STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	**08/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	**350 EAST LA CANADA AVONDALE, AZ 85323**

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 0552 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Ensure that residents are fully informed and understand their health status, care and treatments.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review and staff interviews, the facility failed to ensure that one (#85) of two sampled residents/representative was informed of the risks and benefits of an anti-depressant medication, prior to administration. The deficient practice could result in residents/representatives not being fully informed of the risks and benefits of psychoactive medications. Findings include: Resident #85 was readmitted to the facility on (MONTH) 26, (YEAR), with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. A quarterly MDS (Minimum Data Set) assessment dated (MONTH) 3, 2019 revealed the resident had a BIMS (Brief Interview for Mental Status) score of 6, which indicated severe cognitive impairment. Review of a care plan revised on (MONTH) 11, 2019 revealed the resident had a [DIAGNOSES REDACTED]. An intervention was to administer medication as ordered. Review of the clinical record revealed the resident received [MEDICATION NAME] at bedtime in April, May, (MONTH) and (MONTH) 2019. However, there was no clinical record documentation that the resident/resident representative had been informed of the risks and benefits of the medication, prior to being administered. Further review of the clinical record revealed a [MEDICAL CONDITION] Medication Administration Disclosure form was completed on (MONTH) 11, 2019, which was more than two months after the medication was first ordered. The form included the risk and benefits of the medication and it was signed by two providers. An interview was conducted with a licensed practical nurse (LPN/staff #78) on (MONTH) 31, 2019 at 10:16 a.m. Staff #78 stated that prior to the administration of an antidepressant, the resident is informed of the risks and benefits of the medication. Staff #78 stated the [MEDICAL CONDITION] Medication Administration Disclosure form is kept in the front of the resident's clinical record. An interview was conducted with a LPN (staff #67) on (MONTH) 31, 2019 at 12:38 p.m. Staff #67 stated that before a resident is started on an antidepressant, they explain the risks and benefits of the medication to the resident/representative. Staff #67 stated if the resident is able to understand the risks and benefits, they sign the [MEDICAL CONDITION] Medication Administration Disclosure form and it is put in the resident's clinical record. An interview was conducted with the Director of Nursing (DON/staff #113) on (MONTH) 31, 2019 at 1:30 p.m. Staff #113 stated that the [MEDICAL CONDITION] Medication Administration Disclosure form is completed prior to the administration of antidepressants and it explains the risks and benefits. Staff #113 further stated that the facility did not have a policy regarding this.
F 0578 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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, resident and staff interviews, and policy review, the facility failed to ensure an advance directive was formulated and placed in the clinical record for 9 of 12 sampled residents (#18, #21, #27, #28, #32, #66 #85, #86, and #237) and failed to ensure one sampled resident (#129) was provided information about advance directive upon admission. The deficient practice could result in residents receiving services which are not in accordance with their wishes. The census was 151. Findings include: -Resident #27 was readmitted to the facility on (MONTH) 9, (YEAR), with [DIAGNOSES REDACTED]. Review of the care plan meeting notes dated (MONTH) 8 and 13, (YEAR), revealed the resident was a DNR. An annual Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019, revealed a score of 11 on the Brief Interview for Mental Status (BIMS) which indicated the resident had moderate impaired cognition. A care plan meeting note dated (MONTH) 7, 2019 revealed the resident was a DNR. Review of the care plan revised on (MONTH) 22, 2019 revealed the resident had established an advanced directive and the resident was a Do Not Resuscitate (DNR) status. The goal was that the resident or the healthcare decision maker shall participate in decisions regarding medical care and treatment. Interventions included activating the resident's advanced directive as indicated and reviewing the advanced directives with the resident and/or the healthcare decision maker quarterly. Further review of the clinical record revealed a Patient Health Care Instructions form which included sections to choose a code status (full code or DNR) and additional treatment options. However, this form was blank. There was no clinical record documentation that the resident had formulated any advance directives and there was no physician's order for a DNR status. -Resident #237 was readmitted to the facility on (MONTH) 23, 2019, with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 23, 2019 included the resident was a Full code The annual MDS assessment dated (MONTH) 25, 2019 revealed a BIMS score of 14 which indicated the resident had intact cognition. Review of the care plan revealed the resident was a full code. Interventions included activating the advanced directive as indicated and reviewing advance directive with the resident and healthcare decision maker quarterly. Further review of the clinical record revealed the Patient Health Care Instructions form was blank, and there was no documentation that the resident had formulated an advance directive. During an interview conducted with the Director of Medical Records (staff #141) on (MONTH) 30, 2019 at 2:43 p.m., staff #141 stated the Patient Health Care Instructions form was not completed because the resident was a full code. Another interview was conducted with staff #141 on (MONTH) 31, 2019 at 8:10 a.m. Staff #141 stated that no advance directive was formulated because the resident was a Full Code.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	**08/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	**350 EAST LA CANADA AVONDALE, AZ 85323**

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 -** Some	(continued... from page 1) -Resident #129 was admitted to the facility on (MONTH) 5, 2019, with [DIAGNOSES REDACTED]. Review of the physician orders dated (MONTH) 9, 2019, revealed an order for [REDACTED].>Review of the admission MDS assessment dated (MONTH) 12, 2019 revealed a BIMS score of 14 which indicated the resident was cognitively intact. Review of the clinical record revealed no evidence that the resident had formulated an advance directive from admission through (MONTH) 28. Further review of the clinical record revealed a Patient Health Care Instructions form was signed and dated by the resident on (MONTH) 29, 2019. The documentation included that the resident was a full code. On (MONTH) 30, 2019 at 10:59 a.m., an interview was conducted with the resident who stated that he was not provided information about advanced directives until yesterday (July 29). Resident #129 stated that he should have been provided information about advanced directives, when he was admitted to the facility. An interview was conducted on (MONTH) 31, 2019 at 1:21 p.m. with the Social Services assistant (staff #139). Staff #139 stated advance directives are discussed with a resident on admission. She said that she discusses the difference between full code and DNR. Staff #139 stated that if the resident chooses DNR, the Patient Health Care Instructions form is completed by Social Services and placed in the resident's clinical record. She said that if the resident chooses full code, she reports this verbally to the nurse who will complete the Patient Health Care Instructions form with the resident and contact the physician for an order. She said the process should be done as soon possible. -Resident #18 was admitted to the facility on (MONTH) 8, 2012, with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 29, 2019 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Review of the clinical record revealed a face sheet which included the resident was a Full Code. A physician's order dated (MONTH) 16, 2019 included the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident that the resident had formulated an advance directive. -Resident #21 was admitted to the facility on (MONTH) 10, 2011, with [DIAGNOSES REDACTED]. Review of the clinical record revealed a face sheet that the resident was a Full Code. A physician's order dated (MONTH) 8, 2019, included the resident was a Full Code. A quarterly MDS assessment dated (MONTH) 30, 2019 revealed a BIMS score of 15, which indicated the resident was cognitively intact. Further review of the clinical record revealed no documentation signed by the resident that the resident had formulated an advance directive. -Resident #28 was admitted to the facility on (MONTH) 23, (YEAR), with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 28, 2019 included the resident was a Full Code. A quarterly MDS assessment dated (MONTH) 22, 2019 revealed a BIMS score of 8, which indicated the resident had moderate impaired cognition. Review of the clinical record revealed a face sheet that the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident or resident representative that the resident had formulated an advance directive. -Resident #32 was admitted to the facility on (MONTH) 29, 2014, with [DIAGNOSES REDACTED]. A review of the annual MDS assessment dated (MONTH) 3, 2019 revealed a BIMS score of 3, which indicated the resident had severe cognitive impairment. Review of a Medication Review Report dated (MONTH) 31, 2019 revealed the resident was a Full Code. Review of the clinical record revealed a face sheet that the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident or resident representative that the resident had formulated an advance directive. -Resident #66 was readmitted to the facility on (MONTH) 10, 2019 with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 14, 2019 included the resident was a Full Code. A review of the quarterly MDS assessment dated (MONTH) 5, 2019 revealed a BIMS score of 14, which indicated the resident was cognitively intact. Review of the clinical record revealed a face sheet that the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident that the resident had formulated an advance directive. -Resident #85 was admitted to the facility on (MONTH) 14, (YEAR), with [DIAGNOSES REDACTED]. A physician's order dated (MONTH) 27, (YEAR) included the resident was a Full Code. A review of the quarterly MDS assessment dated (MONTH) 3, 2019 revealed the BIMS score was a 6 which indicated the resident had severely impaired cognition. Review of the clinical record revealed a face sheet that the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident or resident representative that the resident had formulated an advance directive. -Resident #86 was admitted to the facility on (MONTH) 23, (YEAR) with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 10, 2019 revealed a BIMS score of 11, which indicated the resident had moderate impaired cognition. Review of a Medication Review Report dated (MONTH) 31, 2019 revealed the resident was a Full Code. Review of the clinical record revealed a face sheet that the resident was a Full Code. Further review of the clinical record revealed no documentation signed by the resident or resident representative that the resident had formulated an advance directive. An interview was conducted with a unit manager (staff #10) on (MONTH) 29, 2019 at 10:49 a.m. Staff #10 stated that a form should be signed by the resident or their representative if they wish to be a full code and the form should be placed in the resident's clinical record. An interview was conducted with the social services assistant (staff #94) on (MONTH) 30, 2019 at 10:11 a.m. Staff #94 stated that code status is reviewed with the resident on admission to the facility. Staff #94 stated that if a resident chooses to be a DNR, a form is signed and placed in the clinical record. Staff #94 stated that if a resident chooses to be a full code, they did not have a form that the resident signed. Staff #94 stated that just recently they have implemented the Patient Health Care Instructions form, which designates the code status the resident desires and is signed by the resident. Staff #94 further stated that this form is then placed at the front of the resident's clinical record. An interview was conducted with the Director of Nursing (DON/staff #113) on (MONTH) 31, 2019 at 1:30 p.m. Staff #113 stated that the facility used to just have the resident sign a form if they chose to be a DNR, but did not have them sign a form for full code. The DON stated that they recently implemented the Patient Health Care Instructions form, which has specific instructions as to what the resident's wishes are. Review of the facility's policy regarding Health Code Decision Making revised (MONTH) 1, 2019, revealed the facility is to inform and provide written information to all residents concerning the right to accept or refuse medical or surgical treatment and at the patient's option, formulate an advance directive. The policy included to approach a capable resident who does not have an advance directive upon admission to discuss whether he/she wishes to consider developing an advance directive. Inquire with the resident's representative if the resident is incapacitated at the time of admission as to whether an advance directive has been completed/executed in accordance with state law. The policy also included .Establish mechanisms for documenting and communicating the patient's choices to the inter-professional team and staff responsible for the patient's care .
