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	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 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** 42319 Based on clinical record review, staff interviews and facility policy, the facility failed to ensure that a medication was provided as ordered; and, failed to ensure that the physician was notified for a missed dose of antibiotic therapy for one resident (#104). The deficient practice could result in resident not receiving the treatment needed to meet his needs. Findings include: Resident #104 was admitted on [DATE] with diagnoses of encephalopathy, pneumonia, and urinary tract infection. An Admission Minimum Data Set (MDS) assessment dated [DATE] revealed a brief interview for mental status (BIMS) score of 13 indicating the resident had intact cognition. It also included that active diagnosis of urinary tract infection (UTI) in the last 30 days. The care area assessment (CAA) worksheet signed and dated May 12, 2024 included that the resident had a diagnosis of dementia and had difficulty with making her needs known. Medications included gentamycin (antibiotic) and tobramycin (antibiotic). A care plan dated May 15, 2024 revealed that the resident had UTI and Fosfomycin (antibiotic). Intervention included to administer antibiotic therapy per physician's orders. A nursing progress note dated May 15, 2024 included that a urinalysis results were received and was positive for UTI. Per the documentation, new orders for Fosfomycin was received from the nurse practitioner (NP). A physician order dated May 15, 2024 included for Fosfomycin Tromethamine oral packet 3 grams, give 1 packet by mouth in the morning every 2 days related to UTI for 3 administrations and to give 1 packet every 2 days for 3 doses. This order had a start date of May 16, 2024. The medication administration record for May 2024 revealed that Fosfomycin was not marked as administered on May 16; and, was marked as administered on May 19 and May 20. The documentation in the MAR included that the resident only received 2 of 3 administrations/doses ordered by the physician. An eMAR administration note dated May 16, 2024 included that the facility was waiting for pharmacy to bring in Fosfomycin. (continued on next page)

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

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	01/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The encounter note dated May 20, 2024 revealed that the resident was on Fosfomycin 1 packet every 2 days for 3 doses for UTI. The plan for the 3 doses of Fosfomycin was active from May 16 through May 22, 2024. However, the clinical record revealed no evidence that the resident received the 3rd dose of Fosfomycin; and that, the physician had been informed of the missed dose of antibiotic. An interview was conducted on January 17, 2025 at 1:12 p.m. with a registered nurse (RN/staff 76) who stated that if a resident was on a scheduled antibiotic therapy and it has not been delivered from pharmacy yet, the RN would get it from their emergency kit if they have it. The RN also said that any time a resident was going to miss or missed a dose of antibiotic she would notify the physician; and that, she would document that notification and any attempts to obtain the medication in the medication administration progress note, or in a standard progress note. In an interview with the RN Nurse Manager (staff #223) conducted on January 17, 2025 at 1:21 p.m., the RN nurse manager stated that if an antibiotic was ordered for a resident and was not available for administration, staff would check the facility's emergency kit. The RN nurse manager said that if the medication such as an antibiotic was not available from the emergency kit, she would notify the provider then let the pharmacy know to deliver the medications STAT. Regarding resident #104, the RN nurse manager stated that Fosfomycin was not available in their emergency kit; and that, Fosfomycin was not given on May 16 when it was ordered to start but, it was given on the next dose. An interview was conducted on January 17, 2025 at 3:37 p.m. with the Director of Nursing (DON/staff #241) who stated that if a resident missed a dose of an antibiotic, staff should absolutely notify the physician; and, follow the physician's order. During an interview with the administrator conducted on January 17, 2025 at 2:00 p.m., the administrator said that the facility did not have a policy on notification of the physician. The facility policy on Medication/Treatment Administration Schedule included a purpose to ensure medications and treatments are provided timely. Review of the facility policy on Medication Administration included that it is their policy to ensure that medications are administered to residents by qualified personnel in compliance with Federal and State laws and standards of professional practice.