), revealed it is their policy to ensure the assessment accurately reflects the resident's status. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. The policy included the Registered Nurse must sign and certify that the assessment is completed. The RAI manual instructs to attempt to conduct the interviews with ALL residents during the look-back period. The manual also instructs that if the interview was not conducted during the look-back period, code yes that the interview should be conducted with the resident and enter the standard no information code (a dash -) in the resident interview items. The manual further included the Centers for Medicare and Medicaid Services (CMS) expects the dash use to be a rare occurrence.
F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Assure that each resident's assessment is updated at least once every 3 months.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, policy review, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure the quarterly Minimum Data Set (MDS) assessment for 2 of 20 sampled residents (#5 and #46) included resident interviews. The deficient practice could delay tracking a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. Findings include: -Resident #5 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated (MONTH) 1, 2019, revealed the Brief Interview for Mental Status (BIMS) should be conducted with the resident. However, further review of the MDS assessment revealed no evidence the interview was conducted with the resident. The areas were coded with a dash (-). -Resident #46 was admitted to the facility on (MONTH) 10, 2019, with [DIAGNOSES REDACTED]. Review of a significant change MDS assessment dated (MONTH) 2, 2019, revealed the BIMS and the Resident Mood Interview should be conducted with the resident. However, further review of the MDS assessment revealed no evidence the interview was conducted with the resident. The areas were coded with a dash (-). During an interview conducted with the MDS Coordinator (staff #74) on (MONTH) 18, 2019 at 08:35 a.m., she stated that the MDS assessment for resident #5 and resident #46 did not contain complete interview information. She also stated that the assessments were not complete assessments as directed by the RAI manual. An interview was conducted with the Director of Nursing (DON/staff #104) on (MONTH) 18, 2019 at 9:14 a.m. She stated that they follow the RAI manual to complete the MDS assessment. The DON stated her expectation is that the MDS assessment be accurate and complete. She stated that if the MDS assessment indicated an interview should be conducted with the resident and the resident is able to be interview, the interview is expected to be conducted in the timeframe defined by the RAI manual. The DON stated that if the RAI manual directions were not followed then the facility policy and her expectation for MDS completion, timeliness, and accuracy were not followed. Review of the facility's policy regarding Resident Assessment reviewed (MONTH) (YEAR), revealed it is their policy to ensure the assessment accurately reflects the resident's status. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. The policy included the Registered Nurse must sign and certify that the assessment is completed. The RAI manual instructs to attempt to conduct the interviews with ALL residents during the look-back period. The manual also instructs that if the interview was not conducted during the look-back period, code yes that the interview should be conducted with the resident and enter the standard no information code (a dash -) in the resident interview items. The manual further included the Centers for Medicare and Medicaid Services (CMS) expects the dash use to be a rare occurrence.

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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F 0638 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1)
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, policy review, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure that the Minimum Data Set (MDS) assessment for two sampled residents (#65 and #93) accurately reflected their status. The deficient practice could affect continuity of care. The census was 90. Findings include: -Resident #65 was admitted to the facility on (MONTH) 17, 2019, with [DIAGNOSES REDACTED]. Review of the admission MDS assessment dated (MONTH) 24, 2019, revealed the resident had received insulin injections for 7 days. However, review of the physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED]. -Resident #93 was admitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 20, 2019. Review of the discharge MDS assessment dated (MONTH) 20, 2019, revealed the resident was discharged to an acute hospital. However, review of the physician's orders [REDACTED]. Review of the Discharge Summary dated (MONTH) 20, 2019, revealed the resident was discharged home with home health services for nursing and therapy. An interview was conducted on (MONTH) 18, 2019 at 8:35 a.m. with the MDS Coordinator (staff #74). She stated that she follows the RAI manual to ensure MDS assessments are completed accurately. The MDS Coordinator stated that she reviews the physician orders [REDACTED]. She also stated resident #65 did not receive insulin and that the MDS assessment should have been coded as zero days of insulin injections. The MDS Coordinator stated that she reviews the discharge plan and a discharge report provided by the business office to code the discharge location for a resident. She stated resident #93 was discharged home, not to an acute