F 0600 **Level of harm -** Actual harm **Residents Affected -** Few	**Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, resident and staff interviews, facility documentation and policies and procedures, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 2) facility failed to ensure one resident (#237) was free from neglect, by failing to provide the necessary nursing services when changes of condition occurred. The deficient practice resulted in a lack of nursing care being provided when a resident experienced a change of condition. The facility also failed to ensure one resident (#36) was free from physical abuse by another resident (#124). The deficient practice could result in residents being subjected to physical abuse. Findings include: -Resident #237 was readmitted to the facility on (MONTH) 23, 2019, with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident was a full code status. The annual MDS (Minimum Data Set) assessment dated (MONTH) 25, 2019 included a BIMS (Brief Interview for Mental Status) score of 14, indicating the resident was cognitively intact. The MDS included the resident was totally dependent on one person for assistance with bed mobility, toilet use and personal hygiene, and required extensive assistance of one person for dressing. Per the MDS, the resident was receiving oxygen therapy and was on a [MEDICAL CONDITION] (Bi-level Positive Airway Pressure) machine. A care plan for cardiovascular complications (with an initiation date of (MONTH) 22, 2014) revealed the resident was at risk for cardiovascular symptoms/complications. Interventions included checking oxygen saturation every shift; assessing/monitoring vital signs as ordered and reporting abnormalities to the physician; and for oxygen at ,[DATE] LPM (liters per minute) via nasal cannula as needed to keep oxygen saturation greater than 90%. A respiratory care plan (with an initiation date of (MONTH) 8, (YEAR)) revealed the resident was at risk for complications related to [MEDICAL CONDITION] and was non-compliant with oxygen and [MEDICAL CONDITION] placement. A goal was that the resident would have no signs and symptoms of respiratory distress. Interventions included the following: administer medications and [MEDICAL CONDITION] as ordered; monitor and report oxygen saturation levels via pulse oximetry as ordered and as needed; and observe for signs and symptoms indicating respiratory distress and report to physician. Review of the physician recapitulation orders for (MONTH) and (MONTH) 2019 included the following orders: -Oxygen saturation every day and night shift -Pulse oximetry to keep oxygen saturations greater than or equal to 90% -Oxygen ,[DATE] LPM per nasal cannula to keep oxygen above 88% every day and night shift -[MEDICAL CONDITION] at 3 LPM oxygen to be applied at bedtime and removed in the morning. These orders were transcribed onto the (MONTH) 2019 MAR (medication administration record) and the TAR (treatment administration record). Further review of the MAR/TAR for (MONTH) 2019 revealed that the oxygen saturation levels were done every day and night shift. The scheduled times were 7 a.m. and 7 p.m. The documentation showed the following oxygen saturation levels for resident #237: Date 7 am 7 pm [DATE]: 89% 95% [DATE]: 98% 97% [DATE]: 90% 92% [DATE]: 90% 91% [DATE]: 91% 93% [DATE]: 98% 96% [DATE]: 90% 95% [DATE]: 90% 95% [DATE]: 95% 96% [DATE]: 90% 92% [DATE]: 92% 93% [DATE]: 90% 90% [DATE]: 90% 95% [DATE]: 98% 92% [DATE]: 90% 93% [DATE]: 93% 91% [DATE]: 93% 90% [DATE]: 90% 92% [DATE]: 97% 93% [DATE]: 92% 90% In addition, the MAR indicated [REDACTED]. The SVN treatments were given on the following days at various times as follows: (MONTH) 1, 5, 6, 7, 8, 11, 13, 14, 15, 19 and 20, and the oxygen saturation levels ranged between 90%-96%. A medication nursing note dated (MONTH) 20, 2019 at 7:03 p.m., revealed the resident was administered [MEDICATION NAME] (antianxiety) 0.25 mg (milligrams) by mouth for anxiety as evidenced by panic attacks. Further review of the (MONTH) 2019 MAR indicated [REDACTED]. A nursing note at 8:35 p.m. by a LPN (licensed practical nurse/staff #30) revealed that [MEDICATION NAME] 325 mg 2 tablets by mouth was administered to the resident for general discomfort. The MAR indicated [REDACTED]. A general nursing note dated (MONTH) 20, 2019 at 10:15 p.m., by staff #30 revealed that she answered the resident's call light and the resident complained of shortness of breath. Per the note, the resident's oxygen saturation was 56%, and the resident was on oxygen at 6 LPM per nasal cannula. The intervention documented was that staff #30 gave the resident a breathing treatment. Further review of the clinical record revealed there was no documentation of any other interventions which were done at that time other than a breathing treatment, there was no documentation of a thorough assessment of the resident which was done at that time, including a thorough respiratory assessment, and there was no documenation of any change of condition charting that was done. In addition, there was no documentation that the resident's physician/provider was notified of the resident's change in condition/low oxygen level. The clinical record documentation also showed that the resident's oxygen saturation level was not checked again until 40 minutes later. According to a general nursing note dated (MONTH) 20, 2019 at 10:55 p.m. by staff #30, the resident's oxygen saturation level was 79% on 6 LPM of oxygen per nasal cannula, with no signs and symptoms of respiratory distress or shortness of breath at this time. Per the note, the resident was sleeping. Continued review of the clinical record revealed no evidence that the physician/provider was notified that the resident's oxygen saturation level continued to be low, and there was no documentation that additional interventions were implemented to address the resident's ongoing low oxygen saturation levels. Also, there were no nursing notes or other documentation regarding the resident's status or that the resident's oxygen saturation levels were rechecked between 10:56 p.m. and 12:53 a.m. A general nursing note dated (MONTH) 21, 2019 at 12:54 a.m. included the nurse (staff #30) went into the resident's room to recheck the resident's oxygen saturation and the resident looked pale, fingernails were turning blue but resident was warm to touch. The resident was not responding, CPR (cardiopulmonary resuscitation) was started and 911 was called. Another general nursing note dated (MONTH) 21, 2019 at 1:05 a.m. included the physician was notified. Review of the facility's investigative report dated (MONTH) 26, 2019 included that a licensed practical nurse (LPN/staff #30) was the nurse on shift (on (MONTH) 20 evening shift through (MONTH) 21 night shift) and took care of resident #237. The report included that on (MONTH) 20, 2019 at 7:00 p.m., the resident complained of not feeling well (shortness of breath) and a breathing treatment was administered. (Although there is no clinical record documentation of this.) At 10:00 p.m., the resident complained of shortness of breath and oxygen saturation was 56% on 6 LPM of oxygen via nasal cannula. The resident was administered a breathing treatment. At 10:55 p.m., resident's oxygen saturation was rechecked and was 79% on 6 LPM of oxygen via nasal cannula. At 12:52 a.m. on (MONTH) 21, 2019, the resident was observed to be pale with blue fingers and unable to get an oxygen saturation level and no heartbeat. At approximately 12:57 a.m., code blue was called and CPR was initiated. The EMS (Emergency Medical Services) came at 1:10 a.m. and at 1:28 a.m., the EMS medical director

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	**08/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	**350 EAST LA CANADA AVONDALE, AZ 85323**

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 3) pronounced the death of resident #237. Continued review of the facility's investigative report revealed that staff #30 failed to document the SVN treatment at 7 p.m. and 10:15 p.m., failed to complete a change in condition for respiratory distress, did not place the [MEDICAL CONDITION] on the resident and admitted that she was unable to notify physician/provider until after the resident was pronounced dead. The report also included that staff #30 failed to adhere to Cardio [MEDICAL CONDITION] Resuscitation policy and procedure by delaying the initiation of Cardio [MEDICAL CONDITION] Resuscitation. The investigative report further included a written statement from staff #30 titled Station 2 on evening of (MONTH) 20, 2019 to (MONTH) 21, 2019, which included that a certified nursing assistant (CNA) reported the resident wanted to see her. The resident told her (staff #30) I can't breathe. Vital signs were as follows: RR (respiratory rate) was 24 per minute, PR (pulse rate) was 66 per minute and oxygen saturation level was 56% on 6 LPM of oxygen per nasal cannula. A breathing treatment was administered at 10:15 p.m. She rechecked the resident's oxygen saturation level at 10:55 p.m. and was 79% on 6 LPM of oxygen per nasal cannula, with no signs and symptoms of respiratory distress or shortness of breath and that the resident was resting at this time. The statement further included that she (staff #30) continued with nursing work at this time. Staff #30 stated the CNA informed her that the resident was sweating. She returned to the resident's room at 24:52 midnight (which is 12:52 a.m.) on (MONTH) 21, 2019 and observed that the call light was pulled out of the wall and the resident's bed was in a flat position. The resident's oxygen saturation was rechecked and nothing came up. The resident's face was pale with mouth opened and fingernails were blue. She (staff #30) tried to arouse the resident, but was unsuccessful. The report included a witness statement dated (MONTH) 21, 2019 by a CNA (staff #121), who reported that at 7:00 p.m., the resident reported she did not feel well and did not have any evidence of distress. Staff #121 reported that at 9:00 p.m. the resident felt she was hot, at 12:00 a.m. the resident was banging on her table, another CNA assisted her with a pitcher of water and at 12:56 a.m. code blue was called. Another witness statement dated (MONTH) 21, 2019 by a CNA (staff #58) included that at 1:00 a.m. on (MONTH) 21, 2019, she heard an