

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER AZ - Rio Vista Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, and review of policy and procedure, the facility failed to ensure one of three sampled residents (#6) was provided written notice of discharge as soon as practicable prior to discharge, that the written notice included date and location of discharge, as well as contact information for the state long term care ombudsman, and that the notice of discharge was also sent to the state long term care ombudsman prior to discharge. The deficient practice could result in residents and their representatives being unaware of their appeal and advocacy rights and could prevent the ombudsman from reviewing and advocating for safe and appropriate discharge planning before the discharge occurred.-Findings include:Resident #6 admitted to the facility August 27, 2025, with diagnoses that included osteomyelitis of right femur, peripheral vascular disease, diabetes mellitus, hyponatremia, hyperlipidemia, and arthritis.A Minimum Data Set (MDS) assessment, dated September 2, 2025, revealed Resident #6 had a Brief Interview for Mental Status (BIMS) assessment score of 15, indicating intact cognition.A nurse practitioner (NP)/physician assistant (PA) progress note date October 13, 2025, revealed the resident was seen, was tearful, and did not want to discharge that day. The progress note further documented that the resident was to discharge that day, but elected to private pay for two days pending his state long term care insurance application results.An NP/PA progress note dated October 24, 2025, revealed that the discharge paperwork and prescriptions were completed with a case manager. The note included no evidence that the resident received either verbal or written notification of discharge.A Discharge Summary - nursing note dated October 27, 2026, revealed Resident #6 was to discharge to the homeless shelter on October 28, 2026. The documentation revealed no evidence that this information was provided in writing to the resident.A Required Notification of Interfacility Transfers Infection Control Transfer form dated October 28, 2025, and related discharge documents packet, uploaded into the medical record on October 28, 2025, included a physician order that the resident may discharge to a specified homeless shelter. The documentation revealed no evidence that this information was provided to the resident in writing prior to discharge.A Discharge Summary and Post-Discharge Plan of Care dated October 28, 2025, revealed that the resident was being discharged to a specified homeless shelter on October 28, 2025, and that the resident was provided a donated wheelchair and would receive medications and scripts. The document also included that the resident required ongoing treatment for wound care to bilateral buttocks; to cleanse with wound cleanser or normal saline, pat dry, apply triad paste to wound bed, leave open to air, and to apply every shift and as needed. Lastly, the documentation included the name of the state long term care ombudsman; however, the phone number listed revealed an incorrect phone number for the state long term care ombudsman.An NP/PA note progress note dated October 28, 2025, revealed the resident stated that he was not discharging that day and was (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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	waiting on placement. The plan included for discharge, pending placement per case manager.A Functional Abilities Discharge assessment dated [DATE], revealed Resident #6 was dependent on a caregiver for showering/bathing, putting on/taking off footwear, sit to stand, and toilet transfers. Additionally, the resident required substantial/maximal assistance with oral hygiene and lower body dressing. The documentation revealed the resident required partial/moderate assistance with chair/bed to chair transfers and lying to sitting on the side of the bed.A Nursing note dated October 28, 2025, revealed Resident #6 discharged from the facility at 5:10 p.m. with personal belongings and medications.Review of Resident #6's clinical record revealed no evidence of a Notice of Medical Non-Coverage (NOMNC) document.An email from the social services supervisor (Staff #19) sent on October 31, 2025, to the state long term care ombudsman, which was sent three days after the resident's discharge, contained a discharge report that revealed Resident #6 was discharged to a medical shelter on October 28, 2025, and not the previously specified homeless shelter listed in the resident's Discharge Summary.A written statement submitted to the State Agency (SA) on November 24, 2025 by the state long term care ombudsman, revealed that the ombudsman office received a discharge report from the facility on October 31, 2025, which was several days after Resident #6 had already discharged . Additionally, the statement revealed that the information that the ombudsman's office received from the facility was not accurate, as the discharge list informed the ombudsman's office that the resident was discharged to a medical shelter providing medical care, when the resident was instead sent to a homeless shelter that did not provide medical care or assistance. The statement revealed that the facility did not provide the resident written notice of the discharge prior to the discharge, or orient the resident to prepare for the discharge. The statement revealed that Resident #6 was not notified of where he was going until he was placed in the transportation vehicle by facility staff on October 28, 2025. The statement further revealed that Resident #6 arrived at the homeless shelter at dusk and had to wait in a long line for intake, and then was forced to pack up his belongings