hospital. An interview was conducted on (MONTH) 18, 2019 at 9:14 a.m. with the Director of Nursing (DON/staff #104). She stated that they follow the RAI manual to complete the MDS assessment. The DON stated her expectation is that the MDS assessment be complete, timely, and accurate. Review of the facility's policy regarding Resident Assessment revealed it is the policy of the facility to ensure the assessment accurately reflects the resident's status. The policy included each individual who completed a portion of the assessment would sign and certify accuracy of that portion of the assessment. The RAI manual instructs to review the MAR indicated [REDACTED]. The RAI manual also instructs to review the clinical record including the discharge plan and discharge orders for documentation of the discharge location and code the resident's discharge status.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy review, the facility failed to ensure a care plan for urinary incontinence was developed for one sampled resident (#5). The deficient practice could result in the resident not receiving appropriate urinary treatment and services. The census was 90. Findings include: Resident #5 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 21, (YEAR), revealed the resident was at risk for potential/actual impairment to skin integrity related to fragile skin. Interventions were educating resident/family/caregivers of causative factors and measures to prevent skin injury, encouraging good nutrition and hydration in order to promote healthier skin, and monitoring for side effects of the antibiotics and over the counter pain medications which could exacerbate skin injury. The annual Minimum Data Set (MDS) assessment dated (MONTH) 29, (YEAR) revealed a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The assessment included that the resident required supervision for toilet use and was frequently incontinent of urine. The Care Area Assessment (CAA) for urinary incontinence revealed that urinary incontinence would be addressed on the care plan. A quarterly Minimum Data Set assessment dated (MONTH) 31, 2019, revealed a Brief Interview for Mental Status (BIMS) score of 13 which indicated that the resident had intact cognition. The assessment included the resident was frequently incontinent of urine and needed supervision for toilet use. Review of a quarterly MDS assessment dated (MONTH) 1, 2019 revealed the resident required supervision for toilet use and was frequently incontinent of urine. A Monthly Nursing Summary dated (MONTH) 11, 2019 revealed the resident had incontinent/constant dribbling. Review of the task documentation for (MONTH) 1 through (MONTH) 17, 2019 revealed the resident was incontinent over 20 times. However, further review of the care plan did not reveal a care plan regarding the resident's urinary incontinence. An interview was conducted with a Licensed Practical Nurse (LPN/staff #46) on (MONTH) 17, 2019 at 1:35 a.m. She stated that the care plan should be updated for a resident on an ongoing basis and with changes. The LPN stated that for resident #5, she would expect urinary incontinence to be care planned because the incontinence had worsened and was a change in his condition. She also stated that his skin integrity could be impacted by the urinary incontinence. An interview was conducted with the MDS Registered Nurse (staff #74) on (MONTH) 17, 2019 at 11:59 a.m. She stated that the care plans are updated based upon the discussion of changes in their stand up meeting. She stated that resident #5 is incontinent if he stays in activities too long. Staff #74 also stated that the resident can take himself to the bathroom. She stated that, maybe; the resident incontinence should be mentioned on the care plan related to the risk factors. An interview was conducted with the Director of Nursing (DON/staff #104) on (MONTH) 17, 2019 at 12:56 p.m. The DON stated that the resident's incontinence and what is being implemented regarding the incontinence should be reflected on the resident's care plan. She stated that any nurse can update the care plan and that the MDS coordinator would close the loop by making sure the care plan is complete. The DON stated that it is her expectation the care plan is updated with new orders or changes in the resident status. Review of the facility's policy on Care Planning revealed the interdisciplinary team (IDT) shall develop a comprehensive care plan for each resident. The policy included that a care plan for a resident is reviewed and revised on an ongoing basis, quarterly at a minimum and/or as needed with changes in condition.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, clinical record review, and policy review, the facility failed to ensure one sampled resident (#13) received treatment and care in accordance with professional standards of practice regarding leg and foot support in a wheelchair. The deficient practice could result in residents physical needs not being met. Findings include: Resident #13 was admitted on (MONTH) 5, (YEAR), with [DIAGNOSES REDACTED]. Review of a physician's progress note dated (MONTH) 5, 2019, revealed the resident's past surgical history included bilateral total knee arthrodesis, hip replacement, and three different lumbar surgeries. The quarterly Minimum Data Set assessment dated (MONTH) 16, 2019, revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident had limited range of motion in both upper extremities, required extensive to total assistance with activities of daily living, and utilized a wheelchair as a mobile device. A care plan with a review date of (MONTH) 30, 2019, revealed the resident had impaired circulation related to [MEDICAL