overhead page for Code Blue in the resident's room. She responded immediately and a LPN (staff #112) initiated CPR to the resident and she assisted the nurse (the statement did not include the identity of this nurse) with calling 911 at 1:02 a.m. EMS responded around 1:10 a.m. and continued CPR. A witness statement by a CNA (staff #28) dated (MONTH) 22, 2019, revealed that on (MONTH) 20, 2019 between 11:30 p.m. and 12:00 a.m., resident #237 had her call light on to be changed. After changing the resident, she said that she could not breathe. She notified staff #30 who replied that she would see resident when she is done with her medication pass. Per the statement, the resident was heard pounding the bedside table with her call light and another CNA (staff #121) went in to assist the resident. The resident turned her call light on again and staff #30 was informed. A witness statement by a LPN (staff #112) dated (MONTH) 25, 2019, revealed that on (MONTH) 21, 2019 at 1:00 a.m., an overhead page for Code Blue was heard and she responded immediately, she assessed the resident and initiated CPR. EMS responded around 1:10 a.m. and continued CPR. At 1:28 a.m., EMS stopped the code and pronounced the resident's death. Further review of the investigative report revealed that staff #30 was terminated. During an interview with a CNA (staff #121) conducted on (MONTH) 31, 2019 at 9:11 a.m., she stated that she worked the evening/night shift on (MONTH) ,[DATE], 2019 and throughout her shift, the resident kept pressing the call light and kept banging on her bedside table with the call light for help. She said that after providing assistance, she would leave the room and the resident would start banging on the table again. She stated it was crazy that day because so many things were going on. She stated right after dinner that day, she noticed the resident's bedside table was pushed away, the resident had oxygen on, and was sitting straight up in her bed and was pale and sweaty. She said this was not normal for the resident, because the resident's room was freezing cold and the resident did not look good. She stated when she exited the resident's room, she informed staff #30 and the MDS (Minimum Data Set) Coordinator (staff # 35) who were standing outside of the resident's room about the resident's condition. In an interview with the MDS Coordinator (staff #35) conducted on (MONTH) 31, 2019 at 11:29 a.m., she stated that she worked the day shift on (MONTH) 20, 2019 and throughout that day the resident kept turning the call light on and kept banging her bedside table. She stated that she had answered the resident's call light multiple times that day and the resident wanted to have regular water or just wanted some company. She stated there was a time that day when a CNA reported the resident did not look good. She said the day shift nurse came into the resident's room and administered a breathing treatment to the resident. A phone interview with a LPN (staff #30) was conducted on (MONTH) 1, 2019 at 8:03 a.m. Staff #30 stated the outgoing day shift nurse gave a report that the resident had a low oxygen saturation and a breathing treatment was administered, resulting in the resident's oxygen saturation going back to 95%. She denied receiving reports from a CNA around dinner time that the resident was sweaty and was not looking good. She stated at 10:00 p.m., she went into the resident's room as requested and she checked the resident's oxygen saturation, which read 56%. She stated the resident was breathing normal and there were no signs and symptoms of respiratory distress. She said that she gave the resident a breathing treatment but did not call the physician, because the resident's oxygen saturation usually runs low and after treatment it will go back to normal. She said at 10:55 p.m., she went to check on the resident and the resident was comfortable and resting in bed, with no signs and symptoms of respiratory distress. She stated the resident had the oxygen on and the resident's color and breathing were fine. She stated the [MEDICAL CONDITION] was not on the resident and was not in the room, because it was broken. She said she checked the resident's oxygen saturation and it read 79%, which is normal for the resident so she went back to work and did not call the physician. She said at 12:52 a.m. (on (MONTH) 21, 2019) she checked on the resident and the resident's bed was in a flat position and the call light was off the wall. She said the CNA informed her then that the resident was sweaty, so she checked the resident's blood sugar and oxygen saturation. She stated that when she placed the pulse oximetry machine on the resident, there were no numbers registered on the machine and she noticed the resident's fingers were blue. She said she then went to grab the chart to check the resident's code status, called a code and called 911. However, she stated that when she called 911 she was not successful, because the facility's phone was not working properly. She said the nurses from the other station came to help and CPR was started. She said a CNA was able to call 911 on her personal cell phone. She stated that she called the physician three times at this time, but the physician did not return the call until 3:00 a.m. Multiple attempts were made to conduct a phone interview with a CNA (staff #28), who reported to staff #30 that the resident could not breathe on (MONTH) 20, 2019 between 11:30 p.m. and 12:00 a.m., however were unsuccessful. An interview with the Director of Nursing (DON/staff #113) was conducted on (MONTH) 2, 2019 at 8:52 a.m. Staff #113 stated that on (MONTH) 21, 2019 at 1:00 a.m., she received a call from staff #30 who was flustered and reported that paramedics were at the facility performing CPR to the resident. She stated staff #30 told her the physician was not notified and that 911 was not called when the resident's oxygen saturations were 56% and 79%, because staff #30 thought the oxygen saturations would go back up, after the breathing treatment. She stated the resident's oxygen saturation levels ranged between 88% and 90% and can go as low as 79%. However, staff #113 said staff #30 is expected to call the physician or 911 after treatment is provided and a resident's oxygen saturation does not go back up to normal range. She stated the breathing treatment takes 10 to 15 minutes and that a nurse is expected to take the oxygen saturation after the treatment is done and call the physician or 911 as appropriate. Further she stated that staff #30 did not do what she was supposed to do given the circumstances of the events that day. She said staff #30 called the physician only when the resident was coding, not when the resident's oxygen saturations were low. Review of the Abuse Prohibition policy revealed the facility prohibits abuse and neglect for all residents. The policy defined neglect as the failure of the facility, its employees or service providers to provide goods and services to a patient that is necessary to avoid physical harm, pain, mental anguish or emotional distress. The policy regarding Notification of Change in Condition included the facility must immediately consult with the patient's physician when there is a significant change in the patient's physical, mental, or psychosocial status. A policy titled, Physician/Advanced Practice Provider (APP) Notification included the purpose was to communicate a change in the resident's condition to the physician/AAP. Upon identification of a resident who has clinical changes, change in condition, or abnormal lab values, trained staff will perform appropriate clinical observations and data collection and report to physician as indicated. Staff observations and resident baseline should always be the primary determinate of the timing of physician notification. If the resident's condition indicates urgent physician notification, staff is to notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0600 **Level of harm -** Actual harm **Residents Affected -** Few	(continued... from page 4) the physician immediately with the vital signs information, report all pertinent data and obtain and implement specific orders for intervention. -Resident #36 was admitted to the facility on (MONTH) 26, (YEAR) with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 7, 2019 included a BIMS score was 15, which indicated the resident was cognitively intact. In an interview with resident #36 on (MONTH) 30, 2019 at 9:09 a.m., she reported that she had recently been physically abused by another resident. She stated a resident (#124), whose name she did not know, came into her room and wanted to use her bathroom. She said the other resident had her wheelchair sideways in the doorframe, so she was unable to get past her to go into the hallway. When she asked the resident to leave her room, she stated that it was not her room and she then hit her with the back of her hand. She stated this incident was about a month ago and this resident had previously tried to come into her room and use the bathroom. She stated after this incident she was finally able to get into the hall to go ask for help. She reported this incident to the nurse who was on duty, staff #16. She further stated that the police came out to speak with her. She said she has had no further incidents with this resident. -Resident #124 was admitted to the facility on (MONTH) 13, 2019 with [DIAGNOSES REDACTED]. A quarterly MDS assessment dated (MONTH) 21, 2019 revealed the resident had a BIMS score of 4 out of 15, which indicated the resident was severely cognitively impaired. No wandering behavior was noted. The resident required extensive assistance by staff for activities of daily living and used a wheelchair for mobility. Per the MDS, the resident had impairment on one side to the upper extremity which interfered with daily functions. Review of the facility's investigative documentation revealed that on (MONTH) 10, 2019, resident #36 reported to a LPN (staff #16) that she was assaulted by resident #124. Staff #16 immediately approached resident #125 and brought her to the nurses station for close monitoring. Staff #16 assessed both residents and no injury was noted to either resident. Resident #36 was interviewed and explained that she was in her room sitting in her chair, and noticed a shadow and then fingers on her