STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035183	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, facility documentation and policies and procedures, the facility failed to ensure one of four sampled residents (#1) was free from neglect. The deficient practice could place residents at risk for further neglect. Findings include: -Regarding the incident on (MONTH) 30, 2019: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 6, 2019 included the resident was blind and required assistance with all activities of daily living (ADL). An intervention included to encourage the resident to use bell to call for assistance. A care plan dated (MONTH) 9, 2019 revealed the resident was at risk for falls related to deconditioning. The goal was the resident would not sustain serious injury. Interventions were to anticipate and meet needs, be sure the call light is within reach and encourage to use it to call for assistance as needed, and to offer toileting every two hours. Review of a care plan dated (MONTH) 20, 2019 revealed a focus area of bowel and bladder incontinence related to impaired mobility, dementia and a history of urinary tract infections [MEDICAL CONDITION]. The goals included that the risk for [MEDICAL CONDITION] would be minimized/prevented via prompt recognition and treatment of [REDACTED]. Interventions included to use briefs and change briefs as needed and check as required for incontinence. A care plan dated (MONTH) 20, 2019 revealed the resident was at risk for impaired visual function related to [MEDICAL CONDITION]. The goal included to maintain an optimal quality of life. A care plan for impaired cognitive function/dementia dated (MONTH) 20, 2019 included an intervention for staff to identify themselves at each interaction. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019 revealed a brief interview for mental status score was 12, which indicated the resident had mild cognitive impairment. Also included was the resident had clear speech, could make herself understood, could understand others, and had severe impaired vision. Per the MDS, the resident required the assistance of one staff with transfers from the wheelchair and required extensive assistance of one staff for toilet use. The MDS also noted that the resident was frequently incontinent of bowel and bladder. Review of the facility's incident investigation documentation dated (MONTH) 1, 2019 revealed an incident was reported on (MONTH) 31, 2019 by a family member of the resident. The investigative note stated that the resident told a family member the following: a CNA (identified by the facility as staff #21) came into the resident's room to get her ready for bed and was rough with her and had refused to identify herself, and had put the resident in the bathroom and did not return for her in a timely manner (no time frame was included), and then sent another CNA (staff #4) to finish her p.m. care. Per the investigation, staff #21 was moved from the unit where resident #1 resided on (MONTH) 1, 2019. Further review of the incident investigation revealed that staff #21 was interviewed on (MONTH) 5, 2019. Staff #21 reported that the resident appeared anxious and repeatedly asked her what her name was, and that she had identified herself to the resident. Staff #21 reported that she had placed the resident in the bathroom, but did not finish her p.m. care. The investigation also included an interview conducted on (MONTH) 5, 2019, with a CNA (staff #4). Staff #4 reported that staff #21 asked her to finish the evening care for resident #1, as she was working with another resident. Staff #4 reported the resident asked her what the other aids name was and she told the resident that she did not know her name. The investigation further included that staff #38 (CNA) had not provided care to the resident on this shift. The specific shift was not was included. (However, in an interview with staff #38, she stated that she had worked with the resident during the time of this incident on (MONTH) 30). Continued review of the incident investigation revealed the best course of action was to re-assign staff #21 to a different floor to avoid further potential for conflict. The facility's investigation did not address the allegation of rough treatment or if staff #21 had returned to the resident in a timely manner. The documentation also did not include the date or time that the incident had occurred, only the date it was reported. An interview was conducted on (MONTH) 3, 2019 at 11:31 a.m., with a corporate Registered Nurse (RN/staff #40). Staff #40 stated there was no further documentation or investigation conducted for this incident, because the facility staff did not believe it happened. An interview was conducted on (MONTH) 3, 2019 at 12:43 p.m., with the administrator (staff #29), who stated that she was the author of the incident investigation. An interview was conducted with a CNA (staff #21) on (MONTH) 4, 2019 at 9:09 a.m. Staff #21 stated she was the staff who found the resident in the bathroom on (MONTH) 30, 2019, and that the resident was screaming and yelling for help. Staff #21 stated the resident is blind and told her that another CNA would not give her their name even though the resident asked her many times. She said the resident stated that she had been left in the bathroom for a very long time and had to scream, so she could get help from staff. Staff #21 stated she tried to calm the resident and then helped her get into bed. Staff #21 stated she was not the staff who left the resident in the bathroom for a long time and to do so would be neglect. Staff #21 said that she told her supervisor of this incident during her shift. Staff #21 also denied that she had physically abused or was rough with the resident and denied that she had been neglectful by leaving the resident in the bathroom for a long time. An interview was conducted with a CNA (staff #38) on (MONTH) 4, 2019 at 10:14 a.m. She stated that she had worked with staff #21 for a portion of the shift on (MONTH) 30, 2019. Staff #38 said that staff #21 told her the resident was being difficult again. Staff #38 said the resident told her earlier that on (MONTH) 30, 2019, a CNA had treated her roughly. An interview was conducted with resident #1 and a family member on (MONTH) 4, 2019 at 12:25 p.m. During the interview, the resident was able to correctly answer questions regarding the year, the date, the day and the name of facility. The resident stated if she talked about the incident from (MONTH) 30, 2019, she would probably cry and be sad. The resident stated she was willing to answer questions and would do her best. The resident stated she could remember the incident and that she had been left in the bathroom for too long of a time. She said that she was scared and called out for help and no one came. She said that she wears an incontinence brief and she had soiled and wet herself and felt very bad. She also said that she had been treated roughly by a staff person and could not identify the staff by name, because the staff do not always tell her their name even though she asks. The resident then became tearful and said that she could no longer talk of the incident. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at

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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RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 1) 12:25 p.m. She stated that she was aware of the incident on (MONTH) 30, 2019 regarding resident #1, but had not been very involved. She stated the incident was only treated as a customer service incident, because the resident stated that a CNA would not tell the resident her name. Staff #70 stated if she had been aware that the resident reported rough treatment, she would have identified it as an allegation of abuse. Staff #70 stated that leaving a resident in the bathroom for a long period of time and not providing timely care would be considered neglect. Staff #70 stated she had not been called, texted or notified regarding the incident. Staff #70 stated that all allegations of abuse and neglect have to be reported, fully investigated and there needs to be protection of residents during the investigation, so residents can be safe. Staff #70 stated that none of these steps had been implemented regarding this incident. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident regarding resident #1, which had occurred on (MONTH) 30, 2019. Staff #29 stated even though she has been fully trained on identification of abuse and neglect, mandatory reporting requirements to various agencies and timeframes, investigation protocols and the protection of residents, this incident was not identified as abuse and/or neglect and therefore, the mandatory steps were not implemented. -Regarding the incident on (MONTH) 16, 2019: Review of an incident note dated (MONTH) 17, 2019 revealed the resident was alert, oriented, and able to state her needs and is legally blind. Per the note, the nurse (RN/staff #23) was making rounds and found the resident in her wheelchair in the bathroom. The bathroom door and the main door to her room were both closed. The resident reported that one of the CNA's put her in the bathroom and never showed up. The resident was reassured and was put back to bed and no change in condition was noted. Review of the facility's investigation dated (MONTH) 28, 2019 revealed that on (MONTH) 17, 2019, staff #23 reported to the Administrator (staff #29) that she found resident #1 in the bathroom of her room around 2:00 a.m., with the door closed. Staff #23 reported the resident said that she was left in the bathroom in her wheelchair for an extended period of time. The investigation included an interview with the resident, however, it was not conducted until (MONTH) 19, 2019 at 11:45 a.m. The resident reported that she had been assisted to the bathroom by a CNA (identified as staff #106) to brush her dentures but she could not remember the CNA's name, however, the resident reported that this CNA was with another CNA (identified as staff #38). The resident reported the CNA (staff #106) told her that she would be back to get her, but no one came back. The resident stated she called for help and no one came. The resident stated she did not know how long she was in the bathroom, but said that she fell asleep for a period of time, while waiting for staff to come back. The investigation included an interview with a RN (staff #23), however, the date of the interview was not documented. Staff #23 reported that she had been the nurse on duty from 10:00 p.m. on (MONTH) 16 until 6:00 a.m. on (MONTH) 17, 2019. Staff #23 stated she found resident #1 in her wheelchair in the middle of the night, but did not recall the time. The report included an interview with a CNA (staff #106) who worked the 2-10 p.m. shift on (MONTH) 16, 2019. There was no date to indicate when this interview was conducted. Staff #106 stated she was the CNA who assisted resident #1 to the bathroom around 9:30 p.m. (on (MONTH) 16) to brush her teeth and complete her evening care. Staff #106 reported that she thought she had put the resident to bed. Staff #106 stated she forgot to go back and check on the resident, prior to leaving for the night. Per the investigation, an interview with a CNA (staff #38) was conducted, however, there was no date to indicate when the interview occurred. Staff #38 worked on (MONTH) 16, 2019 from 10:00 p.m. until 6:00 a.m. on (MONTH) 17, 2019. Staff #38 reported that the CNA's do not have individual assignments and they take full responsibility for the entire floor. Staff #38 reported that she had been made aware of the resident being found in the bathroom by the nurse. Staff #38 stated she had not been in the room of resident #1, because the resident was typically already in bed and will use the call light if she needs anything. The investigation also included an interview with a CNA (staff #102) who worked the 10pm-6am shift on Augsut 16-17. She reported that she worked with staff #38 that night. She said they did not have set assignments and that both of them were responsible for all of the residents together. She said that she did not go into the resident's room during that shift. She said the resident is always already in bed when she gets on shift, and if she needs anything she uses her call light. Further review of the facility's investigative documentation revealed the following conclusions: 1. It was determined that the resident was left in a wheelchair in the bathroom but it is unknown how long. 2. Nursing staff are not assigned to specific residents on any shift and they just work together. 