and leave the shelter early the next morning.An interview was conducted with the Case Manager Assistant (Staff #66) on July 16, 2026, at 12:54 p.m. Staff #66 stated she was responsible for coordinating resident discharges. She explained that when a resident's insurance coverage ended, she issued a Notice of Medicare Non-Coverage (NOMNC) to the resident or responsible party identifying the last covered day, obtained the required signature, arranged necessary durable medical equipment and transportation, and coordinated discharge planning. If a resident was homeless or the planned discharge location was unsafe, she stated she would involve a placement agent. She further stated that residents who wished to remain in the facility after insurance coverage ended could private pay; however, for private-pay residents, no written discharge notice was provided and discharge notification was communicated verbally.Staff #66 stated the State Long-Term Care Ombudsman's contact information was included only on the discharge summary provided to the resident as the resident was leaving the facility. She stated the facility did not notify the Ombudsman before discharge. Instead, she completed a daily discharge list each evening, and another social services staff member emailed the list of discharged residents to the Ombudsman the following morning. Staff #66 acknowledged that delaying notification until after discharge, and not providing the Ombudsman's contact information before discharge, could prevent the Ombudsman from assisting with appropriate discharge placement and aftercare services.Regarding Resident #6, Staff #66 stated she knew the homeless shelter listed on the discharge summary operated only overnight, required individuals to wait in line each evening for bed availability, and provided no medical or caregiving assistance. She also stated the medical shelter identified on the discharge report sent to the Ombudsman required residents to qualify for admission and provided housing, caregiving, and medical (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	services to eligible individuals. Staff #66 stated she worked with a discharge placement agent for Resident #6. She explained the resident had approximately \$1,500 borrowed from a friend, which was insufficient to pay for placement in a group home, and the funds were instead used to pay for several days of private-pay stay at the facility while staff attempted to secure placement. Staff #66 stated Resident #6 was not provided written notice identifying the date and location of discharge before leaving the facility. She stated the resident was discharged to the homeless shelter identified on the discharge summary, not the medical shelter listed in the report sent to the Ombudsman. After reviewing the clinical record during the interview, Staff #66 stated she was unaware before discharge that Resident #6 required daily wound care. She further confirmed the resident required caregiver assistance with lower-body dressing and footwear and partial to moderate assistance with wheelchair transfers. Based on those care needs, Staff #66 stated discharge to the homeless shelter was not safe or appropriate and placed the resident at risk for falls. When asked why Resident #6 was discharged, Staff #66 stated management informed her the resident no longer had a payer source and needed to be discharged. She also stated that, at the time of Resident #6's discharge, the facility was not sending discharge notices to the Ombudsman before discharge and that notification occurred several days later. A telephonic interview was conducted with Resident #6's emergency contact / friend on July 16, 2026, at 2:53 p.m., who stated that she was not contacted by the facility prior to Resident #6's discharge, and that she was contacted by Resident #6 after he was discharged to the homeless shelter. The friend stated that Resident #6 told her that while he was in the hospital, his roommate passed away and that he had lost his previous living situation. The friend stated that Resident #6 had told her that while he was at the facility, he was attempting to find discharge placement, and suddenly the facility staff told him he was being discharged and put him on transportation to the homeless shelter at the same time. The friend stated that she picked Resident #6 up from the homeless shelter, and that he could barely stand, could not walk, and needed help with dressing and bathing. The friend stated Resident #6 had to go back to the hospital a short time later. A telephonic interview was conducted with Resident #6 on July 16, 2026, at 3:02 p.m., who stated that he did not receive any prior verbal or written notice regarding the date and location of his discharge from the facility on October 28, 2025. He stated that on the day of his discharge, he had been participating in activities, and was informed by staff that his belongings in his room had been packed up by staff, and that he was being discharged, and they brought him outside in his wheelchair and helped him get into the transportation vehicle, and left him with his prescription medications. Resident #6 stated he had to ask the transportation vehicle driver where he was being transported to find out that he was being discharged to the homeless shelter. Resident #6 stated that he was dropped off in front of the shelter and was left unassisted. Resident #6 stated that he could barely stand but could not walk, and could not dress himself or bathe/shower himself. An interview was conducted with the Administrator (Staff #90) on July 16, 2026, at 3:22 p.m. who stated that the facility did not have a policy for notification of discharge. The Administrator stated that the facility uses the NOMNC document as the written notification of