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) CONDITIONS], hypertension, and [MEDICAL CONDITION]. The goal was that the resident will be free from signs and symptoms of poor circulation. Interventions included elevating the resident's legs when resting and monitoring for signs and symptoms of acute cardiovascular distress. Continued review of the clinical record did not reveal a wheelchair assessment or evaluation had been requested or completed.An observation of resident #13 was conducted on (MONTH) 15, 2019 at 10:33 a.m. The resident was observed reclined in the wheelchair with no leg or foot supports. The resident's legs were observed hanging off the edge of the seat from above the knee, in a dependent position not touching the floor moving up and down and side to side. An observation was conducted of the resident on (MONTH) 16, 2019 at 10:19 a.m. The resident was observed reclined in the wheelchair with no leg or foot supports. The resident's legs were observed hanging off the edge of the seat from above the knee, in a dependent position not touching the floor moving in an up and down and side to side motion. During an observation conducted of the resident on (MONTH) 17, 2019 at 8:00 a.m., the resident was observed reclined in the wheelchair with no leg or foot supports. The resident's legs were observed hanging off the edge of the seat from above the knee, in a dependent position not touching the floor moving in an up and down and side to side motion. During an observation conducted of the resident on (MONTH) 17, 2019 at 1:05 p.m. while being assisted with lunch, the resident was observed semi-reclined in the wheelchair with her legs in a dependent position with her feet not touching the floor without leg or foot supports. After the resident finished her lunch, the Certified Nursing Assistant (CNA) was observed to recline the wheelchair more. The resident's legs were observed in a dependent position from the mid-thigh down moving constantly. An interview was conducted on (MONTH) 17, 2019 at 1:17 p.m. with a CNA (staff #68). She stated that the wheelchair was the resident's own wheelchair. The CNA stated that at one time the wheelchair did have foot rests, but that staff had taken them off because the resident was banging her legs on them. She said the resident moves her feet and legs all the time and that staff has to keep the resident tilted back because she would kick and hit her legs on things. The CNA then stated that all she knew was that one day the wheelchair had foot rests and the next day it did not. During an interview conducted on (MONTH) 17, 2019 at 1:22 p.m. with a Licensed Practical Nurse (LPN/staff #46), the LPN stated that the resident had always kicked her legs a lot and that she did not have any idea why the foot rests were taken off the resident's wheelchair. An interview was conducted on (MONTH) 17, 2019 at 1:45 p.m. with a Physical Therapy Assistant (PTA/staff #30), who stated leg and foot rests for the wheelchair might be a recommendation, but that he had not received a request for screening. An interview was conducted with a Physical Therapist (staff #40) on (MONTH) 18, 2019 at 8:27 a.m. The resident was seated in her tilt-back wheelchair in her room. Staff #40 observed the resident's positioning, and then he flexed both of the resident's legs. He stated that maybe the resident would be more comfortable if she had her legs and feet supported, but she moves her legs and they might fall off the supports and she could get skin tears. He stated that for him to do a thorough assessment of the resident, the nurse would first have to request for him to do an evaluation. An interview was conducted on (MONTH) 18, 2019 at 8:36 a.m. with a LPN (staff #46). The LPN stated that she observes a resident's position in a wheelchair and will reposition the resident if the resident is sliding, leaning over, or verbalize they are not comfortable. She stated that if she had further concerns, she would request an evaluation from Occupational Therapy (OT) and notify the physician if further orders were needed. The LPN stated that OT conducts wheelchair evaluations at the request of nursing. The LPN stated that she has not had much concern with resident #13's positioning in the wheelchair because she has a specialty chair. She stated that the resident is reclined back and safe from falls. The LPN also stated that there may be a concern of strain on the resident's knees due to how the resident is positioned in the wheelchair. An interview was conducted on (MONTH) 18, 2019 at 8:47 a.m. with the Director of Nursing (DON/staff #104). The DON stated that the expectation is that a resident will be reposition if the resident is crooked in the wheelchair. She stated that staff can request a screening evaluation as needed from PT and OT. The DON stated that resident #13's wheelchair was custom made for her, and based off of her body stature and the way she sits; she feels that it is appropriate for her. The DON stated they had not identified any areas of concern regarding the resident's position in the wheelchair. She also stated the wheelchair company had been contacted to come evaluate the wheelchair for adjustments. The facility's policy regarding Resident Safety included supporting the resident's body well during all positioning and to avoid pulling on the resident's extremities. The policy also included using protective equipment to prevent damage to the resident's skin and to cover all protective pads with light cloth covers.