3. Two hour rounds are not conducted on the night shift on every resident, just on those residents that are incontinent or have dementia, and other residents are attended to as they call for help using the call light. 4. The resident's call light cord was sufficient in length to reach, but could not be clipped to the resident. An interview was conducted with resident #1 and a family member on (MONTH) 4, 2019 at 12:25 p.m. The resident stated if she talked about the incident on (MONTH) 16, 2019, she would probably cry and be sad. The resident stated she was willing to answer questions and would do her best. The resident stated she could remember the incident and that she had been left in the bathroom for too long of a time. She said that she was scared and called out for help, but no one came. She said that she wears an incontinence brief and she had soiled and wet herself, and felt very bad. The resident stated there had been a similar incident in (MONTH) 2019 of her being left in the bathroom for a long time and the incident in (MONTH) 2019 was not nearly as bad as the second incident that occurred on (MONTH) 16. The resident stated she had been left in the bathroom for many hours and she knew this because of her talking watch, which she uses due to her [MEDICAL CONDITION]. The resident stated she could not reach the call light and she was scared. The resident stated the two incidents were very difficult for her and that she relives them in her mind. The resident then became tearful and stopped talking. An interview was conducted with a RN (staff #23) on (MONTH) 4, 2019 at 1:32 p.m. Staff #23 stated she can recall the incident on (MONTH) 16, 2019 with resident #1. Staff #23 stated the resident is alert and oriented x 4, can communicate her needs, needs one person assist for much of her care and is legally blind. Staff #23 stated she gave the resident her evening medications about 9:00 p.m. (on (MONTH) 16) and entered the resident's room again around 4:00 a.m. Staff #23 stated the door to the resident's room and the bathroom door were both closed and the entire room was dark. Staff #23 stated she opened the bathroom door and the resident was sleeping in her wheelchair. Staff #23 stated she went to find the CNA's, so the resident's brief could be changed and she could be put to bed. Staff #23 stated she asked the CNA's who was responsible for leaving the resident in the bathroom and for not checking on her every 2 hours, and there was not one CNA who accepted responsibility. Staff #23 stated she identified this incident as neglect. She said that she informed the Administrator (staff #29) the following day. Staff #23 stated she also notified the ADON (staff #70) by text the following day. She said that staff #70 did not contact her about this incident until days later. Staff #23 stated that neither staff #70 or staff #29 told her this was an incident of neglect. An interview was conducted with a CNA (staff #38) on (MONTH) 4, 2019 at 3:25 p.m. She stated that she worked on (MONTH) 16 from 6:00 p.m. until 6:00 a.m. on (MONTH) 17, 2019. Staff #38 stated that she knows the resident well and cares for her on a routine basis, and that the resident is blind. Staff #38 stated the resident uses her call light when she needs help from staff. Staff #38 said that during the night shift (on (MONTH) 16-17), she worked with another CNA and neither of them had specific residents or room assignments. Staff #38 said they were both responsible for the care of all of the residents on the floor. She said resident #1 always used her call light if she needed anything, so they did not check on resident #1 from 10:00 p.m. on (August 16), until approximately 4:00 a.m. (on (MONTH) 17). Staff #38 stated the shift had been very busy and chaotic. She said that she had noticed the door to the resident's room had been closed which was not normal, but it did not register with her why the door would be closed. Staff #38 stated it was wrong that resident #1 had been stuck and left in the bathroom for such a long time. Staff #38 stated about 4:00 a.m., staff #23 came and got her and they went to the room of resident #1 and the resident was sitting in her wheelchair. She said the resident was very upset and was crying. She said because the resident knew her when she started talking to her, she grabbed onto her tightly and just kept on crying and crying. Staff #38 stated the resident told her she had been hollering and hollering for someone to come and help her and no one came for a very long time. Staff #38 stated the call light cord was too short for the resident to reach when the resident was by the sink, so the resident did not have a way to call for staff. Staff #38 said she then went to get another CNA to help her to give extra support to the resident. Staff #38 stated the Administrator talked with the resident about the incident the following day. She said that she did not immediately report the incident, however she did identify the incident as neglect. She said that she had been educated and trained on identification and timely reporting of incidents of neglect. Staff #38 stated that she took full responsibility for the lack of care for resident #1 and the long

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F 0600 **Level of harm** - Actual harm **Residents Affected** - Few	(continued... from page 2) time that the resident had been left in the bathroom and knew the resident had been very afraid. During the survey, staff #102 was unable to be reached by telephone. An interview was conducted with a CNA (staff #106) on (MONTH) 5, 2019 at 9:03 a.m. Staff #106 stated she knows the resident well and cares for her on a routine basis. Staff #106 stated the resident is alert, oriented, can communicate her needs and is blind. Staff #106 stated she can recall the incident from (MONTH) 16-17. She said the resident's routine is to be placed by the sink in her bathroom while sitting in the wheelchair. Staff #106 stated she left the resident in the bathroom about 9:00 p.m., so she could finish her bedtime routine. Staff #106 stated she learned the next day that the resident had been left in the bathroom a really long time from the evening on (MONTH) 16 through the early morning on (MONTH) 17. Staff #106 stated she was in shock, because in her mind she had helped the resident get into bed and did not mean to leave her in the bathroom. Staff #106 stated at that time, the CNA's did not do actual rounds like every 2 hours to check on the residents and make sure they were okay. Staff #106 also stated there were no specific room assignments and the CNA's were responsible for all of the residents on the entire floor. She said that she accepted full responsibility for her actions and for not checking that the resident was alright before she left her shift. She said the resident's call light was not within reach and it was a very long time, way too long for her to be in there without anyone checking on her. She said the resident was probably afraid as she could not call for help. Staff #106 stated that she now identifies the incident as neglect. Staff #106 stated about 3-5 days later she was called by management and was told there was going to be an investigation of the incident. An interview was conducted with the ADON (staff #70) on (MONTH) 5, 2019 at 9:25 a.m. Staff #70 stated she had been aware of the incident with resident #1, which occurred on (MONTH) 16, 2019. Staff #70 stated she interviewed resident #1 and the resident reported that she had been left in the bathroom until about 9 a.m. the next morning (on (MONTH) 17). Staff #70 stated the resident told her that she had been placed in her wheelchair in the bathroom by the sink, so she could do her usual denture and mouth care. Staff #70 stated the resident told her no staff came back for her and it was such a long time that she fell asleep in the wheelchair and that the call light was not within reach. She said that during the course of her envolvement with the (MONTH) 16 incident, she identified that the CNA's routine was to not be given assignments on their shifts and that the CNA's were not completing 2 hour checks on all residents. Staff #70 stated this was an allegation of neglect and she now realizes the mandated identification, reporting, investigating and protection of residents was not completed per policy and regulation. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. Staff #29 stated the incident from (MONTH) 16-17 regarding resident #1 being left in the bathroom for an extended period of time had not been accurately identified as neglect. Review of the facility's policies and procedures regarding Abuse and Neglect revealed that each resident has the right to be free from abuse and neglect. Residents must not be subjected to abuse by anyone, including but not limited to facility staff. The facility will provide oversight and monitoring to ensure that staff who are agents of the facility, deliver care and services in a way that promotes and respects the rights of residents to be free from abuse and neglect. The Abuse and Neglect polices further included that neglect is the failure of the facility and employees to provide goods and services to a resident to avoid physical harm, pain, mental anguish or emotional distress. The definition of abuse included the following: Willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. This included the deprivation of goods and services that are necessary to attain or maintain physical, mental, and psychosocial well being. Instances of abuse of residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish.
