Medicare/Medicaid Public Records Documents Only

Survey event #QW7811

Facility: FRIENDSHIP VILLAGE OF TEMPE

Revised 7-2020

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QW78

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: LTC0036

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035074**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **FRIENDSHIP VILLAGE OF TEMPE**
(L4) **2525 EAST SOUTHERN AVENUE**
(L5) **TEMPE, AZ** (L6) **85282**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/04/2022** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 04 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
04 SNF	**08 OPT/SP**	**12 RHC**	**16 HOSPICE**	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **128** (L18)
13.Total Certified Beds **128** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
128				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Friendship Village of Tempe Recertification survey #QW78 was conducted on 08/04/2022. There were deficiencies cited on the Federal and Life Safety Code. Based on the allegation of compliance and acceptable plan of correction with evidence of compliance, the revisit survey completed on 09/01/2022 (Health) and 08/29/2022 (LSC); State Agency recommends recertification.

17. SURVEYOR SIGNATURE Date :
Estrella Geis, HCM, by Monica Miller
Monica Miller 09/01/2022
(L19)

18. STATE SURVEY AGEN Megan whetley Date:
Monica Miller 09/01/2022
(L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/12/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00511
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 1, 2022

Jadyne Schmidt
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Provider Number 035074

Dear Mrs. Schmidt:

Your facility has just undergone its Federal/State recertification survey, as required for the Federal Title XVIII (Medicare) program. As the result of this survey, the facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

Please retain a copy of this notice with your signed provider agreement.

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW/EG:mm

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 1, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On September 1, 2022, an offsite revisit, #QW7812, was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that **no deficiencies** of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Monica Miller

Monica Miller
Program Project Specialist II

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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	R 09/01/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	**2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An offsite follow-up survey was conducted on September 1, 2022. There were no deficiencies cited.	{F 000}		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035074 Y1	A. Building B. Wing Y2	9/1/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0625	Correction	ID Prefix F0655	Correction	ID Prefix F0658	Correction
Reg. # 483.15(d)(1)(2)	Completed	Reg. # 483.21(a)(1)-(3)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	08/25/2022	LSC	08/25/2022	LSC	08/25/2022
ID Prefix F0812	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.60(i)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	08/25/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	TY	9/1/2022		9/1/2022
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
8/4/2022	☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 1, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On August 29, 2022, an offsite **Life Safety Code** revisit, #QW7822, was conducted at your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that **no deficiencies** of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Life Safety Code Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Monica Miller

Monica Miller
Program Project Specialist II

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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING **02 - MAIN BUILDING 01** B. WING _____	R **08/29/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	**2525 EAST SOUTHERN AVENUE** **TEMPE, AZ 85282**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on an acceptable plan of correction submitted to the Arizona Department of Health Services on August 29, 2022, for standard level deficiencies cited during the Medicare and Medicaid (CMS) Life Safety Code survey, no on-site follow up survey will be conducted for Event # QW7822.	{K 000}		

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035074 Y1	A. Building 02 - MAIN BUILDING 01 B. Wing Y2	8/29/2022 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. #	Completed	Reg. #	Completed
LSC K0921	08/29/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	AV	08/29/2022	Anthony Valenti	08/29/2022
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
8/4/2022

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 18, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, Arizona 85282

Dear Mrs. Schmidt:

On **August 4, 2022**, a recertification survey, #QW7811, was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed **Emergency Preparedness** deficiency form which indicates that **no deficiencies** were found at the time of the recertification inspection. This form will become a part of your public file; please retain a copy for your files.

If we may be of any further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW\mm

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	**2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 42CFR 483.73, Long Term Care Facilities The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. No apparent deficiences noted during the survey conducted on 08/03/2022 Kevin Whitlock Sr Compliance Officer.	E 000		

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.

UPOC F Tag

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 29, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

The State Agency has received the Statement of Deficiencies and Plan of Correction for the annual survey investigation, #QW7811, which was conducted on August 4, 2022 and submitted to the Bureau of Long Term Care on August 26, 2022.

1) The facility should indicate the completion date for each tag in their POC; and,
2) The facility must submit audits completed to date

The requested documents are required to be returned to this office no later than **September 6, 2022**, please retaining a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **September 6, 2022,** licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW\mm

Attachments

RECEIVED BLTC 8-30-22 MM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	INITIAL COMMENTS The Recertification Survey was conducted August 1, 2022 through August 4, 2022, in conjunction with the investigation of Complaints AZ00168946, AZ00168945, AZ00174716, AZ00174718, AZ00182828, AZ00182829. The following deficiencies were cited:	F 000	This plan of correction is to serve as Friendship Village Tempe's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Friendship Village Tempe or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625 SS=D	It is the intention of Friendship Village of Tempe to ensure each Resident and/or Resident Representative has received policies regarding facility Resident screening, admission, transport, transfer, discharge planning and discharge to ensure physical health services and behavioral health services are established, documented and implemented to protect the health and safety of the Resident. 1. The Admissions Director and Administrator reviewed and followed the current policy and procedure and information given to the Resident and/or Resident Representative upon admission. The Admissions Director and Administrator have updated the Bed Hold Policy (8/22/2022) to charge the private pay daily rate past the 72 hour required hold. Additionally, the Admissions Director and Administrator have updated the Behold Policy (8/22/2022) form to either be signed in person or receive a verbal acknowledgement by the Resident and/or Resident Representative upon discharge from the facility within 24 hours. All Admissions employees have been educated on the new Bed Hold Policy and Procedure (8/23/2022). Completion date 8/23/2022.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/30/2022

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 IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 625	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility failed to ensure one resident (#3) and/or their representative was provided written Information regarding the facility's bed hold policy before transfer to the hospital. The deficient practice could result in the residents not being informed of the facility's bed hold policy when transferred or discharged. Findings include: Resident #3 was initially admitted to the facility on March 11, 2022 with diagnoses that included anxiety, depression, dizziness/giddiness, insomnia, and pain. An admission Minimum Data Set (MDS) assessment dated March 18, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment also indicated the resident experienced pain frequently. Review of a nursing note dated April 11, 2022 revealed that resident was transferred to the emergency room due to complaint of pain. However, review of the clinical record revealed no evidence the resident and/or the resident's representative was informed in writing of the bed hold policy. Review of the medical record revealed no signed bed hold policy completed at the time of admission on March 11, 2022. During an interview conducted on August 4, 2022 At 08:59 AM with a Registered Nurse, Manager	F 625	2. All residents, employees, volunteers, students and guests have the potential to affected by the facility's failure to ensure each Resident and/or Resident Representative has received policies regarding facility Resident screening, admission, transport, transfer, discharge planning and discharge to ensure physical health services and behavioral health services are established, documented and implemented to protect the health and safety of the Resident. Effective 8/23/2022, all private pay Medicare A Residents will be given the opportunity to pay the Health Care Center current daily rate to ensure a bed past the 72 hour required hold. 3. Administrator and Admissions Director & Team will ensure the information is provided, discussed and documented at time of admission and discharge to ensure compliance. 4. The Admissions Director or designee will review all discharges for one month, then 10% of discharges the following month and adjust audits thereafter based on compliance. The Admissions Director will report the findings monthly to QAPI and quarterly to QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of page one.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 625	Continued From page 2 (RN Manager/staff #54), she stated the process for transferring a resident to the hospital includes: a call to the MD (medical doctor) for orders, an email to leadership, a secretary prints the transfer paperwork, and a call to the hospital for report. She also stated that a transfer form is completed in the EMR (electronic medical record). She further stated the bed hold is discussed with the resident and/or family, but that it has never been is documented in the EMR. She reviewed the medical record and stated that the resident was transferred to the hospital on April 11, 2022, and that there was no documentation regarding notification of bed hold. The RN also stated that there was no signature obtained from the resident on the transfer paperwork. An interview was conducted on August 4, 2022 with a Licensed Practical Nurse (LPN/staff #58) at 08:10 AM, who stated that they do not have the resident sign any bed hold paperwork when transferring to the hospital. An interview was conducted on August 4, 2022 at 10:43 AM with the Director of Nursing (DON/Staff #172), who states that a Medicare resident is not informed in writing of the bed hold policy at the time of transfer to the hospital, as the bed is automatically held for 3 days. An interview was conducted on August 4, 2022 at 11:39 AM with the Admissions Director (staff #173), who stated that they do not offer/review the bed hold policy to Medicare residents on transfer to hospital, as they hold the bed for 3 days. She also stated that if the resident is out for over 3 days, they don't hold the bed. She further stated that they are not giving the resident/family the option to pay if they would like to hold the bed	F 625		