bathroom door. She observed resident #124 halfway into her bathroom and approached her by telling her that she did not feel comfortable with her using the bathroom. Resident #124 then stated that she owned the building and was going to get rid of resident #36. Resident #36 told resident #124 to get out of the bathroom and attempted to pull resident #124's wheelchair out of the bathroom, when resident #124's wheelchair became lodged between the bathroom door and the room door. Resident #36 then began to seek staff assistance but was unable to get into the hallway. Resident #124 then struck resident #36 with the back of her right hand against resident #36's right side of her face. Resident #124 then self-propelled her wheelchair out of the room and stated to resident #36, you're mean and crazy. Just hit me. Hit me already. Resident #36 explained that she did not strike out and did not hit resident #124, and did not have any type of stick and/or object in her hand. Resident #36 explained that resident #124 wandered into her room approximately ,[DATE] times before. Further review of the investigation documentation revealed resident #124 was interviewed and explained that she went into her room and into her bathroom and saw the lady in the wheelchair (resident #36) in her room. Resident #124 explained that she then tried to go into the bathroom when resident #36 would not let her in because resident #36 told her it wasn't her bathroom. Resident #124 stated that resident #36 had a stick and was pushing her shoulder with it and she was trying to defend herself because resident #36 continued to poke her with the stick. She said she then struck out and swung her hand out to hit resident #36. Resident #124 became tearful and stated, I'm sorry. I know this is childish but she provoked me to swing at her. I'm not a fighter. I don't bother anyone. I just needed to go to the bathroom and she wouldn't let me. Resident #36 is always in my room at night after dinner. The facility investigation also includes staff who were working the night of (MONTH) 10, 2019 were interviewed and there were no witnesses. Staff reported that resident #124 has wandered towards other rooms and is easily redirected, but entering into other rooms is not a common behavior that she exhibits. Staff #16 reported resident #124 had been toileted 30 minutes prior to this incident. The investigation concluded that resident #36 has continued with her activities of daily living without any changes. Staff are to monitor for any changes in mood and/or behavior and notify the provider as indicated. Resident #124 has requested a room change, which will be completed when a room/bed becomes available. Resident #124's chart was reviewed by the nurse practitioner and labs were ordered. Based on the results of the labs, resident #124 was started on an antibiotic for a urinary tract infection. Psych services also followed up with resident #124 and noted that the incident appeared to have been an isolated event due to confusion and this was out of character for resident #124. Social serviced followed up with both residents and no concerns were noted. A psychiatric follow up note dated (MONTH) 12, 2019 indicated resident #124 was seen for an urgent visit after a recent altercation with resident #36. Staff reported that resident #124 appeared to be confused and tried to use resident #36's bathroom. Resident #36 reportedly got upset with resident #124 and pushed resident #124's wheelchair so resident #124 slapped resident #36. Resident #124 admits to the altercation with resident #36. Staff reported that resident #124 was easily redirected after the incident and that this incident was very out of character for her and there were no other concerns at that time. The note continues that resident #124 has not previously had trouble with aggression or agitation and it is believed that this was an isolated incident, but her behavior will be monitored. In an interview with staff #16 on (MONTH) 30, 2019 at 1:46 p.m., she stated she is familiar with residents #36 and #124 and the incident between them. She stated that it was shift change when resident #36 came out of her room to the nurses station and stated that she had been assaulted. She said that resident #36 reported resident #124 came into her room to use the bathroom and wouldn't leave. She stated that resident #36 may not have understood how confused resident #124 might have been and resident #36 began pulling on resident #124's wheelchair, which may have been what caused the altercation. She also stated the residents were immediately separated and assessed. She stated that resident #36 did not have any red marks to her face, and there were no injures noted to either resident. She stated there were no witnesses and she had not seen that kind of behavior from resident #124 before. She stated resident #124 was known to be very confused, but not violent or aggressive. She stated the Director of Nursing (DON/staff #113) was informed right away of this incident. In an interview with staff #113 on (MONTH) 1, 2019 at 1:21 p.m., she stated she was unaware of this behavior of resident #124 going into resident #36's room. She stated their rooms were right across the hallway from each other when this incident happened. She said that resident #124 could have mistaken resident #36's room for hers. The DON stated there had been no prior reports of this type of behavior. She said after this incident, resident #36 reported that there had been several other incidents of resident #124 coming into her room and trying to use the bathroom. She stated that if they would have known about this behavior by resident #124 before the incident, perhaps it could have been prevented. Review of a facility policy regarding Abuse revealed the definition of physical abuse is: hitting, slapping, pinching, kicking, etc., as well as controlling behavior through corporal punishment. Staff will identify events .and determine the direction of the investigation. This also includes patient to patient abuse. If the suspected abuse is resident to resident, the resident who has in anyway threatened or attacked another will be removed from the setting or situation and an investigation will be completed .options for room changes will be provided based on the situation.
F 0623 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews and resident and staff interviews, the facility failed to ensure there was evidence that the Long Term Care ombudsman was sent a copy of a facility initiated discharge for one resident (#137), and failed to ensure one resident (#101)/representative received written notification of transfers to the hospital. The deficient practice could result in the ombudsman not being aware of facility practices related to discharges and advocating for residents regarding options and rights. The deficient practice could also result in residents/representative not being aware of the reasons for transfers to the hospital. Findings include: -Resident #137 was admitted to the facility on (MONTH) 24, 2007, with a primary [DIAGNOSES REDACTED]. Per the clinical record, the resided on the secured dementia unit. Review of a final discharge form documented the resident was discharged on (MONTH) 1, 2019 to a group home following the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0623 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 5) closure of the dementia unit. Review of the clinical record revealed no documentation that the ombudsman had been sent a copy of the notice of transfer for resident #137. An interview was conducted with the medical records director (staff #141) on (MONTH) 2, 2019 at 10:45 a.m. She stated that she is responsible to notify the ombudsman regarding discharges, however, she does not notify the ombudsman when the facility initiates the discharge. Staff #141 further stated there was no notification sent to the ombudsman regarding resident #137's discharge. An interview was conducted with a corporate resource nurse (staff #193) on (MONTH) 2, 2019 at 10:50 a.m. Staff #193 stated the facility did not have a procedure or policy in place regarding ombudsman notification when the facility initiates a discharge. -Resident #101 was admitted to the facility on (MONTH) 3, (YEAR), with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set assessment dated (MONTH) 9, 2019 revealed the resident had a Brief Interview for Mental Status score of 14, which indicated intact cognition. A nurse's progress note dated (MONTH) 30, 2019, revealed the resident had an unplanned transfer to the hospital. Review of a nurse's progress note dated (MONTH) 24, 2019, revealed the resident had another unplanned transfer to the hospital. Review of the clinical record revealed no documentation that the resident/resident's representative received written notification of the transfers and the reasons for the transfer, prior to transferring the resident to the hospital on (MONTH) 30, 2019 and (MONTH) 23, 2019. On (MONTH) 1, 2019 at 9:52 a.m. an interview was conducted with a Licensed Practical Nurse (LPN/staff #54). She stated that when a resident is being transferred to the hospital, she verbally explains the reason for the transfer to the resident. She said that the Business Office Manager (#133) follows up with the resident when the resident is transferred to the hospital. An interview was conducted on (MONTH) 1, 2019 at 10:00 a.m. with resident #101, who said that she never received a written explanation about why she was transferred to the hospital on (MONTH) 30, 2019 and (MONTH) 23, 2019. On (MONTH) 1, 2019 at 10:38 a.m., an interview was conducted with the Business Office Manager (staff #133), who stated that she is responsible for contacting the resident when the resident is transferred to the hospital. She said that she sends the resident or representative a form explaining why the resident was transferred to the hospital. She also stated that if the resident or representative does not sign and return the form, she makes a note in PCC (the electronic medical record system). Another interview was conducted on (MONTH) 1, 2019 at 3:00 p.m. with staff #133, who stated that she did not have any documentation to show that the resident was notified in writing regarding the reasons why she was transferred to the hospital on (MONTH) 30, 2019 and (MONTH) 23, 2019.