F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Develop and implement policies and procedures to prevent abuse, neglect, and theft.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to implement their Abuse policy, by failing to ensure that two incidents of neglect and an allegation of physical abuse for one of four sampled residents (#1) were thoroughly investigation, immediatley reported to the Administrator and reported to the State Survey Agency within 2 hours after the allegations were made, and that residents were protected from the potential for further abuse/neglect during the invesitgation. The deficient practice could result in allegations of abuse and neglect not being reported to the State Agency and administration not being aware of abuse/neglect allegations, resulting in a lack of corrective action being implemented Findings include: -Regarding the incident on (MONTH) 30, 2019: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. Review of the facility's incident investigation documentation dated (MONTH) 1, 2019 revealed an incident was reported on (MONTH) 31, 2019 by a family member of the resident. The investigative note stated that the resident told a family member the following: a CNA (identified by the facility as staff #21) came into the resident's room to get her ready for bed and was rough with her and had refused to identify herself, and had put the resident in the bathroom and did not return for her in a timely manner (no time frame was included), and then sent another CNA (staff #4) to finish her p.m. care. Per the investigation, staff #21 was moved from the unit where resident #1 resided on (MONTH) 1, 2019. The incident investigation included that staff #21 was interviewed on (MONTH) 5, 2019. Staff #21 reported that the resident appeared anxious and repeatedly asked her what her name was, and that she had identified herself to the resident. Staff #21 reported that she had placed the resident in the bathroom, but did not finish her p.m. care. The investigation included an interview was conducted on (MONTH) 5, 2019, with a CNA (staff #4). Staff #4 reported that staff #21 asked her to finish the evening care for resident #1, as she was working with another resident. Staff #4 reported the resident asked her what the other aids name was and she told the resident that she did not know her name. The investigation also included that staff #38 (CNA) had not provided care to the resident on this shift. The specific shift was not was included. (However, in an interview with staff #38, she stated that she had worked with the resident during the time of this incident on (MONTH) 30). Continued review of the incident investigation revealed the best course of action was to re-assign staff #21 to a different floor to avoid the potential for further conflict. Further review of the facility's investigation revealed the following concerns: -There was no documentation of the day and time that the incident occurred. -No evidence that staff immediately reporting the incident to the Administrator. -No evidence that resident #1 was interviewed. -No evidence that the allegation of being treated roughly by staff had been investigated. -There was no documentation that additional staff members who had worked on (MONTH) 30 or 31, on various shifts had been interviewed. -No evidence that other residents had been interviewed regarding the care and services provided by the accused staff. -No evidence of a conclusion of the investigation to determine if abuse or neglect had occurred. -No evidence that the the allegations of abuse and neglect were reported to the State Agency within two hours of the allegations being made and that the results of the investigation were submitted to the State Survey Agency with 5 working days of the incident. -There was no documentation that the accused CNA (staff #21) was immediately removed from providing care to residents, as staff #21 was only reassigned to a different floor. During an interview conducted on (MONTH) 3, 2019 at 11:31 a.m. with a Corporate Registered Nurse (RN/staff #40), she stated there was no further documentation or investigation conducted for this incident because the facility staff did not believe it happened. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated that she was aware of the incident on (MONTH) 30, 2019 regarding resident #1 and that she had not been very involved. She stated the incident was only treated as a customer service incident, because the resident stated that a CNA would not tell the resident her name. Staff #70 stated if she had been aware that the resident reported rough treatment she would have identified it as an allegation of abuse. Staff #70 stated leaving a resident in the bathroom for a long period of time and not providing timely care would be considered neglect. Staff #70 stated she had not been called,

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F 0607 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) texted or notified regarding the incident. Staff #70 stated that all allegations of abuse and neglect have to be reported, fully investigated and there needs to be protection of residents during the investigation, so residents can be safe. Staff #70 stated that none of these steps had been implemented regarding the incident. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident of resident #1 that occurred on (MONTH) 30, 2019. Staff #29 stated that she has been fully trained on identification of abuse and neglect, mandatory reporting requirements to various agencies and timeframes, investigation protocols and protection of residents. Staff #29 further stated this incident was not identified as abuse and/or neglect and therefore, the mandatory steps were not implemented. -Regarding the (MONTH) 16, 2019 incident: Review of an incident note dated (MONTH) 17, 2019 revealed the resident was alert, oriented, and able to state her needs and was legally blind. Per the note, the nurse (RN/staff #23) was making rounds and found the resident in her wheelchair in the bathroom. The bathroom door and the main door to her room were both closed. The resident reported that one of the CNA's put her in the bathroom and never showed up. The resident was reassured and was put back to bed and no change in condition was noted. Review of the facility's investigation dated (MONTH) 28, 2019 revealed that on (MONTH) 17, 2019, staff #23 reported to the Administrator (staff #29) that she found resident #1 in the bathroom of her room around 2:00 a.m., with the door closed. Staff #23 reported the resident said that she was left in the bathroom in her wheelchair for an extended period of time. The investigation included an interview with the resident however, it was not conducted until (MONTH) 19, 2019 at 11:45 a.m. The resident reported that she had been assisted to the bathroom by a CNA (identified as staff #106) to brush her dentures but she could not remember the CNA's name, however, the resident reported that this CNA was with another CNA (identified as staff #38). The resident reported the CNA (staff #106) told her that she would be back to get her, but no one came back. The resident stated she called for help and no one came. The resident stated she did not know how long she was in the bathroom, but said that she fell asleep for a period of time, while waiting for staff to come back. The investigation included an interview with a RN (staff #23) however, the date of the interview was not documented. Staff #23 reported that she had been the nurse on duty from 10:00 p.m. on (MONTH) 16 until 6:00 a.m. on (MONTH) 17, 2019. Staff #23 stated she found resident #1 in her wheelchair in the middle of the night, but did not recall the time. The investigation included an interview with a CNA (staff #106) who worked the 2-10 p.m. shift on (MONTH) 16, 2019. There was no date to indicate when this interview was conducted. Staff #106 stated she was the CNA who assisted resident #1 to the bathroom around 9:30 p.m. (on (MONTH) 16) to brush her teeth and complete her evening care. Staff #106 reported that she thought she had put the resident to bed. Staff #106 stated she forgot to go back and check on the resident, prior to leaving for the night. Per the report, an interview with a CNA (staff #38) was conducted, however, there was no date to indicate when the interview occurred. Staff #38 worked on (MONTH) 16, 2019 from 10:00 p.m. until 6:00 a.m. on (MONTH) 17, 2019. Staff #38 reported that the CNA's do not have individual assignments and they take full responsibility for the entire floor. Staff #38 reported that she had been made aware of the resident being found in the bathroom by the nurse. Staff #38 stated she had not been in the room of resident #1, because the resident was typically already in bed and will use the call light if she needs anything. The investigation also included an interview with a CNA (staff #102), who worked the 10pm-6am shift on (MONTH) 16-17. She reported that she worked with staff #38 that night. She said they did not have set assignments and that both of them were responsible for all of the residents together. She said that she did not go into the resident's room during that shift. She said the resident is always already in bed when she gets on shift, and if she needs anything she uses her call light. Further review of the investigative documentation revealed the following conclusions as determined by the facility: 1. It was determined that the resident was left in a wheelchair in the bathroom but it is unknown how long. 2. Nursing staff are not assigned to specific residents on any shift and they just work together. 