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 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interviews and policy review, the facility failed to ensure one of 23 sampled residents (#288) was informed and provided written information regarding advance directives at the time of admission. The deficient practice could result in residents not receiving advance directive information timely. Findings include: Resident #288 was admitted on (MONTH) 25, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a face sheet that the resident had a Power of Attorney for care. Review of a nursing daily skilled note dated (MONTH) 26, 2019 revealed the resident was alert and oriented x 2 with intermittent confusion. A Social Services progress note dated (MONTH) 28, 2019 included a voice mail had been left for the resident's family member to discuss Advanced Directives. Review of the Advanced Directive Statement revealed the resident was full code status. The form included the resident's Medical Power of Attorney (MPOA) signature with the date (MONTH) 28, 2019. The form also included the facility representative signature with the date (MONTH) 26, 2019. A physician's orders [REDACTED]. However, further review of the clinical record did not reveal evidence that the resident and/or the resident's representative was informed and provided written information regarding the right to formulate an advance directive at the time of admission. On (MONTH) 31, 2019 at 2:29 p.m., an interview was conducted with the Director of Medical Records (staff #96). She stated that the resident was admitted on (MONTH) 25, 2019 and that it was the responsibility of the charge nurse to get the Advanced Directive signed or get a verbal authorization from the POA within the first 24 hours after admission. On (MONTH) 31, 2019 at 2:41 p.m., an interview was conducted with the Director of Nursing (DON/staff #53). She stated that when a new resident is admitted , they are a full code. The DON stated that the expectation is for the admitting nurse to be responsible for obtaining the resident's Advanced Directive within the first 24 hours after the resident is admitted . She stated that if a resident does not have an Advanced Directive, he or she is a full code. The facility's policy titled Advanced Directive Documentation revealed written information will be provided to residents at the time of admission regarding their right under State law to accept or refuse medical treatment and the right to formulate Advanced Directives. The admission coordinator or social service director shall provide the resident or responsible agent information regarding the right to formulate an Advance Directive, inquire whether he/she has completed an Advance Directive, and document in the resident's health record. The policy also revealed documentation shall be included in the resident's health record that, at the time of admission, the resident was provided written information regarding Advanced Directives and whether or not the resident had executed such a document.
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.

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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) 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 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

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F 0677 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) 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. 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.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure one sampled resident (#76) was provided bowel care in accordance with professional standards of practice. The deficient practice could result in residents not receiving bowel care. Findings include: Resident # 76 was admitted to the facility on (MONTH) 3, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed physician orders [REDACTED]. Review of the Certified Nursing Assistant (CNA) daily flowsheet for bowel movements (BM) dated (MONTH) 2019 revealed the resident did not have a BM from (MONTH) 15 through 19, 2019. Review of the Medication Administration Record [REDACTED]. An interview was conducted with a CNA (staff #63) on (MONTH) 31, 2019 at 2:50 p.m. Staff #63 stated all CNAs have to chart every shift on the flowsheet whether the resident did or did not have a BM. Staff #63 stated that if a resident went 3 days without a BM or complained of constipation, the CNAs have to inform the nurse. An interview was conducted with a Licensed Practical Nurse/Assistant Director of Nursing (staff #10) on (MONTH) 1, 2019 at 11:01 a.m. She stated she reviewed the clinical record for resident #76 and that the resident went 4-5 days without a BM. Staff #10 stated all nurses should be asking the resident every shift about constipation and documenting the information. Staff #10 further stated the electronic record system sends out an alert to nurses when a resident has not had a BM for 3 days. She stated the nurses have access to delete the alert without addressing the issue. The facility's policy regarding bowel care management revealed it is the policy of this facility to follow physician orders [REDACTED]. The policy included monitoring and recording BMs daily. The policy also included that if the resident has no BM in 3 days; implement the PRN bowel care orders.