F 0656 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews and policy review, the facility failed to develop a care plan for 1 of 2 sampled residents (#127) who was receiving [MEDICAL CONDITION] medications. The deficient practice could result in resident's not receiving care specific to their needs and preferences. Findings include: Resident #127 was admitted (MONTH) 4, 2019, with [DIAGNOSES REDACTED]. Review of the physician's admission orders [REDACTED]. The orders also included for [MEDICATION NAME] 1.5 mg (benzodiazepine/psychoactive medication) via [DEVICE] every 8 hours for anxiety AEB restlessness. A review of the baseline [MEDICAL CONDITION] care plan dated (MONTH) 4, 2019, revealed a goal that the resident would maintain/improve current activity status and activities of daily living (ADL) functioning through the next review. Interventions were to monitor for adverse effects and psychiatric evaluation as ordered. According to the admission Minimum Data Set (MDS) assessment dated (MONTH) 11, 2019, revealed resident #127 had a Brief Interview for Mental Status (BIMS) score of 3, indicating severe cognitive impairment. The MDS included the resident had no signs or symptoms of depression, had a history of [REDACTED]. Review of the Care Area Assessment (CAA) section revealed the resident received [MEDICATION NAME] and [MEDICATION NAME] without adverse reactions and was at increased risk for falls, anxiety, sedation and disturbances of balance and gait. This section also included to proceed to care planning with an overall goal to maintain the resident's current level of functioning. Review of the Medication Administration Records for June, (MONTH) and (MONTH) 2019 revealed the resident received [MEDICATION NAME] and [MEDICATION NAME] daily. Further review of the clinical record revealed that a comprehensive care plan had not been developed which included specific goals and interventions to address the use of [MEDICAL CONDITION] medication, including risk factors. During an interview conducted with the Director of Nursing (DON/staff #113) on (MONTH) 1, 2019 at 12:30 p.m., the DON stated that if the MDS triggers a care area and the decision to proceed to care plan is made, the MDS nurse will notify the Unit Manager at the daily or quarterly care meeting. She stated that she would expect the Unit Manager to update the care plan accordingly. An interview with the Unit Manager (Licensed Practical Nurse/LPN/staff #106) was conducted on (MONTH) 1, 2019 at 1:42 p.m., who stated that she is responsible for updating the care plan, but if it is triggered by the MDS, the person completing the MDS would develop the care plan. Staff #106 acknowledged that she could not locate a comprehensive care plan, which reflected the use of [MEDICAL CONDITION] medication. In an interview with the MDS Clinical Reimbursement Coordinator (CRC/staff #35), she stated that the CRC is not responsible for the care plan and that the unit manager is responsible to include the triggered areas in the care plan. She said that prior to the comprehensive care plan conference, the unit manager will review the care plan and that she would expect the unit manager would include the [MEDICAL CONDITION] medication use in the care plan at that time. Review of the facility policy regarding Baseline Care Plans revealed the baseline care plan is to assure that the resident's immediate care needs are met and maintained, and that the baseline care plan will be used until staff can conduct the comprehensive assessment and develop an interdisciplinary person-centered care plan.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, resident and staff interviews, and policies and procedure, the facility failed to ensure that one of four sampled residents (#29) with limited range of motion (ROM) received the necessary treatment and services, in order to determine if therapy and/or RNA services and splint device use would assist the resident in maintaining their highest level of ROM and functioning. The deficient practice could result in residents experiencing a decrease in ROM and functioning. Findings include: Resident #29 was readmitted on (MONTH) 27, (YEAR), with [DIAGNOSES REDACTED]. Review of the clinical record revealed the resident last had an OT (occupational therapy) evaluation on (MONTH) 30, (YEAR). The resident was referred to skilled OT due to exacerbation of impaired ROM and impaired strength, indicating the need for OT to design and implement RNP (restorative nursing program) and improve motor control/tone in upper extremity. The evaluation included the following: -Right and left wrists ROM was impaired 5-10 degrees AROM (active ROM) ulnar deviation and flexion contracture at approximately 90 degrees.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 6) -Right and left hands ROM were impaired little or no AROM 0-2 degrees PROM (passive ROM) at MCP (metacarpophalangeal joint) digits 2-5 extensor tone 2nd-5th digits in 0 degrees extension. The evaluation also included that due to documented physical impairments and associated functional deficits, without skilled therapeutic intervention, the patient is at risk for contracture(s) . The recommended level of skilled therapy services was required due to concomitant musculoskeletal condition, impairments to multiple areas of the body, severity of functional limitations and need for intensive caregiver training. Projected status included that resident and RNA (restorative nursing assistant) will demonstrate 90% accuracy and good knowledge and understanding of RNP to maximize resident's bilateral upper extremity ROM and maximize joint mobility. The OT discharge summary dated (MONTH) 2, (YEAR) included the resident was discharged with all short term and long term goals met and was referred to RNA for execution of RNP. Treatment approaches included flexion and extension of wrists, thumb and digits, and abduction and adduction of the thumb. Under Patient progress and Response treatment, it included that AAROM (active assisted ROM) and PROM with RNP for bilateral upper extremity was developed to preserve joint mobility, maximize ROM and prevent/reduce further contracture. The OT discharge recommendations included for RNP. Review of the Restorative Nursing Program Progress Notes and Summary for (MONTH) 20, (YEAR) through (MONTH) (YEAR) revealed the resident was receiving RNA services 1-3 times per week. According to the Restorative Nursing Record for (MONTH) (YEAR), the treatment/goal was for bilateral upper extremity range of motion, wrist and hand flexion/extension three sets of 10 and three times per week. Review of the active ADL (Activities of Daily Living) care plan (with an initiation date of (MONTH) 17, (YEAR)) revealed the resident was dependent for ADL care due to [MEDICAL CONDITION] and contracture of bilateral elbows. Interventions included for CNA (certified nurse assistant) to assist with ROM to bilateral elbows with cares and for the restorative program to maintain and prevent decline in resident's ROM. However, the care plan did not address the concerns related to the resident's right and left wrists and right and left hands, and there were no interventions for these identified areas. The quarterly MDS (Minimum Data Set) assessment dated (MONTH) 18, 2019 included a BIMS (Brief Interview for Mental Status) score of 15, indicating the resident was cognitively intact. The MDS also included the resident had functional limitation and impairment in ROM on both sides of the upper and lower extremities, and was totally dependent on 1-2 persons with ADL's.A general medical note dated (MONTH) 9, 2019 included the resident was quadriplegic and had contractures to the upper extremities. However, the documentation did not include specific locations of the contractures. The note included general debility and the plan was for supportive care. Review of a NP (nurse practitioner) note dated (MONTH) 12, 2019 revealed the resident was alert and oriented x 3, was unable to care for himself secondary to frequent altered mental status, [MEDICAL CONDITION] and muscle weakness. Physical examination included the resident was quadriplegic and had contractures on both upper extremities. However, the documentation did not include the location of the contractures. The plan was for supportive care and continue to monitor. A NP note dated (MONTH) 20, 2019 included the resident was quadriplegic and had bilateral upper extremity contractures. Per the note, the resident was able to move his hands. Additional NP notes dated (MONTH) 24 and 25, 2019 included bilateral upper extremity contractures, however, the documentation did not include the specific location of the contractures the resident had and that the resident was able to move his hands. Further review of the clinical record including the RNA documentation revealed no evidence that the resident received RNA services after (MONTH) (YEAR), nor was there documentation as to why the services were no longer provided. In addition, there was no documentation that the resident was reassessed by therapy for contracture management in (YEAR) through (MONTH) 2019. Review of the RNA documentation from (MONTH) 31, 2019 through (MONTH) 27, 2019 revealed the resident was not listed as one of the residents receiving RNA services. During an interview with the resident conducted on (MONTH) 29, 2019 at 9:07 a.m., the resident was having breakfast in his bed and was being assisted with eating by a staff member. The resident's wrists were bent forward with fingers extended. In an interview with resident #29 conducted on (MONTH) 29, 2019 at 10:09 a.m., he stated that he cannot close his fingers on both hands and that both wrists are bent forward and cannot be extended. The resident then tried to close his hands and move his wrists, but could not. He stated that he had therapy about two years ago and had a splint for both his hands, but they did not fit so he did not use them. He stated that he was never provided other splints that fit. He stated he knows that he is paralyzed, but he used to at least feed himself and wanted to be able to do so again. He said he wanted to have something like a splint device or ROM exercises to save whatever he could do with his hands. An interview with a certified nursing assistant (CNA/staff #122) was conducted on (MONTH) 31, 2019 at 1:22 p.m. She stated that she has been a CNA at the facility for [AGE] years and knows the resident. Staff #122 said the resident is alert and oriented with some confusion. She stated the fingers on both hands of the resident had been in an extended (opened) position since she has known the resident. She said the resident had a splint device that looked like a baseball glove for both his hands which he would wear only when he went to the casino. She stated there is no schedule when to put this splint device on and off. She also stated that RNA performs ROM exercises on the resident's elbows every so often and that she provides these exercises during showers every Saturday. She further stated the resident does not have difficulty chewing/swallowing his food and can finish his food, however, the resident cannot feed himself and required assistance with eating from staff. In an interview with a registered nurse (RN/staff #6) conducted on (MONTH) 31, 2019 at 1:47 p.m., she stated that therapy staff orders the RNP and the use of splint devices. She said the order will include how long and how often to provide RNA services or splint device use. She said the nurse will transcribe the orders into the electronic record and RNP will be administered by the RNA staff. She stated RNA then documents on paper that RNP was provided to the resident. During an interview with a restorative nursing assistant (RNA/staff #26) conducted on (MONTH) 31, 2019 at 2:06 p.m., he stated that the therapy department writes the recommendation for RNA and also provides the training for RNP and splint devices. He said the therapy order for RNP includes the number of times and the duration of ROM exercises that are to be performed and splint application, which should be documented on paper in the RNA notes. He stated when a resident refuses RNA it will be documented as well. He said if a resident refuses several times, he will inform the nurse and they will find out why the resident was refusing and whether to continue or discontinue the RNP and/or splint device. He further stated that after therapy treatment is completed, therapy staff conducts a screening to evaluate the need for restorative nursing services. Regarding resident #29, staff #26 stated the resident is alert and oriented and can verbalize his needs and wants. He said the resident had RNP in the past, but had refused. He said the resident is not currently on any RNA program and he is not aware of any splint device for the resident. He stated he provides ROM exercises for the resident's elbows and shoulders sometimes when he goes to visit the resident in his room. He stated that ROM is provided by CNA's during cares, but he does not know what ROM exercises they provide for the resident. An interview with the Director of Rehabilitation/Therapy (staff #184) was conducted on (MONTH) 31, 2019 at 2:15 p.m. She stated that therapy screenings are based on nursing referrals and there is no schedule when therapy screening is conducted for residents at the facility. She stated nursing determines whether a resident has a change in condition or a decline in status. Staff #184 said if there is an order for [REDACTED]. She stated the therapy department does not deal with or supervise the restorative nursing program at the facility. She stated it is supervised by the nursing department. Regarding resident #29, staff #184 stated the resident was last seen by OT a couple of years ago on (MONTH) 