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 _____	**11/01/2019**

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 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Provide care and assistance to perform activities of daily living for any resident who is unable.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on clinical record reviews, facility documentation, resident and staff interviews and policy review, the facility failed to ensure 4 of 7 sampled residents (#38, #55, #57 and #84) received the necessary services to maintain good personal hygiene. The deficient practice could result in hygiene needs not being met. Findings include: Regarding showers -Resident #38 was admitted to the facility on (MONTH) 29, 2019 with [DIAGNOSES REDACTED]. Review of the care plan initiated (MONTH) 29, 2019 revealed the resident had Activity of Daily Living (ADL) self-care performance deficit related to [MEDICAL CONDITION]. The goal was that the resident would safely perform personal hygiene with assistance. Interventions included encouraging the resident to participate to the fullest extent possible with each interaction and allowing sufficient time for dressing and undressing. Continued review of the care plan initiated (MONTH) 29, 2019 revealed the resident had the potential for impairment to skin integrity related to limited mobility. Interventions included keeping the resident's skin clean and dry. The admission Minimum Data Set (MDS) assessment dated (MONTH) 4, 2019 revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident had intact cognition and that the resident required total staff assistance for bathing. Review of the bathing documentation for (MONTH) 2019 revealed the resident received a shower on (MONTH) 1, 3, 4, 7, 10, and 14, 2019. The documentation also included the resident refused a shower on (MONTH) 18 and 21, 2019. Review of the bathing documentation for (MONTH) 2019 revealed the resident received a shower on (MONTH) 5, 20, 27, and 30, 2019. No refusals were documented. Continued review of the clinical record revealed no further documentation of showers given or refused and no corresponding shower/skin sheets. During an interview conducted with resident #38 on (MONTH) 28, 2019 at 2:21 p.m., the resident stated that the staff are not very good about giving residents showers. The resident stated the staff missed giving her one of her showers the previous week. An interview was conducted with a Certified Nursing Assistant (CNA/staff #105) on (MONTH) 30, 2019 at 1:16 p.m. The CNA stated residents are offered showers two to three times a week. She stated that when she has provided a resident a shower, she documents the shower on the shower sheet, sign it and put it into the book at the nurses' station to be reviewed by the nurse. The CNA stated that if a resident refuses a shower, the resident is offered a shower later, and that if the resident continues to refuse, she would document the refusal on the shower sheet and in the electronic record. After reviewing the bathing documentation for resident #38, the CNA stated that if there was no shower sheet and no further documentation in the electronic record, there would be no evidence that the resident was provided showers or refused showers. An interview was conducted with a Licensed Practical Nurse (LPN/staff #7) on (MONTH) 30, 2019 at 1:38 p.m. The LPN stated that the bathing task in the electronic record should reflect whether a shower was given or refused. She stated that if a resident refuses a shower, she instructs the CNAs to offer the resident a shower a second time during their shift. She stated that if the resident continues to refuse a shower, it should be documented in a progress note and the shower would pass to the next shift. The LPN stated that a shower sheet is created whenever a shower is offered. She stated that if the resident refused a shower, the CNA would mark refused on the shower sheet. She stated that if there was no shower documentation found, then it would mean no shower was offered and/or given. After reviewing the bathing documentation for resident #38, the LPN stated the documentation did not meet the expectation for provision of showers and shower documentation. In interview conducted with the Director of Nursing (DON/staff #53) on (MONTH) 1, 2019 at 11:56 a.m., the DON stated that she expects every resident to be offered two shower a week. She stated that if the resident requests showers more frequently, they would attempt to accommodate the request. She stated that each unit has a shower schedule which is included on the daily CNA assignment. She stated that if the resident refuses their shower, she would like staff to re-approach the resident and get the nurse involve. The DON stated the CNA should document whether the shower given or refused in the electronic record. She stated that a shower sheet is