| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER<br>**035132** | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING ______<br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br>**03/14/2019** |
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| NAME OF PROVIDER OF SUPPLIER<br>**CORONADO HEALTHCARE CENTER** | | STREET ADDRESS, CITY, STATE, ZIP<br>**11411 NORTH 19TH AVE PHOENIX, AZ 85029** | |

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) |
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| F 0677<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Some | **Provide care and assistance to perform activities of daily living for any resident who is unable.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ><br>Based on clinical record reviews, staff interviews, and policy review, the facility failed to ensure two of two sampled residents (#'s 457 and 207) were provided and/or offered showers. The resident census was 175. This deficient practice could result in residents not being provided hygiene care and services.<br>Findings include:<br>-Resident #207 was admitted to the facility on (MONTH) 27, (YEAR) with [DIAGNOSES REDACTED]. The resident was discharged on (MONTH) 15, (YEAR).<br>Review of a care plan dated (MONTH) 28, (YEAR) revealed the resident had self care deficit related to activities of daily living (ADL) and personal hygiene. Interventions included conversing with the resident while providing the necessary care and encouraging participation to the fullest extent possible.<br>The admission Minimum Data Set (MDS) assessment dated (MONTH) 4, (YEAR) revealed a score of 14 on the Brief Interview for Mental Status (BIMS) which indicated the resident had no cognitive impairment. The assessment included the resident was totally dependent on staff for bathing.<br>Review of the Certified Nursing Assistant (CNA) bathing Flowsheet for (MONTH) (YEAR) revealed bathing did not occur for this resident on (MONTH) 27, 28, 29, 30, and 31, (YEAR).<br>Review of the clinical record and nursing notes revealed no evidence the resident had been offered a bath or shower and refused, or that baths or showers had been provided.<br>Review of the (MONTH) (YEAR) CNA ADL Flowsheet revealed documentation the resident was provided a shower on (MONTH) 3, (YEAR). For the remaining 12 days the resident resided at the facility, there was no evidence a bath or shower had been offered or provided. In addition, there was no evidence in the nursing notes that the resident had been offered or provided a bath or shower.<br>The Administrator (staff #219) stated on (MONTH) 7, 2019 at 12:46 p.m., that she could not locate paper shower sheets for resident #207 for (MONTH) and (MONTH) (YEAR).<br>An interview was conducted with a CNA (staff #141) on (MONTH) 6, (YEAR) at 12:52 p.m. Staff #141 stated a resident is scheduled two times a week for a bath or shower. The CNA stated the shower/bath schedule is kept in a binder at nursing station on each unit. The CNA stated that when a resident is provided a bath or shower, the form is completed and placed back in the binder for the nurse to review. Staff #141 stated that if a bath or shower is offered and the resident refuses, the refusal is documented on the shower form and in the electronic chart.<br>-Resident #457 was admitted on (MONTH) 12, (YEAR) with [DIAGNOSES REDACTED].<br>Review of the care plan initiated (MONTH) 14, (YEAR) revealed the resident had a self-care performance deficit and required assistance. The goal was that the resident would maintain his current level of function for grooming and personal hygiene. Interventions included encouraging the resident to participate to the fullest extent possible with each interactions.<br>The admission MDS assessment dated (MONTH) 19, (YEAR) revealed a BIMS score of 14 which indicated the resident had intact cognition. The assessment also included the resident required extensive assistance with bed mobility, limited assistance with transfer and personal hygiene, and physical help limited to transfer only with bathing.<br>Review of the task documentation for showers revealed the resident received one shower the week of (MONTH) 24 to 30, no showers the week of (MONTH) 8 to14, and no showers the week of (MONTH) 15 to 21, (YEAR).<br>The clinical support staff (staff #216) stated on (MONTH) 6, 2019 at 8:15 a.m., they were unable to locate any shower sheets for this resident.<br>Review of the progress notes did not reveal any further documentation of showers provided or refused.<br>An interview was conducted with a CNA (staff #184) on (MONTH) 6, 2019 at 1:08 p.m. She stated that there is shower schedule for each resident and that each resident is scheduled for two showers a week. She stated that she documents a shower with how much assistance the resident required in the electronic record. The CNA stated that if the resident is independent for showers, a shower sheet would still be completed and the nurse would sign the shower sheet. The CNA also stated that all residents require at least supervision and set up and that no resident, including independent residents, should be left alone in the shower room. She stated that if a resident refuses a shower, the resident is asked to sign the sheet that he/she refused the shower. After reviewing the task documentation, the CNA stated that if there are no shower sheets, there would be no documentation that the resident was offered or received showers.