F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe, appropriate pain management for a resident who requires such services.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0697 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) Based on clinical record review, interviews, and policy review, the facility failed to ensure that pain medication was provided as scheduled to one resident (#84). The sample size was 3 residents. The deficient practice could result in unrelieved pain for residents. Findings include: Resident #84 was admitted to the facility on (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. The resident's care plan for pain dated (MONTH) 30, 2019, revealed that the resident was prescribed an opioid for chronic pain. The goal of this plan was that the resident would remain free from pain or at a level of comfort acceptable to the resident. An intervention included to administer the opioid as prescribed. A physician's orders [REDACTED]. Review of the Medication Administration Record (MAR) for (MONTH) 2019 revealed that the medication was to be given at 8:00 a.m. and again at 8:00 p.m. There was no documentation that the medication was administered on (MONTH) 19 for the a.m. dose or (MONTH) 27 for the p.m. dose. The clinical record was reviewed and did not include a reason why the medication was not given on these dates. A Controlled Drug Record for the [MEDICATION NAME] (MONTH) 2019, revealed that the medication was given more than an hour after the administration times of 8:00 a.m. or 8:00 p.m. This occurred on the following occasions: -August 3 at 09:40 a.m. -August 4 at 9:40 p.m. -August 8 at 10:27 p.m. -August 12 at 09:13 p.m. -August 19 at 09:39 p.m. -August 23 at 09:45 p.m. A Quarterly Minimum Data Set (MDS) assessment dated (MONTH) 9, 2019, indicated the resident had a Brief Interview for Mental Status (BIMS) score of 8 indicating cognitive impairment. The resident was coded to have pain frequently and received scheduled and as needed pain medications in the last 5 days. A Controlled Drug Record for the [MEDICATION NAME] (MONTH) 2019, revealed that the medication was given more than an hour before or after the administration times of 8:00 a.m. or 8:00 p.m. or the time of administration was not documented. This occurred on the following occasions: -September 6 at 11:10 a.m. and 9:30 p.m. -September 14 at 9:05 a.m. -September 15 at 9:48 p.m. -September 17 at 9:30 a.m. -September 23 there was no documented time. Review of the MAR for (MONTH) 2019 revealed that the resident had pain levels documented on the dates that the medications were administered more than an hour after the administration times of 8:00 a.m. and 8:00 p.m. or the time of administration was not documented. These included: -September 6 at the 8:00 p.m. administration time, the pain level was 7 -September 14 at the 8:00 a.m. administration time, the pain level was 8 -September 15 at the 8:00 p.m. administration time, the pain level was 8 -September 23 at the 8:00 p.m. administration time, the pain level was 7 A Controlled Drug Record for the [MEDICATION NAME] (MONTH) 2019, revealed that the medication was given more than an hour before or after the administration times of 8:00 a.m. or 8:00 p.m. or the administration time was not documented. This occurred on the following occasions: -October 11 a.m. there was no documented time and (MONTH) 11 at 9:17 p.m. -October 12 at 9:30 p.m. -October 16 at 11:00 a.m. -October 22 at 9:10 p.m. -October 23 at 9:30 p.m. -October 24 at 4:00 a.m. -October 25 at 4:30 p.m. In an interview with resident #84 on (MONTH) 28, 2019 at 09:41 a.m., the resident stated that she doesn't get her pain pill timely. She said that often she has to wait hours for it. During an interview conducted with a Registered Nurse (RN/ staff #94) on (MONTH) 1, 2019 at 9:21 a.m., she stated that her procedure for passing medications include that she checks the five rights which include the right dose, right medication, right person, right route, and the right time. She stated that medications are provided to residents timely when there are four Certified Nursing Assistants (CNAs) working the unit, but when there are three CNAs, she can't always get the residents their medications timely because she ends up doing some CNA work. She said it is especially hard on one side of the unit because there are a lot of time consuming resident needs such as feeding tubes. She stated that resident #84 does go downstairs and when she does, she does not always get her medication on time. She reviewed the electronic clinical record and said that the [MEDICATION NAME] showing in red on this date, which indicates that the medication has not been given and that it is past the correct time of administration, making it late. She said this is because she has been so busy on this date and there are only 3 CNAs. She said the staffing is mostly consistent, but when there aren't enough CNA's, that is when the nurses struggle to get everything done. In an interview with the Director of Nursing (DON/staff #53) on (MONTH) 1, 2019 at 1:59 p.m., she stated that her expectation for medication administration is that medications will be administered as ordered, per the five rights including the right time. She stated that the facility uses the hour rule, meaning that a medication can be administered up to an hour before and as late as an hour after it is scheduled. She said that if the resident is not available in the unit, but is in the building, her expectation is that the nurse will locate the resident and attempt to give them their medications on time. She said the nurse should have found resident #84 to give the [MEDICATION NAME] time. A policy titled Medication Administration Controlled Medications revealed that when a controlled medication (such as an opioid medication) is administered, the licensed nurse administering the medication will immediately enter all of the following: date and time of administration, amount administered, and the signature of the nurse administering the dose. In a policy titled MAR and Treatment Administration Record (TAR) Documentation reveals that it is the policy of the facility that medication and treatment records shall reflect the administration as prescribed by the physician.
