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 _____	**08/26/2020**

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 0885 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, facility documentation, staff interviews and policy review, the facility failed to ensure that facility residents and family members/representatives were notified that a resident had tested positive for COVID-19, within the required timeframe. The deficient practice could result in residents and their representatives/families not being aware of new COVID-19 cases in the facility and the actions implemented to reduce the risk of transmission. Findings include: Resident #1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A nursing progress note dated August 23, 2020 at 10:00 p.m. included that a call was placed to the physician regarding a change of condition for resident #1, due to new shortness of breath, slight elevation of temperature and complaints of dry mouth. The note included the resident stated that something is not right with my head. Per the note, the physician was also informed that the resident had an elevated temperature the night before, which resolved with Tylenol. Orders were received for blood work, chest x-ray (to be completed in the morning) and a breathing treatment to be given now. A nursing progress note dated August 24, 2020 at 3:17 a.m. included that a change of condition had been noted. One of the resident's symptoms was shortness of breath at night. The note stated the resident's primary care clinician had been notified and that orders included for a chest x-ray, and the resident's medical power of attorney (POA) had been notified. A physician's orders [REDACTED]. Review of a nursing progress note dated August 24, 2020 at 10:20 a.m. revealed the resident's POA was called and the nurse informed her of the chest x-ray and that the resident's test results were positive for COVID. It was explained that the resident would be sent to another facility, until cleared and safe to return. A nursing progress note dated August 24, 2020 at 10:24 a.m. included the resident had hit the line listing today for signs and symptoms of COVID-19. The note stated an order was obtained for POC rapid [MEDICATION NAME] testing and the testing was completed, with positive COVID-19 results. The resident was to be transferred to another facility on their COVID unit. A nursing note dated August 24, 2020 at 1:00 p.m. included the resident was positive for COVID and was waiting for transportation. The note stated the infection was newly identified. A nursing progress note dated August 24, 2020 at 1:30 p.m. revealed the resident left the facility in an electric wheelchair, via transport to another facility. Review of facility documentation revealed no evidence that other residents in the facility or their representatives/family members had been notified of the new positive COVID-19 case by 5 p.m. the next calendar day following this occurrence. In addition, the facility was unable to provide any documentation that other residents in the facility or their representatives/families were notified of the new positive case of COVID-19. According to a scripted telephone message dated August 19, 2020 regarding a different occurrence, the facility had made telephone calls to resident's representatives and their family members to inform them that one staff member and one resident had tested positive for COVID-19. The message stated that the facility was currently testing 100% of staff and residents that week and the following weeks, until the facility was cleared of [MEDICAL CONDITION]. The message included the representatives and family members would be notified directly if their loved one became positive for COVID-19. An interview was conducted on August 26, 2020 at 1:23 p.m., with the Director of Nursing (DON/staff #18). She stated that residents, families or resident representatives were not notified that resident #1 had tested positive for COVID-19. She stated that notification would be given in the event of a new outbreak or cluster, but because the facility had not experienced two consecutive weeks with 100% of residents and staff testing negative for COVID, she did not consider resident #1's positive result to be a new outbreak, but rather a part of the last one. She stated if a positive COVID result was obtained after a two-week period of negative test results, she would consider it a new outbreak, and then would notify the other residents and their families. On August 26, 2020 at 1:50 p.m., an interview was conducted with the Infection Preventionist (staff #9). She stated that for the past month, she has conducted Zoom calls with families and/or resident representatives on Fridays at 3:30 p.m. She stated that during those calls, she gives an update regarding the facility's positive cases, testing and education on rapid testing. She stated that on August 21, 2020, she notified families and/or their representatives of the positive cases which had occurred that week. She said that this Friday (August 28, 2020), she was going to provide notification that the facility had a new resident who had tested positive on August 24, 2020. Staff #9 reviewed the facility policy regarding notification and timeline requirements and said they did not inform the other residents and families, in accordance with their policy. Review of a facility policy titled, COVID-19 Reporting to Residents, Resident Representatives and Families revealed the purpose was to provide guidance and communication while meeting federal COVID-19 reporting requirements to residents, resident representatives and families. The policy stated the facility would inform residents, resident representatives and families of those residing in the facility by 5:00 p.m. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or three or more residents or staff with new onset of respiratory symptoms occurring within 72 hours of each other.

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.