F 0690 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure one sampled resident (#5) received appropriate treatment and services to restore continence to the extent possible. The deficient practice could result in residents not maintaining optimal continence. Findings include: Resident #5 was admitted to the facility on (MONTH) 21, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 21, (YEAR), revealed the resident was at risk for potential/actual impairment to skin integrity related to fragile skin. Interventions were educating resident/family/caregivers of causative factors and measures to prevent skin injury, encouraging good nutrition and hydration in order to promote healthier skin, and monitoring for side effects of the antibiotics and over the counter pain medications which could exacerbate skin injury. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 30, (YEAR) revealed the resident was occasionally incontinent of urine. Review of the facility's Reports for bladder continence for (MONTH) (YEAR) through (MONTH) (YEAR) revealed the resident had between 7 and 13 episodes of urinary incontinence per month. Review of the physician's orders [REDACTED]. Review of the Bowel and Bladder Evaluations dated (MONTH) 21, (YEAR) and (MONTH) 21, (YEAR), revealed the resident was continent of urine and that the evaluation did not need to be completed. However, review of the bladder continence Reports for (MONTH) through (MONTH) of (YEAR) revealed the episodes of urinary incontinence increased to 25 to 31 episodes per month. The annual MDS assessment dated (MONTH) 29, (YEAR) revealed a Brief Interview of Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. The assessment included that the resident required supervision for toilet use and was frequently incontinent of urine. The Care Area Assessment (CAA) for urinary incontinence revealed urinary incontinence would be addressed in the care plan with objectives that included slowing or minimizing the decline. A Review of the Monthly Nursing Summary dated (MONTH) 11, 2019 revealed the resident was continent and needed no physical help from staff for toileting. Review of the Bowel and Bladder Evaluation dated (MONTH) 21, 2019 revealed the resident was continent of urine and that the evaluation did not need to be completed. Review of the quarterly MDS assessment dated (MONTH) 31, 2019 revealed the resident was frequently incontinent of urine and needed supervision for toilet use. The assessment also included a BIMS score of 13 which indicated that the resident had intact cognition. A Review of the Monthly Nursing Summary dated (MONTH) 11, 2019, revealed the resident was continent and needed no physical help from staff for toileting. Review of the Monthly Nursing Summary dated (MONTH) 11, 2019 revealed the resident needed no physical help from staff for toileting and was incontinent/constant dribbling. A urogram, an exam to evaluate the urinary tract, was done on (MONTH) 6, 2019 which detected trace blood in the urine. Review of the Monthly Nursing Summary dated (MONTH) 11, 2019 revealed the resident needed no physical help from staff for toileting and was incontinent/constant dribbling. Review of the Bowel and Bladder Evaluation dated (MONTH) 21, 2019 revealed the resident was continent of urine and that the

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F 0690 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) evaluation did not need to be completed. Further review of the Reports regarding bladder continence for (MONTH) 2019 through (MONTH) 2019 revealed the episodes of urinary incontinence per month increased to 27 to 55 episodes per month. Review of a quarterly MDS assessment dated (MONTH) 1, 2019 again revealed the resident required supervision for toilet use and was frequently incontinent. Review of the Monthly Nursing Summary dated (MONTH) 11, 2019 revealed the resident needed no physical help from staff for toileting and was incontinent/constant dribbling. Additional review of the clinical record did not reveal evidence that interventions were implemented to restore continence to the extent possible. An interview was conducted with the resident on (MONTH) 15, 2019 at 2:31 p.m. The resident stated that his urinary incontinence was getting worse and that he tried, but was unable to get a hold of it. The resident stated that he thinks he may be having bladder spasms and that he has informed the staff of his worsening urinary incontinence. An interview was conducted with a Certified Nursing Assistant (CNA/staff #68) on (MONTH) 17, 2019 at 11:32 a.m. She stated that Resident #5 