discharge. An interview was conducted with the Director of Nursing (DON / Staff #50) on July 16, 2026, at 3:30 p.m. who stated that the case management staff were responsible for providing notification of discharge and setting up a safe discharge. The DON stated that her expectation for notifying a resident of discharge was that the nurse would review the resident's discharge summary with the resident on the actual day of discharge. The DON stated that some nurses review the discharge summary with the resident earlier in the day, while some nurses review the discharge summary just prior to the resident exiting the facility. The DON stated that not all residents receive prior notice of discharge in writing, as some residents receive NOMNC forms, and (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	others do not, depending on the insurance or payor source. Regarding notification to the state long term care ombudsman, the DON stated that the facility used to email a list of residents who had already discharged , including their discharge date and location, after every month; however, the facility staff have since changed their process to send the notice daily after the residents have discharged . The DON stated that she had received no training that the notification to the ombudsman was required to be sent prior to the residents' discharges.The DON stated that due to the Resident #6's payor source, that her understanding was that no notice of discharge needed to be provided in writing. The DON stated that she believed the notification for Resident #6's discharge was provided in the discharge summary and given to the resident at the time of his discharge. The clinical record was reviewed, and the DON stated that the resident's functional abilities for discharge assessment showed the resident required partial/moderate assistance for transfers from bed to chair, and dependent for toilet transfers. The DON stated that based on reviewing the resident's required assistance, that the resident's discharge to the homeless shelter was not safe. The DON declined to state if there would be any risk to the resident if not provided written notice of discharge including the state long term care ombudsman's contact information prior to discharge, and the DON stated that residents were notified verbally prior to their discharge.A telephonic interview was attempted on July 17, 2026, at 9:46 a.m. with the state long term care ombudsman, using the phone contact information provided on Resident #6's discharge summary. The phone number was an incorrect phone number for a different state agency.A telephonic interview was conducted on July 17, 2026, at 11:00 a.m. with the state long term care ombudsman regional director (RD) who stated that she was familiar with Resident #6's discharge from the facility, and that the ombudsman's office did not receive notice of the resident's discharge until several days after the resident had already discharged . Further, the RD stated that the ombudsman's office received incorrect information, that the resident had been discharged to a medical shelter, when in actuality, the resident had been dropped off at a homeless shelter that did not provide any medical or caregiving assistance. Additionally, the RD stated that the ombudsman's office became involved in the resident's case, and that the resident had stated he had received no written notice of discharge prior to the time he was being escorted out of the facility.Review of facility policy titled Admission, Transfer and Discharge, reviewed May 2025 and May 2026, revealed that each resident will remain in the facility, and not be transferred or discharged unless the discharge or transfer is appropriate as per the existing criteria. When the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The policy included that the facility shall permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:(A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;(B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;(D) The health of individuals in the facility would otherwise be endangered;(E) The resident has failed, after reasonable and appropriate notice, to pay for a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission, the facility may charge a resident only allowable charges under Medicaid; or(F) The facility ceases to operate.The policy included no evidence of information regarding notice of transfer or discharge or notification to the state (continued on next page)		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ombudsman.Review of federal regulation S483.15 revealed that before a facility transfers or discharges a resident, the facility must notify the resident and the resident's representative(s) of the transfer or discharge and the reason for the move in writing. Before a facility transfers or discharges a resident, the facility must also send a copy of the notice to a representative of the state ombudsman. The notice must include: the reason for transfer or discharge, the effective date of transfer or discharge, the location to which the resident is transferred or discharge, and the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. Regarding timing of the notice, the notice must be made as soon as practicable before transfer or discharge when the safety of individuals in the facility would be endangered, the health of individuals in the facility would be endangered, the resident's health improves sufficiently to allow a more immediate transfer or discharge, an immediate transfer or discharge is required by the resident's urgent medical needs, or a resident has not resided in the facility for 30 days. Excluding the exceptions specified in the regulation, the notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged .		

