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	03/20/2025

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that the abuse policy was followed regarding an incident of abuse between a staff member and one resident (#63). The deficient practice could result in continued staff to resident abuse. Findings include: Resident #63 was admitted to the facility on [DATE] with diagnoses that included sepsis, anemia, long term use of anticoagulants, depression, insomnia, and type 2 diabetes. A progress note dated March 7, 2025 at 1:29 p.m. revealed that Resident #63 reported to overnight staff that another staff member threw a TV remote at him, and that the staff member cussed him out and raised her voice when she came into the room. A Minimum Data Set (MDS) assessment initiated on March 9, 2025 revealed that Resident #63 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the facility investigation dated March 7, 2025 at 1:55 p.m. revealed that the incident occurred on March 7, 2025 at 5:30 a.m The investigation also revealed that an interview was conducted with an LPN who stated that Resident #63 complained to her about the CNA grabbing his hand and scratching it, but she did not get the chance to tell a supervisor because she was so busy. An interview was conducted on March 20, 2025 at 11:31 a.m. with a Licensed Practical Nurse (LPN/Staff#117) who stated that Resident #63 reported to her in the early morning during medication administration that a CNA had held his hand too tight during a brief change. The LPN stated that she intended to report it but failed to, and that, as per the facility policy, she should have reported the allegation to a supervisor that day. The LPN stated that she had received abuse training in February of 2025. An interview was conducted on March 20, 2025 at 12:00 p.m. with Resident #63 who stated that an incident occurred with a staff member (CNA/staff #150) who he thought threw a remote at him but he concluded that she did not intentionally throw anything or hurt him. (continued on next page)

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.