to be completed for all showers assigned whether the shower was given or refused and signed by the CNA and the nurse. After reviewing the clinical record for resident #38, she stated that based off the documentation, there is no documented evidence resident #38 was offered showers two times a week as required. -Resident #55 was admitted on (MONTH) 11, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed [MEDICATION NAME] ointment was being applied twice a day to the entire body for dry skin related to rash and other nonspecific skin eruption since (MONTH) 1, 2019 and that [MEDICATION NAME] Powder was being applied to the left lower abdominal fold twice a day for rash since (MONTH) 18, 2019. Review of the care plan initiated (MONTH) 21, 2019 revealed the resident had ADL self-care performance deficit related to [MEDICAL CONDITION] and pain. The goal was that the resident would maintain the current level of function in personal hygiene. Interventions included the resident was totally dependent on staff for bathing. Continued review of the care plan initiated (MONTH) 21, 2019 revealed the resident was resistive to care at times related to poor attitude towards staff. The goal was that the resident would cooperate with care. Interventions included if possible, negotiate a time for ADLs so that the resident participates in the decision process and return upon the agreed time, if the resident resists ADLS, reassure the resident, leave and return 5-10 minutes later, and maintain consistency in timing of ADLs, caregivers and routine as much as possible. Review of the quarterly MDS assessment dated (MONTH) 20, 2019 revealed a score of 15 on the BIMS which indicated the resident had intact cognition. The assessment included the resident required the physical assistance of one person for bathing and that bathing did not occur during the 7 day look-back period. Review of the shower schedule for the hall that resident #55 resided on revealed all showers must be completed and the shower sheet is to be filled out. The schedule also included if you have more than 2 showers in your assignment, please see your charge nurse to have one of your showers signed out to a co-worker. The skin observation/shower sheets for (MONTH) 2019 revealed resident #55 received showers on (MONTH) 17, 19, and 27, 2019. The skin observation/shower sheet for (MONTH) 22, 2019 revealed the resident refused. Review of the shower documentation for (MONTH) 2019 revealed the resident received a shower on (MONTH) 3 and a sponge bath

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 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) on (MONTH) 24, 2019. During an interview conducted with resident #55 on (MONTH) 28, 2019 at 9:22 a.m., the resident stated that in September, he waited for over 2 weeks to get a shower. He stated that he reported it to the Assistant Director of Nursing (ADON) on (MONTH) 17, 2019. The resident stated that his complaint was investigated and substantiated. The resident stated that he has a rash under his pannus on the left side. He stated that it hurts and smells, and that it embarrasses him. The resident stated that he thinks the area needs to be thoroughly washed in the shower and dried. On (MONTH) 31, 2019 at 12:29 p.m., an interview was conducted with a staff member. The staff member stated that when there are fewer CNAs things get done, just not right away. The staff member said especially when you have larger residents such as resident #55, who require two staff member to transfer into the shower chair, two staff members to push the shower chair into and out of the shower room, and two staff members to transfer the resident back into the wheelchair or into the bed. The staff member stated that residents who require two-person assistance for showers take a lot of time. The staff member said the CNAs may not get the showers done when the residents want especially if they are short staffed and that sometimes they have to put showers off until the next shift. The staff member said that if showers are put off until the next shift she typically does not follow up to ensure the shower was provided. An interview was conducted on (MONTH) 31, 2019 at 1:39 p.m. with a CNA (staff #51). She stated that resident #55 was showered on the dates indicated on the skin observation sheets. She said that if there was not a skin observation form/shower sheet for the resident, there was CNA task documentation for showers in the electronic record that would indicate if the resident received a shower. Staff #51 stated that if there was no skin observation sheet or no CNA shower task documentation, then the resident did not receive a shower. After reviewing the CNA task documentation, the CNA stated there was a place to document when a resident refuses to be showered. However, she said there was no documentation to indicate the resident had