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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 observation, interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure quality of care was provided, including that a physician order for a wheelchair cushion was followed, for one of three sampled residents (#10). The deficient practice could lead to skin breakdown or discomfort to the resident. -Findings include: Resident #10 admitted to the facility on [DATE], with diagnoses that included severe morbid obesity, metabolic encephalopathy, type 2 diabetes mellitus, acute respiratory failure with hypoxia, pneumonitis, malignant neoplasm of pancreas, and age-related physical debility. A Clinical admission note dated July 12, 2026, revealed the Resident #10 was alert and oriented x 3, was able to understand and could be understood when speaking. The documentation included that the resident was bedfast all or most of the time, and was very weak and severely debilitated. A Braden Scale for Predicting Pressure Ulcer Risk Evaluation dated July 12, 2026, revealed Resident #12 had a high risk for pressure ulcer development. A physician's order dated July 12, 2026, included a wheelchair cushion every shift. A care plan focus initiated July 12, 2026, revealed Resident #10 had the potential for pressure ulcer development due to pneumonia, sepsis, pancreatic cancer with metastasis, neuropathy, diabetes, muscle weakness, and debility. Interventions included that the resident needed monitoring, reminding, and assistance with turning and repositioning, and to turn and reposition the resident as tolerated. An additional intervention included for a pressure-reducing device in the wheelchair. A Brief Interview for Mental Status (BIMS) Evaluation dated July 14, 2026, revealed Resident #10 had a BIMS score of 15, indicating cognitively intact. A physical therapy (PT) evaluation dated July 13, 2026, and completed by a physical therapist (Staff #96) revealed that Resident #10 required substantial/maximal assistance for rolling left and right in bed, sit to lying, sit to stand, and bed to chair transfers. A physical therapy treatment encounter note dated July 13, 2026, by Staff #96, revealed Resident #10 performed bed mobility with maximal assistance, and performed a transfer with maximal assistance. The note included no evidence specifying whether the resident performed a sit to stand transfer or a bed to chair transfer or other type of transfer. The note included no evidence whether one or two staff were required to assist with the transfer, or if an assistive device was utilized. A PT treatment encounter note dated July 14, 2026, by Staff #96, revealed Resident #10 performed bed mobility with maximal assistance, and performed a transfer with maximal assistance x 2 person. The note included no evidence specifying if the resident performed a sit to stand transfer or a bed to chair transfer or other type of transfer. The note included no evidence if an assistive device such as a walker was utilized. Additionally, the note included that the resident had increased pain with sitting in the wheelchair, but did not include a pain rating, or the resident's time tolerated sitting in the wheelchair. The clinical record revealed that despite an occupational therapy (OT) evaluation documented on July 13, 2026, there was no evidence of an OT daily treatment encounter note for July 13, 2026, nor any OT minutes logged on that date. An OT treatment encounter note dated July 14, 2026, by an occupational therapist (OT / Staff #33) revealed Resident #10 performed a stand pivot transfer from the edge of the bed to the wheelchair with maximal assistance, and with extra time and verbal cues required for hand placement for safety. The note revealed that a sit to stand transfer was attempted in the parallel bars, and the resident was able to clear his hips from the wheelchair, but could not achieve full upright standing, despite maximal assistance of two staff provided. The note also included that the resident required maximal assistance of 2 staff for a stand pivot transfer from the wheelchair to the bed. The documentation revealed that Resident #10 had poor activity tolerance, requiring multiple rest (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	breaks throughout the session. The note did not include any evidence of the resident's tolerance to sitting in the wheelchair or pain level. A weight log dated July 13, 2026, revealed Resident #10 weighed 278.4 pounds. A vital log for pain revealed that Resident #10 had the following numerical pain values: -July 12, 2026, at 9:34 p.m.: 1-July 13, 2026, at 5:08 a.m.: 0-July 13, 2026, at 9:31 p.m.: 1-July 14, 2026, at 5:08 a.m.: 1-July 14, 2026, at 11:05 a.m.: 5-July 14, 2026, at 8:02 p.m.: 3-Review of the Medication Administration Record for July, 2026, revealed Resident #10 was administered Acetaminophen Oral Tablet 325 mg, 2 tablets by mouth for a pain level of 5, on July 14, 2026, at 2:00 p.m. An observation was conducted on July 16, 2026, at 8:56 a.m. of Resident #10 lying in bed in his room. Outside the doorway of his room in the hallway, was a bariatric size wheelchair with no wheelchair cushion. Additionally, the left armrest of the wheelchair was missing the padding piece, and the remaining part of the armrest was a bare metal tube. An interview was conducted on July 16, 2026, at 8:50 a.m., with Resident #10, who stated that he had a horrible experience after his therapy session on July 14, 2026. Resident #10 stated that the day prior, on July 13, 2026, two male therapists, an