30, (YEAR). She stated that therapy was completed and the resident was transferred to the RNA program. She further stated that resident #29 is currently not receiving therapy services. An interview with another CNA (staff #102) was conducted on (MONTH) 1, 2019 at 11:28 a.m. Staff #102 stated that she provides assistance with eating to the resident as he cannot grab a fork or spoon, because he cannot close his fingers on both hands. She stated the resident's fingers are in a fixed position and cannot be moved. She said the resident uses the web between the thumb and the second finger of the right hand to maneuver his power chair. Further, she stated the resident receives ROM exercises during showers and RN[NAME] However, she said that she does not know how frequent the resident receives RNP, because it is done by RN[NAME] Another interview with resident #29 was conducted on (MONTH) 1, 2019 at 12:16 p.m. He stated about a month ago, he informed the newer RNA (whose name he could not recall) that he's getting more stiff and his hands were getting more bent. He stated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 7) that he was told by the RNA that nursing staff was informed, but he has not heard from anyone since. He stated since his last therapy which was a couple years ago, he has not been evaluated by a therapist for ROM or for a splint device. He stated that the RNA program stopped about a year ago. He stated that he used to have a splint that goes around his hand and staff used to put it on him, but he does not know where the splint is. Further, he said that he asked staff specifically if he could have a splint to use on his right hand especially his right thumb, which would enable him to hold a spoon or fork to feed himself. He stated that he has good strength on his right thumb. He also said that his wrists used to be more straight but now his wrists are more flexed inward. He stated he understand that he has a lot of medical issues and has something with his nerves, but he has a strong right thumb which he can still move and he thinks he can benefit from the use of a splint. He said that he has told staff about his condition and that he needs therapy or RNA or a splint device or whatever it takes to prevent him from getting crooked and save whatever function or ability he has left. During an interview with a licensed practical nurse (LPN/staff #67) conducted on (MONTH) 1, 2019 at 2:14 p.m., she stated that when a resident has limited ROM or contractures, or when a decline in functional status is identified, she will notify the therapy department. She stated the resident will be evaluated by a therapist who will make recommendations and write an order for [REDACTED]. Regarding resident #29, she stated the resident is alert and oriented and can verbalize his needs and wants. She said the resident complained of being more stiff but she could not recall when he complained. She stated that she believes the resident is currently on RNA program. She stated when the resident complained of being more stiff, she informed therapy who evaluated the resident and this is the reason why the resident is currently on the RNA program. On (MONTH) 1, 2019 at 2:31 p.m., an OT staff member (staff #187) performed a therapy screen on resident #29. At this time, the resident told staff #187 that he used to have therapy and someone was doing exercises on his shoulder, arms and hands, but these exercises stopped about a year ago and he has not received any since. Staff #187 stated that she could not tell whether the resident's condition was the same, had plateaued or had declined, because the process would then be an evaluation and not a screening. She stated that she did not do an evaluation of the resident's ability to move the involved joints and would not say that the resident has contractures on his wrists and hands, until she conducted an evaluation and not a screening. She stated the condition of the resident's joints is related to a spinal injury sustained from a motor vehicle accident. A review of the therapy documentation from (YEAR) was conducted with staff #187 immediately following the therapy screening. Staff #187 stated the discharge summary included recommendations for RNP, but not the use of a splint device. She stated that she will talk with the RNA and come up with a plan to address the resident's issues. During an interview with the Director of Nursing (DON/staff #113) conducted on (MONTH) 2, 2019 at 8:52 a.m., she stated that after therapy services are completed, therapy will recommend RNA, ROM exercises and/or splint device if and when the resident needs it. She stated an order for [REDACTED]. She said when a resident stops cooperating, they will work with the resident/family to encourage participation. She stated that after the last survey, all orders for RNA were discontinued because of reimbursement issues. She said RNA is provided to the resident if the need arises. She stated the facility's policy on Restorative Nursing is not followed, because the facility is not charging for the RNA program. She said that the RNA program does not need a physician's orders [REDACTED]. With regards to resident #29, staff #113 stated that RNA program for the resident was discontinued in (MONTH) (YEAR), due to refusal because the resident got sick. She stated the restorative nursing intervention in the care plan should have been removed, because the resident is not currently in the RNA program. She stated the resident has not been evaluated by therapy since the last time in (YEAR). She said she has been at the facility for 4 years and has known the resident to be in the same position. However, she said she has no way of knowing if the resident's joint mobility to his wrists, hands and fingers is the same or gotten worse. An interview with the RNA supervisor (staff #106) was conducted on (MONTH) 2, 2019 at 11:41 a.m. She stated if and when the need for RNA is identified for a resident or when a resident has come off therapy, the resident will be referred to therapy who will evaluate and make recommendations for the RNA program. Staff #106 said then an RNA program sheet will be completed and given to the RNA, who will implement the program. She stated that after efforts are made to encourage a resident to participate in the RNP, but the resident continues to refuse, then the RNA program will be discontinued. She stated the facility does not set a schedule when the resident is to be re-evaluated by therapy, but a resident will be re-evaluated by therapy when the resident has a change in condition or a decline was identified. Regarding resident #29, she stated the reasons why the RNA program was discontinued for resident #29 was refusal, and that after the last survey, all RNA orders were discontinued. She stated resident #29 has not been re-evaluated by therapy and has not been in the RNA program since (MONTH) (YEAR). Review of a policy titled, Range of Motion and Mobility revealed the facility ensures that a patient with limited ROM receives appropriate treatment and services to increase and/or prevent further decrease in ROM. It also stated, A patient with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction immobility is demonstrably unavoidable. The policy included that documentation must reflect attempts made to implement the care plan and revise interventions to address the changing needs of the patient and evidence show the declines in ROM/mobility were unavoidable. A policy on Restorative Nursing included the facility may provide restorative nursing programs for patients who will benefit from restorative programs in conjunction with formalized rehabilitation therapy. Restorative programs are coordinated by nursing or in collaboration with rehabilitation and are patient specific based on individual patient needs. The policy included the following purposes: (1) To promote the patient's ability to adapt and adjust to living as independently and safely as possible; and (2) To help the patient attain and maintain optimal physical, mental and psychosocial functioning. According to practice standards, the restorative nursing program is evaluated by a licensed nurse in the care plan evaluation progress note monthly if RNP is reimbursable or, quarterly if RNP is not reimbursable. Review of a policy on Therapy Screenings revealed that Screens are solely provided for the benefit of the individual and to assist in interprofessional case management . The purpose for therapy screening was to gather information about a patient's physical/cognitive/functional performance .for the purpose of identifying the individual's care needs and/or facilitation of interprofessional team collaboration and care planning; and .to determine the need for more comprehensive evaluation/assessment and/or referral for additional services. The policy also included that therapy screens may be conducted upon admission or re-admission; change in condition; upon request of the interprofessional team, the individual, caregivers and other providers; and upon a regularly scheduled frequency to support optimal function, health and wellness.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, facility documentation and policy review, the facility failed to ensure oxygen was administered in accordance with physician's orders [REDACTED].#106 and #122). The deficient practice could result in residents receiving oxygen at higher rates than ordered. Findings include: -Resident #106 was admitted on (MONTH) 24, (YEAR) with [DIAGNOSES REDACTED]. Review of a quarterly Minimum Data Set (MDS) assessment dated (MONTH) 6, 2019, revealed the resident had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS included the resident was independent with bed mobility, transfers and personal hygiene, required limited assistance with dressing, and was totally dependent on staff for bathing. The MDS further included the resident received oxygen therapy. Review of the progress notes for (MONTH) 2019 through (MONTH) 2019 revealed multiple references to the resident receiving oxygen. A review of the (MONTH) 2019 physician orders [REDACTED]. Review of the treatment administration records (TARs) from (MONTH) through (MONTH) 2019 revealed documentation that oxygen was being administered at 3 LPM every day and night shift. A respiratory care plan included a goal that the resident would have no signs or symptoms of respiratory distress. Interventions included oxygen as ordered via nasal cannula, and monitor and report O2 SAT levels via pulse oximetry, as ordered and as needed (PRN).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0695 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) During an observation conducted on (MONTH) 29, 2019 at 9:46 a.m., resident #106 was observed with the nasal cannula on the upper lip area, instead of in the nares. On (MONTH) 31, 2019 at 1:55 p.m., resident #106 was observed in a wheelchair and the nasal cannula was in place in the nares, however, the oxygen concentrator rate was set at 4 LPM instead of 3 LPM as ordered. On (MONTH) 1, 2019 at 10:40 a.m., resident #106 was observed with the nasal cannula in place, however, the oxygen concentrator rate was set at 4 LPM. In an interview conducted with a licensed practical nurse (LPN/staff #67) on (MONTH) 1, 2019 at 10:40 a.m., the nurse stated that the oxygen rate should be set at 3 LPM. She said the nurses are responsible to check the oxygen rate each shift. -Resident #122 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED]. Review of a significant change MDS assessment dated (MONTH) 25, 2019 revealed a BIMS score of 4, which indicated the resident had severe cognitive impairment. A physician's orders [REDACTED]. Review of the TAR for (MONTH) 2019 revealed the above order. The documentation included that licensed nursing staff had documented that 2 liters of oxygen had been administered to the resident on a daily basis. A care plan dated (MONTH) 30, 2019 documented Resident exhibits or is at risk for respiratory complications related to [DIAGNOSES REDACTED]. An observation was conducted on (MONTH) 30, 2019 at 8:46 a.m. of the resident lying in bed, with the nasal cannula in place. However, the oxygen concentrator was set at a rate of 3 LPM. Another observation was conducted on (MONTH) 1, 2019 at 10:14 a.m. of the resident lying in bed, with the nasal cannula in place. Again, the oxygen concentrator was set at 3 LPM. An interview was conducted with a licensed practical nurse (LPN/staff #78) on (MONTH) 1, 2019 at 10:15 a.m. Staff #78 stated the licensed nurses check the rate of the oxygen when they start their shift and other times in between. Staff #78 stated the resident's oxygen concentrator was set at 3 LPM and should have been set at 2 LPM. Staff #78 said that she didn't know if someone turned the concentrator up or possibly it was bumped by something. An interview was conducted with another LPN (staff #83) on (MONTH) 1, 2019 at 10:31 a.m. Staff #83 stated that licensed nurses are responsible to ensure that oxygen is being administered as ordered by the resident's physician. Staff #83 stated that after ensuring the oxygen was administered at the proper rate, it should be documented in the Treatment Administration Record. An interview was conducted with the Director of Nursing (DON/staff #113) on (MONTH) 1, 2019 at 10:51 a.m. Staff #113 stated the licensed nurses are responsible for ensuring that oxygen is administered at the proper rate. Staff #113 stated it was ultimately the responsibility of the licensed nurses to ensure oxygen is administered as ordered. Review of the facility's policy regarding Medication Administration dated (MONTH) 1, 2019 revealed A licensed nurse will administer medications to patients. Acceptable standards of practice will be followed .