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

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 20, 2025 at 1:24 p.m. with a Registered Nurse (RN/Staff#157) who stated that no matter what the allegation was or if you felt like it did not occur, the policy would be to report allegations of abuse immediately to the managers and the Director of Nursing, and that it would be important because they would need to fully investigate the allegation and ensure that the resident was removed from harm. An interview was conducted on March 20, 2025 at 1:30 p.m. with a Certified Nursing Assistant (CNA/Staff#111) who stated that the facility policy for reporting abuse was 2 hours, and it would need to be reported to the supervisors. An interview was conducted on March 20, 2025 at 1:37 p.m. with a CNA (Staff #60) who stated allegations of abuse would need to be reported immediately to the supervisor per the facility policy to provide safety to the resident and everyone else. The CNA stated that the risk of not following the policy could be that the resident would not be helped and abuse could continue. An interview was conducted on March 20, 2025 at 1:48 p.m. with the Health Services Administrator (Administrator/Staff #26) and Associate Administrator (Staff #120) who stated that they expected staff to report allegations of abuse to management immediately so that the facility could report to all appropriate agencies within 2 hours of becoming aware. The administrator stated that they suspended and fired the LPN for not following the facility ' s abuse policy. The administrator stated that the facility staff were responsible for following the abuse policy and that the risk of not following the abuse policy could result in further abuse, unknown abuse, or fear of reporting. An interview was conducted on March 20, 2025 at 2:05 p.m. with the Director of Nursing (DON/Staff #51), who stated that the facility became aware of the abuse allegation at around 12:30 p.m. on March 7, 2025. The DON stated that the LPN told her that she did not have time to report the allegation to management. The DON stated that the allegation would have been reported by the resident to the LPN between 4-6 a.m. and they did not begin the investigation or reporting process until 12:30 p.m. the following day. The DON stated that the risk of not following the abuse policy would be that residents would suffer harm or injury. Review of a policy titled, Abuse Prevention Program, revealed that employees were required to report any incident, allegation, or suspicion of potential abuse if they had observed, heard about, or suspected it immediately to the administrator or person in charge of the community. The policy also revealed that physical abuse with injury should have been reported within 2 hours of forming the suspicion.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50166 Based on clinical record review, resident and staff interviews, and policy review, the facility failed to ensure that an incident involving abuse between a staff member and one resident (#63) was reported in a timely manner. The deficient practice could result in continued staff to resident abuse. Findings include: Resident #63 was admitted to the facility on [DATE] with diagnoses that included sepsis, anemia, long term use of anticoagulants, depression, insomnia, and type 2 diabetes. A progress note dated March 7, 2025 at 1:29 p.m. revealed that Resident #63 reported to overnight staff (Licensed Practical Nurse/LPN) (Staff #117) that another staff member (Certified Nursing Assistant/CNA) (Staff#150) threw a TV remote at him. A 5-Day Medicare Minimum Data Set (MDS) assessment initiated on March 9, 2025, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. Review of the facility investigation dated March 7, 2025 at 1:55 p.m. revealed that the incident occurred on March 7, 2025 at 5:30 a.m. The investigation also revealed that an interview was conducted with an LPN (Staff #117) who stated that Resident #63 complained to her about a CNA (Staff #50) grabbing his hand and scratching it, but she did not get the chance to tell a supervisor because she was so busy. The facility investigation revealed the incident was reported on March 7, 2025 at approximately 12:30 p.m An interview was conducted on March 20, 2025 at 11:31 a.m. with a Licensed Practical Nurse (LPN/Staff#117) who stated allegations of abuse should be reported to her supervisor immediately. The LPN stated that Resident #63 reported to her in the early morning during medication administration, that a CNA (Staff #150) had held his hand too tight during a brief change. The LPN also stated that she could not find her supervisor to report the allegation of abuse during her shift change, and that she went home without reporting the allegation. The LPN stated that she intended to report it but failed to, and that she should have reported the allegation to a supervisor that day. The LPN stated that she had received abuse training in February of 2025, and that she knew she needed to report it immediately. An interview was conducted on March 20, 2025 at 12:00 p.m. with Resident #63 who stated that an incident occurred with a staff member (CNA/staff #150) who he thought threw a remote at him but he concluded that she did not intentionally throw anything or hurt him. An interview was conducted on March 20, 2025 at 1:24 p.m. with a Registered Nurse (RN/Staff#157) who stated that no matter what the allegation was or if you felt like it did not occur, the policy would be to report allegations of abuse immediately to the manager and the Director of Nursing. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on March 20, 2025 at 1:30 p.m. with a Certified Nursing Assistant (CNA/Staff#111) who stated the timeframe for reporting abuse was 2 hours, and it would need to be reported to the supervisors. An interview was conducted on March 20, 2025 at 1:37 p.m. with a CNA (Staff #60) who stated allegations of abuse would need to be reported immediately to the supervisor as per the facility policy to provide safety to the resident and everyone else. An interview was conducted on March 20, 2025 at 1:48 p.m. with the Health Services Administrator (Administrator/Staff #26) and Associate Administrator (Staff #120), who stated that they expected staff to report allegations of abuse to management immediately so that the facility could report to all appropriate agencies within 2 hours of becoming aware. The administrator stated that failure to report would result in residents continuing to be abused or it was possible for other residents to be abused. The administrator stated that staff were responsible for reporting allegations of abuse immediately and that the risk of staff failing to do so could result in further abuse, unknown abuse, or fear of reporting. An interview was conducted on March 20, 2025 at 2:05 p.m. with the Director of Nursing (DON/Staff #51), who stated that the facility became aware of the allegation at around 12:30 p.m. on March 7, 2025 when the resident reported to an admissions assistant that a caregiver yelled at him and threw a remote at him. The DON stated that while investigating the allegation, she interviewed the staff working the nightshift and the LPN (staff #117) stated that nothing happened, but later changed her story and stated oh yeah, he said that the CNA hurt his hand. The DON stated that the LPN stated that she did not have time to report the allegation to management. The DON stated that the LPN ' s failure to report was not within her expectations, and that the facility had done education the week before the incident occurred in which all staff took a competency quiz to indicate they knew the abuse policies. The DON stated that the allegation would have been reported by the resident to the LPN between 4-6 a.m. and they did not begin the investigation or reporting process until 12:30 p.m. the following day. Review of a policy titled, Abuse Prevention Program, revealed that employees were required to report any incident, allegation, or suspicion of potential abuse if they had observed, heard about, or suspected it immediately to the administrator or person in charge of the community. The policy also revealed that physical abuse with injury should have been reported within 2 hours of forming the suspicion.