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	**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 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.

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

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.

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 1) 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 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

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) 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 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

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) 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.