3. Two hour rounds are not conducted on the night shift on every resident, just on those residents that are incontinent or have dementia, and other residents are attended to as they call for help using the call light. 4. The resident's call light cord was sufficient in length to reach, but could not be clipped to the resident. Continued review of the facility investigation revealed the following concerns: -There was no evidence that staff immediately reporting the incident to the Administrator. -No evidence of any conclusion if abuse or neglect had occurred. -No evidence that residents were protected from the potential for further neglect at the time of the incident and during the investigation, as no staff were removed from providing care to residents. -No evidence that the results of the investigation were submitted to the State Survey Agency within 5 working days of the incident. In addition, review of the State Agency complaint data base revealed the facility reported the incident on (MONTH) 4, 2019 at 10:56 a.m., which was over the 2 hour time frame for reporting. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated she was aware of the incident of (MONTH) 16, 2019 regarding resident #1. She said that she only conducted some interviews and is now aware that the investigations were not complete. Staff #70 stated that all allegations of abuse and neglect have to be reported in a timely manner, fully investigated and there needs to be protection of residents during the investigation, so residents can be safe. Staff #70 stated that none of these steps had been implemented regarding the incident, per policy and regulations. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident regarding resident #1 which occurred on (MONTH) 16, 2019. Staff #29 stated she has been fully trained and was knowledgeable about the investigation protocols for allegations of abuse and neglect. She stated that she did not identify the incident as neglect and just tried to move forward and resolve the issue. Staff #29 stated a more complete investigation had not been conducted and there was no protection of residents, as there were no staff who were suspended. She also said that reporting had not been done within the required timeframes and that the incident was not fully investigated, according to facility policy and the regulations. Review of the facility's policies and procedures regarding Abuse and Neglect revealed the following regarding investigations: All identified events are reported to the administrator immediately. After receiving the allegation, and during and after the investigation, the administrator shall ensure that all residents are protected from physical and psychosocial harm. All allegations of abuse and neglect will be promptly and thoroughly investigated by the administrator or designee. The investigation will include an interview with the resident; interviews with any witnesses to the incident; a review of the resident's medical record; interviews with staff on all shifts who may have information regarding the alleged incident; interviews with staff on all shifts having contact with the accused employee and a review of all circumstances surrounding the incident. At the conclusion of the investigation, the facility will attempt to determine if abuse or neglect has occurred. The investigation and the results of the investigation will be documented. Regarding protection, the policy included that if an allegation of abuse or neglect is reported, discovered or suspected, the facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation: Respond immediately to protect the alleged victim for any sign of injury including a psychosocial assessment if needed; increase supervision of the alleged victim and residents; make room or staffing changes, if necessary to protect the residents from the alleged perpetrators and provided emotional support and counseling to the resident during and after the investigation. If the allegation of abuse and neglect involves an employee, the facility will immediately remove the employee from the care of any resident and suspend the employee during the investigation. The policy further included that the results of all investigations are reported within 5 working days of the incident to the State Survey Agency. The policies further included the facility will ensure that all alleged violations involving abuse and neglect are reported within 2 hours to the State Survey Agency.
F 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.** **Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035183	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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 0609 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, facility documentation and policies and procedures, the facility failed to ensure that two incidents of neglect and an allegation of physical abuse were immediately reported to the Administrator and reported to the State Agency, within two hours after the allegations were made for one of four sampled residents (#1). The deficient practice could result in additional allegations of abuse and neglect not being reported to the State Agency and administration not being aware of abuse/neglect allegations, resulting in a lack of corrective action being implemented. Findings include: -Regarding the incident on (MONTH) 30, 2019: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. Review of the facility's incident investigation documentation dated (MONTH) 1, 2019 revealed an incident was reported on (MONTH) 31, 2019 by a family member of the resident. The investigative note stated that the resident told a family member the following: a CNA (identified by the facility as staff #21) came into the resident's room to get her ready for bed and was rough with her and had refused to identify herself, and had put the resident in the bathroom and did not return for her in a timely manner (no time frame was included), and then sent another CNA (staff #4) to finish her p.m. care. Further review of the incident investigative documentation revealed there was no evidence that the allegations of abuse and neglect were reported to the State Agency within two hours of the allegation being made or that staff immediately reported the incident to adminstration. During an interview conducted on (MONTH) 3, 2019 at 11:31 a.m. with a corporate Registered Nurse (RN/staff #40), she stated there was no further documentation or investigation conducted for this incident, because the facility staff did not believe it happened. An interview was conducted with a CNA (staff #38) on (MONTH) 4, 2019 at 10:14 a.m. She stated that she had worked with staff #21 for a portion of the shift on (MONTH) 30, 2019. Staff #38 said that staff #21 told her the resident was being difficult again. Staff #38 said the resident told her earlier that on (MONTH) 30, 2019, a CNA had treated her roughly. Staff #38 stated she did not report the allegation, because she thought all of the staff already knew about it. She said that she had been trained on immediately reporting any allegations of abuse and neglect. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated that she was aware of the incident on (MONTH) 30, 2019 regarding resident #1 and that she had not been very involved. She stated the incident was only treated as a customer service incident, because the resident stated that a CNA would not tell the resident her name. Staff #70 stated if she had been aware that the resident reported rough treatment, she would have identified it as an allegation of abuse. Staff #70 stated leaving a resident in the bathroom for a long period of time and not providing timely care would be considered neglect. Staff #70 stated she had not been called, texted or notified regarding the incident. Staff #70 stated that all allegations of abuse and neglect have to be reported and fully investigated. Staff #70 stated that none of these steps had been implemented regarding this incident. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated she was aware of the incident of resident #1 that occurred on (MONTH) 30, 2019. Staff #29 stated she has been fully trained on identification of abuse and neglect, mandatory reporting requirements to various agencies and timeframes and the investigation protocol. Staff #29 further stated this incident was not identified as abuse and/or neglect and therefore, the mandatory steps were not implemented. -Regarding the (MONTH) 16, 2019 incident: Review of an incident note dated (MONTH) 17, 2019 revealed the resident was alert, oriented, and able to state her needs and is legally blind. Per the note, the nurse (RN/staff #23) was making rounds and found the resident in her wheelchair in the bathroom. The bathroom door and the main door to her room were both closed. The resident reported that one of the CNA's put her in the bathroom and never showed up. The resident was reassured and was put back to bed and no change in condition was noted. Review of the facility's investigation dated (MONTH) 28, 2019 revealed that on (MONTH) 17, 2019, staff #23 reported to the Administrator (staff #29) that she found resident #1 in the bathroom of her room around 2:00 a.m., with the door closed. Staff #23 reported the resident said that she was left in the bathroom in her wheelchair for an extended period of time. The investigation included an interview with the resident however, it