STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER **035074**	(X2) MULTIPLE CONSTRUCTION A. BUILDING ______ B. WING _____	(X3) DATE SURVEY COMPLETED **01/31/2019**

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0640 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Encode each resident's assessment data and transmit these data to the State within 7 days of assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record reviews, staff interview, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS (Minimum Data Set) assessments were transmitted to the CMS (Centers for Medicare and Medicaid Services) QIES ASAP (Quality Improvement Evaluation System Assessment Submission and Processing) system for 4 residents (#s 2, 3, 4, and 5). Findings include: Review of the QIES ASAP system revealed the last submitted MDS assessments for the following residents were over 120 days old. -Resident #2 was readmitted on (MONTH) 3, 2014 with [DIAGNOSES REDACTED]. Review of the QIES ASAP system revealed the last MDS assessment submitted was a quarterly MDS assessment dated (MONTH) 22, (YEAR). -Resident #3 was admitted on (MONTH) 30, 2013 with [DIAGNOSES REDACTED]. Review of the QIES ASAP system revealed the last MDS assessment submitted was an annual MDS assessment dated (MONTH) 22, (YEAR). -Resident #4 was admitted on (MONTH) 19, (YEAR) with [DIAGNOSES REDACTED]. Review of the QIES ASAP system revealed the last MDS assessment submitted was a SNF PPS (Skilled Nursing Facility Prospective Payment System) Part A Discharge (End of Stay) assessment dated (MONTH) 11, (YEAR). -Resident #5 was admitted on (MONTH) 9, (YEAR) with [DIAGNOSES REDACTED]. Review of the QIES ASAP system revealed the last MDS assessment submitted was a SNF PPS Part A Discharge (End of Stay) assessment dated (MONTH) 26, (YEAR). An interview was conducted with the MDS coordinator (staff #122) on 01/31/19 at 11:02 AM. The MDS coordinator stated that assessments had been completed for the 4 residents but that they were not submitted to the QIES ASAP system. She stated that she would submit the assessments immediately. After reviewing the RAI manual, the MDS coordinator admitted MDS assessments have to be submitted for a resident whose Medicare Part A stay has ended and the resident remains in a Medicare certified bed. The RAI manual instructs a discharge assessment is required if the resident is transferred from a Medicare-certified bed to a noncertified bed and is required if the resident's Medicare Part A stay ends, but the resident remains in the facility. The manual included when a resident's Medicare Part A stay ends but he/she remains in the facility in a Medicare certified bed with another payer source, the facility must continue with the OBRA (Omnibus Budget Reconciliation Act) schedule from the resident's original date of admission and must also complete a Part A PPS discharge assessment. The manual also included if the end date of the most recent Medicare stay occurs on the day of or one day before the discharge date , the OBRA discharge assessment and Part A PPS discharge assessment are both required and may be combined. The manual instructs MDS assessments must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS assessment completion date.
F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that one resident (#176) received diuretic medication as per a physician's recommendation. Findings include: Resident #176 was admitted to the facility on (MONTH) 20, (YEAR) with [DIAGNOSES REDACTED]. Per the resident's weight record documented on (MONTH) 21, (YEAR), the resident weighed 154 pounds. The admission MDS (Minimum Data Set) assessment dated (MONTH) 27, (YEAR) revealed the resident scored a 13 on the BIMS (Brief Interview for Mental Status), indicating he was cognitively intact. Nursing notes from (MONTH) 28 through (MONTH) 31, (YEAR) indicated that the resident had bruising and [MEDICAL CONDITION] to his right arm and had been encouraged to elevate it. Also noted, the resident had swelling of BLE (Bilateral Lower Extremities). There was no evidence that the physician was notified of the resident's [MEDICAL CONDITION]. A physician's progress note dated (MONTH) 31, (YEAR) revealed no comment regarding the resident's BLE [MEDICAL CONDITION]. The physician recommended that the resident's right arm be elevated while in bed. Per the resident's weight record documented on (MONTH) 31, (YEAR), the resident's weight was 160.8 pounds. This was a 6.8 pound increase in 10 days. Nursing notes from (MONTH) 1 through 5, (YEAR) continued to document that the resident had [MEDICAL CONDITION] of BLE and the right arm. On (MONTH) 5, the nursing notes documented that the resident's right foot did not fit into his brace that was used for foot drop because his foot was too swollen. The resident was noted to be scheduled for a nephrologist appointment on (MONTH) 6, (YEAR). Review of the progress note from the nephrology appointment dated (MONTH) 6, (YEAR) revealed the resident was seen for follow-up and evaluation for CKD. The note stated that the [MEDICAL CONDITION] of the resident's lower extremity was much worse. The instructions the nephrologist provided were to start treating the resident with [MEDICATION NAME] (a diuretic, also known as [MEDICATION NAME]). The medication list from the nephrologist included an order dated (MONTH) 6, (YEAR) for [MEDICATION NAME] 40 milligrams (mg) per day. The resident's physician at the facility signed his initials at the bottom of the page. Review of the physician orders [REDACTED]. A nursing progress note dated (MONTH) 8, (YEAR) stated the resident's foot brace did not fit because of foot swelling. Review of the MAR (Medication Administration Record) for (MONTH) 1 through 17, (YEAR) revealed that [MEDICATION NAME] was not administered. Review of the resident's care plan revealed no evidence that the resident's [MEDICAL CONDITION] had been addressed. Per the resident's weight record documented on (MONTH) 17, (YEAR), the resident's weight was 160.4 pounds, indicating that the resident's weight was 6.4 pounds higher than on admission.