OT and a PT had come to his room together to complete evaluations. Resident #10 stated that with the two therapists' assistance, he was able to sit on the edge of the bed, and briefly stand with a walker, however was not able to take any steps, nor was he able to transfer to the wheelchair. Resident #10 stated that the next day, on July 14, 2026, an OT (Staff #33) and a PT (Staff #96) had entered his room together at approximately 10:00 a.m., and helped him to stand and shuffle his feet to transfer to the wheelchair. The resident stated that the therapists had not put a wheelchair cushion in the wheelchair, nor was there a hoyer sling in the wheelchair. Resident #10 stated that he went to the therapy gym to complete his session, then the two therapists brought him back to the room at approximately 11:00 a.m. The resident stated that the two therapists had left him sitting in the wheelchair and had informed him that they would return in one hour to assist him with transferring back to bed. The resident also stated that they informed him that they had to go to a therapy staff meeting. The interview with Resident #10 continued, and the resident stated that one hour had passed, and he was uncomfortable in the wheelchair and put his call light on for staff to help him get back in bed. He stated that two certified nursing assistants (CNAs) came to the room, and did not place a gait belt around his waist because they stated they could not find one, and attempted to help him get out of the wheelchair by pulling under his armpit region. Resident #10 stated that the CNAs were unsuccessful in getting him out of the wheelchair. Resident #10 stated he waited in the wheelchair for over another hour for the therapists to come back to the room, at which point he was in 10/10 pain and in tears due to the pain in his bottom, low back, and arm from resting on the bare metal of the wheelchair armrest. The resident stated the pain in his bottom was due to not having a wheelchair cushion in the wheelchair. Resident #10 stated that when the therapists returned to the room, they put a gait belt around his waist and had to use brute force to lift him out of the wheelchair and transfer him back to the bed because he was in so much pain. Resident #10 stated that this painful experience had made him not want to do therapy anymore. An interview was conducted with Resident #10's family member, on July 16, 2026, at 8:54 a.m., who stated that she was at the facility with Resident #10 all day on July 14, 2026, and corroborated Resident #10's statement and stated that she had witnessed the events as he had described, and additionally stated that she took a picture of the wheelchair after Resident #10 finally got out of the wheelchair on the afternoon of July 14, 2026. At that time, Resident #10's family showed a picture of the wheelchair, which revealed the bariatric size wheelchair with no wheelchair cushion, with the left armrest padding missing, and the bare metal tube of the armrest exposed. An interview was conducted with a PT (Staff #96) on July 16, 2026, at 11:01 a.m., who stated that prior to completing a therapy evaluation, he conducts a thorough review of the (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	medical record to become aware of the resident's medical conditions, precautions, and prior level of function. He stated that during the evaluation, he assesses the resident's strength, and how much assistance is required for the resident to complete mobility tasks. Staff #96 stated that if a resident was transferred to a wheelchair, and there was any question of safety for the resident transferring back to bed, he stated that he would give the resident a call light device, and alert nursing staff of the resident's transfer status, and to request help if needed. Staff #96 stated that staff would always use a gait belt when assisting a resident with a transfer, and that placement of the gait belt may change if there was a medical reason such as an incision, however a gait belt would always be used for transfers. The interview with Staff #96 continued, who stated that he completed the physical therapy evaluation along with the occupational therapist who conducted the occupational therapy evaluation at the same time on July 13, 2026. He stated that on July 13, Resident #10 was able to sit on the edge of the bed, and then was able to perform a sit to stand transfer at the side of the bed, with maximal assistance of the two therapists, and using a walker in front of the resident. He stated that the resident could only tolerate standing for 5 seconds, and could not take any steps to get into the wheelchair. The interview continued, and Staff #96 stated that the next day, on July 14, 2026, that the OT (Staff #33) and he went to Resident #10's room for a therapy session. Staff #96 stated that the resident was able to stand and transfer to the wheelchair with maximal assistance from the two therapists. Staff #96 stated that there was not a wheelchair cushion in the wheelchair, nor was there a hoyer lift sling placed in the wheelchair in case the resident could not stand and transfer back out of the wheelchair. The resident was then brought to the therapy gym for the remainder of his treatment session. After the therapy session was over, Staff #96 stated that the two therapists brought Resident #10 back to his room and the therapists requested that the resident try to stay sitting up in the wheelchair, and requested that he use his call light to get assistance to transfer back to bed. Staff #95 stated that after