STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035064	A. Building B. Wing	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Foothills Rehabilitation Center	2250 North Craycroft Road Tucson, AZ 85712

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47911 Based on observation, clinical record review, staff interviews and policy review, the facility failed to provide incontinence care for one resident (#2). The deficient practice could result in an increased risk for resident discomfort and or infection. Findings include: Resident #2 was admitted on [DATE] with diagnosis including end stage renal disease, surgical aftercare on the circulatory system, type 2 diabetes with diabetic neuropathy, chronic diastolic congestive heart failure, chronic pain syndrome, and major depressive disorder-recurrent. A review of the admission MDS (minimum data set) dated July, 18, 2023 revealed no noted BIMS (brief interview of mental status) score. A review of the resident's care plan revealed that the resident required a one person assist for all activities of daily living to include toileting and hygiene. The care plan further revealed that the resident had the potential for skin breakdown and pressure related injuries due to the normal aging process and incontinence, further noting that the resident needed staff assistance with bed mobility, transfers and toileting. A review of the skin assessments in the resident's electronic health record revealed no evidence of skin breakdown as related to incontinence care. A review of the facility's 5-day investigation revealed that staff #11 (CNA-certified nursing assistant) and the resident's former roommate (no longer at the facility) observed that staff #190 (CNA) left resident #2 sitting on the side of the bed, while taking the roommate to lunch, during which time resident #2 had been left soiled and not changed. It was further noted that the roommate stated that the staff member had told resident #2 to just sit on the edge of her bed, because her briefs were dirty and then walked out of the room. The facility's investigative report noted that staff #190 did not follow the facility policy and procedure for caring for residents and further noted that the resident felt a little bit abused. The 5-day investigative reported noted no injuries to the resident. A telephone call was placed on December 4, 2024 at 10:50 A.M. to staff #11, transportation coordinator, left message on voicemail. No return call received. (continued on next page)

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

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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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on December 4, 2024 at 11:01 A.M. with resident #2. The resident stated that she recalled that incident where she had been cursed out by the staff member and had been left soiled sitting on the side of the bed. She stated that she had been left soiled, sitting on the side of the bed for about 30 minutes or maybe a bit longer. She further stated that she recalled staff #190 screaming at her but could not recall what she had said. The resident reported no resulting skin breakdown. Resident #2 stated that she felt embarrassed at the time, but feels safe and well-cared for currently. An interview was conducted on December 4, 2024 at 11:05 A.M with a licensed practical nurse (LPNstaff #155). Staff #155 stated that when a resident is soiled, the resident has to be changed right away-generally within a few minutes. She stated that the risk for not changing residents promptly could include skin breakdown. An interview was conducted on December 4, 2024 at 11:10 A.M. with a Certified Nursing Assistant (CNA/staff #10) and another CNA (CNA/staff #88). Staff #88 stated that it generally only takes a few minutes to attend to a resident's call light, and if she was unable to attend to the resident right away, she would alert one of her co-workers to assist. Staff #10 stated that if a resident's incontinence was not addressed promptly, then the risk could be at risk for skin breakdown. Both CNA's stated that the maximum time for call light response is about 10 minutes and that each CNA generally has about 7-8 resident's to care for. Neither reported any staffing concerns. An interview was conducted on December 4, 2024 at 11:16 A.M. with an LPN nursing manager (LPN/staff #69). Staff #69 stated that the expectation is that a resident is changed right away when soiled, to ensure that waste does not remain on the resident's body. Staff #69 stated that this is why aids conduct rounds. Staff #69 further stated that it would not meet his expectations if staff did not attend to a soiled resident right away or ensure that another staff member was able to assist. Staff #69 stated that the risk for a resident remaining soiled for extended periods could include moisture associated skin disease or skin breakdown. A telephone call was placed to former staff #190 (CNA) on December 4, 2024 at 11:25 A.M. A message was left requesting a call back; however, the former staff member did not return the call. An interview was conducted on December 4, 2024 at 11:38 A.M. with the Director of Nursing, (DON/staff #50) and the Administrator (admin/staff #76). When asked if 30 minutes met the DON's expectation for a resident wait time to be changed when soiled, staff #50 stated that 30 minutes was a long time and that her expectation is that staff reach out to other staff to ensure that residents are changed timely. Staff #50 further stated that the risk for a resident being soiled for 45 minutes, as noted in the facility's 5-day investigative report for resident #2, is skin breakdown. A review of the facility policy entitled Perineal Care revised October 2023, revealed that the purpose of the procedure is to ensure cleanliness and comfort to the resident, and prevent infection and skin irritation.