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.

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F 0684 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) A nursing progress note dated (MONTH) 17, (YEAR) reported that the resident had [MEDICAL CONDITION] to BLE and also had a new order for [MEDICATION NAME]. A physician's orders [REDACTED]. Review of the (MONTH) MAR indicated [REDACTED]. The resident's weight documented on (MONTH) 21, (YEAR) was 149 pounds which is about 10 pounds of weight loss after the [MEDICATION NAME] was ordered. An interview was conducted on (MONTH) 30, 2019 at 08:32 a.m. with an RN (Registered Nurse/staff #165). She stated that when a resident goes to an appointment, the nurse will fill out a form that includes what time the resident left the facility, what time they return, who they went to see, and how they were transported. She said that when the resident returns, they usually have a progress note that they give to staff. She said that if the resident does not have any notes, either the unit clerk or a nurse will call the doctor's office in case there are new medication orders or other changes to the resident's care that need to be implemented. Staff #165 stated she wasn't working on the day of the appointment in question and that she wasn't familiar with the information concerning the [MEDICATION NAME]. An interview was conducted on (MONTH) 30, 2019 at 09:16 a.m. with an RN (staff #209). She stated that she usually checks for resident appointments on the computer first thing in the morning on the days she works. She said that when a resident returns to the facility from an appointment, she reviews the paperwork to see if there are any new medication orders or changes to medications. She said she would then follow-up with the physician to report these changes. She said that regarding a resident with BLE [MEDICAL CONDITION] or with a brace that wasn't fitting because of [MEDICAL CONDITION], she would check the resident's weight and notify the physician of these issues to determine if the physician wanted to implement interventions or reassess the resident. Staff #209 also stated she was not working on the day of the resident's appointment and did not know what happened with the recommendation for [MEDICATION NAME]. On (MONTH) 31, 2019 at 12:39 p.m. the DON (Director of Nursing/staff #10) was interviewed. She stated that when a resident has an outside appointment, her expectation is that the resident will return with paperwork from the appointment and that if they do not, there would be a phone call to the the physician's office so that any recommendations can be sent to the facility. She said that this information would then be shared with the resident's physician who would then be responsible to respond to the recommendation. In response to why the [MEDICATION NAME] was not given per the nephrologist's order, she said that it is up to the physician's discretion whether or not to implement any recommendations and write and sign any new orders. An interview was conducted with the resident's physician (staff #255) on (MONTH) 31, 2019 at 3:07 p.m. He stated that he did see the note from the nephrologist that was dated (MONTH) 7, (YEAR) and that he did sign his initials to the note on (MONTH) 8, (YEAR), but that he must have missed the information regarding the [MEDICATION NAME] order from the nephrologist. He stated that he remembered that the resident's arm sling was too tight, but that he believed the resident had come from the hospital with it that way. He stated that he does remember thinking about [MEDICATION NAME] use for this resident, but did not implement this at the time. The facility policy on transcription of physician orders [REDACTED]. Upon completion of a physician order [REDACTED]. This ensures all steps have been completed.