that, the therapists went to a therapy staff meeting that started at 12:00 p.m. Staff #95 stated that during the meeting, a CNA student whom he was not familiar with the student's name, had entered the meeting and informed Staff #96 that Resident #10 wanted to go back to bed. Staff #95 stated that he informed the CNA student that they were in a meeting, and the student left the meeting. Staff #95 stated that the meeting ended at 1:30 p.m., and Staff #96 and Staff #33 went to Resident #10's room after the meeting. Upon entry to the resident's room, Staff #96 stated he observed Resident #10 sitting in his wheelchair and crying. Staff #96 stated that Resident #10 stated that he was in a lot of pain and wanted assistance transferring back to bed, and stated that he wanted a wheelchair cushion, and also stated to Staff #96 that the armrest of the wheelchair was missing the padding piece. Staff #96 stated that he and Staff #33 then assisted Resident #10 with transferring from the wheelchair to the bed with maximal assistance x 2 person, using a gait belt. At the end of the interview, Staff #96 then observed the wheelchair sitting outside Resident #10's room, and stated that it was the same wheelchair that was used for the resident on July 14, 2026, and that it did not have a wheelchair cushion, was missing the left armrest padded piece, and that he had only noticed that the armrest padding was missing when Resident #10 had brought it up to him on July 14. Staff #96 stated that he had not informed anyone that the wheelchair armrest needed repaired. Staff #96 stated that a risk to a resident if padding or cushioning was missing from a wheelchair could be pain, discomfort, or skin breakdown. An interview was conducted with the Director of Nursing (DON / Staff #50) on July 16, 2026, at 3:24 p.m., who stated that the facility staff's process for preventing skin breakdown was to perform an initial skin assessment upon admission, to complete a Braden Scale assessment along with other assessments, and if a resident were determined to be high risk for skin breakdown, then resident-specific interventions would be put (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035183	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2026
NAME OF PROVIDER OR SUPPLIER AZ - Rio Vista Post Acute and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	in place. The DON stated that the importance of following the interventions was to prevent skin breakdown. The DON stated that it was her expectation that staff follow physician's orders, that the physician's orders were where staff get their guidance, and that it was very important for staff to follow them. Regarding wheelchairs, the DON stated that staff would fit a resident with a wheelchair and offer various equipment to the resident as needed, and that if the wheelchair or equipment were broken or missing parts, that it could still be offered to the resident, as long as it was not harmful to the resident. The DON stated that if there was a physician order for a wheelchair cushion, then she would expect staff to follow the order and provide a wheelchair cushion in the wheelchair. Regarding Resident #10, the DON stated that she had not been made aware of any care concerns from the resident. The clinical record was reviewed and the DON stated that Resident #10 had a physician order for a wheelchair cushion dated July 12, 2026, and that it would not meet her expectations if the order was not followed. Review of the facility policy titled Physician Orders, revised May 2021, revealed it is the policy of the facility to accurately implement physician orders in addition to medication, treatment, and procedure orders, only upon the order of a person duly licensed and authorized to do so in accordance with the resident's plan of care. Review of the facility policy titled Specialized Rehabilitative Services, revised May 2021, revealed it is the policy of the facility to provide rehabilitative services to residents as determined by their comprehensive plan of care to assist them to attain, maintain, or restore their highest practicable level of physical, mental, functional and psycho-social well-being. Review of the facility policy titled Comprehensive Person-Centered Care Planning, revised January 2022, revealed it is the policy of the facility that the interdisciplinary team (IDT) shall develop a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. The IDT team will also develop and implement a baseline care plan for each resident, within 48 hours of admission, that includes minimum healthcare information necessary to properly care for each resident and instructions needed to provide effective and person-centered care that meet professional standards of quality care. Review of the facility policy titled Transfers, Types of, revised November 2017, revealed that for a maximal assistance stand pivot transfer, the procedural steps included: 1. The resident slides to the edge of bed, placing feet apart, flat on the floor. 2. Stand facing the resident, grasping the safety belt with both hands at the resident's side. Block the resident's knee. 3. At 1-2-3, stand the resident up by straightening your knees. 4. Pivot the resident, then guide him to sitting position in the chair. The resident's strong-arm position is up to your preference and resident's physical ability. 5. When the resident is in position in front of wheelchair, the resident reaches back to grasp middle of arm rest and lowers himself into wheelchair. 6. Steady the wheelchair as it tends to move even with the brakes locked.		