F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.** Based on observation, resident and staff interviews, facility documentation and policy review, the facility failed to ensure there was sufficient nursing staff to meet the needs of the residents. The deficient practice resulted in resident needs not being met. The facility census was 96. Findings include: During resident interviews, five residents stated that they had concerns with the nurse staffing in the facility. They all said that there were not adequate staffing levels to meet their needs. One resident said staff do not answer her call light timely. She said that she has soiled herself because staff have taken over an hour to respond to her call light. Another resident said she feels there needs to be more staff and that it takes anywhere from thirty minutes to over two hours before the staff answer her call light. She said she worries that she might have an incontinent accident from having to wait so long. Another resident said that it can take up to an hour for staff to answer his call light. He said that this makes him very anxious and worried. Another resident said that she has waited for up to three hours for staff to answer her call light. She said she had to wait in her bed in a wet brief. A resident said that the facility is short-staffed and that it takes staff over an hour to respond to her call light. She said she has had to wait this long while lying in a wet brief.

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

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F 0725 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) An interview was conducted with a Certified Nursing Assistant (CNA) on (MONTH) 31, 2019, at 10:24 a.m. She reported there are not enough staff on duty to meet the needs of the residents. She stated residents have wet themselves because she has not been able to get to them in time. During an observation conducted on (MONTH) 31, 2019 at 10:42 a.m., a resident was observed to come out of his room and tell the Licensed Practical Nurse (LPN) that he would like to take a shower. The LPN stated that he could not take a shower. She said that all the nurse's aids were busy helping other people and that there was no one to help him at that time. She told the resident to go back into his room, sit on the end of his bed, and wait for a staff member to come. During an interview with a LPN on (MONTH) 31, 2019, at 11:15 a.m., she reported there are not enough staff on duty. She said that she has to care for thirty-two residents on a regular basis and that this has gone up from twenty-four residents. She stated that she does not have time to actually assess how the residents are doing and she cannot sit down and talk with them when they need to talk. An interview was conducted with a CNA on (MONTH) 31, 2019, at 11:35 a.m. She stated currently thirty-three residents are split between two staff because one is on lunch. She stated she feels they need another staff member to meet the needs of the residents. She stated there are times when a resident has soiled themselves because staff is not able to get to the resident in time. An interview was conducted with a LPN on (MONTH) 31, 2019, at 11:45 a.m. She reported the residents do not receive the care they need because of the low staffing levels in the building. She stated the facility is always short staffed and she feels the residents' needs are not being met. She reported pool staff will come in for a shift and will not return because of how low the staffing levels are in the facility. She stated the residents will be left soiled for extended periods of time because they are short staffed. An interview was conducted with the Director of Nursing (DON/staff #53) on (MONTH) 1, 2019 at 8:59 a.m. She stated staff levels are based on census and acuity in the building. She stated staff and family have brought concerns forward regarding staffing. She stated the staffing coordinator attempts to find someone to come in to fill the gap. She stated the facility uses pool staff for CNAs at this time because the facility still needs to fill areas for staffing. She stated there has been turnover since the facility was purchased by a new company. She stated she was aware residents have had to sit in a wet brief or have accidents because there is not enough staff on duty to meet the needs of the residents. During an interview with a Registered Nurse (RN) on (MONTH) 1, 2019 at 9:21 a.m., she stated that she is able to complete her medication pass timely when there are adequate levels of CNAs on the floor, but that sometimes, there are not. She said that when this happens, she ends up doing some CNA work and the medication pass is completed late. She said that it is especially difficult on one side of the unit she works because there are residents who have complicated needs such as feeding tubes. Review of the facility assessment revealed, The purpose of the assessment is to determine what resources are necessary to care for residents. This assessment will help make decisions about direct care staff needs, as well as our capabilities to provide services to the residents in the facility. Using a competency-based approach focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The facility assessment further noted the facility's general staffing meets the needs of the residents at any given time. This includes the following: -The facility considers both census numbers and acuity levels that impact staffing needs and therefore, staffs accordingly. -The facility projects census and staffing needs daily, weekly, and monthly. The facility is actively hiring for line staff positions in nursing. When necessary, as needed (PRN) staff or staff overtime is scheduled for additional coverage. -If necessary, the facility has contracts in place for temporary agency personnel for RNs, LPNs and CNAs. A review of the facility's policy states, It is the policy of this facility to provide services by sufficient number on a 24-hour basis to provide nursing care to all resident's . which promotes each resident's physical, mental and psychosocial well-being.