<br>An interview was conducted with a CNA (staff #23) on (MONTH) 6, 2019 at 3:00 p.m. She stated that there is a shower schedule and that each resident receives two showers a week. The CNA stated that she documents a shower on the paper shower form and in the electronic record. She stated that if a resident refuses a shower, she would offer a shower again. She stated if the resident refuses a second time, she would notify the nurse. She also stated that if the resident refused a third time, she would have the resident sign that he/she refused and why on the shower sheet. The CNA stated that she would also document the refusal in the electronic record.<br>During an interview conducted with a Licensed Practical Nurse (LPN/staff #3) on (MONTH) 7, 2019 at 10:41 a.m., she stated that residents are scheduled for 2 showers a week. The LPN stated that if a resident refuses a shower, the CNA notifies the nurse. She stated the nurse would speak with the resident to find out why the resident refused the shower. She stated that if a resident still declined the shower, she would mark refused on the shower sheet and have the resident sign the sheet. The LPN stated that if the CNA did not chart a shower in the electronic record and there is no shower sheet, she would not be able to say whether a resident received a shower or if a shower was offered.<br>An interview was conducted with the Administrator (staff #219) on (MONTH) 7, 2019 at 12:45 p.m. She stated that the short term residents do not have a set in stone shower schedule because many of them shower independently. She stated that her expectation is that residents' requests and personal hygiene needs be met. The Administrator stated that a resident should be offered a shower on the scheduled shower days and there should be documentation that the resident received the shower or refused the shower.<br>Review of the facility's policy regarding ADL services revealed residents who are unable to carry out ADL's will receive necessary services to maintain grooming and personal hygiene. The policy also included residents are given the appropriate treatment and services to maintain or improve his/her abilities. |
| F 0777<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Provide or obtain x-rays/tests when ordered and promptly tell the ordering practitioner of the results.** |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0777<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 1)<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ><br>Based on closed clinical record review, staff interviews and policy review, the facility failed to ensure that a STAT chest x-ray was obtained as ordered by the physician for one resident (#307). The deficient practice has the potential to adversely affect care or treatment.<br>Findings include:<br>Resident #307 was readmitted on (MONTH) 6, (YEAR), with [DIAGNOSES REDACTED].<br>The initial admission record dated (MONTH) 6, (YEAR) included the resident was alert and oriented to time, place, person and was able to follow simple commands.<br>The NP (nurse practitioner) progress note dated (MONTH) 8, (YEAR) included the resident was alert and oriented x 4. The note included [DIAGNOSES REDACTED].<br>A physician's orders [REDACTED].<br>According to the MAR (medication administration record) for (MONTH) 12, (YEAR), the resident had a temperature of 99.4 degrees Fahrenheit.<br>A physician's orders [REDACTED].<br>A late entry NP progress note dated (MONTH) 12, (YEAR) at 4:42 p.m. included that the NP was notified in the morning that resident was more somnolent than usual. Physical examination included the resident had no acute distress but not able to get comfortable. Neurological examination included the resident was awake and alert, followed some commands, but speech was slurred. The note included altered mental status, with unclear etiology.<br>A nursing progress note dated (MONTH) 12, (YEAR) at 5:40 p.m. revealed the resident's speech was slurred and mentation was altered and that the resident was monitored hourly throughout the shift.<br>Per the clinical record documentation, the resident was admitted to the hospital on (MONTH) 13, (YEAR).<br>Further review of the clinical record revealed there was no evidence that the STAT chest x-ray was done as ordered.<br>During an interview with a licensed practical nurse (LPN/staff #153) conducted on (MONTH) 6, 2019 at 11:21 a.m., she stated that she was on shift when resident had the change in condition. She stated the NP ordered a STAT chest x-ray, which was done.<br>An interview with medical records staff (staff #112) was conducted on (MONTH) 7, 2019 at 2:03 p.m. She stated there was no record of any chest x-ray which was done for resident #307.<br>An interview with another LPN (staff #47) was conducted on (MONTH) 12, 2019 at 2:28 p.m. Staff #47 stated when she receives a STAT order, she will transcribe it in the electronic record, complete a requisition form and call the laboratory. She said depending on what company the request was made and forwarded to, the turnaround time is between 1 and 4 hours for a STAT order. She stated she will follow up in an hour to ensure receipt of the order and requisition; and if the STAT order was not done after the turnaround time, she would call right away and inform them of the STAT order again.<br>In an interview with the Director of Nursing (DON/staff #215) conducted on (MONTH) 12, 2019 at 3:25 p.m., she stated the window period for STAT laboratory orders including chest x-rays is 4 hours and that it should be done by then. She stated that she expects the nurses to follow up on the requests. Further, she stated the STAT chest x-ray ordered for resident #307 was not done and she does not know the reason why.<br>Review of the policy regarding Physician order [REDACTED].in accordance with the resident's plan of care. |