was not conducted until (MONTH) 19, 2019 at 11:45 a.m. The resident reported that she had been assisted to the bathroom by a CNA (identified as staff #106) to brush her dentures but she could not remember the CNA's name, however, the resident reported that this CNA was with another CNA (identified as staff #38). The resident reported the CNA (staff #106) told her that she would be back to get her, but no one came back. The resident stated she called for help and no one came. The resident stated she did not know how long she was in the bathroom, but said that she fell asleep for a period of time, while waiting for staff to come back. The investigation included an interview with a RN (staff #23) however, the date of the interview was not documented. Staff #23 reported that she had been the nurse on duty from 10:00 p.m. on (MONTH) 16 until 6:00 a.m. on (MONTH) 17, 2019. Staff #23 stated she found resident #1 in her wheelchair in the middle of the night, but did not recall the time. The investigation included an interview with a CNA (staff #106) who worked the 2-10 p.m. shift on (MONTH) 16, 2019. There was no date to indicate when this interview was conducted. Staff #106 stated she was the CNA who assisted resident #1 to the bathroom around 9:30 p.m. (on (MONTH) 16) to brush her teeth and complete her evening care. Staff #106 reported that she thought she had put the resident to bed. Staff #106 stated she forgot to go back and check on the resident, prior to leaving for the night. Per the report, an interview with a CNA (staff #38) was conducted, however, there was no date to indicate when the interview occurred. Staff #38 worked on (MONTH) 16, 2019 from 10:00 p.m. until 6:00 a.m. on (MONTH) 17, 2019. Staff #38 reported that the CNA's do not have individual assignments and they take full responsibility for the entire floor. Staff #38 reported that she had been made aware of the resident being found in the bathroom by the nurse. Staff #38 stated she had not been in the room of resident #1, because the resident was typically already in bed and will use the call light if she needs anything. The investigation also included an interview with a CNA (staff #102), who worked the 10pm-6am shift on (MONTH) 16-17. She reported that she worked with staff #38 that night. She said they did not have set assignments and that both of them were responsible for all of the residents together. She said that she did not go into the resident's room during that shift. She said the resident is always already in bed when she gets on shift, and if she needs anything she uses her call light. Further review of the facility's investigative report revealed it was unclear as to the exact time staff had first reported the incident to administration. Review of the State Agency complaint data base revealed the facility reported the incident on (MONTH) 4, 2019 at 10:56 a.m., which was over the 2 hour time frame for reporting. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated that she was aware of the incident on (MONTH) 16, 2019 regarding resident #1 related to the allegations of neglect. Staff #70 stated that all allegations of neglect have to be reported and this was not completed in a timely manner, per policy and regulations. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident regarding resident #1 which occurred on (MONTH) 16, 2019. Staff #29 stated she has been fully trained and was knowledgeable about the investigation protocol for allegations of abuse and neglect. She stated that she did not identify the incident as neglect and just tried to move forward and resolve the issue. Staff #29 stated that reporting had not been done within the required timeframes. Staff #29 stated the incident was not reported according to facility policy and the regulations. Review of the policies and procedures regarding Abuse and Neglect revealed the following: Reporting/Response: All allegations of abuse and neglect should be reported immediately to the Administrator. Allegations of abuse and neglect will be reported to the appropriate state or federal agencies in the applicable timeframes, as per this policy and applicable regulations. The policies further included the facility will ensure that all alleged violations involving abuse and neglect are reported within 2 hours to the State Survey Agency.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035183	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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 0609 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 5)
F 0610 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Respond appropriately to all alleged violations.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure that two incidents of neglect and an allegation of physical abuse were thoroughly investigated involving one of 4 sampled residents (#1) and that the results of the investigations were submitted to the State Survey Agency within 5 working days of the incident, and that residents were protected from the potential for further abuse and neglect during the investigations. The deficient practice could result in additional allegations of abuse and neglect not being thoroughly investigated and residents not being protected from the potential for further abuse/neglect. Findings include: -Regarding the incident on (MONTH) 30, 2019: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 6, 2019 included the resident was blind and required assistance with all activities of daily living (ADL). An intervention included to encourage the resident to use bell to call for assistance. A care plan dated (MONTH) 9, 2019 revealed the resident was at risk for falls related to deconditioning. The goal was the resident would not sustain serious injury. Interventions were to anticipate and meet needs, be sure the call light is within reach and encourage to use it to call for assistance as needed, and to offer toileting every two hours. A care plan dated (MONTH) 20, 2019 revealed the resident was at risk for impaired visual function related to [MEDICAL CONDITION]. The goal included to maintain an optimal quality of life. Review of the facility's incident investigation documentation dated (MONTH) 1, 2019 revealed an incident was reported on (MONTH) 31, 2019 by a family member of the resident. The investigative note stated that the resident told a family member the following: a CNA (identified by the facility as staff #21) came into the resident's room to get her ready for bed and was rough with her and had refused to identify herself, and had put the resident in the bathroom and did not return for her in a timely manner (no time frame was included), and then sent another CNA (staff #4) to finish her p.m. care. Per the investigation, staff #21 was moved from the unit where resident #1 resided on (MONTH) 1, 2019. The incident investigation included that staff #21 was interviewed on (MONTH) 5, 2019. Staff #21 reported that the resident appeared anxious and repeatedly asked her what her name was, and that she had identified herself to the resident. Staff #21 reported that she had placed the resident in the bathroom, but did not finish her p.m. care. The investigation included an interview was conducted on (MONTH) 5, 2019, with a CNA (staff #4). Staff #4 reported that staff #21 asked her to finish the evening care for resident #1, as she was working with another resident. Staff #4 reported the resident asked her what the other aids name was and she told the resident that she did not know her name. The investigation also included that staff #38 (CNA) had not provided care to the resident on this shift. The specific shift was not was included. (However, in an interview with staff #38, she stated that she had worked with the resident during the time of this incident on (MONTH) 30). Continued review of the incident investigation revealed the best course of action was to re-assign staff #21 to a different floor to avoid further potential for conflict. Further review of the facility's investigation revealed the following concerns: -There was no documentation of the day and time that the incident occurred. -No evidence that staff immediately reporting the incident to the Administrator. -No evidence that resident #1 was interviewed. -No evidence that the allegation of being treated roughly by staff had been investigated. -There was no documentation that additional staff members who had worked on (MONTH) 30 or 31, on various shifts had been interviewed. -No evidence that other residents had been interviewed regarding the care and services provided by the accused staff. -No evidence of a conclusion of the investigation to determine if abuse or neglect had occurred. -No evidence that the results of the investigation were submitted to the State Survey Agency with 5 working days of the incident. -There was no documentation that the accused CNA (staff #21) was immediately removed from providing care to residents, as staff #21 was only reassigned to a different floor. During an interview conducted on (MONTH) 3, 2019 at 11:31 a.m. with a corporate Registered Nurse (RN/staff #40), she stated there was no further documentation or investigation conducted for this incident, because the facility staff did not believe it happened. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated that she was aware of the incident on (MONTH) 30, 2019 regarding resident #1 and had not been very involved. She stated the incident was only treated as a customer service incident, because the resident stated that a CNA would not tell the resident her name. Staff #70 stated if she had been aware that the resident reported rough treatment, she would have identified it as an allegation of abuse. Staff #70 stated leaving a resident in the bathroom for a long period of time and not providing timely care would be considered neglect. Staff #70 stated that all allegations of abuse and neglect have to be investigated and there needs to be protection of residents while the investigation is in progress. Staff #70 stated there was no thorough investigation for the incident that occurred on (MONTH) 30, 2019. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident regarding resident #1 which occurred on (MONTH) 30, 2019. Staff #29 stated she has been fully trained and was knowledgeable about the investigation protocol for allegations of abuse and neglect. She stated that she did not identify the incident as abuse or neglect and just tried to move forward and resolve the issue. Staff #29 stated a more complete investigation had not been done and there was no protection of residents, as the CNA (staff #21) was moved to a different floor. Staff #29 stated the incident was not correctly identified as an allegation of neglect, was not immediately reported to her and was not fully investigated according to facility policy and the regulations. -Regarding the incident on (MONTH) 16, 2019: Review of an incident note dated (MONTH) 17, 2019 revealed the resident was alert, oriented, and able to state her needs and is legally blind. Per the note, the nurse (RN/staff #23) was making rounds and found the resident in her wheelchair in the bathroom. The bathroom door and the main door to her room were both closed. The resident reported that one of the CNA's put her in the bathroom and never showed up. The resident was reassured and was put back to bed and no change in condition was noted. Review of the facility's investigation dated (MONTH) 28, 2019 revealed that on (MONTH) 17, 2019, staff #23 reported to the Administrator (staff #29) that she found resident #1 in the bathroom of her room around 2:00 a.m., with the door closed. Staff #23 reported the resident said that she was left in the bathroom in her wheelchair for an extended period of time. The investigation included an interview with the resident however, it was not conducted until (MONTH) 19, 2019 at 11:45 a.m. The resident reported that she had been assisted to the bathroom by a CNA (identified as staff #106) to brush her dentures but she could not remember the CNA's name, however, the resident reported that this CNA was with another CNA (identified as staff #38). The resident reported the CNA (staff #106) told her that she would be back to get her, but no one came back. The resident stated she called for help and no one came. The resident stated she did not know how long she was in the bathroom, but said that she fell asleep for a period of time, while waiting for staff to come back. The investigation included an interview with a RN (staff #23) however, the date of the interview was not documented. Staff #23 reported that she had been the nurse on duty from 10:00 p.m. on (MONTH) 16 until 6:00 a.m. on (MONTH) 17, 2019. Staff #23 stated she found resident #1 in her wheelchair in the middle of the night, but did not recall the time. The investigation included an interview with a CNA (staff #106) who worked the 2-10 p.m. shift on (MONTH) 16, 2019. There was no date to indicate when this interview was conducted. Staff #106 stated she was the CNA who assisted resident #1 to the bathroom around 9:30 p.m. (on (MONTH) 16) to brush her teeth and complete her evening care. Staff #106 reported that she thought she had put the resident to bed. Staff #106 stated she forgot to go back and check on the resident, prior to leaving for the night. Per the report, an interview with a CNA (staff #38) was conducted, however, there was no date to indicate when the interview occurred. Staff #38 worked on (MONTH) 16, 2019 from 10:00 p.m. until 6:00 a.m. on (MONTH) 17, 2019. Staff #38 reported that the CNA's do not have individual assignments and they take full responsibility for the entire floor. Staff #38 reported that she had been made aware of the resident being found in the bathroom by the nurse. Staff #38 stated she had not been in

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NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0610 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) the room of resident #1, because the resident was typically already in bed and will use the call light if she needs anything. The investigation also included an interview with a CNA (staff #102), who worked the 10pm-6am shift on (MONTH) 16-17. She reported that she worked with staff #38 that night. She said they did not have set assignments and that both of them were responsible for all of the residents together. She said that she did not go into the resident's room during that shift. She said the resident is always already in bed when she gets on shift, and if she needs anything she uses her call light. Further review of the investigative documentation revealed the following conclusions as determined by the facility: 1. It was determined that the resident was left in a wheelchair in the bathroom but it is unknown how long. 2. Nursing staff are not assigned to specific residents on any shift and they just work together. 3. Two hour rounds are not conducted on the night shift on every resident, just on those residents that are incontinent or have dementia, and other residents are attended to as they call for help using the call light. 4. The resident's call light cord was sufficient in length to reach, but could not be clipped to the resident. Continued review of the facility investigation revealed the following concerns: -There was no evidence that staff immediately reporting the incident to the Administrator. -No evidence of any conclusion if abuse or neglect had occurred. -No evidence that residents were protected from the potential for further neglect at the time of the incident and during the investigation, as no staff were removed from providing care to residents. -No evidence that the results of the investigation were submitted to the State Survey Agency within 5 working days of the incident. An interview was conducted with the Assistant Director of Nursing (Licensed Practical Nurse/staff #70) on (MONTH) 5, 2019 at 12:25 p.m. She stated that she was aware of the incident on (MONTH) 16, 2019 regarding resident #1 related to the allegations of neglect and that she only conducted some interviews. She stated that she now has become aware that the investigation was not complete. Staff #70 stated that all allegations of neglect have to be investigated and there needs to be protection of residents, while the investigation is in progress. An interview was conducted with the Administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated that she was aware of the incident regarding resident #1 which occurred on (MONTH) 16, 2019. Staff #29 stated she has been fully trained and was knowledgeable about the investigation protocol for allegations of abuse and neglect. She stated that she did not identify the incident as neglect and just tried to move forward and resolve the issue. Staff #29 stated a more complete investigation had not been conducted and there was no protection of residents, as there were no staff who were suspended. Staff #29 stated the incident was not fully investigated according to facility policy and the regulations. Review of the facility's policies and procedures regarding Abuse and Neglect revealed the following regarding investigations: All identified events are reported to the administrator immediately. After receiving the allegation, and during and after the investigation, the administrator shall ensure that all residents are protected from physical and psychosocial harm. All allegations of abuse and neglect will be promptly and thoroughly investigated by the administrator or designee. The investigation will include an interview with the resident; interviews with any witnesses to the incident; a review of the resident's medical record; interviews with staff on all shifts who may have information regarding the alleged incident; interviews with staff on all shifts having contact with the accused employee and a review of all circumstances surrounding the incident. At the conclusion of the investigation, the facility will attempt to determine if abuse or neglect has occurred. The investigation and the results of the investigation will be documented. Regarding protection, the policy included that if an allegation of abuse or neglect is reported, discovered or suspected, the facility will take the following steps to protect all residents from physical and psychosocial harm during and after the investigation: Respond immediately to protect the alleged victim for any sign of injury including a psychosocial assessment if needed; increase supervision of the alleged victim and residents; make room or staffing changes, if necessary to protect the residents from the alleged perpetrators and provided emotional support and counseling to the resident during and after the investigation. If the allegation of abuse and neglect involves an employee, the facility will immediately remove the employee from the care of any resident and suspend the employee during the investigation. The policy further included that the results of all investigations are reported within 5 working days of the incident to the State Survey Agency.