refused. On (MONTH) 31, 2019 at 1:44 p.m., an interview was conducted with another staff member. The staff member stated that when CNA staffing is low, showers get skipped. The staff member stated the larger residents probably get their showers skipped more often because they require two staff assistance, and take more time and effort. The staff member said shower sheets are filled out each time a resident receives showered. The staff member further stated that if there are no shower sheets, that means the resident was not showered. An interview was conducted with the DON (staff #53) on (MONTH) 1, 2019 at 11:56 a.m. She stated that her expectation is that every resident is offered two showers per week and as needed. She said every floor has a shower schedule. She stated that the CNAs can pick up the shower schedules/assignments from the nurses' station. The DON stated that if a resident refuses a shower, she would expect the CNAs to approach the resident later to offer the shower again or get the nurse involved. She said showers are documented in the electronic record, CNAs complete shower sheets - whether or not the shower was given or refused, and that the CNAs give the shower sheets to the nurse to sign. She stated that official documentation is contained and tracked in the Point of Care (P[NAME]) CNA task documentation. She stated that in (MONTH) 2019, resident #55 had complained that he was not receiving his showers. She further stated that she addressed the issue in a CNA in-service meeting on (MONTH) 26, 2019. The DON stated that if there are no shower sheets or P[NAME] documentation for showers, then the showers most likely were not given. She said that not providing showers does not meet her expectations or follow the facility policy. Review of the facility's policy titled Quality of Care revealed it is the policy of this facility that residents are given the appropriate treatment and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident in accordance with a written plan of care. Additionally, the policy included bathing will be offered at least twice weekly and as needed per resident request, and ADL care provided will be documented in the medical record accordingly. Regarding incontinent care -Resident #57 was admitted on (MONTH) 19, 2019 with [DIAGNOSES REDACTED]. The admission MDS assessment dated (MONTH) 25, 2019 revealed a BIMS score of 14 which indicated the resident had intact cognition. The assessment included the resident was totally dependent on staff for toilet use and required the assistance of two + persons. The assessment also included the resident had frequent episodes of urinary incontinence and occasional episodes of bowel incontinence. Review of the care initiated (MONTH) 20, 2019 revealed the resident had a potential for impairment to skin integrity related to disease process and incontinence. The goal was the resident would be free from injury/skin breakdown. Interventions included keeping hands and body parts from excessive moisture and identifying/documenting potential causative factors and eliminating/resolving where possible. A care plan initiated (MONTH) 1, 2019 revealed the resident had bladder/bowel incontinence. The goal was that the resident's skin would remain free from skin breakdown due to incontinence and brief use. Interventions included checking as required for incontinence, washing, rinsing, and drying perineum, and changing clothing as needed after incontinence episodes. Review of the ADL report for (MONTH) 2019 revealed resident #57 received incontinence care 3 times during a 24 hour period on (MONTH) 21, 2 times during a 24 hour period on (MONTH) 1, 17, 19, 20, 25, and 30, and one time during a 24 hour period on (MONTH) 3, 4, 6, 7, 9, 10, 14, 15, 22, 23, 24, 26, 27, and 29. Additionally, the ADL report revealed the resident received no incontinence care during a 24 hour period on (MONTH) 2, 5, 8, 11, 12, 13, 16, 18, 28, and 31, 2019. A physician's orders [REDACTED]. Review of the Medication Administration Record [REDACTED] A nursing progress note dated (MONTH) 1, 2019 at 00:19 a.m. revealed the CNAs reported to this nurse about this resident having spots of redness on her lower back. Observed from the resident a new skin issue of spots of redness of varied sizes on her lower back. The note included the nurse informed the physician who gave an order for [REDACTED]. The note revealed the resident took the first dose of fluconazole. Another physician order [REDACTED]. An interview was conducted with resident #57 on (MONTH) 28, 2019 at 9:02 a.m. The resident stated there have been times when she has waited over 2 - 3 hours for someone to answer her call light. She stated that there have been instances when her call light was not answered at all during the day, evening, and night shifts. The resident stated the outcome has been broken skin on her buttocks and a