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F 625	Continued From page 3 longer than 3 days. An interview was conducted on August 4, 2022 on August 4, 2022 at 11:51 AM with the Administrator (staff #240), who stated that Medicare residents are not informed of the bed hold policy in writing when they are transferred to the hospital. Review of the Facility Admission Agreement revealed that a copy of the current bed hold policy shall be provided to the resident and family Member or representative before transfer. Further review of the agreement did not reveal any mention regarding residents on Medicare at the time of admission. Review of the facility policy titled, Bed hold, revealed that the purpose is to inform the resident and/or resident representative of bed hold availability if the resident has to go into the hospital. It also stated that a bed hold is not offered to residents on Medicare A. Upon admission to the health care center at Friendship Village the resident/representative will be provided the opportunity to elect a bed hold status for any future transfer. Upon admission the resident and/or representative is informed of the facility's bed hold policy.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655	It is the practice of Friendship Village of Tempe to develop and implement a comprehensive person-centered care plan for each Resident that includes measureable objectives and timeframes to meet a Resident's medical, nursing, mental and psychosocial needs that are identified within 48 hour of admission into the Health Care Center.	

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F 655	Continued From page 4 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social Services. (F) PASARR recommendation, if applicable §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews	F 655	1. A copy of the comprehensive care plan for Resident #90 has been given/offered to the Resident/Resident Representative on 8/5/2022. Completion date 8/5/2022. 2. All Resident care plans have been reviewed and any Resident or Resident Representative have been given a copy of the care plan or documented as not wanting a copy (8/5/2022). 3. The community has updated the Comprehensive Care Plan Policy, 8/5/2022, see attached. The interdisciplinary team (IDT) has been educated on this policy 8/23/2022. Residents and/or Resident Representatives will be offered a copy of the care plan summary and the IDT will document if they do not want a copy of the care plan summary in the medical record. 4. The DON or designee is conducting quality improvement audits of care plans as it relates to documentation of sending comprehensive care plans, making a copy or documenting a refusal in the medical record. A random sample of 3 residents will be reviewed weekly for 30 days; then every other week for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to the QAPI Committee monthly and the QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 655	Continued From page 5 and policy review, the facility failed to ensure one of thirteen sampled residents (#90) and/or their representatives were provided a copy of the baseline care plan summary. The deficient practice could result in residents not receiving appropriate care. Findings include: The resident was admitted to the facility on June 13, 2922 with diagnoses that included depression, pain, and mood disorder. Review of the care plan initiated on June 13, 2022 revealed goals including daily preferences with interventions that it is important for the resident to have family involved in discussions about care. It further included goals regarding discharge with interventions to discuss needs and goals to be met prior to community discharge. Review of collaborative care review notes dated June 17, 2022, revealed no documentation that the resident or her representative had been provided a copy of the care plan summary. Review of the Minimum Data (MDS) Set Assessment dated June 19, 2022, revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated cognitive impairment. Continued review of the clinical record revealed that there was no documentation that a written summary of the resident's baseline care plans had been provided to the resident's legal representative. During an interview conducted on August 4, 2022 at 09:25 AM with a registered nurse, manager.	F 655		

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F 655	Continued From page 6 (staff #54), the nurse stated that the resident's care plan was initiated on June 13, 2022, and a care plan meeting was conducted on June 17, 2022. The nurse also stated that there is no documentation in the medical record that the baseline care plan summary was provided to the resident or her representative. An interview was conducted with a Licensed Practical Nurse (LPN/Staff #58) on August 4, 2022 at 9:35 AM, who stated that they are to complete the baseline care plan within 48 hours, and they will sometimes review it with the resident, but they do not give them a copy. An interview was conducted on August 4, 2022 at 02:27 PM with a RN Manager (staff #54), who stated that they do not give residents a copy of the care plan summary unless they ask. She reviewed the medical record for resident #90 and stated that there is no documentation that the resident or their representative were provided a copy of their care plan summary. An interview was conducted on August 4, 2022 at 02:41 PM with the Director of Nursing (DON/staff #172), who stated that the facility policy is to initiate the care plan on admission, and it is reviewed with the resident and/or family within seven days. She stated that the care plan summary is offered, and social services would be documented in social services notes. She reviewed the medical records for the resident and Stated that she did not see any documentation that the family/resident had been given a copy of the care plan summary. She also stated that it is the facility process to give the resident and/or family a copy of the care plan summary.	F 655		

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F 655	Continued From page 7 An interview was conducted on August 8, 2022 at 03:04 PM with the Director of Social Services (staff #176) who stated that they do not offer to give a copy of the care plan summary to the resident or representative, unless they ask for one. She stated that t is not documented in the medical record, but she would have an email that it was sent. She reviewed her emails and stated that she has no documentation that the resident or their representative were provided a copy of the care plan summary. Further interview was conducted with the DON on August 4, 2022 at 3:25 PM. She stated that the nurse manager reviewing the care plan with the resident/representative is supposed to give the resident or family a copy of the care plan summary. She further stated that they were educated on this. A request for a copy of the facilities policy related to Baseline Care Plan was requested on August 4, 2022, the administrator (staff #240) stated that there is no individual policy for a baseline care plan. Review of the facility policy titled, Comprehensive Care Plans, revealed that the resident's comprehensive care plan is developed within seven days of the completion of the MDS assessment. The resident has the right to refuse to participate in the development of his/her care plan. When such refusals are made, appropriate documentation will be entered into the clinical records. Review of the facility Admission Agreement revealed that the facility will perform a baseline	F 655		

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F 655	Continued From page 8 care plan and/or comprehensive care plan in accordance with applicable Federal and State laws and regulations.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that three residents (#3, 90, 38) medications were administered per physician ordered parameters. The deficient practice could result in ineffective management of resident's blood pressure and pain. Findings include: -Regarding resident #3 Resident #3 was initially admitted to the facility on March 11, 2022 with diagnoses that included anxiety, depression, dizziness/giddiness, insomnia, and pain. A care plan initiated on March 11, 2022 revealed a goal related to pain with interventions to medicate per physician's order. An admission Minimum Data Set (MDS) assessment dated March 18, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The	F 658	It is the practice of Friendship Village of Tempe to develop and implement a comprehensive person-centered care plan for each resident that includes measureable objectives and timeframes to meet a Resident's medical, nursing, mental and psychosocial needs that are identified in within 48 hours of admission into the Health Care Center. Ensuring medications are administered per physician ordered parameters to ensure Resident safety from receiving unnecessary medications. 1. The physical order for pain management and blood pressure parameters for Residents, #3, #90 and #38, respectively have been clarified by the physician and written for clear direction to the nurses administering pain medications and/or blood pressure medications, 8/5/2022, see attached. Completion date 8/25/2022. 2. All Residents with parameters on all medications have the potential to be ineffective for condition management. All Resident orders have been reviewed and medications with parameters have been clarified 8/25/2022. 3. The community has updated the Medication Administration policy on 8/5/2022, see attached. The interdisciplinary team (IDT) and full-time skilled nursing Nurses have been educated on this policy 8/25/2022.	