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, and review of facility documentation and policies, the facility failed to ensure there was adequate supervision and monitoring of one resident (#1) due to the lack of routine checks by the nursing staff throughout the shifts. The deficient practice could result in an unsafe environment for all residents. Findings include: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 6, 2019 identified a focus area as a self care deficit regarding the [MEDICAL CONDITION] and the resident required assistance with all activities of daily living. The goal was to maintain the current level of functioning. An additional area of focus was the resident's risk for falls and an intervention was to offer toileting every two hours. A care plan dated (MONTH) 20, 2019 documented a focus area of bowel and bladder incontinence with interventions to use briefs, change briefs twice per shift and as needed, and to use the call bell for assistance. An additional focus area as the resident being at risk due to [MEDICAL CONDITION] with a goal to maintain an optimal quality of life. Review of the quarterly Minimum Data Set assessment dated (MONTH) 6, 2019 documented a brief interview for mental status was 12, which indicated mild cognitive impairment. Also included was the resident used clear speech, could make herself understood, could understand others, and had severely impaired vision. The resident required the assistance of one staff to transfer from the wheelchair and required extensive assistance from one staff for toilet use. The resident was assessed to be infrequently incontinent of bowel and bladder. Review of a facility self report dated (MONTH) 28, 2019 documented an allegation of staff abuse/neglect regarding resident #1 that occurred on the evening and night shifts on (MONTH) 16 and 17, 2019. Continued review of the facility self report documented an interview had been conducted with a Certified Nursing Assistant (CNA/staff #38). There was no evidence of a date to indicate when the interview was actually conducted. Staff #38 stated no CNAs have room or resident assignments and the CNAs take responsibility for the entire floor. Staff #38 stated she had not been in the room of resident #1 because typically the resident is already in bed and will use the call light and call if she needs anything. Continued review of the facility self report included an interview with a CNA (staff #102). There was no evidence of a date to indicate when the interview actually occurred. Staff #102 stated she worked with staff #38 on the night of (MONTH) 16, 2019. Staff #102 stated the CNAs do not have set assignments and that the CNAs are responsible for all residents together. Staff #102 stated she did not go into the room of resident #1 during the shift and the resident is always already in bed when she gets on shift and calls if she needs anything. Continued review of the facility report included the following findings and conclusions: Interviews with the Assistant Director of Nursing and night shift revealed there is not a two hour rounding on every resident, just those residents who have dementia or incontinence, and that other residents are attended to as they call for help using the call light. Examining the call light cord in the bathroom for resident #1 revealed the call light had not been made accessible to the resident and the resident had been left in the bathroom for an unknown period of time. In addition, nursing staff and CNAs were not being assigned to specific residents and that staff just work together and care for all of the residents. All staff have since been inserviced on nursing standards of care including rounding on their assigned sections when coming on shift and every 2 hours to ensure each resident needs are being met. New assignments have been put into place that assign specific staff to specific rooms. Continued review of the facility report included actions that had been taken by the facility staff inclusive of 1)

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	035183	A. BUILDING _____ B. WING _____	09/05/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
RIO VISTA POST ACUTE AND REHABILITATION	10323 WEST OLIVE AVENUE PEORIA, AZ 85345

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 0689 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 7) notification to the compliance officer, 2) performance improvement plan written and implemented regarding the failure of assigning nursing staff to residents and failure of rounding of each resident, 3) CNAs were all given final warning disciplinary action for rounding on all residents, 4) staff assignments sheets were developed and nursing staff inserviced on assignments and rounding and specific resident assignments implemented. An interview was conducted with resident #1 and family member on (MONTH) 4, 2019 at 12:25 p.m. (family member requested she attend and resident approved). The resident was assessed to be alert and oriented x 4 and stated if she talked of the incident of (MONTH) 16, 2019 she would probably cry and be sad. Despite this, the resident stated she was willing to answer questions and would do her best. The resident stated she could remember the incident and stated she had been left in the bathroom for too long of a time. Stated she was scared and called out for help and no one came. The resident stated she was by the sink and could not reach the call light because she was in her wheelchair and could not move by herself. The resident stated she wore an incontinence brief and she had soiled and wet herself and felt very bad. The resident then became tearful and stated she could no longer talk of the incident. At this time the interview was ended by the surveyor. An interview was conducted with a Registered Nurse (RN/staff #23) on (MONTH) 4, 2019 at 1:32 p.m. Staff #23 stated she worked the night shift that started on (MONTH) 16 through 17, 2019 and also knew the resident and could recall the incident. Staff #23 stated she went to check on resident #1 at about 4:00 a.m. on (MONTH) 17, 2019. She stated the door to the resident room and the door to the resident bathroom was closed and she found the resident in the bathroom. Staff #23 stated the resident told she had been left in the bathroom for a long time and staff did not come to check on her. Staff #23 then stated she called all the CNAs working with her so she could ask who was responsible for leaving the resident in the bathroom and not checking on her, like every 2 hours. Staff #23 stated not a single CNA accepted responsibility for this incident and reported the incident to the administrator on (MONTH) 17, 2019. Review of the personnel file for staff #23 revealed a RN job description that was signed and dated by staff #23. Summary: The RN is responsible for providing direct care nursing care to the residents. Such care must be delivered in accordance with current federal, state, and local standards, guidelines, and regulations that govern our facility. Included in the description was the following: 1) Review care plans to verify appropriate care is being rendered. 2) Ensure that assigned CNAs are aware of resident care plans and ensure the CNAs refer to the plan of care prior to administering daily care to the resident. Continued review of the personnel file for staff #23 revealed a counseling/disciplinary notice dated (MONTH) 23, 2019. Included was the following: Reason for notice: Failing to supervise that CNAs have assignments and are rounding on all residents throughout the shift. An interview was conducted with CNA (staff #38) on (MONTH) 4, 2019 at 3:25 p.m. She stated she worked (MONTH) 16 and 17, 2019 from 6:00 p.m. until 6:00 a.m. and could recall the incident with resident #1 being left in the bathroom. Staff #38 stated she and other CNAs did not do resident rounds together and the oncoming staff would not actually see the resident and would just take the word from the off going CNA about the resident status. Staff #38 stated she did not make routine resident checks on resident #1 and other residents in the same area as those residents always used their call lights if they needed anything so the residents were not checked every 2 hours or on any regular basis. Resident #38 stated she had received a disciplinary notice about the lack to complete resident checks every 2 hours. Review of the personnel file for staff #38 revealed a job description that was signed and dated by staff #38. Purpose: The primary purpose of the job position is to provide each of your assigned residents with routine daily nursing care and services in accordance with the resident's assessment and care plan and as directed by your supervisor. Included in the description included the following: 1) Perform all tasks in accordance with the facility established policies and procedures. 2) Keep incontinent residents clean and dry. 3) Answer call lights promptly. 4) Ensure residents who are unable to call for help are checked frequently. 5) Keep the call light within easy reach of the resident. Continued review of the personnel file for staff #38 revealed a counseling/disciplinary notice dated (MONTH) 22, 2019. Included was the following: Reason for notice: Failing to conduct every 2 hour resident checks for safety, comfort, and incontinence resulting in resident being left in restroom for an extended period of time from previous shift. If initial rounds and subsequent every 2 hour checks were being performed per expectation of care this situation would have been avoidable. An interview was conducted with CNA (staff #106) on (MONTH) 5, 2019 at 9:03 a.m. Staff #106 stated she has worked at the facility about two years . Staff #106 stated the CNAs did not do routine rounding to check on residents at the beginning and end of the shifts and therefore did not actually see the residents to make sure they were okay. Staff #106 stated that all CNAs were responsible for all residents and there were no resident or room assignments. An interview was conducted with the Assistant Director of Nursing (staff #70) on (MONTH) 5, 2019 at 11:25 am. Staff #70 stated on (MONTH) 17, 2019 she was made aware the CNAs were not doing every 2 hour checks on the residents to ensure the residents were all right. Stated once she and other management staff were aware they made immediate changes and stated it was standard nursing practice for CNAs to do every 2 hour rounds. According to a facility policy regarding safe supervision of residents the following was included: Policy: It is the policy of this facility to create a safe environment for the resident. Procedures: Make routine checks to check on the resident's condition and comfort. An additional policy regarding the rounds of licensed staff included the following: Policy: Is it the policy of this facility to ensure the safety and comfort of the resident and to assist in the continuity of care and to identify potential change of condition. Procedures: Residents will be checked by the nursing staff a minimum of every 2 hours. Note positioning of the call light.
