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	05/07/2025

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 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, clinical record review, resident and staff interviews, and review of facility policy, the facility failed to ensure one (#5) of three sampled residents' choices regarding personal hygiene care were considered and honored in regard to shower preferences. The deficient practice could result in residents not having their choice in personal preferences that are significant to them. Findings include: Resident #5 was admitted to the facility on [DATE] with diagnoses that included metabolic encephalopathy, urinary tract infection, and end stage renal disease. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. Review of the care plan revealed a problem focus initiated on September 10, 2024, which revealed that the resident could be resistive to care, such as refusing showers. Interventions in place included allowing the resident to make decision about treatment regime to provide a sense of control, providing consistency in care to promote comfort with Activities of Daily Living (ADLs) as much as possible, and providing the resident with opportunities for choice during care provision. Review of the bathing charting in the Electronic Health Record (EHR) revealed that from April 7, 2025 to May 6, 2025, Resident #5 received one shower, two sponge baths, and one full-body bath. At that time period, there were three documented instances of the resident refusing, on April 9, April 16, and April 30 of 2025, which all were on Wednesdays. Review of the provider order dated March 14, 2025 revealed that Resident #5 received dialysis three times a week on Monday, Wednesday, and Friday. (continued on next page)

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the shower sheets for February 2025 through May 4, 2025 revealed that Resident #5 received six showers, nine bed baths, and refused ten showers. Of the ten documented refusals, eight of these were on Wednesdays, which was one of the resident's scheduled dialysis days. Review of the shower sheet dated Wednesday, April 2, 2025, revealed that the staff documented that the resident left before a shower could be completed. There was no evidence found that a shower was completed or attempted again until April 6, 2025. Additionally, review of the shower sheet dated April 9, 2025 revealed a comment from staff that indicated that the resident had refused her shower; and that, stated she did not want to go outside after shower because she was concerned about developing pneumonia. Review of the progress notes revealed psychiatric notes, from December 2024 to the most recent note dated April 22, 2025. These notes revealed that the resident had been documented by staff to occasionally refuse showers. There was no evidence found in the progress notes that the resident had been asked about why she had refused. An interview was conducted on May 6, 2025 at 10:07AM with Resident #5, who stated that she did not like her shower schedule. She explained that one of her scheduled shower days fell on Wednesdays, which was a day she was also scheduled for dialysis outside of the facility. The resident explained that she normally leaves for dialysis between 08:00AM and 9:00AM and she does not return to the facility until 3:00 or 4:00PM. The resident further explained that she does not want to go out to dialysis with wet hair, so she often denies a shower on Wednesday mornings when staff offer her a shower. The resident stated she had told multiple staff that she does not like showering on dialysis days, but claimed that none of the staff have done anything to change her shower schedule. Interview was conducted on May 7, 2025 at 10:50AM with a Certified Nursing Assistant (CNA/Staff #16), who confirmed that Resident #5's shower days were Sundays and Wednesdays during the day shift. The CNA stated that Resident #5 could take showers, but had lately been preferring to do bed baths instead. The CNA also stated that staff attempt to shower Resident #5 before dialysis because she is often tired after dialysis. The CNA stated that Resident #5 will sometimes say that she does not want to shower before going to dialysis because she does not want to get sick with pneumonia again. The CNA then stated that the resident is particular in her wants, as she will often deny her shower before dialysis, but she almost always gets up for her smoke breaks. The CNA stated that she felt there was time to complete Resident #5's showers before dialysis, as her transportation does not arrive until around 0830AM, however Resident #5 often does not want to get up or she gets cold. When asked what is done for a resident that is frequently refusing baths, the CNA explained that the staff will attempt to talk to the resident and offer to do a bed bath instead. The CNA stated that a shower is always offered first, and if the resident refuses, the staff should document on the shower sheets that a shower was offered and the resident chose a bed bath instead. The CNA also explained that each room is assigned a shower date and time, though staff attempt to accommodate if the residents have preferences. She also stated that if a shower is missed due to an appointment, staff would attempt to complete later that day or the following day. (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 7, 2025 at 11:35AM with a Licensed Practical Nurse (LPN/Staff #33) who stated that Resident #5 decides what she wants to do regarding her care, including showers. The LPN stated that the resident will often be tired the day of and the day after dialysis. The LPN explained that Resident #5's shower times were Sundays and Wednesdays between 6:00AM and 2:00PM. She stated that the resident's transportation normally arrives between 08:30AM and 09:30AM. The LPN explained that staff attempt to provide showers before her dialysis. The LPN also stated that the resident will sometimes refuse, stating that she does not want her hair to be wet when going to dialysis. The LPN stated that she had attempted to tell the resident that she could get a shower without wetting her hair, but the resident did not accept. Interview was conducted on May 7, 2025 with the Director of Nursing (DON/Staff #18) who stated that resident preferences are considered when implementing the facility shower schedule. The DON also stated that some residents may have dialysis or appointments on their shower days, and if this was the case, staff discuss with the resident if they would like their shower moved to another day. The DON stated that if a resident was noted to frequently refuse showers, staff would discuss with the resident to ask for the resident's preferences, and staff would see if the preferences could be accommodated. When asked if she was aware of Resident #5's preference to not have showers on dialysis days, the DON stated she was unsure if the concern had been brought up to any management, but stated that staff did not bring up shower concerns during the weekly interdisciplinary team (IDT) rounds. Review of the facility policy titled, ADL's - hygiene, grooming, toileting, bathing, oral care, dressing, grooming, mobility, transfers, ambulation, etc. (Revised July 2025), revealed that residents should be involved in decision making and given choices related to ADL activities as much as possible.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, clinical record review, staff interviews, and review of facility policy, the facility failed to ensure one (#2) of four residents reviewed for pressure ulcers was provided care and services to prevent and safely treat pressure ulcers. The deficient practice could result in the development and worsening of pressure ulcers. Findings include: Resident #2 was admitted to the facility on [DATE] with diagnoses that included (cystitis) inflammation of the bladder, Type two diabetes mellitus, and generalized muscle weakness. Review of the nursing progress note dated April 8, 2025 revealed that on admission, the resident was noted to have a wound to the right heel, which had a clean dressing in place. There was no evidence of other wounds noted at this time. Review of the Initial Admission Record revealed that on April 9, 2025, the resident was observed to have a right heel wound. There was no evidence of any other wounds or skin impairments at that time. Review of Resident #2's care plan revealed a problem focus, initiated on April 9, 2025, that revealed that the resident had a pressure ulcer or potential for pressure ulcer development. The goal in place for this focus was that the resident would have intact skin, free of redness, blisters, or discoloration through the review date. Interventions in place for this focus included: weekly head to toe skin assessments; informing the resident, family, and caregivers of any new areas of skin breakdown; and monitoring, documenting, and reporting to the Medical Doctor (MD) any changes in skin status. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the nursing notes revealed a note dated April 20, 2025, which indicated that Resident #2 was noted to have a superficial popped out blister at the sacral area with redness on surrounding skin. The note revealed that the area was about one and a half inches in diameter. The nurse indicated that they had cleansed the area and applied a healing cream to avoid irritation. There was no evidence found in this note that the medical doctor (MD) had been notified or new orders were ordered to administer treatment. There was no evidence found to indicate what type of cream treatment was applied to the wound. An interview was conducted on May 7, 2025 at 10:50AM with a Certified Nursing Assistant (CNA/Staff #16), who stated that if she noticed a new skin impairment on a resident, she would let the nurse know and contact the wound nurse to determine if it was a new skin impairment. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on May 7, 2025 at 1:00PM with the Registered Nurse (RN/Staff #24) who initially noted the new skin impairment. The RN described that he had noticed on April 20, 2025, that Resident #2 had a sore on his bottom, which he described as a red open area with tearing skin, about a one-inch area. The RN stated that he had never seen a bed sore prior to this, but stated that he knew that they often started with a blister. The RN detailed that he had applied a cream to the wound when he noticed it. The RN could not identify the name of the cream he had used, but knew that the CNAs often used the cream for patients with bedsores. When asked if staff should obtain an order to apply a treatment to a wound, the RN explained that he did not think the treatment would require an order, as he believed this was a treatment he could begin and notify the MD after. The RN stated that he had spoken to his Director of Nursing (DON) about this case this morning, May 7, 2025, and understood that he had failed to follow protocol with this case. An interview was conducted on May 7, 2025 at 2:34PM with the wound care Registered Nurse (RN/Staff #27), who stated that she was not aware of Resident #2's new skin impairment, which was noted on April 20, 2025. The RN explained that she was on vacation at that time, so the DON was covering her job at the time. The RN reviewed the nursing note in which the skin impairment was described, and the RN stated that the wound described could be a potential pressure ulcer or it could be a skin tear. An interview was conducted on May 7, 2025 at 4:10PM with the Director of Nursing (DON/Staff #18), who stated that she would expect that if staff noticed a change of condition, the staff should notify the provider, who would give instruction on what to do next. She stated she would then expect staff to follow any new orders, notify family, and document the change of condition. When asked if she felt that Resident #2's new noted skin impairment on April 20, 2025 would be considered a change of condition, the DON stated it was potentially a change of condition, depending on what type of open area was discovered. When asked if she could determine what type of treatment was applied by the nurse, the DON stated that she would assume the nurse applied a protective barrier cream with zinc. The DON stated that the nurse should have notified the wound care nurse and put in a nursing note upon discovering the skin impairment. When asked if the DON felt this wound could have potentially been a pressure ulcer developing, the DON denied that this was a pressure ulcer, stating that the nurse had the skills to assess and determine the nature of the wound, though the wound nurse should have been notified. Review of the facility policy titled, Wound Management (reviewed June 2024), revealed that once a wound has been identified, assessed, and documented, nursing shall administer treatment to each affected area per the Physician's order. The policy also indicated that all wound or skin treatments should be documented in the resident's clinical record at the time they are administered. Review of the facility policy titled, Change of Condition Reporting (reviewed June 2024), revealed that all changes in resident condition will be communicated to the physician and resident representative and documented.