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F 658	Continued From page 9 assessment also included the resident experienced pain frequently. Review of a nursing note dated April 11, 2022 am, revealed that resident was transferred to the emergency room due to complaints of pain. Review of the current and active medications for the March 2022 admission Clinical Physician Orders revealed the following medication: -Acetaminophen 325mg (milligram) tablet, give 2 tablets by mouth every 4 hours as needed for pain level 1-4, start date 3/11/2022. However, review of the April 2022 Medication Administration Record (MAR) revealed that Acetaminophen had been administered for pain levels outside the ordered pain parameters of 1-4 on the following dates: -April 6, 2022 pain level 5 -April 10,2022 pain level 0 -April 11, 2022 pain level 9 The clinical record revealed no documentation of a reason why these medications were not administered as ordered and that the physician has been notified. An interview was conducted on August 3, 2022 at 02:28 PM with a Registered Nurse, Manager (RN/staff #54), who stated that the facility process is to follow physician orders and parameters as written. She reviewed the medical record and stated that was acetaminophen was ordered as needed for pain level 1-4. She reviewed the MAR for April 2022 and stated that acetaminophen had been administered for pain levels outside the ordered parameters three times during the month. She reviewed the medical record and	F 658	4. The DON or designee is conducting quality improvement audits of physician orders for medications with parameters. All new admission orders will be reviewed daily, including checking MAR for documentation of parameters for 30 days; then every other week for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to QAPI Committee monthly and QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 658	Continued From page 10 stated that there were no progress notes on those dates as to why the medication was administered outside of parameters or that the physician had been notified. The RN further stated that this did not follow the facility policy, that the parameters on the physician orders was not followed. An interview was conducted on August 03, 2022 at 02:31 PM, with a RN (staff #113), who stated that she was aware of the resident and that she has a lot of pain. She reviewed the April 2022 MAR and stated acetaminophen had been administered outside of the ordered parameters on April 6, 10 and 11. She further stated that there was no documentation in the progress notes as to why the medication had been administered outside of the parameters, or that the physician had been notified. She stated that it should be documented in the progress notes, would usually notify the physician as well. She also stated that this did not follow the facility policy and the risk could be that the medication is not effective. -Regarding Resident #90 The resident was admitted to the facility on June 13, 2022 with diagnoses that included depression, pain and mood disorder. Review of the care plan initiated on June 13, 2022 revealed goals that included the potential alterations in level of comfort related to pain, with interventions that included to medicate per physician's order. Review of the Minimum Data (MDS) Set Assessment dated June 19, 2022, revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated cognitive impairment.	F 658		

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F 658	Continued From page 11 Review of the physician orders active in June 2022 included the following start and discontinue/stop dates: -Start date 6/13/22, Tramadol HCL tablet 50 mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/16/22) -Start date 6/16/22, Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/17/22)- -Start date 6/17/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/24/22) - start date 6/24/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 7/04/22) Further review of the physician's orders for July 2022 included the following start/stop/discontinue dates: -Start date 6/24/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 7/04/22) -Start date 7/4/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 8 hours as needed for pain 4-10 (current) However, review of the June and July 2022 Medication Administration Record (MAR) revealed that Tramadol had been administered with no documentation of the pain level at the time of administration, or the medication was administered outside of parameters on the following dates: -6/14/2022 – no documentation of pain level at 4:00pm -6/15/2022 – no documentation of pain level twice at 12:00pm	F 658		

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F 658	Continued From page 12 -6/16/2022 – no documentation of pain level at 0:30 -6/17/2022 – no documentation of pain level at 1:30 AM -6/21/22 – pain level documented as 0 -6/29/22 – Pain level documented as 2 -7/4/2022 – Pain level documented as 3 Review of pain level documentation in the medical record revealed: -6/14/2022 pain level documented one time at 20:44 as level 0. -6/15/2022 pain level documented at 7:14 am level 0, -6/16/2022 – no pain level documented until 7:28 am with level 0. -6/17/2022 – no pain level documented until 8:34 AM with level 4. The clinical record revealed no documentation of a reason why these medications were not administered as ordered or that the physician had been notified. An interview was conducted on August 4, 2022 at 9:15am with RN, Manager (staff#54), who stated that the facility policy is to follow physician orders as written including any parameters. She also stated that if a medication is administered outside of parameters the nurse would notify the physician and document in the progress notes. She further stated that the facility process is to document the pain level at the time the pain medication is administered, including Tramadol. The RN reviewed the June 2022 MAR and stated that the medication had been administered without documentation of the pain level four times, and had been administered two times outside of the ordered parameters with no	F 658		

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documentation of why, or that the physician had been notified. She reviewed the July 2022 MAR and stated that the documentation showed that Tramadol had been administered outside of parameters on July 4, 2022 with no documentation of why or physician notification. She stated that this did not meet the facility policy. The RN stated that the risk of not administering pain medication as ordered could that they would not know if the medication is effective.

An interview was conducted on August 4, 2022 at 10:53 AM with the Director of Nursing (DON/staff #240), who stated that the facility process is to follow physician orders as written including parameters. She further stated that if a medication is administered outside of the ordered parameters, they would need to document why in the progress notes. She reviewed the medical record of resident #3 and stated that acetaminophen had been administered outside of parameters three times in April 2022, with no progress note or physician notification. The DON reviewed the medical records for resident #90 and stated that the pain level had not been documented when Tramadol was administered 4 times, and was administered for pain levels outside of parameters three times in June 2022. She also stated that Tramadol had been administered outside of parameters one time in July 2022. The DON further stated that there was no documentation of why the medications were administered, pain level or physician notification. She stated that this did not meet her expectations and that she was not sure what the risk would be.

Review of the facility policy titled, Pain Management, revealed that pharmacological

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F 658	Continued From page 14 treatment of pain as ordered by the physician will be administered in dosage and time frame specified. Review of the facility policy titled, Opioid Prescribing and Treatment, revealed that nurses may also administer opioids consistent with the prescriber's order. Document the resident's pain before administration of the opioid in the resident's medical record. -Regarding resident #38 Resident #38 was admitted to the facility on July 18, 2022 with diagnoses that pulmonary hypertension, acute respiratory failure with hypoxia, and chronic pulmonary edema. A care plan initiated on July 19, 2022 pertaining to hypertension indicated interventions that included: medicate per physician's orders; monitor vital signs as ordered. An admission Minimum Data Set (MDS) assessment dated July 24, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Review of the current and active medications for the July 2022 admission Clinical Physician Orders revealed the following medication: -Metoprolol Tartrate Tablet 100mg, give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold for SBP (systolic blood pressure) <110 and BP (diastolic) <60. Start date 7/18/2022. However, review of the July 2022 Medication Administration Record (MAR) revealed that Metoprolol had been held outside the ordered	F 658		

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	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 658	Continued From page 15 parameters of Hold for SBP <110 and BP <60 on the following dates: -July 19, 2022, P.M. dose, BP 131/58, Pulse 60 -July 22, 2022, A.M. dose, BP 144/58, Pulse 49 -July 25, 2022, A.M. dose, BP 167/62, Pulse 51 -July 31, 2022, P.M. dose, 105/66, Pulse 55 According to the corresponding Medication Administration Report notes, the medication was held because the vital sign was outside of the parameter. This is not in accordance with the ordered parameter of Hold for SBP <100 and BP <60. An interview was conducted with resident #38 on August 4, 2022 at 2:38 p.m., she stated that her blood pressure is not under control. She noted that she is concerned about it. She said she will know more tonight when it is next taken. An interview was conducted on August 4, 2022 at 3:18 p.m. with a registered nurse (RN/staff #244), who stated that if an order is unclear or have a potential typo, the nurse should clarify with the doctor and let the nurse manager know, then check if there was a change or if there is indeed a typo. The order was reviewed with staff #244 on August 4, 2022 at 3:18 p.m. Staff #244 said that looking at the order, it will need to be clarified because it seemed unclear. However, because it used the word AND, both have to occur for the medication to be administered. An interview conducted with the director of nursing (DON/staff #172) on August 4, 2022 at 3:39 p.m. She said that her expectation is that her staff will ensure that it is the right resident	F 658		

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F 658	Continued From page 16 right dose, follow infection control protocols and follow physician order prior to administering medication. She stated that she also expects staff to clarify orders that they are unclear about. The order was reviewed with staff #172 on August 4, 2022 at 3:39 p.m. she said she does not have a problem with the order. When the July 2022 MAR was reviewed along with her pertaining to the order and the discrepancy was noted, she stated she understood why the order might be confusing. Review of the facility's policy titled "Medication Administration" revised June 2014 indicated to assess and document vital signs as ordered or indicated prior to the administration of medication.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must – §483.60(i)(1) – Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) – Store, prepare, distribute and serve food in accordance with professional	F 812	It is the intention of Friendship Village to follow food safety requirements in an effort to store, prepare, distribute and serve food to meet standards for food service safety. 1. The cantaloupe, onions and discolored dishware were thrown away in the kitchen at the time of the observation (8/5/2022). Daily inspection of dishware and produce inspection are completed by Registered Dietician or designee to ensure compliance. Completion date 8/25/2022. 2. All Residents and employees have the risk of being affected by contamination if safe food and dishware handling practices are not in place to maintain the safety and wholesomeness of food for human consumption. All employees have been educated on proper food storage and soiled dishware/flatware procedures for safety on 8/24/2022, see attached. 3. Inspection of dishware and produce is conducted by Registered Dietician or designee daily to ensure compliance. Education regarding food safety requirements has been provided to all employees, 8/24/2022 (see attached).	