F 0745 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide medically-related social services to help each resident achieve the highest possible quality of life.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident, family, and staff interviews, and review of facility documentation and policy, the facility failed to ensure one resident (#1) was provided social services after the resident experienced two separate incidents of being left alone in the bathroom. The deficient practice could result in residents not being identified as needing additional supportive care and counseling after a traumatic event. Findings include: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 6, 2019 included the resident is blind and requires assistance with all activities of daily living (ADL). An intervention included to encourage the resident to use bell to call for assistance. Review of a care plan dated (MONTH) 9, 2019 revealed the resident was at risk for falls related to deconditioning. The goal was the resident would not sustain serious injury. Interventions were to anticipate and meet needs, be sure the call light is within reach and encourage to use it to call for assistance as needed, and offer toileting every two hours. A care plan dated (MONTH) 20, 2019 documented a focus area of bowel and bladder incontinence related to impaired mobility, dementia, and a history of urinary tract infections [MEDICAL CONDITION]. The goals included that the risk for [MEDICAL CONDITION] would be minimized/prevented via prompt recognition and treatment of [REDACTED]. Interventions included to use briefs and change briefs as needed and check as required for incontinence. An additional care plan dated (MONTH) 20, 2019 identified the resident's wish to remain in the facility due to the need of 24 hour oversight. An intervention included for the resident to discuss feelings and concerns about living in the long term care community and to monitor for episodes of anxiety, fear, and distress. A care plan dated (MONTH) 20, 2019 revealed the resident was at risk for impaired visual function related to [MEDICAL CONDITION]. The goal included to maintain an optimal quality of life. Review of the quarterly Minimum Data Set assessment dated (MONTH) 6, 2019 documented a brief interview for mental status was 12, which indicated mild cognitive impairment. Also included was the resident used clear speech, could make herself understood, could understand others, and had severely impaired vision. The resident required the assistance of one staff to transfer from the wheelchair and required extensive assistance from one staff for toilet use. The resident was assessed to be infrequently incontinent of bowel and bladder.

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F 0745 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 8) Review of facility investigative reports identified two separate incidents on (MONTH) 30 and (MONTH) 16, 2019 in which the resident had been left in the bathroom for unknown periods of time. On (MONTH) 16, 2019 the resident had been left in the bathroom for approximately 6 hours and did not have access to the call light. Included in the report was a statement that the social services staff had followed up with the resident on several occasions. An interview was conducted with resident #1 and family member on (MONTH) 4, 2019 at 12;25 p.m. The resident was assessed to be alert and oriented x 4 and stated if she talked of the incidents of (MONTH) 30 and (MONTH) 16, 2019 she would probably cry and be sad. Despite this, the resident stated she was willing to answer questions and would do her best. The resident stated she had been left in the bathroom for a long time and was scared and called out for help and no one came. Stated she wears an incontinence brief and she had soiled and wet herself and felt very bad. The resident stated the first incident in July, 2019 was not nearly as bad as the second incident that occurred in August, 2019. The resident stated she could not reach the call light and was scared and stated the two incidents were very difficult for her and she relives them in her mind. The family member stated the incidents had caused increased anxiety and [MEDICAL CONDITIONS] symptoms for the resident. The family member stated the resident will have individual counseling to deal with the increased anxiety and [MEDICAL CONDITION] distress. An interview was conducted with the social worker (staff #74) on (MONTH) 5, 2019 at 9:25 a.m. Staff #70 stated she knows the resident well and had been aware of both incidents in (MONTH) and August, 2019 of the resident being left in the bathroom. Staff #74 stated there had been facility investigations of abuse and neglect allegations due to the incidents. Staff #74 stated she had only met with the resident on informal occasions since the two incidents occurred and made no contact with the resident that was considered worthy of a progress note. Staff #74 stated she was not aware of any need to meet with the resident to determine how the resident was and how she was dealing with the fear she experienced when being left alone in the bathroom without having access to a call light. Staff #74 stated there was a recent physician's orders [REDACTED]. Review of the clinical record revealed documentation of a social service progress note dated (MONTH) 5, 2019 revealed a referral had been made for outside individual counseling for resident #1. Interview with administrator (staff #29) on (MONTH) 5, 2019 at 1:21 p.m. She stated she would expect some follow up from the social services staff when a resident reported allegations of abuse and neglect and stated she thought follow up had been done. Staff #29 stated she was unaware social services had not followed up with the resident since the two incidents occurred. According to a facility policy regarding social services the following was included: Policy: Is is the policy of this facility to provide medially related social service to assure each resident can achieve and maintain her highest practical physical, mental, or psychosocial well being. Medically related social services are provided to meet mental or psychosocial needs (sense of identity, coping abilities, and sense of meaningfulness or purpose. The staff will be responsible to obtain pertinent information related to care needs, identify social and emotional needs, maintain regular progress and follow up notes indicating the resident's response to the care plan and interventions, provide supportive counseling to resident and family, participate in interdisciplinary staff conferences to ensure appropriate intervention and treatment of [REDACTED].
F 0919 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that a working call system is available in each resident's bathroom and bathing area.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record review, resident and staff interviews, and review if facility documentation, policies, and personnel files, the facility failed to ensure one resident (#1) was provided a means to communicate with the staff by having a call light accessible to her. The deficient practice could result in residents not having the means to communicate with staff. Findings include: Resident #1 was readmitted to the facility on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 20, 2019 documented a focus area of bowel and bladder incontinence with interventions to use briefs, to change briefs as needed, and to use the call bell for assistance. An additional focus area was the resident being at risk due to [MEDICAL CONDITION] with a goal to maintain optimal quality of life, Review of the quarterly Minimum Data Set assessment dated (MONTH) 6, 2019 documented a brief interview for mental status was 12, which indicated mild cognitive impairment. Also included was the resident used clear speech, could make herself understood, could understand others, and had severely impaired vision. The resident required the assistance of one staff to transfer from the wheelchair and required extensive assistance from one staff for toilet use. Review of a facility investigative report documented resident #1 had been placed in the bathroom by the sink by a Certified Nursing Assistant (CNA) staff #106 on (MONTH) 16, 2019 and was left there for an unknown period of time. Despite the call light cord in the bathroom being long enough to reach the resident, the call light could not be clipped to the resident and therefore not accessible to the resident. An interview was conducted with a Registered Nurse (staff #23) on (MONTH) 4, 2019 at 1:32 p.m. Staff #23 stated she found the resident in the bathroom at approximately 4:00 a.m. on (MONTH) 17, 2019 and this was about 6 hours after the resident had been placed in the bathroom the previous evening. Staff #23 stated the resident was not able to reach the call light. An interview was conducted with staff #106 on (MONTH) 5, 2019 at 9:03 a.m. Staff #106 stated she left resident #1 in the bathroom on (MONTH) 16, 2019 at about 9:00 p.m. Staff #106 stated the resident did not have a call light within reach during the time she was in the bathroom and because of this the resident could not contact the staff. Staff #106 stated the resident should have had a call light to call for staff assistance. Review of the personnel file for staff #106 revealed a counseling/disciplinary notice dated (MONTH) 22, 2019. Included was staff #106 left resident #1 in the restroom without a call light and failed to return to the resident prior to ending her shift. The incident caused the resident to be left in the restroom for an extended period of time with no way to ask for assistance. An interview was conducted with the Assistant Director of Nursing (staff #70) on (MONTH) 5, 2019 at 9:25 a.m. Staff #70 stated she interviewed resident #1 on (MONTH) 19, 2019 and the resident told her she had been left in the bathroom for a long time and the call light was not within reach. The resident stated she had to wait a long time for staff to help her because she could not use the call light. Staff #70 stated it was standard nursing practice that all residents have accessibility to their call lights. According to a policy regarding call lights the following was included: Policy: It is the policy of this facility to provide the resident a means of communication with nursing staff. Procedures: Place the call light device within the resident's reach before leaving the room.