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, facility documentation and policies and procedures, the Quality Assessment and Assurance (QA) committee failed to identify concerns related to infection control procedures not being followed for one resident on contact precautions for [MEDICAL CONDITIONS], and regarding concerns related to the cohorting of an immonsuppressed resident with the resident who had active [MEDICAL CONDITION]. As a result, the Condition of Immediate Jeopardy (IJ) was identified. The deficient practice resulted in quality concerns not being identified and corrective action being implemented, in order to reduce the risk for the potential of the transmission of [MEDICAL CONDITION] infection. Findings include: Observations during the survey revealed that contact precautions were not being followed for one resident (#63) with active [MEDICAL CONDITION]. Specifically, a certified nursing assistant did not remove gloves upon exiting the resident's room, and when the CNA re-entered the room, the CNA did not don a gown or gloves and provided personal care to the resident. In addition, a resident who was immunocompromised (diagnosed with [REDACTED]. Review of the Quality Assessment and Performance Improvement (QAPI) Plan updated on (MONTH) 28, 2019, revealed that all staff and stakeholders are involved in QAPI to improve the quality of life and quality of care that patients and residents experience. Review of the Facility Assessment Tool dated (MONTH) 25, 2019 included the facility evaluates all components of the Infection Prevention and Control Program through the process of ongoing outcome and process surveillance, with reporting to the QAPI committee. It also included that on an annual basis, the facility conducts an Infection Control Risk Assessment to identify areas of improvement and develop action plans for those areas. During an interview with the Administrator (staff #207) conducted on (MONTH) 2, 2019 at 12:20 p.m., she stated the facility uses a system for identifying issues and quality problems, which are also identified daily during morning meetings with staff. She stated that plans of action are developed, implemented and followed up on daily. She stated if the problem is not resolved and continues as the month goes along, the issue will be part of the QAPI agenda in the next monthly meeting. She stated that during the QAPI meeting, the identified issues and plans of action in place will be evaluated. She stated that during the QAPI meeting, interventions are also reviewed and revised as appropriate. She stated that goals will be set-up and the identified issue will remain in QA until it is resolved. She said that concerns related to contact precautions with [MEDICAL CONDITION] infections had not been identified in Q[NAME] She stated the only thing that was identified in QA which is related to infection control was the cleaning of resident equipment after each use. According to a policy regarding Quality Assurance and Performance Improvement, the QAPI program is ongoing, integrated data driven and comprehensive, and addresses all aspects of care, quality of life and resident-centered rights and choices. The policy further included that Improvement Activities and Performance Improvement Projects are the structure and means through which identified problem areas are addressed, with data analysis, process improvements and ongoing monitoring, whenever necessary using an interdisciplinary team.
F 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, clinical record review, staff interviews, facility documentation, review of the Center for Disease Control (CDC) 2007 Guideline for Isolation Precautions and policies and procedures, the facility failed to maintain an effective infection control program, by failing to ensure that contact precautions were followed for one resident (#63) with active [MEDICAL CONDITIONS], and an immunocompromised resident (#122) was cohorted with a resident (#63) who had active [MEDICAL CONDITION]. As a result, the Condition of Immediate Jeopardy (IJ) was identified. The deficient practice increased the potential for the transmission of the [MEDICAL CONDITION] infection and placed residents and staff at risk. Findings include: On (MONTH) 29, 2019 at 2:36 p.m., the Condition of Immediate Jeopardy (IJ) was identified. The Administrator was informed of the facility's failure to implement infection control procedures for resident #63, who was on contact precautions for active [MEDICAL CONDITION]. Observations were conducted of one certified nursing assistant (CNA/staff #85), who did not remove gloves upon exiting the room, and when the CNA re-entered the room, the CNA did not don a gown or gloves and provided personal care to the resident. In addition, resident #63 was observed sharing a room with another resident (#122), who did not have [MEDICAL CONDITION] and was not being treated for [REDACTED].#122 was immunocompromised (diagnosed with [REDACTED]. The Administrator presented a plan of correction on (MONTH) 29, 2019 at 6:05 p.m. The Administrator was informed that the plan of correction needed to include in-service training and education on contact precautions for [MEDICAL CONDITION], handwashing, the wearing of PPE (personal protective equipment) while disposing of soiled trash, the cohorting of resident #63 with resident #122, and the facility's process for determining who can cohort with residents who have [MEDICAL

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	08/02/2019

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	350 EAST LA CANADA AVONDALE, AZ 85323

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 9) CONDITION]. A revised plan of correction was presented and was accepted at 7:15 p.m. The plan included all staff education on donning/doffing of PPE and proper handwashing for residents on contact precautions including [MEDICAL CONDITION]; and cohorting residents needing contact precautions according to the Centers for Disease Control guideline. The plan further included that resident #122 was removed to another room. Multiple observations were conducted on (MONTH) 29 and 30, 2019 of the facility implementing their plan of correction, which included staff in-services were being done regarding infection control and contact precautions for [MEDICAL CONDITION]; staff interviewed were knowledgeable of infection control procedures including contact precautions for [MEDICAL CONDITION], observations were conducted of staff implementing contact precautions when entering and exiting resident #63's room, and resident #122 was moved to another room. As a result, the Condition of Immediate Jeopardy was abated on (MONTH) 30, 2019 at 3:13 p.m. -During an observation conducted on (MONTH) 29, 2019 at 11:55 a.m., an isolation cart which contained personal protective equipment (PPE/gowns, gloves etc.) was outside of resident #63's room. At this time, a CNA (staff #85) removed his gown and disposed of it in the resident's room prior to exiting. Staff #85 then exited the room, while still wearing the gloves which were worn in the resident's room and walked out of the room with a bag of soiled linen. Staff #85 then opened the soiled utility room door, which was next to the resident's room with the same gloves on. Approximately 5 seconds later, staff #85 exited the soiled utility room door, without gloves on. Staff #85 then entered the clean utility room, which was adjacent to the soiled utility room. Staff #85 exited the clean utility room carrying clean linen. Staff #85 was then observed to enter resident #63's room with the clean linen and did not apply a gown or gloves. Shortly thereafter, staff #63 exited the resident's room holding a soiled incontinent pad in a plastic bag, without gloved hands. Staff #63 then entered the soiled utility room and disposed of the plastic bag. An interview was conducted with the CNA (staff #85) on (MONTH) 29, 2019 at 11:59 a.m. Staff #85 stated that when he entered the resident's room with the clean linen he did not put gloves or a disposable gown on, because he just had to put a sheet on the resident. Staff #85 stated the plastic bag which he was holding without gloves had an incontinent pad with bowel movement on it. Another interview was conducted with staff #85 on (MONTH) 29, 2019 at 1:55 p.m. In clarifying what care was provided when staff #85 entered the resident's room carrying the clean linen and without donning a gown or gloves prior to entering, staff #85 said that he placed a clean sheet under the resident's buttocks and did not wear gloves or a gown. Staff #85 stated that when he went into the soiled utility room to dispose of the soiled linen he washed his hands real quick, not long, just a little soap and water. An interview was conducted with a CNA (staff #50) on (MONTH) 30, 2019 at 8:58 a.m. Staff #50 stated that if a resident was on isolation, a gown and gloves should be put on before entering the room. Staff #50 stated that prior to exiting the room, the gown and gloves should be removed and disposed of in the resident's room. Staff #50 further stated that it was facility policy to wash hands with soap and water. An interview was conducted with a CNA (staff #91) on (MONTH) 30, 2019 at 9:00 a.m. Staff #91 stated that before she enters an isolation room she dons gloves and a disposable gown. Staff #91 stated that before she leaves the room, she would remove the PPE and dispose of it in the resident's room. Staff #91 said she would then wash her hands with soap and water for thirty seconds. An interview was conducted with a CNA (staff #122) on (MONTH) 30, 2019 at 9:05 a.m. Staff #122 stated that before she went into an isolation room, she would put a gown and gloves on. Staff #122 stated that after caring for the resident, she would remove the protective equipment and place it in the container in the resident's room. Staff #122 further stated that she would then wash her hands with soap and water for twenty to thirty seconds. -Resident #63 was admitted to the facility on (MONTH) 25, 2019, with [DIAGNOSES REDACTED]. A care plan dated (MONTH) 26, 2019 revealed the resident required assistance with activities of daily living (ADL) (bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfer, locomotion and toileting) related to weakness, [MEDICAL CONDITION] and end stage [MEDICAL CONDITION]. Interventions included to provide the resident with total assistance of 2 for bed mobility and transfers using a hoyer lift. Review of the clinical record revealed that resident #63 was moved to the same room as resident #122 on (MONTH) 22, 2019. A quarterly Minimum Data Set (MDS) assessment dated (MONTH) 1, 2019 included a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact. The MDS included the resident required total assistance with toilet use and transferring, and extensive assistance with dressing, personal hygiene and bed mobility. The MDS also included the resident was always incontinent of bowel and bladder. Review of ADL documentation revealed no evidence that the resident was having loose stools from (MONTH) 6, 2019 through (MONTH) 13, 2019. The documentation indicated the resident was having soft formed stools. Review of the clinical record revealed the resident had a change in condition on (MONTH) 13, 2019, related to altered mental status and fever, and the resident was transferred to the hospital. The