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F 812	Continued From page 17 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and policy review, the facility failed to ensure food items were not moldy and failed to ensure stored dishware was clean. The deficient practice could increase the risk of foodborne illness. Findings include: Regarding moldy food: During the initial kitchen observation conducted on August 1, 2022 at 7:57 a.m., 2 cantaloupes which appeared to have mold on them were found stored in a box located in the dry storage room. Another observation of the kitchen was conducted on August 3, 2022 at 10:10 a.m. During this observation, two red onions which appeared to have mold on them were found stored in a box in the dry storage room. One of the red onions was also wet due to being rotten. In an interview conducted with the kitchen manager (staff #241) on August 3, 2022 at 2:07 p.m., he stated that with produce they put it away as soon as they receive it. They take out the old inventory and put in the new inventory so that they are able to use it, first in, first out. Every day they go in to check inventory and if there are moldy items they get rid of it and bring in the replacement the next day. Staff #241 said that dry items such as onions, bananas, cantaloupe, honey dew and watermelon normally go in the dry storage and all other produce goes in the walk-in fridge. The dry storage's thermostat is set at 70.	F 812	4. The Registered Dietician or designee is conducting quality improvement audits of dishware and produce storage, daily for the first 30 days; then weekly for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to the QAPI Committee monthly and QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 812	Continued From page 18 degrees Fahrenheit. The thermostat is checked each time they do an inventory to ensure the setting is right. The kitchen's policy titled "Food and Supply Storage" revised January 2018, stated that all food, non-food items and supplies used in food preparation shall be stored in a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Regarding dishware: An observation of the dining room kitchen located on the second floor was conducted on August 3, 2022 at 11:10 a.m. During the observation a rusted knife and two blue cups that had a film of debris and appeared slightly wet were found stored in the ready to use area. An interview was conducted with the lead diet aide supervisor (staff #154) on August 3, 2022 at 11:43 a.m. Staff #154 said that dishware was manually inspected before use. If the dishware is not clean, it is taken downstairs to the main kitchen so that it can be washed. When asked about the utensil found during the observation, she noted that it was rusted and threw the knife in the trash. During an interview with the kitchen manager (staff #241) on August 3, 2022 at 2:07 p.m., he said that the person unloading the dishware is responsible for making sure it is good to go. If it is not, then it needs to go back in thru the dishwasher. Diet aides are also supposed to double check the items are clean prior to putting the items away.	F 812		

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F 812	Continued From page 19 The facility did not have a policy pertaining to the washing and storage of dishware which outlines the process. The kitchen's 2018 policy and procedure manual titled "Food Storage and Date Marking" indicated that temperatures for refrigerators may be between 35 to 41 degree Fahrenheit. Thermometers should be checked routinely. Check for proper functioning of the unit at the same time.	F 812		

POC F Tag

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 18, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On **August 4, 2022**, a Medicare recertification survey, #QW7811, was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

[X] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **August 28, 2022** may result in the imposition of remedies.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

ltc.licensing@azdhs.gov
SUBJECT LINE: the name of your facility and POC

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

- Please provide all in-service records to include:

    - What was taught
    - When it was taught
    - Sign-in sheets of those who attended
    - Any copies of monitoring aduits being done up to your Allegation of Compliance date

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of September 18, 2022**.**

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continue until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, effective August 4, 2022
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on August 4, 2022. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions. The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by **January 31, 2023**.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Notice for Statutory Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective **November 2, 2022**. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an

administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **August 28, 2022**, licensure and/or recertification may be denied. If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Megan Whitby

Megan Whitby
Interim Long Term Care Bureau Chief

MW:mm

Attachments

RECEIVED BLTC 8-26-22 MM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 000	INITIAL COMMENTS The Recertification Survey was conducted August 1, 2022 through August 4, 2022, in conjunction with the investigation of Complaints AZ00168946, AZ00168945, AZ00174716, AZ00174718, AZ00182828, AZ00182829. The following deficiencies were cited:	F 000	This plan of correction is to serve as Friendship Village Tempe's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Friendship Village Tempe or the management company that the allegations contained in the survey report are a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.	
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.	F 625 SS=D	It is the intention of Friendship Village of Tempe to ensure each Resident and/or Resident Representative has received policies regarding facility Resident screening, admission, transport, transfer, discharge planning and discharge to ensure physical health services and behavioral health services are established, documented and implemented to protect the health and safety of the Resident. 1. The Admissions Director and Administrator reviewed and followed the current policy and procedure and information given to the Resident and/or Resident Representative upon admission. The Admissions Director and Administrator have updated the Bed Hold Policy (8/22/2022) to charge the private pay daily rate past the 72 hour required hold. Additionally, the Admissions Director and Administrator have updated the Behold Policy (8/22/2022) form to either be signed in person or receive a verbal acknowledgement by the Resident and/or Resident Representative upon discharge from the facility within 24 hours. All Admissions employees have been educated on the new Bed Hold Policy and Procedure (8/23/2022).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Administrator | (X6) DATE: 9/26/2022

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 625	Continued From page 1 This REQUIREMENT is not met as evidenced by: The facility failed to ensure one resident (#3) and/or their representative was provided written Information regarding the facility's bed hold policy before transfer to the hospital. The deficient practice could result in the residents not being informed of the facility's bed hold policy when transferred or discharged. Findings include: Resident #3 was initially admitted to the facility on March 11, 2022 with diagnoses that included anxiety, depression, dizziness/giddiness, insomnia, and pain. An admission Minimum Data Set (MDS) assessment dated March 18, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The assessment also indicated the resident experienced pain frequently. Review of a nursing note dated April 11, 2022 revealed that resident was transferred to the emergency room due to complaint of pain. However, review of the clinical record revealed no evidence the resident and/or the resident's representative was informed in writing of the bed hold policy. Review of the medical record revealed no signed bed hold policy completed at the time of admission on March 11, 2022. During an interview conducted on August 4, 2022 At 08:59 AM with a Registered Nurse, Manager	F 625	2. All residents, employees, volunteers, students and guests have the potential to affected by the facility's failure to ensure each Resident and/or Resident Representative has received policies regarding facility Resident screening, admission, transport, transfer, discharge planning and discharge to ensure physical health services and behavioral health services are established, documented and implemented to protect the health and safety of the Resident. Effective 8/23/2022, all private pay Medicare A Residents will be given the opportunity to pay the Health Care Center current daily rate to ensure a bed past the 72 hour required hold. 3. Administrator and Admissions Director & Team will ensure the information is provided, discussed and documented at time of admission and discharge to ensure compliance. 4. The Admissions Director or designee will review all discharges for one month, then 10% of discharges the following month and adjust audits thereafter based on compliance. The Admissions Director will report the findings monthly to QAPI and quarterly to QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of page one.	