painful, burning rash in her peri area from sitting in wet briefs for extended time periods. She stated the nurses have been putting cream on it, but that the real solution would be to have her brief changed on a regular basis. The resident stated she spoke to the CNAs and the DON about the delay in providing incontinent care. The resident stated the DON asked her about it but that nothing has changed since she spoke to the DON. An interview was conducted with a staff member on (MONTH) 31, 2019 at 11:38 a.m. The staff member stated that on the night shift, there is only one CNA assigned to assist 32 residents. The staff member stated that as a result, residents frequently do not get changed or repositioned. On (MONTH) 1, 2019 at 1:09 p.m., an interview was conducted with another staff member. The staff member stated that incontinence care and CNA rounding to check on the residents does not always occur in a timely manner due to a shortage of staff. She stated that some residents require an additional CNA to assist in transfers and care. She said that those residents often wait the longest for assistance. She stated that the CNAs really have a tough time providing care for all the residents because they are constantly understaffed. She said that another issue with being understaffed is that residents' incontinence needs get neglected and that the residents who require total assistance are not always turned every 2 hours as required. On (MONTH) 1, 2019 at 1:16 p.m., an interview was conducted with a staff member. The staff member said they document incontinence care in the bladder/bowel and toileting areas of the ADL report. The staff member stated that if there are only 2 checkmarks in the column, it meant the resident was only provided incontinence care 2 times during the 24 hour period. -Resident #84 was admitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of a care plan initiated (MONTH) 15, 2019 revealed the resident had bowel and bladder incontinence related to dementia and impaired mobility. The goal was the resident will remain free from skin breakdown due to incontinence and brief use. Interventions include required checking every two hours for incontinence, washing, rinsing and drying perineum, and changing clothes as needed after incontinence episodes.

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F 0677 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) A quarterly MDS assessment dated (MONTH) 9, 2019, revealed a score of 8 on the BIMS which indicated the resident had moderately impaired cognition. The assessment included the resident required one person physical assistance for toilet use and had frequent episodes of urinary and bowel incontinence. On (MONTH) 28, 2019 at 9:26 a.m., an interview was conducted with resident #84. The resident stated that she has waited three hours many times for assistance to the toilet. The resident further stated that she has especially had accidental incontinence episodes many times in the morning when she wakes up. Review of the ADL report for (MONTH) 2019, revealed bowel and bladder care was provided to resident #84 twice a day on (MONTH) 4 and 5, three times a day on (MONTH) 10, 11, 12 and 19, four times a day on (MONTH) 7, 14, 18 and 26, and five times a day on (MONTH) 2, 8, 9, 13, 17, 20, 21 and 29. Further review of the ADL report for (MONTH) 2019 revealed bowel and bladder care was provided six to ten times on the other days in October. On (MONTH) 1, 2019 at 10:37 a.m. an interview was conducted with a staff member. This staff member said it is frustrating for the residents and the staff when residents have to wait for incontinent care. The staff member stated that when there are less than three CNAs, call lights will remain on for twenty to thirty minutes or more before staff can answer the call lights. Later, at 12:44 p.m., this same staff member stated resident #84 is able to tell staff when she needs to use the toilet. The staff member stated that occasionally they are not able to get resident #84 to the toilet timely. The staff member also stated that bowel and bladder care is documented in the electronic record. On (MONTH) 1, 2019 at 1:25 p.m., an interview was conducted with the DON (staff #53). She stated the CNAs make rounds every 2 hours and incontinence care is to be provided as needed. She stated her expectation is that every time a resident is incontinent, they would receive incontinence care. She said that it is her expectation that whenever the resident requests to be changed or toileted, their request is met. The facility's policy titled Quality of Care, ADL Services to Carry Out reviewed on (MONTH) (YEAR), revealed if a resident is unable to carry out activities of daily living; the necessary services will be provided by qualified staff. The policy included ADL care provided will be documented in the medical record accordingly.