hospital records included a final infectious disease progress note dated (MONTH) 18, 2019, which stated the resident tested positive for [MEDICAL CONDITION], continue [MEDICATION NAME] for 14 more days and continue contact precautions. Review of the clinical record revealed the resident was readmitted to the facility on (MONTH) 19, 2019 at 3:30 p.m. Resident #63 was placed back into the same room with resident #122. A nursing note dated (MONTH) 20, 2019 included that resident #63 was a readmitted with [DIAGNOSES REDACTED]. Another nursing note dated (MONTH) 20, 209 revealed the first dose of [MEDICATION NAME] was given this morning with no adverse reaction noted. Continues with precaution. A physician's orders [REDACTED]. Review of ADL documentation for (MONTH) 20, 2019 revealed the resident had a medium soft/formed stool. For (MONTH) 21, the documentation showed that the resident had one medium soft/loose stool. A care plan dated (MONTH) 22, 2019 revealed the resident was at risk for complications of infection related to [MEDICAL CONDITION]. A goal was for the infection to resolve within 14 days. Interventions included to administer medication as ordered, use contact precautions, encourage hand washing, monitor for any signs and symptoms of pain and notify provider as indicated, monitor for skin breakdown and report to physician as indicated, and to monitor vital signs and report any abnormalities. A nurse practioner note dated (MONTH) 22, 2019 included the resident was being seen for a return from the hospital where she was treated for [REDACTED]. The plan included to monitor [MEDICAL CONDITION], continue [MEDICATION NAME] and when the resident had 2 to 3 soft stools, do a repeat stool sample. A physician's orders [REDACTED]. According to a general progress note dated (MONTH) 24, 2019, the resident continues with antibiotic for [MEDICAL CONDITION] and to continue with infection contact precautions. A nurse practitioner note dated (MONTH) 24, 2019 included the resident was being seen for follow up related to [MEDICAL CONDITION]. The note included the resident stated that she had one bowel movement this day. The plan included to monitor for [MEDICAL CONDITION], continue [MEDICATION NAME] and to repeat stool sample when antibiotic is completed. Review of (MONTH) 2019 ADL documentation regarding bowels revealed the following: July 24: the resident had 3 medium soft/loose stools July 25: the resident had one medium soft/loose stool and 3 small soft/loose stools July 26: the resident had 3 small soft/loose stools and one large soft/loose stool July 27: the resident had one medium soft/loose stool and 2 small soft/loose stools July 28: the resident had one medium soft/formed stool and 3 soft/loose extra large stools July 29: the resident had 2 large soft/loose stools, 1 medium soft formed stool, and 1 large soft/loose stool A nurse practitioner note dated (MONTH) 29, 2019 at 5:28 p.m. (after the IJ was called) included the resident was being seen for a follow up for [MEDICAL CONDITION]. The note stated the resident had reported that she was having 3 to 4 normal stools per day, with an increase amount of stool due to the food she ate. The plan included to monitor for [MEDICAL CONDITION], continue [MEDICATION NAME] until (MONTH) 2, 2019 and stools are at resident's baseline, and to continue contact precautions per facility policy. Regarding the cohorting of residents: -Resident #122 was admitted to the facility on (MONTH) 15, 2019, with [DIAGNOSES REDACTED].

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035166	A. BUILDING _____ B. WING _____	**08/02/2019**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ESTRELLA CENTER	**350 EAST LA CANADA AVONDALE, AZ 85323**

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 0880 **Level of harm -** Immediate jeopardy **Residents Affected -** Some	(continued... from page 10) A care plan dated (MONTH) 17, 2019 included the resident requires assistance for ADL care with bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers and toileting related to weakness. Interventions included to provide resident with extensive assistance of 1 for bed mobility and extensive assistance of 1 to 2 for transfers using a gait belt. According to a nursing note dated (MONTH) 21, 2019, the resident was under hospice services with a [DIAGNOSES REDACTED]. Another care plan dated (MONTH) 22, 2019 included the resident was receiving hospice care services starting (MONTH) 21, 2019, due to end stage [DIAGNOSES REDACTED]. Interventions were to provide ADL support and companionship, and other interventions as desired by resident to promote comfort, and provide emotional and social support to patient and family, address anticipatory grief and end of life wishes and planning. A physician's note dated (MONTH) 23, 2019 revealed the resident's status was poor, due to a terminal illness. The note included the resident will be admitted to hospice once paperwork is completed and per oncology, they are unable to provide treatment for [REDACTED]. A significant change MDS assessment dated (MONTH) 25, 2019 included the resident was severely cognitively impaired, with disorganized thinking. The MDS included the resident required total staff dependence for toilet use and dressing, and had impairment in functional limitation in range of motion in bilateral upper and lower extremities. A nurse practitioner note dated (MONTH) 10, 2019 included the resident had a 20 pound weight loss since February, and continues to not be a candidate for [MEDICAL CONDITION] or [MEDICAL CONDITION] treatment for [REDACTED]. She is being followed by hospice with a terminal prognosis of [MEDICAL CONDITION]. An observation was conducted on (MONTH) 29, 2019 at 9:08 a.m. of the room shared by resident #63 and #122. Outside of the room, was an isolation cart and a sign which indicated to see the nurse before entering the room. There were also two resident names (resident #63 and resident #122) listed on the outside of the room. At this time, resident #122 was observed lying in the bed by the window, however, resident #63's bed was unable to be seen from the doorway. An interview was conducted with a licensed practical nurse (LPN/staff #37) immediately following this observation. Staff #37 stated there were two residents in this room and only bed A (resident #63) was on contact isolation for [MEDICAL CONDITION].In an interview with a LPN (staff #71) on (MONTH) 29, 2019 at 11:50 a.m., she stated that she was the nurse assigned to this room today. She stated that resident #63 was on contact isolation for [MEDICAL CONDITION] and the other resident (resident #122) did not have [MEDICAL CONDITION]. She stated that resident #63 came back from the hospital with [MEDICAL CONDITION] and is still currently receiving antibiotics for the infection. An interview was conducted with the Infection Preventionist (staff #192) on (MONTH) 29, 2019 at 2:26 p.m. Staff #192 stated that it was facility policy for resident's who have a [MEDICAL CONDITION] infection to be placed in an isolation room. Staff #192 stated that if a private room was not available, the resident should be placed in a room (cohort) with another resident who had [MEDICAL CONDITION]. Staff #192 further stated that if a resident had a [DIAGNOSES REDACTED]. Review of the CDC guidelines updated in (MONTH) 2019 revealed that [MEDICAL CONDITION] is a spore forming bacterium that causes inflammation of the colon known as [MEDICAL CONDITION]. Risk factors include antibiotic use, serious underlying illness and age over 65. [MEDICAL CONDITION] spores are shed in feces and transferred to patients mainly via the hands of people who have touched a contaminated surface or item. [MEDICAL CONDITION] spores can live for months or sometimes years on surfaces. For prevention of transmission of [MEDICAL CONDITION] in healthcare settings, use contact precautions for patients with known or suspected [MEDICAL CONDITION]. Contact precautions are intended to prevent transmission of infectious agents, which are spread by direct or indirect contact with the patient or the patient's environment. The CDC guidelines further included to use gloves and gowns when entering patient rooms and during care, and for all interactions that may involve contact with the patient or potentially contaminated areas in the patient's environment. Before exiting the patient room, discard gowns and gloves to contain pathogens, especially those that have been implicated in transmission through environmental contamination (e.g. [MEDICAL CONDITION] .and other intestinal tract pathogens). The CDC guidelines also included the following: Cohorting is the practice of grouping together patients who are colonized or infected with the same organism to confine their care to one area and prevent contact with other patients. Cohorts are created based on clinical diagnosis, microbiologic confirmation when available, epidemiology and mode of transmission of the infectious agent. A single patient room is preferred for patients who require contact precautions. It is generally preferred not to place severely immunosuppressed patients in rooms with other patients. When a single patient room is not available, consultation with infection control personnel is recommended to assess the various risks associated with other patient placement options (e.g. cohorting, keeping the patient with an existing roommate). Review of the facility's Infectious Disease Management policy dated 5/1/18 revealed the facility will use appropriate infection control, environmental decontamination and prevention measures for the prevention and management of infectious diseases and communicable diseases. Patients who have evidence of an infectious disease will be treated according to physician/provider orders and current guidelines. Contact precautions will be followed when there is a high risk for transmission. Review of a facility policy regarding Contact Precautions dated (MONTH) 15, 2019 revealed that in addition to standard precautions, contact precautions will be used for diseases transmitted by direct or indirect contact with the patient or the patient's environment. The purpose is to reduce the risk of transmission of epidemiologically important microorganisms by direct or indirect contact. Instruct staff regarding precautions and the use of PPE. Staff must use barrier precautions when entering the room, including gowns and gloves. Change gown and gloves during care if they come in direct contact with infectious material. Before exiting the room, remove and bag gown and gloves, and wash hands upon exiting the room. Remove bagged PPE from the room and discard in soiled utility and wash hands. The policy further included to place patient in private room, if possible. Patient may cohort with an individual who has the same organism. Do not place colonized or infected patient with another patient who has severe immunosuppression (e.g. cancer .etc.) A policy titled, Clostridioides Difficile Infection (CDI) dated (MONTH) 15, 2019 revealed .Place patient in private room. If private rooms are not available, place patient in room (cohort) with other CDI patient. If no private room or cohorting with another CDI is not possible, then do not place patient with another patient who has severe immunosuppression (e.g., cancer). The policy also included to maintain stringent hand washing procedures.