F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident's drug regimen must be free from unnecessary drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to ensure one resident's (#15) drug regimen was free from unnecessary drugs, by failing to provide narcotic pain medication per the physician ordered parameters. The deficient practice could result in the administration of unnecessary pain medication. Findings include: Resident #15 was admitted to the facility on (MONTH) 7, 2019 with [DIAGNOSES REDACTED]. A care plan with a focus on acute back pain was initiated on (MONTH) 8, (YEAR). The goal was for the resident to verbalize adequate relief of pain or ability to cope with incompletely relieved pain through the review date. Interventions included following the pain scale to medicate as ordered, and a pain assessment every shift. A care plan with a focus on opioid medication use was initiated on (MONTH) 20, 2019. The goals were for the resident to be free of adverse reactions related to opioid use, and free from pain or at a level of discomfort acceptable to the resident through the review date. An intervention included to administer the opioid as prescribed. A physician's orders [REDACTED]. Review of the Medication Review Report for (MONTH) 1 2019 - (MONTH) 31, 2019 revealed the following order: [MEDICATION NAME] 650 mg 2 tablets every 4 hours as needed for general pain of 1-3. The quarterly Minimum Data Set (MDS) assessment dated (MONTH) 13, 2019 revealed the resident scored a 15 on the Brief Interview for Mental Status, indicating intact cognition. The MDS also included the resident received opioid pain medication daily. Review of the (MONTH) 2019 Medication Administration Record [REDACTED] August 2: AM shift for a pain level of 6 August 8: PM shift for a pain level of 6 August 9: AM shift for a pain level of 4 August 15: PM shift for a pain level of 4 August 16: AM shift for a pain level of 5 August 17: AM shift for a pain level of 5 August 18: PM shift for a pain level of 5 August 19: AM shift for a pain level of 0; and PM shift for a pain level of 5 August 22: PM shift for a pain level of 0 August 23: PM shift for a pain level of 4 August 25: AM shift for a pain level of 4; and PM shift for a pain level of 6 August 29: AM shift for a pain level of 5 August 30: AM shift for a pain level of 4; and PM shift for a pain level of 5 Review of the (MONTH) 2019 MAR indicated [REDACTED] September 6: AM shift for a pain level of 6 September 8: PM shift for a pain level of 3 September 12: AM shift for a pain level of 5; and PM shift for a pain level of 6 September 13: AM shift for a pain level of 5 September 23: PM shift for a pain level of 5 September 24: AM shift for a pain level of 5 September 27: AM shift for a pain level of 3; PM shift for a pain level of 1 September 30: PM shift for pain level of 0; later in the PM shift for a pain level of 2 Review of the (MONTH) 2019 MAR indicated [REDACTED] October 2: AM shift for a pain level of 5 October 7: PM shift for a pain level of 6 October 11: PM shift for a pain level of 5; another PM shift for a pain level of 6 October 15: PM shift for a pain level of 6

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F 0757 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) October 17: AM shift for a pain level of 5 October 20: AM shift for a pain level of 0 October 29: AM shift for a pain level of 6; PM shift for a pain level of 0 Review of the nursing notes from August, (MONTH) and (MONTH) 2019 revealed no indication of why the medication was administered outside of the ordered parameters. An interview was conducted on (MONTH) 1, 2019 at 9:07 a. m., with a Licensed Practical Nurse (LPN/Staff #59). He stated he always asks residents for their pain level prior to administering as needed pain medications. Staff #59 stated he checks the parameters on the order prior to administering medications. He said that he would give Tylenol for minor pain. Staff #59 stated that resident #15 knows when she is allowed to have another dose of pain medication, and will ask for it every 6 hours. He stated if he or the nurses try to withhold the medication after she has requested it, she will become angry. Staff #59 stated he has not discussed resident #15's pain medication with the physician. An interview was conducted on (MONTH) 1, 2019 at 9:47 a.m., with the Director of Nursing (DON/staff #53). She stated that she expects all medications to be administered as ordered, and that the nurse should contact the physician if a resident is requesting medications outside of the parameters. The DON said she expects the nurses to ask the resident what their pain level is and to only give opioid medications when the pain level is within the ordered parameters. While reviewing the clinical record for resident #15, the DON stated the [MEDICATION NAME] had been given outside of the parameters of the physician's orders [REDACTED]. A policy titled, physician's orders [REDACTED].