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F 625	Continued From page 2 (RN Manager/staff #54), she stated the process for transferring a resident to the hospital includes: a call to the MD (medical doctor) for orders, an email to leadership, a secretary prints the transfer paperwork, and a call to the hospital for report. She also stated that a transfer form is completed in the EMR (electronic medical record). She further stated the bed hold is discussed with the resident and/or family, but that it has never been is documented in the EMR. She reviewed the medical record and stated that the resident was transferred to the hospital on April 11, 2022, and that there was no documentation regarding notification of bed hold. The RN also stated that there was no signature obtained from the resident on the transfer paperwork. An interview was conducted on August 4, 2022 with a Licensed Practical Nurse (LPN/staff #58) at 08:10 AM, who stated that they do not have the resident sign any bed hold paperwork when transferring to the hospital. An interview was conducted on August 4, 2022 at 10:43 AM with the Director of Nursing (DON/Staff #172), who states that a Medicare resident is not informed in writing of the bed hold policy at the time of transfer to the hospital, as the bed is automatically held for 3 days. An interview was conducted on August 4, 2022 at 11:39 AM with the Admissions Director (staff #173), who stated that they do not offer/review the bed hold policy to Medicare residents on transfer to hospital, as they hold the bed for 3 days. She also stated that if the resident is out for over 3 days, they don't hold the bed. She further stated that they are not giving the resident/family the option to pay if they would like to hold the bed	F 625		

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F 625	Continued From page 3 longer than 3 days. An interview was conducted on August 4, 2022 on August 4, 2022 at 11:51 AM with the Administrator (staff #240), who stated that Medicare residents are not informed of the bed hold policy in writing when they are transferred to the hospital. Review of the Facility Admission Agreement revealed that a copy of the current bed hold policy shall be provided to the resident and family Member or representative before transfer. Further review of the agreement did not reveal any mention regarding residents on Medicare at the time of admission. Review of the facility policy titled, Bed hold, revealed that the purpose is to inform the resident and/or resident representative of bed hold availability if the resident has to go into the hospital. It also stated that a bed hold is not offered to residents on Medicare A. Upon admission to the health care center at Friendship Village the resident/representative will be provided the opportunity to elect a bed hold status for any future transfer. Upon admission the resident and/or representative is informed of the facility's bed hold policy.	F 625		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide	F 655	It is the practice of Friendship Village of Tempe to develop and implement a comprehensive person-centered care plan for each Resident that includes measureable objectives and timeframes to meet a Resident's medical, nursing, mental and psychosocial needs that are identified within 48 hour of admission into the Health Care Center.	

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F 655	Continued From page 4 effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social Services. (F) PASARR recommendation, if applicable §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews	F 655	1. A copy of the comprehensive care plan for Resident #90 has been given/offered to the Resident/Resident Representative on 8/5/2022. 2. All Resident care plans have been reviewed and any Resident or Resident Representative have been given a copy of the care plan or documented as not wanting a copy (8/5/2022). 3. The community has updated the Comprehensive Care Plan Policy, 8/5/2022, see attached. The interdisciplinary team (IDT) has been educated on this policy 8/23/2022. Residents and/or Resident Representatives will be offered a copy of the care plan summary and the IDT will document if they do not want a copy of the care plan summary in the medical record. 4. The DON or designee is conducting quality improvement audits of care plans as it relates to documentation of sending comprehensive care plans, making a copy or documenting a refusal in the medical record. A random sample of 3 residents will be reviewed weekly for 30 days; then every other week for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to the QAPI Committee monthly and the QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 655	Continued From page 5 and policy review, the facility failed to ensure one of thirteen sampled residents (#90) and/or their representatives were provided a copy of the baseline care plan summary. The deficient practice could result in residents not receiving appropriate care. Findings include: The resident was admitted to the facility on June 13, 2922 with diagnoses that included depression, pain, and mood disorder. Review of the care plan initiated on June 13, 2022 revealed goals including daily preferences with interventions that it is important for the resident to have family involved in discussions about care. It further included goals regarding discharge with interventions to discuss needs and goals to be met prior to community discharge. Review of collaborative care review notes dated June 17, 2022, revealed no documentation that the resident or her representative had been provided a copy of the care plan summary. Review of the Minimum Data (MDS) Set Assessment dated June 19, 2022, revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated cognitive impairment. Continued review of the clinical record revealed that there was no documentation that a written summary of the resident's baseline care plans had been provided to the resident's legal representative. During an interview conducted on August 4, 2022 at 09:25 AM with a registered nurse, manager.	F 655		

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F 655	Continued From page 6 (staff #54), the nurse stated that the resident's care plan was initiated on June 13, 2022, and a care plan meeting was conducted on June 17, 2022. The nurse also stated that there is no documentation in the medical record that the baseline care plan summary was provided to the resident or her representative. An interview was conducted with a Licensed Practical Nurse (LPN/Staff #58) on August 4, 2022 at 9:35 AM, who stated that they are to complete the baseline care plan within 48 hours, and they will sometimes review it with the resident, but they do not give them a copy. An interview was conducted on August 4, 2022 at 02:27 PM with a RN Manager (staff #54), who stated that they do not give residents a copy of the care plan summary unless they ask. She reviewed the medical record for resident #90 and stated that there is no documentation that the resident or their representative were provided a copy of their care plan summary. An interview was conducted on August 4, 2022 at 02:41 PM with the Director of Nursing (DON/staff #172), who stated that the facility policy is to initiate the care plan on admission, and it is reviewed with the resident and/or family within seven days. She stated that the care plan summary is offered, and social services would be documented in social services notes. She reviewed the medical records for the resident and Stated that she did not see any documentation that the family/resident had been given a copy of the care plan summary. She also stated that it is the facility process to give the resident and/or family a copy of the care plan summary.	F 655		

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F 655	Continued From page 7 An interview was conducted on August 8, 2022 at 03:04 PM with the Director of Social Services (staff #176) who stated that they do not offer to give a copy of the care plan summary to the resident or representative, unless they ask for one. She stated that t is not documented in the medical record, but she would have an email that it was sent. She reviewed her emails and stated that she has no documentation that the resident or their representative were provided a copy of the care plan summary. Further interview was conducted with the DON on August 4, 2022 at 3:25 PM. She stated that the nurse manager reviewing the care plan with the resident/representative is supposed to give the resident or family a copy of the care plan summary. She further stated that they were educated on this. A request for a copy of the facilities policy related to Baseline Care Plan was requested on August 4, 2022, the administrator (staff #240) stated that there is no individual policy for a baseline care plan. Review of the facility policy titled, Comprehensive Care Plans, revealed that the resident's comprehensive care plan is developed within seven days of the completion of the MDS assessment. The resident has the right to refuse to participate in the development of his/her care plan. When such refusals are made, appropriate documentation will be entered into the clinical records. Review of the facility Admission Agreement revealed that the facility will perform a baseline	F 655		

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F 655	Continued From page 8 care plan and/or comprehensive care plan in accordance with applicable Federal and State laws and regulations.	F 655		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality This REQUIREMENT is not met as evidenced by: Based on clinical record review, interviews, and facility policy, the facility failed to ensure that three residents (#3, 90, 38) medications were administered per physician ordered parameters. The deficient practice could result in ineffective management of resident's blood pressure and pain. Findings include: -Regarding resident #3 Resident #3 was initially admitted to the facility on March 11, 2022 with diagnoses that included anxiety, depression, dizziness/giddiness, insomnia, and pain. A care plan initiated on March 11, 2022 revealed a goal related to pain with interventions to medicate per physician's order. An admission Minimum Data Set (MDS) assessment dated March 18, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. The	F 658	It is the practice of Friendship Village of Tempe to develop and implement a comprehensive person-centered care plan for each resident that includes measureable objectives and timeframes to meet a Resident's medical, nursing, mental and psychosocial needs that are identified in within 48 hours of admission into the Health Care Center. Ensuring medications are administered per physician ordered parameters to ensure Resident safety from receiving unnecessary medications. 1. The physical order for pain management and blood pressure parameters for Residents, #3, #90 and #38, respectively have been clarified by the physician and written for clear direction to the nurses administering pain medications and/or blood pressure medications, 8/5/2022, see attached. 2. All Residents with parameters on all medications have the potential to be ineffective for condition management. All Resident orders have been reviewed and medications with parameters have been clarified 8/25/2022. 3. The community has updated the Medication Administration policy on 8/5/2022, see attached. The interdisciplinary team (IDT) and full-time skilled nursing Nurses have been educated on this policy 8/25/2022.	