is both continent and incontinent, but that he was totally continent approximately two months ago. The CNA stated that she does not know why the resident became incontinent but that she did notify the nurse the resident had changed from continent to incontinent. An interview was conducted with a Licensed Practical Nurse (LPN/staff #46) on (MONTH) 17, 2019 at 11:35 a.m. She stated that to maintain a resident's continence they encourage the resident, if able, to call for assistance and they do two hour toileting with the residents. The LPN stated that they would also check to see if the resident would benefit from a bowel and bladder program. She stated that they may talk to the resident about potential issues, the physician may order labs, and they would notify the family. The LPN stated that the physician was notified of resident #5's change in urinary continence and ordered [MEDICATION NAME] to help with the incontinence. She stated that she was not aware if the resident was assessed for the bowel and bladder program with Restorative Nursing Assistant (RNA), but that the resident could potentially benefit from the program. She stated that a urine test that was done was negative so there was no indication that the increased incontinence was cause by an infection. The LPN stated that the nurses complete a bowel and bladder assessment in the electronic record every three months. After reviewing the (MONTH) 2019 and (MONTH) 2019 assessments, she stated that they were not accurate because the resident was having incontinence at that time. The LPN stated that because the bowel and bladder assessments were not completed accurately, the incontinence issue did not go through the appropriate channels to ensure implementation of potential interventions. During an interview conducted with a MDS Registered Nurse coordinator (staff #74) on (MONTH) 17, 2019 at 11:59 a.m., she stated that the bowel and bladder assessments are to be accurate and that the assessments allow them to see where the resident is with their urinary continence. Staff #74 stated that if any changes are noted, the nurse will notify the Interdisciplinary Team (IDT) for follow up and interventions. After reviewing resident #5's bladder continence records, she stated that the bowel and bladder assessment dated (MONTH) 21, 2019 was not accurate. The MDS Registered Nurse coordinator stated that despite the inaccurate bladder assessments, there would have been no difference in the further assessment of the incontinence or interventions because they do not have a bladder retraining program. An interview was conducted with a RNA/CNA (staff #14) on (MONTH) 17, 2019 at 12:39 p.m. She stated that they have a bowel and bladder program that involves identifying a pattern to the incontinence so that toileting can be offered before the resident is incontinent. She stated that the program is not to restore a resident's continence. The RNA stated that she was aware that resident #5's incontinence had increased and that she had implemented some interventions such as cueing him to decrease the incontinent episodes. She stated that there is no documentation of those attempts. An interview was conducted with the Director of Nursing (DON/staff #104) on (MONTH) 17, 2019 at 12:56 p.m. She stated that they complete a bowel and bladder assessment on admission, quarterly, and with any change in the resident's status. She stated that based upon the assessment, the resident may be a candidate for a voiding diary done by RN[NAME] The DON stated that it is her expectation that the bowel and bladder assessments be accurate. After reviewing the bowel and bladder assessments for resident #5, she stated that the assessments were not accurate. The DON stated that had the assessments been accurate, interventions/actions may have been implemented to address the incontinence. Review of the facility's policy for Bowel and Bladder Assessment and Management revealed the resident who is incontinent of bladder is provided the appropriate treatment and services to restore as much normal bladder function as possible. The policy stated that the purpose of the bowel and bladder evaluation is to develop an individualized, goal oriented approach to elimination. The policy included the bowel and bladder evaluation form will be completed on residents upon admission, quarterly, and as needed for changes in condition to determine the appropriate level of bowel and bladder program. The policy also included the IDT will meet on a regular basis to review residents on the bowel and bladder program and make recommendations as appropriate.