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews and policy review, the facility failed to ensure that medications and medical supplies were discarded when expired. The deficient practice could result in residents receiving medications that are less potent, decreasing effectiveness. Findings include: On (MONTH) 31, 2019 at 8:54 a.m., an observation of the La Casitas medication storage area was conducted with the Assistant Director of Nursing (ADON/staff #10) and the Director of Nursing (DON/staff #53). The following expired items were observed on the shelf and were available for resident use: -4 bottles of hand sanitizer (4 ounces) with an expiration date of (MONTH) 2019 -1 half box of safety needles 25 G x 1 inch (approximately 50-60) with an expiration date of (MONTH) 2019 -2 bottles of hydrogen peroxide 3% strength, one bottle had an expiration date of (MONTH) 2019 and the other one had an expiration date of (MONTH) 2019. On (MONTH) 31, 2019 at 9:41 a.m., an observation of the Desert Sunrise medication room was conducted with a Licensed Practical Nurse (LPN/staff #54). The following expired items were observed on the shelf and were available for resident use:-2 bottles of hand sanitizer (4 ounces) with an expiration date of (MONTH) 2019 -Argenaid powder (supplement) 1 box (approximately 14 packets) had an expiration date of (MONTH) 15, 2019 An interview was conducted on (MONTH) 31, 2019 at 9:44 a.m., with a licensed practical nurse (LPN/staff #54). She stated that when the nurses come in for supplies, they are supposed to monitor for expired items. She stated that it is every nurses' responsibility to identify and dispose of expired products. She said if a nurse finds an expired product on the shelf, they are supposed to throw them into the trash or into the sharps container. She said if a nurse finds a medication that is expired, they should send it back to pharmacy. On (MONTH) 31, 2019 at 10:19 a.m., an observation was conducted of the Serenity Springs medication storage area, with the DON. Review of the medication refrigerator temperature log revealed no documentation of the refrigerator temperature on the following dates in (MONTH) 2019: (MONTH) 1, 2, 4, 5, 9, 10, 15, 16, 23, 24 and 25. An interview was conducted on (MONTH) 31, 2019 at 10:35 a.m., with the DON. She stated that her expectation is for the nurses to take the expired products out of circulation and re-order if needed. She said that all of the nurses are responsible to ensure there are no expired products on the shelves for resident use. She stated the facility has two unit managers that go through the over-the-counter products and dispose of expired products. The DON further stated that it was her expectation for the refrigerator temperature logs to be completed on a daily basis. On (MONTH) 31, 2019 at 10:40 a.m., an observation of the Serenity Springs medication cart #2 was conducted with a LPN (staff #58). The following expired medications/items were in the medication cart and available for resident use: -[MEDICATION NAME] 0.12% (antiseptic) oral rinse with an expiration date of (MONTH) 17, 2019 -triple antibiotic ointment, 1 tube with an expiration date of (MONTH) 2019 -1 bottle of hand sanitizer (4 ounces) with an expiration date of (MONTH) 2019 On (MONTH) 31, 2019 at 12:03 p.m., an observation of the Desert Sunrise South hall medication cart was conducted with a Registered Nurse (RN/staff #94). The following medications were in the medication cart and were available for resident use: -folic acid 400 microgram (vitamin) tablets with an expiration date of (MONTH) 2019 -[MEDICATION NAME] 25 mg (antidepressant), approximately five tablets which was labeled with a resident's name and had an expiration date of (MONTH) 2019 Review of the facility's Medication Access and Storage policy revealed to store all drugs and biologicals in locked compartments, under proper temperature controls. The policy stated that medications requiring refrigeration or temperatures between 36 degrees F and 46 degrees F are kept in a refrigerator, with a thermometer to allow temperature monitoring. The policy also stated that outdated, contaminated or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medication destruction and reordered from the pharmacy, if a current order exists.
F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview, and policy review, the facility failed to ensure the clinical record was complete regarding medications for one resident (#39).The deficient practice could result in residents' clinical records not being complete. Findings include: Resident #39 was admitted on (MONTH) 30, (YEAR) with [DIAGNOSES REDACTED]. Review of the Medication Administration Records (MARs) for August, September, and (MONTH) 2019 revealed no documentation for multiple medications which included insulin, diuretic, and opioid [MEDICATION NAME] medications. Review of the clinical record revealed no documentation to indicate if the medications were administered, held, or refused. On (MONTH) 1, 2019 at 9:01 a.m., an interview was conducted with the Director of Nursing (DON/staff #53). The DON stated her expectation is for the nurses to document medications were administered or write a progress note in the resident's clinical record providing a rationale why the medication was not administered. She said the incomplete documentation did not meet her expectation. The facility's policy regarding Medication Administration revealed it is the policy of this facility that medication records shall reflect the administration as prescribed by the physician. The nurse who administers the medication shall record his/her initials in the appropriate box on the medication record. When a routine medication is refused by the resident or withheld, the nurse must document the reason. The policy also included when routine pertinent medications, such as cardiac, blood pressure, antibiotics, etc., are withheld or refused by the resident for two doses, the attending physician shall be

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F 0842 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 6) notified.