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F 658	Continued From page 9 assessment also included the resident experienced pain frequently. Review of a nursing note dated April 11, 2022 am, revealed that resident was transferred to the emergency room due to complaints of pain. Review of the current and active medications for the March 2022 admission Clinical Physician Orders revealed the following medication: -Acetaminophen 325mg (milligram) tablet, give 2 tablets by mouth every 4 hours as needed for pain level 1-4, start date 3/11/2022. However, review of the April 2022 Medication Administration Record (MAR) revealed that Acetaminophen had been administered for pain levels outside the ordered pain parameters of 1-4 on the following dates: -April 6, 2022 pain level 5 -April 10,2022 pain level 0 -April 11, 2022 pain level 9 The clinical record revealed no documentation of a reason why these medications were not administered as ordered and that the physician has been notified. An interview was conducted on August 3, 2022 at 02:28 PM with a Registered Nurse, Manager (RN/staff #54), who stated that the facility process is to follow physician orders and parameters as written. She reviewed the medical record and stated that was acetaminophen was ordered as needed for pain level 1-4. She reviewed the MAR for April 2022 and stated that acetaminophen had been administered for pain levels outside the ordered parameters three times during the month. She reviewed the medical record and	F 658	4. The DON or designee is conducting quality improvement audits of physician orders for medications with parameters. All new admission orders will be reviewed daily, including checking MAR for documentation of parameters for 30 days; then every other week for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to QAPI Committee monthly and QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 658	Continued From page 10 stated that there were no progress notes on those dates as to why the medication was administered outside of parameters or that the physician had been notified. The RN further stated that this did not follow the facility policy, that the parameters on the physician orders was not followed. An interview was conducted on August 03, 2022 at 02:31 PM, with a RN (staff #113), who stated that she was aware of the resident and that she has a lot of pain. She reviewed the April 2022 MAR and stated acetaminophen had been administered outside of the ordered parameters on April 6, 10 and 11. She further stated that there was no documentation in the progress notes as to why the medication had been administered outside of the parameters, or that the physician had been notified. She stated that it should be documented in the progress notes, would usually notify the physician as well. She also stated that this did not follow the facility policy and the risk could be that the medication is not effective. -Regarding Resident #90 The resident was admitted to the facility on June 13, 2022 with diagnoses that included depression, pain and mood disorder. Review of the care plan initiated on June 13, 2022 revealed goals that included the potential alterations in level of comfort related to pain, with interventions that included to medicate per physician's order. Review of the Minimum Data (MDS) Set Assessment dated June 19, 2022, revealed a Brief Interview for Mental Status (BIMS) score of 08, which indicated cognitive impairment.	F 658		

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F 658	Continued From page 11 Review of the physician orders active in June 2022 included the following start and discontinue/stop dates: -Start date 6/13/22, Tramadol HCL tablet 50 mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/16/22) -Start date 6/16/22, Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/17/22)- -Start date 6/17/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 6/24/22) - start date 6/24/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 7/04/22) Further review of the physician's orders for July 2022 included the following start/stop/discontinue dates: -Start date 6/24/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 6 hours as needed for pain 4-10 (discontinue date 7/04/22) -Start date 7/4/22 Tramadol HCL tablet 50mg – give 50mg by mouth every 8 hours as needed for pain 4-10 (current) However, review of the June and July 2022 Medication Administration Record (MAR) revealed that Tramadol had been administered with no documentation of the pain level at the time of administration, or the medication was administered outside of parameters on the following dates: -6/14/2022 – no documentation of pain level at 4:00pm -6/15/2022 – no documentation of pain level twice at 12:00pm	F 658		

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F 658	Continued From page 12 -6/16/2022 – no documentation of pain level at 0:30 -6/17/2022 – no documentation of pain level at 1:30 AM -6/21/22 – pain level documented as 0 -6/29/22 – Pain level documented as 2 -7/4/2022 – Pain level documented as 3 Review of pain level documentation in the medical record revealed: -6/14/2022 pain level documented one time at 20:44 as level 0. -6/15/2022 pain level documented at 7:14 am level 0, -6/16/2022 – no pain level documented until 7:28 am with level 0. -6/17/2022 – no pain level documented until 8:34 AM with level 4. The clinical record revealed no documentation of a reason why these medications were not administered as ordered or that the physician had been notified. An interview was conducted on August 4, 2022 at 9:15am with RN, Manager (staff#54), who stated that the facility policy is to follow physician orders as written including any parameters. She also stated that if a medication is administered outside of parameters the nurse would notify the physician and document in the progress notes. She further stated that the facility process is to document the pain level at the time the pain medication is administered, including Tramadol. The RN reviewed the June 2022 MAR and stated that the medication had been administered without documentation of the pain level four times, and had been administered two times outside of the ordered parameters with no	F 658		

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F 658	Continued From page 13	F 658		

documentation of why, or that the physician had been notified. She reviewed the July 2022 MAR and stated that the documentation showed that Tramadol had been administered outside of parameters on July 4, 2022 with no documentation of why or physician notification. She stated that this did not meet the facility policy. The RN stated that the risk of not administering pain medication as ordered could that they would not know if the medication is effective.

An interview was conducted on August 4, 2022 at 10:53 AM with the Director of Nursing (DON/staff #240), who stated that the facility process is to follow physician orders as written including parameters. She further stated that if a medication is administered outside of the ordered parameters, they would need to document why in the progress notes. She reviewed the medical record of resident #3 and stated that acetaminophen had been administered outside of parameters three times in April 2022, with no progress note or physician notification. The DON reviewed the medical records for resident #90 and stated that the pain level had not been documented when Tramadol was administered 4 times, and was administered for pain levels outside of parameters three times in June 2022. She also stated that Tramadol had been administered outside of parameters one time in July 2022. The DON further stated that there was no documentation of why the medications were administered, pain level or physician notification. She stated that this did not meet her expectations and that she was not sure what the risk would be.

Review of the facility policy titled, Pain Management, revealed that pharmacological

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F 658	Continued From page 14 treatment of pain as ordered by the physician will be administered in dosage and time frame specified. Review of the facility policy titled, Opioid Prescribing and Treatment, revealed that nurses may also administer opioids consistent with the prescriber's order. Document the resident's pain before administration of the opioid in the resident's medical record. -Regarding resident #38 Resident #38 was admitted to the facility on July 18, 2022 with diagnoses that pulmonary hypertension, acute respiratory failure with hypoxia, and chronic pulmonary edema. A care plan initiated on July 19, 2022 pertaining to hypertension indicated interventions that included: medicate per physician's orders; monitor vital signs as ordered. An admission Minimum Data Set (MDS) assessment dated July 24, 2022 revealed a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. Review of the current and active medications for the July 2022 admission Clinical Physician Orders revealed the following medication: -Metoprolol Tartrate Tablet 100mg, give 1 tablet by mouth two times a day related to ESSENTIAL (PRIMARY) HYPERTENSION Hold for SBP (systolic blood pressure) <110 and BP (diastolic) <60. Start date 7/18/2022. However, review of the July 2022 Medication Administration Record (MAR) revealed that Metoprolol had been held outside the ordered	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	08/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

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F 658	Continued From page 15 parameters of Hold for SBP <110 and BP <60 on the following dates: -July 19, 2022, P.M. dose, BP 131/58, Pulse 60 -July 22, 2022, A.M. dose, BP 144/58, Pulse 49 -July 25, 2022, A.M. dose, BP 167/62, Pulse 51 -July 31, 2022, P.M. dose, 105/66, Pulse 55 According to the corresponding Medication Administration Report notes, the medication was held because the vital sign was outside of the parameter. This is not in accordance with the ordered parameter of Hold for SBP <100 and BP <60. An interview was conducted with resident #38 on August 4, 2022 at 2:38 p.m., she stated that her blood pressure is not under control. She noted that she is concerned about it. She said she will know more tonight when it is next taken. An interview was conducted on August 4, 2022 at 3:18 p.m. with a registered nurse (RN/staff #244), who stated that if an order is unclear or have a potential typo, the nurse should clarify with the doctor and let the nurse manager know, then check if there was a change or if there is indeed a typo. The order was reviewed with staff #244 on August 4, 2022 at 3:18 p.m. Staff #244 said that looking at the order, it will need to be clarified because it seemed unclear. However, because it used the word AND, both have to occur for the medication to be administered. An interview conducted with the director of nursing (DON/staff #172) on August 4, 2022 at 3:39 p.m. She said that her expectation is that her staff will ensure that it is the right resident	F 658		

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F 658	Continued From page 16 right dose, follow infection control protocols and follow physician order prior to administering medication. She stated that she also expects staff to clarify orders that they are unclear about. The order was reviewed with staff #172 on August 4, 2022 at 3:39 p.m. she said she does not have a problem with the order. When the July 2022 MAR was reviewed along with her pertaining to the order and the discrepancy was noted, she stated she understood why the order might be confusing. Review of the facility's policy titled "Medication Administration" revised June 2014 indicated to assess and document vital signs as ordered or indicated prior to the administration of medication.	F 658		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must – §483.60(i)(1) – Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) – Store, prepare, distribute and serve food in accordance with professional	F 812	It is the intention of Friendship Village to follow food safety requirements in an effort to store, prepare, distribute and serve food to meet standards for food service safety. 1. The cantaloupe, onions and discolored dishware were thrown away in the kitchen at the time of the observation (8/5/2022). Daily inspection of dishware and produce inspection are completed by Registered Dietician or designee to ensure compliance. 2. All Residents and employees have the risk of being affected by contamination if safe food and dishware handling practices are not in place to maintain the safety and wholesomeness of food for human consumption. All employees have been educated on proper food storage and soiled dishware/flatware procedures for safety on 8/24/2022, see attached. 3. Inspection of dishware and produce is conducted by Registered Dietician or designee daily to ensure compliance. Education regarding food safety requirements has been provided to all employees, 8/24/2022 (see attached).	

