STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035183	A. Building B. Wing	02/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AZ - 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 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Plan the resident's discharge to meet the resident's goals and needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure a Peripherally Inserted Central Catheter (PICC) line was discontinued when not required prior to, or at time of, discharge for one of three Residents (#1). The deficient practice could result in residents utilizing the PICC line inappropriately or getting infection if not prope. Findings include: Resident #1 was admitted to the facility on [DATE] with diagnoses that included sepsis, psychoactive substance abuse, depression, and anxiety. An order was initiated on January 23, 2025 to flush the PICC line right upper extremity (RUE) before and after use of intravenous IV medications. An order was initiated on January 23, 2025 to do PICC line care and dressing changes. An order initiated on January 24, 2025 revealed that Resident #1 ' s opioid risk was high risk. An order initiated on January 24, 2025 revealed that upon discharge, the facility should have removed the negative pressure wound therapy (NPWT) dressing and discarded it, as well as removed the canister from the device and placed the device in a clear plastic bag to be placed in the med room. There was no evidence of an order to remove Resident #1 ' s PICC line in the clinical record. An assessment utilizing the opioid risk tool was conducted on January 24, 2025 which revealed that Resident #1 had a personal history of substance abuse of illegal drugs. A care plan initiated on January 24, 2025 revealed a focus on the potential for an adverse outcome from opioid use because of her history of opioid abuse or other substance abuse. The care plan also revealed a focus on IV antibiotic therapy with an intervention for RUE PICC line care as ordered with no evidence of a revision to that intervention. The care plan revealed focuses on fall risk, pain, dehydration, ADL self care performance deficit, the risk for impaired cognitive function or impaired thought processes, and the potential for a psychosocial well-being problem all due to opioid dependency, psychoactive substance abuse, depression, and homelessness. The care plan also revealed a focus on the resident ' s wish to be discharged to their home. (continued on next page)

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.

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

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A weekly skin assessment conducted on January 30, 2025 at 6:39 p.m. indicated that the resident had a wound vac on her left foot and a PICC RUE line. A progress note dated January 31, 2025 revealed that the resident was discharged on January 31, 2025 at 2:30 p.m. via wheelchair, and that she left without signing her discharge summary. It was revealed that the resident left with the wound vaccuum in place and that the resident was alert and oriented and could communicate her needs well. The Discharge Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident's Brief Interview for Mental Status (BIMS) score was 14, which indicated intact cognition. A Discharge summary dated [DATE] and signed by the Director of Nursing (DON/Staff#22) revealed that the resident was discharged to a shelter. The skin assessment portion of the discharge summary remained blank and indicated not available na for the need for ongoing treatment, treatment ordered, and other treatments or skin care. The discharge summary revealed that discharge instructions were given to the resident and her personal belongings were sent with her, the resident needed to follow up with wound care, and that her insurance ended on January 31, 2025. An interview was conducted on February 5, 2025 at 11:54 a.m. with a social worker at the hospital (Hospital Social Worker/Staff#507) who stated that a patient came into the emergency room on February 2, 2025 after being homeless following her discharge from the facility. The social worker stated that the resident was discharged from the facility with a PICC line and a history of substance abuse, including methadone. The social worker stated that when they asked Resident #1 about the PICC line she stated the facility did not remove it, and she still had it in. An interview was conducted on February 5, 2025 at 12:37 p.m. with an emergency room physician (emergency room Physician/Staff#398) who stated that she was the physician working at the hospital at the time the resident came into the emergency room on February 2, 2025 and that she did the initial assessment of Resident #1. The physician stated that Resident #1 claimed she was discharged to a shelter from the facility and that they did not have space for her when she arrived. The physician stated that the nurses witnessed and documented a PICC line in the right upper extremity of Resident #1 upon her admission to the hospital. An interview was conducted on February 5, 2025 at 2:18 p.m. with a Licensed Practical Nurse (LPN/Staff#57) who stated that on the day of discharge, the PICC line would be removed from residents with a PICC line. The LPN further stated that residents would not be discharged with a PICC line in place. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 5, 2025 at 2:25 p.m. with the Director of Case Management (DOCM/Staff#77) who stated that when a resident ' s coverage would run out she would try to find a discharge location that works for them, and if a resident had substance abuse problems she would try to get placement. Staff #77 stated that when the facility discharged residents to shelters, they would look at whether or not a resident was alert and oriented because they wouldn't know if there would be a spot at the shelter when they were discharged and there was no way to communicate with the shelter. Staff #77 stated that in Resident #1's case, her coverage was ending on January 31, 2025, the doctor changed the antibiotics from IV antibiotics to PO (by mouth), and that the facility could not send residents with a wound vac if they did not have a place to live. Staff #77 stated that they changed Resident #1 from IV to PO antibiotics because they, would have had to keep her if they did not. Staff #77 stated that it would be dangerous to discharge a resident with a PICC line who had a history of drug abuse. Staff #77 stated that if a resident was discharged with a PICC line left in place, it would indicate an unsafe discharge. An interview was conducted on February 5, 2025 at 2:32 p.m. with a Registered Nurse (RN/Staff#23) who stated that a resident being discharged would need their PICC line removed by a registered nurse before discharging. A telephonic interview was conducted on February 5, 2025 at 3:48 p.m. with a License Practical Nurse (LPN/Staff#66) who stated that his role in the discharge process was to check for wounds, sign the discharge summary, initiate a discharge progress note, document the time the resident left and what they signed, document if the resident took prescriptions, who was taking the resident, and how they left. Staff #66 stated that if he removed a PICC line he would document in the progress note that it was removed. The LPN also stated that there needed to be an order to remove the PICC line. The LPN stated that he had removed a PICC line before, but never at this facility and he stated that it was important to remove a PICC line to avoid problems with infection and to prevent residents from using it for their own purposes like drug abuse. The LPN further stated that he worked with Resident #1 the morning she was to be discharged and he was unsure of why she was moved from IV to PO antibiotics. The LPN relayed that when he got to Resident #1's room to discharge her, she was nowhere to be found, but he did not want to say she was lost. He further stated that at that time he spoke with a staff member at the front desk who stated that they witnessed the resident leaving with the wheelchair and getting into a vehicle. The LPN stated that he does know if the resident left against medical advice because, someone told me (Staff #66) she (the resident) was smoking downstairs by the chapel. Staff #66 further stated that he did not report it to anyone because his, schedule was busy that day, and he did not tell anyone that Resident #1 left without a skin assessment. The LPN stated that he did not remove Resident #1's PICC line prior to her discharge and that he would call it an unsafe discharge if a resident discharged into the community with a PICC line in place and a history of substance abuse. (continued on next page)

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F 0660 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on February 5, 2025 at approximately 4 p.m. with the Director of Nursing, (DON/Staff#22), who confirmed that the resident was discharged with a PICC line. The DON stated that the nurse let Resident #1 know she would be discharging and that she needed to come back to see him. The DON stated that the facility knew Resident #1 left with the PICC line in place because she was on IV antibiotics at the facility. The DON further stated that the facility did have patients who would leave against medical advice in the past; and that, the process would be to call the police, but the police told the facility they are, no longer taking those calls. DON stated that the discharge for Resident #1 was considered a completed discharge and was not considered an against medical advice (AMA) discharge. The DON stated that the facility called the resident a ride for transportation to the shelter, and that they don't know if Resident #1 got into the vehicle. The DON stated that discharging Resident #1 with a PICC line would be a safe discharge because she was alert and oriented, and could leave if she chose to. The DON then stated that you cannot safely discharge to the community a resident with history of drug abuse with a PICC line.