F 0868 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Have the Quality Assessment and Assurance group have the required members and meet at least quarterly** Based on concerns identified during the survey, review of the facility assessment, staff interviews and policy review, the Quality Assessment and Assurance (QA) committee failed to identify quality concerns related to sufficient staffing and provision of care, and implement corrective action and monitoring to correct the issues. The deficient practice resulted in quality care concerns not being identified and corrected. Findings include: During the survey, concerns were identified regarding a lack of sufficient staffing to meet the needs of multiple residents. The concerns included interviews with multiple residents who stated that at times call lights were not answered timely, anywhere from 30 minutes up to three hours. Concerns also included two residents who did not receive adequate showers and two residents who did not receive adequate incontinence care. Multiple staff were also interviewed and reported that there were not enough staff to meet the needs of the residents. An interview was conducted with the Administrator (staff #8) and the Director of Nursing (DON/staff #53) on (MONTH) 1, 2019 at 2:30 p.m. Staff #8 stated that prior to (MONTH) 1, 2019, the staffing for the facility was much different, as the staffing numbers were not sustainable and therefore had to be changed. She said when the facility changed ownership in (MONTH) of 2019, multiple staff members quit and they had to use agency staff to fill the open shifts. She stated that she had received concerns from residents and families regarding increased use of agency staff, concerns regarding the care provided by agency staff and that care needs were not being met. Staff #8 said that they do not have enough of their own staff to deliver quality care and have been trying to hire enough staff since (MONTH) 2019. She said that she has concerns about whether the agency staff ignore the call lights, provides the resident cares, and will show up to work. The DON stated that when she started at the facility in (MONTH) 2019, she identified a concern with customer service as the resident families were upset at the new ownership and the use of agency staff. As a response, she stated that the facility made a goal to cease using agency CNA's by (MONTH) 15, 2019. She stated that in the latter part of August, she had received concerns from three to four residents stating that they did not receive their showers as scheduled. She stated that she did not link the issue to not having enough staff, as she thought it was a breakdown in communication and documentation. The DON further stated that she received concerns regarding quality of staff and provision of care in early September, but has not received any concerns about staffing and provision of care from the resident counsel members, but a family member brought up a concern about a call light not being answered by agency staff last week. The facility was unable to provide any documentation that the above issues had been identified in QA , and that a plan had been developed and implemented, and that ongoing monitoring was done to correct the concerns. Review of the facility assessment dated (MONTH) 4, 2019 revealed the facility will conduct, document and annually review a facility wide assessment, which includes both the resident population and the resources the facility needs to care for its residents. The purpose of the assessment is to determine what resources are necessary to care for residents competently during both day-to-day operations and emergencies. Per the assessment, it will help make decisions about direct care staff needs, as well as our capabilities to provide services to the residents in the facility. Using a competency based approach, focuses on ensuring that each resident is provided care that allows the resident to maintain or attain their highest practicable physical, mental, and psychosocial well-being. The assessment included that types of care provided by the facility include bathing/showers, incontinence prevention and care, and responding to requests for assistance to the bathroom/toilet promptly, in order to maintain continence and promote resident dignity. Staffing needs are based on the projected resident population and their needs for care and support to ensure there is sufficient staff to meet the needs of the residents at any given time. Review of the facility's Quality Assurance policy revealed the plan is a data-driven and proactive approach to quality improvement, in which all staff and residents are involved in continuously identifying opportunities for improvement. The policy included that gaps in systems are addressed through planned interventions with a goal of improving the overall quality of life and quality of care and services delivered to nursing home residents. The facility will partner with each resident, their family, and/or advocate to achieve their individualized goals and provide care and when the need is identified, we will implement corrective action plans or quality improvement projects to improve processes, systems, outcomes, and satisfaction. The policy further included that the facility continually identifies opportunities for improvement and uses criteria to prioritize opportunities including: aspects of care occurring most frequently or affecting large numbers of residents and resident/family expectations/complaints.