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F 812	Continued From page 17 standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, and policy review, the facility failed to ensure food items were not moldy and failed to ensure stored dishware was clean. The deficient practice could increase the risk of foodborne illness. Findings include: Regarding moldy food: During the initial kitchen observation conducted on August 1, 2022 at 7:57 a.m., 2 cantaloupes which appeared to have mold on them were found stored in a box located in the dry storage room. Another observation of the kitchen was conducted on August 3, 2022 at 10:10 a.m. During this observation, two red onions which appeared to have mold on them were found stored in a box in the dry storage room. One of the red onions was also wet due to being rotten. In an interview conducted with the kitchen manager (staff #241) on August 3, 2022 at 2:07 p.m., he stated that with produce they put it away as soon as they receive it. They take out the old inventory and put in the new inventory so that they are able to use it, first in, first out. Every day they go in to check inventory and if there are moldy items they get rid of it and bring in the replacement the next day. Staff #241 said that dry items such as onions, bananas, cantaloupe, honey dew and watermelon normally go in the dry storage and all other produce goes in the walk-in fridge. The dry storage's thermostat is set at 70.	F 812	4. The Registered Dietician or designee is conducting quality improvement audits of dishware and produce storage, daily for the first 30 days; then weekly for 30 days; then monthly for 30 days. Additional audits will be completed based upon the level of compliance. Results of all audits are being reported to the QAPI Committee monthly and QAA Committee, quarterly for additional recommendations as necessary. 5. See signature of Administrator at the bottom of page one.	

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F 812	Continued From page 18 degrees Fahrenheit. The thermostat is checked each time they do an inventory to ensure the setting is right. The kitchen's policy titled "Food and Supply Storage" revised January 2018, stated that all food, non-food items and supplies used in food preparation shall be stored in a manner as to prevent contamination to maintain the safety and wholesomeness of the food for human consumption. Regarding dishware: An observation of the dining room kitchen located on the second floor was conducted on August 3, 2022 at 11:10 a.m. During the observation a rusted knife and two blue cups that had a film of debris and appeared slightly wet were found stored in the ready to use area. An interview was conducted with the lead diet aide supervisor (staff #154) on August 3, 2022 at 11:43 a.m. Staff #154 said that dishware was manually inspected before use. If the dishware is not clean, it is taken downstairs to the main kitchen so that it can be washed. When asked about the utensil found during the observation, she noted that it was rusted and threw the knife in the trash. During an interview with the kitchen manager (staff #241) on August 3, 2022 at 2:07 p.m., he said that the person unloading the dishware is responsible for making sure it is good to go. If it is not, then it needs to go back in thru the dishwasher. Diet aides are also supposed to double check the items are clean prior to putting the items away.	F 812		

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F 812	Continued From page 19 The facility did not have a policy pertaining to the washing and storage of dishware which outlines the process. The kitchen's 2018 policy and procedure manual titled "Food Storage and Date Marking" indicated that temperatures for refrigerators may be between 35 to 41 degree Fahrenheit. Thermometers should be checked routinely. Check for proper functioning of the unit at the same time.	F 812		

POC K Tag

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 18, 2022

Mrs. Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On August 4, 2022, a **Life Safety Code** survey, #QW7821, was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

[X] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (G).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (H).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby significant corrections are required (I).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **August 28, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **August 28, 2022**, may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;

- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

ltc.licensing@azdhs.gov
SUBJECT LINE: the name of your facility and POC

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of **September 18, 2022.**

If, upon the subsequent revisit, your facility has not achieved substantial compliance, The Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continuing until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, per day, per tag, effective August 4, 2022

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Mandatory Remedies

Your current period of noncompliance began on August 4, 2022. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by January 31, 2022 .

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. **Please note: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An informal dispute resolution process will not delay the effective date of any enforcement action.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **August 28, 2022**, recertification may be denied. If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Megan Whitby
Interim Long Term Care Bureau Chief

MW\mm

Attachments

RECEIVED BLTC 8-26-22 MM

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: **02 – MAIN BUILDING 01** B. WING _____	**08/04/2022**

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FRIENDSHIP VILLAGE OF TEMPE	**2525 E SOUTHERN AVENUE TEMPE, AZ 85282**

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K 000	INITIAL COMMENTS 42 CFR 482.41(b) Hospital The facility must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing. The entire facility, was surveyed on Aug 2, 2022. The facility meets the standards, based upon acceptance of a plan of correction.	K 000	K000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 921 SS=D	Kevin Whitlock Sr Compliance Officer LSC Electrical Equipment – Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment – Testing and Maintenance Requirements The physical integrity, resistance, leakage Current, and touch current tests for fixed and Portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and Protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily	K 921	It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure that all electrical equipment is maintained per testing and maintenance requirements from NFPA 101 and NFPA 99 as a complete system 1. Inspection for electrical medical equipment was completed prior to survey close, 8/5/22. The late entry inspection was the cause of miscommunication of older equipment, thought to be under the process for removal from service for the facility. At the time of this inspection, and as result of the findings, the determination has been made to re-enter these devices and medical equipment back into the facilities medical equipment cache.	

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

Kevin Whitlock | ADMINISTRATOR | 9/26/2022

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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K 921	Continued From page 1 available, and safety labels and condensed operating instructions on the appliance are eligible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2. 1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a record of electrical equipment tests, repairs, and modifications. Failing to conduct maintenance on patient care appliances could cause harm to the residentt if the appliance malfunctions. NFPA 10 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99,Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 10, Section 10.5.6 Record Keeping-Patient Appliances Electrical Equipment – Testing and Maintenance Requirements "The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service	K 921	As a temporary and permanent effort all medical devices were inspected and tested for compliance of safe operation in accordance with manufacture service manual specifications by a certified medical equipment inspection, testing and maintenance (ITM) vendor. Records of (ITM) were obtained, and are maintained for record of service request within the facility with the Life Safety Coordinator, see attached. As a permanent step to prevent this type of event from occurring in the future, the devices identified were added to the facilities pre-established (ITM) program management work order system for annual (ITM), a process of compliance already in place, as evident from the record of (ITM) for other electrical medical equipment inspected dated 02/21/2022 and added to the Facility Assessment. 2. All residents, personnel, employees, volunteers, and students have the potential to be affected by medical equipment that is not inspected monthly and annually. This understanding has prompted the inquiry and recognition to maintain the standard of practice for safety for (ITM) of all electrical medical equipment throughout the facility. Upon further review, it is concluded that current (ITM) practices are consistent with (ITM) standards for electrical medical equipment designed and implemented in the continuation of care for patient.	