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50553 Based on observation, clinical record review, staff interviews, and review of facility policy, the facility failed to ensure one (#4) of three sampled residents was provided respiratory care consistent with professional standards and highest practicability of care. The deficient practice could result in respiratory complications. Findings include: Resident #4 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus, hypertension, and heart failure with preserved ejection fraction. Review of the Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 12, indicating moderate cognitive impairment. Review of the care plan revealed no evidence of oxygen use or needs and no evidence of the resident having a focus related to respiratory issues. Review of the progress notes revealed Physician and nurse practitioner (NP)/physician asssistant (PA) progress notes from November 2, 2024 to November 27, 2022 which recommended supplemental oxygen use to keep oxygen saturation (the amount of oxygen circulating in your blood) percent greater than ninety-two percent. Review of the documented oxygen saturations revealed that all oxygen saturations documented included that the resident was on room air, indicating oxygen was not being administered during the reading. Additionally, the documentation revealed eight oxygen saturation readings that were less than or equal to ninety-two percent: November 27, 2024 14:37 82.0% Room Air November 27, 2024 06:55 91.0% Room Air November 25, 2024 07:26 92.0% Room Air November 21, 2024 07:37 92.0% Room Air November 20, 2024 21:12 82.0% Room Air November 20, 2024 06:50 86.0% Room Air November 18, 2024 08:26 90.0% Room Air November 17, 2024 21:13 80.0% Room Air There was no evidence found that the staff re-checked oxygen saturation following these low oxygen saturation readings, or that oxygen was applied. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Further review of the nursing progress notes revealed multiple daily skilled notes (dated November 18, November 19, November 20, November 21, November 25, November 27 of 2024) which included vital signs for Resident #4. In these notes, the recorded oxygen saturation were less than ninety-two percent, and the note indicated that the resident was on room air. There was no evidence found that the provider was notified of these lower readings. Review of provider orders revealed no evidence that oxygen was ordered for Resident #4. Review of the Medication Administration Record (MAR) and Treatment Administration Record (TAR) for November 2024 revealed no evidence that oxygen was ordered or administered to Resident #4. A telephone interview was conducted on May 6, 2025 at 8:32AM with Resident #4's family member, who revealed that she had noticed on multiple occasions, during her stay, that Resident #4 had difficulty breathing. The family expressed that she would tell the staff about the respiratory issues the resident was having, but felt that the staff brushed her off. The family member stated that the facility did not provide Resident #4 with oxygen when Resident #4 was experiencing respiratory distress. A interview was conducted on May 6, 2025 at 08:55AM with a Certified Nursing Assistant (CNA/Staff #7) who stated that if she noticed a resident was in respiratory distress, she would sit them upright to help them breathe better. She stated that if the resident had orders for oxygen, she would ensure the oxygen was on and did not fall off. The CNA stated that she would then call the nurse. Interview was conducted on May 7, 2025 at 1:00PM with a Registered Nurse (RN/Staff #24), who stated that if a negative change in a resident's condition was noticed, he should notify the provider and colleagues. The RN further explained that if the change was emergent, such as one that disrupted the resident's vitals, this would require immediate intervention and he would call his supervisor for assistance. A interview was conducted on May 7, 2025 at 4:10PM with the Director of Nursing (DON/Staff #18), who stated that she would expect that during a change of condition, the staff should notify the provider, who would give instruction on what to do next. She stated she would then expect the staff to follow any new orders, notify family, and document the change of condition. The DON also stated that if a resident needs oxygen therapy, the staff should call the provider, obtain an order, and administer oxygen per the order. The DON stated that oxygen should have an order to administer it. The DON also stated that if a resident's oxygen saturation is noted to be abnormally low, she would expect the staff to notify the nurse, who would then assess the patient. She stated she would then expect the nurse to call the provider for orders if the resident showed signs of distress and follow the orders. When reviewing the chart for Resident #4, the DON could not find evidence that the provider was contacted for the low oxygen saturation readings recorded. Additionally, no order was located for oxygen usage. Review of the facility policy titled, Change of Condition Reporting (reviewed June 2024), revealed that all changes in resident condition will be communicated to the physician and resident representative and documented. Review of the facility policy titled, Oxygen Administration (reviewed January 2025), revealed that oxygen therapy should be administered by a licensed nurse as ordered by the physician or as a nursing measure and an emergency measure until the order can be obtained.