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K 921	Continued From page 2 manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training.: Findings include: Observation, record review and staff interview on August 2, 2022, revealed the facility was unable to produce documentation to identify all electrical equipment tests, repairs, and modifications related to two (2) Blood Pressure machines located on resident floors that were four (4) suction machines located in storage rooms that were rental equipment last inspected in 2020. Employee #1 acknowledged during the exit conference on August 2, 2022, the facility failed to test some electrical equipment. The facility advises the suction machines were not used on residents since they were last inspected.	K 921	3. The facilities Life Safety Coordinator, who is in charge of the (ITM) program and recordkeeping of the electrical medical equipment (ITM) program have since added these devices identified into the inventory of current available medical equipment cache, and has also included these devices in the annual work order cue for annual inspections a qualified/certified medical equipment (ITM) vendor. In the manner of maintaining continuity of safe practice, and in the preservation of the patient safety and continuation of care, the inclusion of these identified electrical medical equipment devices constitute the efforts of systematic changes consistent in the prevention of such practice from reoccurring. 4. The Life Safety Coordinator has set up a monthly preventive maintenance reminder to round with the Director of Nursing and Accounts Receivable Specialist to identify any medical equipment that may require inspection. If the efforts of monitoring compliance with the expected standard of practice, reports of these findings, the corrective action taken, and the compliance (ITM) reports provided will be shared and reported to QAA Committee, quarterly meetings. 5. See signature of Administrator at the bottom of page one.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:
From: F1 *(mm/dd/yyyy)*: 08/01/2022
To: F2 *(mm/dd/yyyy)*: 08/05/2022

Extended Survey:
From: F3 *(mm/dd/yyyy)*:
To: F4 *(mm/dd/yyyy)*:

Name of Facility: Friendship Village of Tempe
Provider Number: 03-5074
Fiscal Year Ending: F5 *(mm/dd/yyyy)*:

Street Address: 2525 East Southern Avenue

City: Tempe
County: Maricopa
State: AZ
Zip Code: 85282

Telephone Number: F6: 480-831-3107
State/County Code: F7: 060
State/Region Code: F8: AZ

F9: 01
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 ..... ○ Yes ⊗ No
If yes, indicate Hospital Provider Number: F11

Ownership: F12: 05

For-Profit	Non-Profit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal
13 Limited Liability Corporation			

Owned or leased by Multi-Facility Organization: F13 ..... ○ Yes ⊗ No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
F18 Disabled Children/Young Adults	F19 Head Trauma	F20 Hospice
F21 Huntington's Disease	F22 Ventilator/Respiratory Care	F23 Other Specialized Rehabilitation

Does the facility currently have an organized residents' group? F24 ..... ⊗ Yes ○ No

Does the facility currently have an organized group of family members of residents? ..... ⊗ Yes ○ No

Does the facility conduct experimental research? F26 ..... ○ Yes ⊗ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ..... ⊗ Yes ○ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:
Date: F28 *(mm/dd/yyyy)*:
Hours waived per week: F29: N/A

Waiver of 24 hr licensed nursing requirement:
Date: F30 *(mm/dd/yyyy)*:
Hours waived per week: F31: N/A

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ..... ○ Yes ⊗ No

Name of Person Completing Form: Sabine M. Schmidt
Time: 0957
Signature:
Date: 9/1/2022

Form CMS-671 (06/2018)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare F75	Medicaid F76	Other F77	Total Residents F78
	38	0	12	50

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 40	F81 10
Dressing	F82 0	F83 50	F84 0
Transferring	F85 0	F86 49	F87 1
Toilet Use	F88 0	F89 50	F90 0
Eating	F91 6	F92 43	F93 1

A. Bowel/Bladder Status

F94 4 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 3 ?

F96 25 Occasionally or frequently incontinent of bladder

F97 17 Occasionally or frequently incontinent of bowel

F98 0 On urinary toileting program

F99 0 On bowel toileting program

B. Mobility

F100 0 Bedfast all or most of time

F101 27 In a chair all or most of time

F102 0 Independently ambulatory

F103 23 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0 ?

F106 13 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 12 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 0 Intellectual and/or developmental disability

F109 26 Documented signs and symptoms of depression

F110 7 Documented psychiatric diagnosis (exclude dementias and depression)

F111 10 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 2 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 2 ?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 8 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission ____ ?

F117 34 Receiving preventive skin care

F118 0 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 0 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 0 Dialysis

F123 4 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 5 Respiratory treatment

F125 0 Tracheostomy care

F126 1 Ostomy care

F127 0 Suctioning

F128 11 Injections (exclude vitamin B12 injections)

F129 2 Tube feedings

F130 4 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 33 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 0 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 17 Any psychoactive medication

F134 2 Antipsychotic medications

F135 1 Antianxiety medications

F136 16 Antidepressant medications

F137 3 Hypnotic medications

F138 12 Antibiotics

F139 34 On pain management program

G. Other

F140 4 With unplanned significant weight loss/gain

F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 0 Who use non-oral communication devices

F143 0 With advance directives

F144 1 Received influenza immunization

F145 28 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
BMallyRN	Director of Nsg	8/1/2022

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ✓ Yes ___ No

F147 Was ombudsman present during any portion of the survey? ✓ Yes ___ No

F148 Medication error rate 0 %

FRIENDSHIP VILLAGE OF TEMPE
2525 EAST SOUTHERN AVENUE
TEMPE, AZ 85282
State's Region Code: AZ
Compliance Status: Provider meets requirements based on an acceptable plan of correction

CCN: 035074
Phone Number: (480)831-3184
Participation Date: 11/12/1980

Provider Beds
Total: 128
Certified: 64

Provider Category: SNF
Type Action: RECERTIFICATION
Type Ownership: NONPROFIT - CORPORATION

Program Requirements

Current Survey/Revisit Dates - None

Prior 3 Survey 11/2016	S/S Code	Prior 2 Survey 10/2017	S/S Code	Prior 1 Survey 01/2019	S/S Code	Current Survey 10/15/2020	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	- -	-	-	REQ	F0252-SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT
-	-	-	-	-	-	- -	-	-	REQ	F0253-HOUSEKEEPING & MAINTENANCE SERVICES
-	-	-	-	-	-	- -	-	-	REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	- -	-	-	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
-	-	-	-	-	-	- -	-	-	REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
-	-	-	-	-	-	- -	-	-	REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
-	-	-	-	-	-	- -	-	-	REQ	F0362-SUFFICIENT DIETARY SUPPORT PERSONNEL
-	-	-	-	-	-	- -	-	-	REQ	F0368-FREQUENCY OF MEALS/SNACKS AT BEDTIME
-	-	-	-	-	-	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0456-ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION
-	-	-	-	-	-	- -	-	-	REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	-	-	- -	-	-	REQ	F0499-EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS
-	-	-	-	-	-	- -	-	-	REQ	F0511-RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN
-	-	-	-	-	-	- -	-	-	REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
-	-	-	-	-	-	- -	-	-	REQ	F0517-WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS
-	-	-	-	-	-	- -	-	-	REQ	F0518-TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS
-	-	-	-	X	E	- -	-	-	REQ	F0640-Encoding/Transmitting Resident Assessments
-	-	-	-	X	D	- -	-	-	REQ	F0684-Quality of Care

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 11/2016	S/S Code	2012 HC Prior 2 Survey 10/2017	S/S Code	2012 HC Prior 1 Survey 01/2019	S/S Code	2012 HC Current Survey 10/15/2020	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	STD	K0291-Emergency Lighting
-	-	-	-	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	X	D	-	-	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	X C	D	11/05/2020	STD	K0355-Portable Fire Extinguishers
-	-	-	-	-	-	- -	-	-	STD	K0363-Corridor - Doors
-	-	-	-	X	D	- -	-	-	STD	K0372-Subdivision of Building Spaces - Smoke Barrie
X	D	-	-	-	-	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0379-Smoke Barrier Door Glazing
-	-	-	-	-	-	- -	-	-	STD	K0511-Utilities - Gas and Electric
-	-	X	D	-	-	- -	-	-	STD	K0712-Fire Drills
X	D	-	-	X	D	- -	-	-	STD	K0920-Electrical Equipment - Power Cords and Extens
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	0	2	0	0
Health Total	0	2	0	0
Life Safety Code	1	2	2	2
Life Safety Code + Health	1	4	2	2

Complaint Survey Information

Survey Date	Status
10/15/2020	Unsubstantiated
01/31/2019	Substantiated
10/13/2017	Unsubstantiated
11/09/2016	Unsubstantiated

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

LTC Resident Census

Resident Census on 10/15/2020
Total: 27
Medicare: 11
Medicaid: 0
Other: 16

Total Certified Beds: 64

SNF	SNF/NF	NF	ICF/IID
64	0	0	0

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement - = No Data Entered

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

September 1, 2022

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Complaint Intake #AZ00174716, #AZ00174718, #AZ00168946, #AZ00168945, #AZ00182828, #AZ00182829
Investigation # QW7811

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Monica Miller

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing