ARIZONA DEPARTMENT
OF HEALTH SERVICES

August 23, 2018

Dear Governor Ducey:

Please accept this letter and accompanying documents as a report on the Arizona Department of Health Services' (ADHS) findings of recent inspections of all thirteen Southwest Key facilities operating in Arizona and a summary of the actions ADHS has taken to ensure the health and safety of these children in Arizona. One of the Department's top priorities and concerns is the safety and care provided in ADHS licensed facilities to patients, residents, especially our smallest Arizona residents and visitors.

Background: ADHS has been investigating and conducting on-site investigations at Southwest Key facilities beginning in early July and has been unable to substantiate multiple complaints regarding overcapacity, failure to report to law enforcement, staff qualifications, and the safety and care of children at Southwest Key. These investigations were limited to the individual facility ADHS received complaints against and in each instance, ADHS conducted an on-site investigation and concluded Southwest Key is in substantial compliance with current law and administrative rules.

In early August, after receiving multiple reports, ADHS conducted an additional on-site investigation at each and every Southwest Key facility to investigate four general allegations:

1. Fingerprint card requirements related to personnel having the required background checks mandated by law.
2. Quality Management (QM) programs related to the establishment, implementation, and documentation of QM to ensure improvements in care and implementation of corrective actions.
3. Quality of Care and Treatment related to personnel qualifications, training, skills and knowledge and providing sufficient staff to meet the needs of the children.
4. Quality of Care and Treatment related to providing continuous protective oversight of the children to ensure safety.

In addition, ADHS investigated all other open complaints received against facilities during the on-site investigations. Our surveyors observed the operations, interviewed staff, and reviewed documentation at each facility to establish our findings. The findings are summarized in the table below. Specifics regarding the findings at each of the facilities can be found in the attached Statement of Deficiency documents.

License Location	Summary of Allegations	Summary of Findings
Glendale | N. 48th Ave	0 of 2 allegations were substantiated	1 of 13 bedroom doors do not contain a curtain for privacy
		4 of 13 bedrooms do not have the required square footage per resident
Tucson | N. Oracle	2 of 13 allegations were substantiated	No documentation of clinical oversight of a behavioral health tech
		8 personnel records revealed late application for fingerprint clearance cards
Phoenix | S. 7th Ave	1 of 6 allegations were substantiated	1 of 30 personnel records do not contain evidence of freedom of tuberculosis
		1 of 30 personnel records do not contain evidence of a good faith effort to contact previous employers
		1 of 30 personnel records revealed a 20 month lapse in having a valid fingerprint clearance card
Youngtown | N. 113th Ave	0 of 4 allegations were substantiated	Bedroom doors do not contain a privacy curtain on windows
Peoria | 98th Lane	0 of 4 allegations were substantiated	1 of 5 bedroom doors do not contain a curtain for privacy
		1 of 4 bedrooms do not have enough space between the beds
Glendale | W. Claremont	0 of 4 allegations were substantiated	Poisonous or toxic materials were unlocked; laundry chemicals; soaps
		2 of 4 bedrooms did not contain a door as required
		1 of 4 bedrooms do not have the required square footage per resident
Peoria | 83rd Drive	0 of 4 allegations were substantiated	Poisonous or toxic materials were unlocked; laundry chemicals; soaps
		1 of 4 bedrooms do not have the required square footage per resident
Glendale | W. Myrtle	0 of 4 allegations were substantiated	2 bathrooms do not have doors as required
		Bedrooms do not have doors as required
		1 bedroom does have the required square footage per resident
Glendale | W. San Miguel	0 of 4 allegations were substantiated	1 of 2 personnel records do not contain evidence of freedom of tuberculosis
		4 of 4 bedrooms do not have doors as required
Mesa | E. 2nd Ave	0 of 4 allegations were substantiated	Facility did not provide records to ADHS within the required 2-hour timeframe
		1 of 21 records do not contain evidence of freedom of tuberculosis
Phoenix |14th St	0 of 4 allegations were substantiated	No deficiencies
Mesa |W. Brown	0 of 4 allegations were substantiated	No deficiencies
Phoenix | W. Campbell	0 of 4 allegations were substantiated	No deficiencies

Future Monitoring: Following the conclusion of the survey process, ADHS conducted a provider meeting with Southwest Key leadership to review and remedy the deficiencies ADHS observed and to enter into an agreement with Southwest Key outlining four additional requirements ADHS is seeking on all Southwest Key facilities:

1. Increased unannounced monitoring by ADHS on all Southwest Keys facilities.
2. Require Southwest Key to verify 100% of their current employees have valid fingerprint clearance cards within 30 days.
3. Increased reporting to ADHS on all events that may present a risk of substantial or serious harm to children in the care and custody of Southwest Keys.
4. Increased reporting to ADHS on corrective actions taken by Southwest Keys.

This provider agreement will enhance ADHS's current authority to be aware of, respond to, and investigate future allegations and events that may occur at Southwest Key. A copy of the signed provider agreement is included in the attachments.

Corrective Action: Southwest Key has agreed with ADHS's findings and to immediately begin corrective action, including installing the necessary doors, providing for proper space for residents in bedrooms, and correcting personnel records that are deficient.

ADHS, at this time, is pursuing the issuance of civil money penalties against Southwest Key for violations regarding the lack of timely personnel fingerprint cards. ADHS always issues the maximum civil money penalties allowed by law when we discover any provider not adhering to the criminal background check mandated by Arizona law. While the licensee may dispute these penalties, we are confident in our position and findings, however, due process must be followed.

Engaging Federal Agencies: Because these children are in the legal custody of the U.S. Federal Government, Southwest Key has contracts with the U.S. Department of Health and Human Services through the Office of Refugee Resettlement to provide care and services to these children. While this provides some challenges, it also represents an additional opportunity for proper oversight and a means to incentivize corrective action.

ADHS will be sharing our findings with the relevant federal entities to ensure transparency and increased communication between ADHS and federal partners. ADHS has scheduled face to face meetings with our federal partners to discuss in detail our findings and the expectations of care for children in Arizona facilities.

Conclusion: The issue of unaccompanied children, who either entered this county alone or were separated from their parents by federal action, is a heartbreaking situation. Certainly,

as a mother of three children, it disturbed me greatly to hear of the reports of inadequate and abusive care occurring in our great state. However, after hundreds of hours of inspections and reviews, I am confident Southwest Key is providing care within the law and Arizona's established standards of care. While the Department has limited jurisdiction and authority in this situation, Southwest Key was cooperative during our inspections and continues to engage with ADHS to ensure they are complying with Arizona healthcare institution licensing laws and rules. Additionally, Southwest Key appears to appropriately report allegations of abuse to the proper authorities, including law enforcement and relevant state agencies, when they become aware of any allegation of criminal or abusive behavior. And while ADHS did observe and cite Southwest Key for various violations, these deficiencies do not constitute an immediate threat to the health or safety of children and are not uncommon in any facility we inspect.

All of the findings of our investigations will be posted on our website, azcarecheck.com, within the next 30 days. This website contains the information regarding ADHS licensed facilities, recent inspection findings, and any enforcement actions taken. Once we receive the Plans of Correction from Southwest Key, they will also be available on this website. We strongly encourage Arizonans to utilize this website as a resource when making decisions about using a facility licensed by ADHS.

The Department takes these reports of abuse with the utmost seriousness and will continue to exercise the fullest extent of our legal authority to investigate and hold healthcare and child care facilities accountable that fail to meet Arizona's licensing standards. It is our commitment to ensure children and all residents of Arizona are safe in licensed ADHS facilities.

Sincerely,

Cara M. Christ, MD
Director

ARIZONA DEPARTMENT OF HEALTH SERVICES
DIVISION OF LICENSING SERVICES
RESIDENTIAL FACILITIES LICENSING

PROVIDER MEETING AGREEMENT

Facility Name: Southwest Key Programs

License #: BH1936, BH3534, BH2426, BH4460, BH3662, BH3661, BH3660, BH4825, BH4474, BH4486, BH4292, BH4051, BH4497

Facility ID#: BH1936, BH3534, BH2426, BH4460, BH3662, BH3661, BH3660, BH4825, BH4474, BH4486, BH4292, BH4051, BH4497

A meeting was held: August 14, 2018

The meeting was attended by: Colby Bower, Kathryn McCanna, Harmony Duport, Shannon Whitenker, & Nicole Morong
Provider Attendees: Kelly Aiello, Silvia Mendoza, Geraldo Rivera, Elizabeth Schepel, & Adriana Saenz

Provider Response:

Agreement:

(initials) AM Although Licensee is exempt from having the Department do unannounced ongoing compliance surveys due to its full accreditation under the Council on Accreditation, the Licensee voluntarily agrees to have the Department conduct unannounced monitoring visits at all Southwest Key locations for the next 12 months. The monitoring visits will be unannounced.

(initials) AM Licensee agrees to audit and verify all current employees have current fingerprint clearance cards and are current in their minimum training requirements by September 14, 2018. Evidence of compliance on fingerprint cards and training will be provided to the Department in writing by the Licensee.

(initials) AJ Licensee agrees to report to the Department within 24 hours anytime an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the physical or mental health, safety, or wellbeing of a resident at the facility or while the resident is in the custodianship of the facility that requires notification to local law enforcement, the Department of Child Safety (DCS), and/or the Office of Refugee Resettlement (ORR). This increased reporting will be in effect for the next 12 months and all reports will be made to Residential.Licensing@azdhs.gov. The Licensee agrees to inform the Department on any information on status updates or any corrective action plans if required by ORR.

I hereby acknowledge that I have discussed the above in detail with the Department.

Licensee/Director/Provider:		Date 8/18/18
Bureau Chief:		Date 8/17/18
Team Lead:	Nicole	Date 8/17/2018
Attendee:	Kathryn McCanna	Date 8/17/2018
Attendee:	AD	Date 8/17/18
Attendee:		Date

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs
P.O. Box 11570
Phoenix, AZ 85061

RE: BH1936
Southwest Key Programs
2613 West Campbell Avenue, Building 1 & 2
Phoenix, AZ 85017
Event ID: ATZN11

Dear Licensee:

Enclosed is the Statement of Deficiencies (SOD) for the complaint inspection conducted on August 3, 2018, which constitutes the inspection report and indicates that the licensee was found to be deficiency free at the time of the inspection. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If you have any questions, please contact the Bureau at (602) 364-2639 or via our email address at residential.licensing@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH1936	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	2613 WEST CAMPBELL AVENUE, BUILDING 1 & 2 PHOENIX, AZ 85017

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150181 was conducted on August 3, 2018. Three of three allegations were unable to be substantiated and no deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor	X 000		

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 13, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs
P.O. Box 11570
Phoenix, AZ 85061

RE: BH1936
Southwest Key Programs
2613 West Campbell Avenue, Building 1 & 2
Phoenix, AZ 85017
Event ID: FOPQ11

Dear Licensee:

Enclosed is the Statement of Deficiencies (SOD) for the complaint inspection conducted on August 2, 2018, which constitutes the inspection report and indicates that the licensee was found to be deficiency free at the time of the inspection. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If you have any questions, please contact the Bureau at (602) 364-2639 or via our email address at residential.licensing@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:ss

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH1936	A. BUILDING: _____ B. WING _____	C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	2613 WEST CAMPBELL AVENUE, BUILDING 1 & 2 PHOENIX, AZ 85017

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150163 was conducted on August 1, 2018 and an off-site review of documentaion conducted on August 2, 2018. Two of two allegations were unable to be substantiated and no deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor	X 000		

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director/ceo
Southwest Key Program, Inc
P.O. Box 609
Glendale, AZ 85311

Re: BH2426 - Event ID #44UG11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018.** The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at Alice.Slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH2426	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	7685 WEST SAN MIGUEL AVENUE GLENDALE, AZ 85303

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150185 was conducted on August 3, 2018 and concluded with an off-site review on August 10, 2018. Four of four allegations were unable to be substantiated and the following deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor Abby Ziegler, RN, BSN, State Licensing Surveyor	X 000		
X 6FA	R9-10-706.F.1-2. Personnel F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis: 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and 2. As specified in R9-10-113. This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure one of two sample personnel members provided evidence of freedom from infectious tuberculosis (TB) as specified in R9-10-113. Findings include: 1. Review of E1's personnel record revealed documentation of a chest x-ray dated April 25,	X 6FA		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH2426	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	7685 WEST SAN MIGUEL AVENUE GLENDALE, AZ 85303

(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
X 6FA	Continued From page 1 2017, which revealed E1 was free from TB. No current documented evidence of E1's freedom from infectious TB was available. 2. In an interview, O2 acknowledged E1 did not have annual documentation of E1's freedom from infectious TB. O2 reported being unaware of the need for annual documentation if the employee had a chest x-ray. O2 explained O2 thought chest x-ray documentation was good for two years.	X 6FA		
X22EI	R9-10-722.B.8.c. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: c. Contains a door that opens into a hallway, common area, or outdoors; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure four of four resident bedrooms contained a door that opened into a hallway, common area or outdoors. Findings include: 1. The surveyors observed four resident bedrooms on the second floor of the facility. The doors to each bedroom had been removed. 2. In an interview, O3 acknowledged the doors had been removed in order to supervise the residents during the night. O3 reported being aware of the requirement of doors on bedrooms and has been in the process of contacting all facilities to ensure compliance.	X22EI		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Administrator
Southwest Key Program Campus
Po Box 609
Glendale, AZ 85301

Re: BH3534 - Event ID #C32D11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 3, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at alice.slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **AL0001 or BH0001**	MULTIPLE CONSTRUCTION BUILDING _____ WING _____	DATE SURVEY COMPLETED **7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3534	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAM, INC	5125 WEST MYRTLE AVENUE GLENDALE, AZ 85301

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150175 was conducted on August 3, 2018. Four of four allegations were unable to be substantiated and the following deficiencies were cited. Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor Alice Slaysman, M.Ed., State Licensing Surveyor	X 000		
X22DJ	R9-10-722.B.5.a-c. Physical Plant Standards B. An administrator shall ensure that: 5. A resident bathroom provides privacy when in use and contains: a. A shatter-proof mirror, unless the resident's treatment plan allows for otherwise; b. A window that opens or another means of ventilation; and c. Nonporous surfaces for shower enclosures and slip-resistant surfaces in tubs and showers. This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a resident bathroom provided privacy when in use. Findings include: 1. The surveyors observed two resident bathrooms in house 1 did not have doors to provide privacy. The surveyors observed one bathroom was labeled for males and one bathroom was labeled for females. The surveyors observed the bathrooms each had two shower stalls with a curtain over the entrance to each shower stall.	X22DJ		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3534	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAM, INC	5125 WEST MYRTLE AVENUE GLENDALE, AZ 85301

(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
X22DJ	Continued From page 1 2. In an interview, O1 acknowledged the bathrooms did not have doors. O1 reported the facility has a procedure to ensure privacy. O1 reported a staff member is assigned to stand outside the bathroom door during the assigned shower times and the residents must dress and undress in the shower stalls for privacy.	X22DJ		
X22EI	R9-10-722.B.8.c. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: c. Contains a door that opens into a hallway, common area, or outdoors; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a resident bedroom contained a door that opens into a hallway, common area, or outdoors. Findings include: 1. The surveyors observed the entrances from the hallway to the resident bedrooms in house 1 did not contain doors. 2. In an interview, O1 acknowledged the resident bedrooms did not have doors.	X22EI		
X22FO	R9-10-722.B.8.g.ii.(2). Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: g. Is a:	X22FO		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3534	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAM, INC	5125 WEST MYRTLE AVENUE GLENDALE, AZ 85301

(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
X22FO	Continued From page 2 ii. Shared bedroom that: (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a shared resident bedroom contained at least 60 square feet for each individual occupying the shared bedroom. Findings include: 1. The surveyors observed bedroom B in house 1 contained 119 square feet and was occupied by two individuals. 2. The surveyors observed bedroom E in house 1 contained 108 square feet and was occupied by two individuals. 3. In an interview, O1 acknowledged the bedrooms did not contain at least 60 square feet for each individual occupying the bedroom.	X22FO		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs - Clarement
2613 West Campbell Avenue
Phoenix, AZ 85017

Re: BH3661 - Event ID #S2FY11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at alice.slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3661	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - CLAREMONT	7580 WEST CLAREMONT STREET GLENDALE, AZ 85303

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150182 was conducted on August 3, 2018 and concluded with an off-site review on August 10, 2018. Four of four allegations were unable to be substantiated and no/the following deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor	X 000		
X21DU	R9-10-721.A.14. Environmental Standards A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that: 14. Poisonous or toxic materials stored by the behavioral health residential facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure poisonous or toxic materials stored by the facility was inaccessible to residents. Findings include: 1. The surveyors observed the door to the laundry room was open and contained Simply Green cleaner.	X21DU		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3661	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - CLAREMONT	7580 WEST CLAREMONT STREET GLENDALE, AZ 85303

(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
X21DU	Continued From page 1 2. In an interview, O2 reported the poisonous or toxic material would be locked.	X21DU		
X22EI	R9-10-722.B.8.c. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: c. Contains a door that opens into a hallway, common area, or outdoors; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure two of four resident bedrooms contained a door that opened into a hallway, common area or outdoors. Findings include: 1. Surveyor observed four resident bedrooms on the second floor of the facility. The doors to two of the bedrooms (Dorm B and Dorm D) had been removed. 2. In an interview, O2 acknowledged the doors had been removed in order to supervise the residents during the night. O2 reported being aware of the requirement of doors on bedrooms and has been in the process of contacting all facilities to ensure compliance.	X22EI		
X22FO	R9-10-722.B.8.g.ii.(2). Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: g. Is a: ii. Shared bedroom that:	X22FO		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3661	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - CLAREMONT	7580 WEST CLAREMONT STREET GLENDALE, AZ 85303

(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
X22FO	Continued From page 2 (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a shared resident bedroom contained at least 60 square feet of floor space for each individual occupying the shared bedroom. Findings include: 1. The surveyors observed one of four resident bedrooms did not have the required 60 square feet per individual occupying the bedroom. Dorm room D measured 214.3 square feet and contained four beds when the room had a capacity for three. 2. In an interview, O2 reported the beds would be moved to other larger rooms to accommodate the required square footage.	X22FO		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs / Stoneview
2613 West Campbell Avenue
Phoenix, AZ 85017

Re: BH3660 - Event ID #K3BM11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at Alice.Slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3660	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	9663 NORTH 83RD DRIVE PEORIA, AZ 85345

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150177 was conducted on August 3, 2018 and concluded with an off-site review on August 10, 2018. Four of four allegations were unable to be substantiated and the following deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor	X 000		
X21DU	R9-10-721.A.14. Environmental Standards A. Except for an outdoor behavioral health care program provided by a behavioral health residential facility, an administrator shall ensure that: 14. Poisonous or toxic materials stored by the behavioral health residential facility are maintained in labeled containers in a locked area separate from food preparation and storage, dining areas, and medications and are inaccessible to residents; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure poisonous or toxic materials stored by the facility were inaccessible to residents. Findings include: 1. The surveyors observed the door to the laundry room was open and the following items were unlocked and accessible to residents: one bottle of Fabuloso, laundry soap, liquid detergent, and	X21DU		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3660	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	9663 NORTH 83RD DRIVE PEORIA, AZ 85345

(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
X21DU	Continued From page 1 Simply Green. 2. In an interview, O2 reported the items would be locked.	X21DU		
X22FO	R9-10-722.B.8.g.ii.(2). Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: g. Is a: ii. Shared bedroom that: (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a shared resident bedroom contained at least 60 square feet of floor space for each individual occupying the shared bedroom. Findings include: 1. The surveyors observed one of four resident bedrooms did not have the required 60 square feet per individual occupying the bedroom. Dorm room C measured 110.8 square feet and contained two beds. 2. In an interview, O2 reported the beds would be moved to other larger rooms to accommodate the required square footage.	X22FO		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs - Northern
2613 W. Campbell Ave
Phoenix, AZ 85017

Re: BH3662 - Event ID #60L411

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 3, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at alice.slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3662	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - NORTHERN	8398 NORTH 98TH LANE PEORIA, AZ 85345

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150184 was conducted on August 3, 2018 and concluded with an off-site review on August 10, 2018. Four of four allegations were unable to be substantiated and the following deficiency was cited: Alice Slaysman, M.Ed., State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Abby Ziegler, RN, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor	X 000		
X22EU	R9-10-722.B.8.e. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: e. Has window or door covers that provide resident privacy; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a resident bedroom had door cover that provided resident privacy. Findings include: 1. The surveyors observed one of five bedrooms in the house was being used as a bedroom to keep residents separated if they were ill. The door to this room, which connects to the hallway, did not have a solid door. The door had ten clear glass panes that provided direct view into the room and did not provide privacy. 2. In an interview, O2 reported the isolation room is used when a resident becomes ill and needs to	X22EU		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH3662	A. BUILDING: _____ B. WING _____	C 08/03/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - NORTHERN	8398 NORTH 98TH LANE PEORIA, AZ 85345

(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
X22EU	Continued From page 1 be separated from the remaining resident. Staff are positioned outside the door and are able to supervise the resident through the glass.	X22EU		
X22FU	R9-10-722.B.8.g.ii.(3). Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: g. Is a: ii. Shared bedroom that: (3) Provides at least three feet of floor space between beds or bunk beds; This RULE Is not met as evidenced by: Based on observation and interview the administrator failed to ensure a shared resident bedroom provided at least three feet of floor space between beds. Findings include: 1. The surveyors observed one of four resident bedrooms did not have the required three feet of floor space between beds. Dorm room D contained four beds. The measurements between each bed varied from 24 - 30 inches. 2. In an interview, O2 reported the beds would be moved.	X22FU		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Program
P.O. Box 10778
Phoenix, AZ 85064

RE: BH4051
Southwest Key Programs
2932 North 14th Street
Phoenix, AZ 85014
Event ID: KCYY11

Dear Licensee:

Enclosed is the Statement of Deficiencies (SOD) for the complaint inspection conducted on August 7, 2018, which constitutes the inspection report and indicates that the licensee was found to be deficiency free at the time of the inspection. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If you have any questions, please contact the Bureau at (602) 364-2639 or via our email address at residential.licensing@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4051	A. BUILDING: _____ B. WING _____	08/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	2932 NORTH 14TH STREET PHOENIX, AZ 85014

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150178 was conducted on August 7, 2018. Four of four allegations were unable to be substantiated and no deficiencies were cited. Lauren Drucker, State Licensing Surveyor Abby Ziegler, State Licensing Surveyor	X 000		

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Director
Southwest Key Programs - Hacienda Del Sol
P.O. Box 669
Youngtown, AZ 85363

Re: BH4292 - Event ID #JU4611

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at Alice.Slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4292	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - HACIENDA D	12030 NORTH 113TH AVENUE YOUNGTOWN, AZ 85363

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150135 was conducted on August 10, 2018. Four of four allegations were unable to be substantiated and the following deficiency was cited: Alice Slaysman, State Licensing Surveyor Lauren Drucker, State Licensing Surveyor	X 000		
X22EU	R9-10-722.B.8.e. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: e. Has window or door covers that provide resident privacy; This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a resident bedroom had door covers that provided resident privacy. Findings include: 1. The surveyors observed the entry doors to several bedrooms had large glass windows in the center of the doors. The surveyors observed the windows in the doors did not have covers to provide resident privacy. 2. The surveyors observed the entry doors to several bedrooms were french style doors with ten glass panels from the top of the door to the bottom. The surveyors observed the doors did not have covers to provide resident privacy. 3. In an interview, O1 acknowledged the doors	X22EU		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4292	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS - HACIENDA D	12030 NORTH 113TH AVENUE YOUNGTOWN, AZ 85363

(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
X22EU	Continued From page 1 did not have covers to provide privacy. O1 reported the rooms were used for isolation for sick residents and the glass in the doors allowed staff to ensure residents were safe while minimizing risk of exposure to other residents.	X22EU		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

August 1, 2018

Ms. Alexia Rodriguez, Administrator
Southwest Key Programs
P.O. Box 609
Glendale, AZ 85311

Re: BH4460 - Event ID #EU1P11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on July 30, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 17, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 15, 2018.** The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at alice.slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	7/22/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	COPY

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16OE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

STATE FORM XXXX11 If continuation sheet 1 of 1

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150064 was conducted on July 30, 2018. Three of three allegations were unable to be substantiated and the following deficiency was cited. Alice Slaysman, M.Ed., State Licensing Surveyor	X 000		
X 8BV	R9-10-708.A.4.a-f. Treatment Plan A. An administrator shall ensure that a treatment plan is developed and implemented for each resident that: 4. Includes: a. The resident's presenting issue; b. The physical health services or behavioral health services to be provided to the resident; c. The signature of the resident or the resident's representative, and date signed, or documentation of the refusal to sign; d. The date when the resident's treatment plan will be reviewed; e. If a discharge date has been determined, the treatment needed after discharge; and f. The signature of the personnel member who developed the treatment plan and the date signed; This RULE is not met as evidenced by: Based on record review, documentation review and interview, the administrator failed to ensure a treatment plan was developed and implemented for three of three sampled residents that included the presenting issue, the date when the treatment plan will be reviewed, the signature of the resident or the residents representative and date signed, and the signature of the personnel member who developed the treatment plan and	X 8BV		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X 8BV	Continued From page 1 the date signed. Findings include: 1. A review of R1's medical record (date: May 27, 2018) revealed R1 was a minor and required a guardian. The record contained an undated document titled "Individual Services Plan." This document did not contain R1's presenting issue, the signature of the resident's guardian, a date of when the treatment plan would be reviewed, or the signature of the personnel member who developed the treatment plan. The bottom of the document contained signature lines; however they were blank. 2. A review of R2's medical record (admit date: May 30, 2018) revealed R2 was a minor and required a guardian. The record contained an undated document titled "Individual Services Plan." This document did not contain R1's presenting issue, the signature of the residents guardian, a date of when the treatment plan would be reviewed, or the signature of the personnel member who developed the treatment plan. The bottom of the document contained signature lines; however they were blank. 3. A review of R3's medical record (admit date: May 18, 2018) revealed R3 was a minor and required a guardian. The record contained an undated document titled "Individual Services Plan." This document did not contain R1's presenting issue, the signature of the residents guardian, a date of when the treatment plan would be reviewed, or the signature of the personnel member who developed the treatment plan. The bottom of the document contained signature lines; however they were blank.	X 8BV		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 07/30/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X 8BV	Continued From page 2 4. A review of documentation revealed a policy titled, "Treatment Planning Policy," which stated, ".....3. Within 24 hours of arriving.....undergo a Mental Health Screening (MHS)...will asssit in he development of the client's Individual Service Plan (ISP), which is the treatment planning mechanism used..... 5. In addition to any information obtained during the MHS, the clinician and/or case manager shall collect all .....and develop an appropriate treatment plan....7. Within 5 days of the MHS, the client will have n individual Services Plan (ISP) developed to address all....needs....8, ...the ISP is required to be updated a minimum of every 30 days thereafter....9. The program director shall ensure that the MHS and ISP process is conducted under the supervision of a lead clinician or another qualified behavioral health professional. 10. The assigned clinician .....include the client, and if applicable, the parents, guardian or designated representative in the development of the treatment plan. 5. In an interview, O1 reported most paperwork was done electronically and acknowledged the treatment plans did not have all the required elements and will be working on a new procedure.	X 8BV		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Administrator
Southwest Key Programs-Las Palms
P.O. Box 4194
Mesa, AZ 85211

RE: BH4474
Southwest Key Programs- Casa Las Palmas
421 West Brown Road
Mesa, AZ 85201
Event ID: EX9H11

Dear Licensee:

Enclosed is the Statement of Deficiencies (SOD) for the complaint inspection conducted on August 6, 2018, which constitutes the inspection report and indicates that the licensee was found to be deficiency free at the time of the inspection. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

If you have any questions, please contact the Bureau at (602) 364-2639 or via our email address at residential.licensing@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4474	A. BUILDING: _____ B. WING _____	C 08/06/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS- CASA LAS PA	421 WEST BROWN ROAD MESA, AZ 85201

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150186 was conducted on August 6, 2018. Four of four allegations were unable to be substantiated and no deficiencies were cited. Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor	X 000		

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Administrator
Southwest Key Programs
P.O. Box 609
Glendale, AZ 85311

Re: BH4460 - Event ID #650311

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Alice Slaysman at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at alice.slaysman@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150180 was conducted on August 3, 2018 and concluded with an off-site review on August 10, 2018. Two of two allegations were unable to be substantiated and the following deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Abby Ziegler, RN, BSN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor	X 000		
X22EU	R9-10-722.B.8.e. Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: e. Has window or door covers that provide resident privacy; This RULE is not met as evidenced by: Based on observation and interview the administrator failed to ensure a resident bedroom had door cover that provided resident privacy. Findings include: 1. The surveyors observed one of thirteen resident bedrooms was being used as a bedroom to keep residents separated if they were ill. The door to this room, which connects to the hallway, was not a solid door. The door had ten clear glass panes that provided direct view into the room and did not provide privacy. 2. In an interview, O3 reported the isolation room	X22EU		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X22EU	Continued From page 1 is used when a resident becomes ill and needs to be separated from the remaining resident. Staff are positioned outside the door and would be able to supervise the resident through the glass.	X22EU		
X22FO	R9-10-722.B.8.g.ii.(2). Physical Plant Standards B. An administrator shall ensure that: 8. A resident bedroom complies with the following: g. Is a: ii. Shared bedroom that: (2) Except as provided in subsection (C), contains at least 60 square feet of floor space, not including a closet, for each individual occupying the shared bedroom; and This RULE is not met as evidenced by: Based on observation and interview, the administrator failed to ensure a shared resident bedroom contained at least 60 square feet of floor space for each individual occupying the shared bedroom. Findings include: 1. The surveyors observed four of thirteen resident bedrooms did not have the required 60 square feet per individual occupying the bedroom. 2. Room B1 measured 176 square feet and contained three beds. Room B3 measured 177 square feet and contained three beds. Room B5 measured 177 square feet and contained three beds. Room B7 measured 175 square feet and contained three beds.	X22FO		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4460	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	7022 NORTH 48TH AVENUE GLENDALE, AZ 85301

(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
X22FO	Continued From page 2 3. In an interview, O3 reported the beds would be moved to other larger rooms to accommodate the required square footage.	X22FO		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Alexia Rodriguez, Administrator
Southwest Key Programs, Inc
1201 South 7th Avenue, Suite 120
Phoenix, AZ 85007

RE: Southwest Key Programs, Inc. - BH4497
Event ID: HY8P11

Dear Ms. Rodriguez:

The purpose of this letter is to inform you that during a recent inspection of the facility on August 9, 2018, by the Arizona Department of Health Services, Public Health Licensing Services ("Department"), the Department substantiated at least one or more violations of Department statutes or rules. Due to the seriousness of the violations, this case has been referred to the Department's Enforcement Team (Enforcement Team) for further review.

Enclosed is a copy of the Statement of Deficiencies (SOD), which describes the violations the Department found at the facility. Because the case has been referred to the Enforcement Team, the Department is **not requesting or accepting a written plan of correction** for the violations at this time. However, the Department requires that you make immediate corrections of violations that present a threat to the health or safety of a client, resident, patient or agency personnel. Additionally, the Department urges correction of all deficiencies at the earliest possible date. The Department will notify you when a written plan of correction is required.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018.** The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call our office at (602) 364-2639.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(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
X 000	Initial Comment An on-site investigation of complaint AZ00149710 was conducted on August 9, 2018. One of six allegations was substantiated, five of six allegations were unable to be substantiated, and the following deficiencies were cited. Alice Slaysman, M.Ed., State Licensing Surveyor Abby Ziegler, RN, State Licensing Surveyor Tiffany Slater, MPH, State Licensing Surveyor	X 000		
X 6FA	R9-10-706.F.1-2. Personnel F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis: 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and 2. As specified in R9-10-113. This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure one of 30 sample personnel members provided evidence of freedom from infectious tuberculosis (TB) as specified in R9-10-113. Findings include: 1. Review of E16's personnel record revealed a TB skin test was done on March 28, 2017, and the result was negative. No current documented evidence of E16's freedom from infectious TB	X 6FA		

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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(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
X 6FA	Continued From page 1 was found. 2. In an interview, O2 acknowledged E16 did not have annual documentation of E16's freedom from infectious TB. O2 explained there was confusion with the dates on the card. O2 reported E16 went to go get a TB test done that day.	X 6FA		
B 043	ARS§ 36-425.03 FINGERPRINTING A.R.S. § 36-425.03. Children's behavioral health programs;personnel; fingerprinting requirements; exemptions; definitions A. Except as provided in subsections B, C and D of this section, children's behavioral health program personnel, including volunteers, shall submit the form prescribed in subsection E of this section to the employer and shall have a valid fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1 or, within seven working days after employment or beginning volunteer work, shall apply for a fingerprint clearance card. B. The following persons are exempt from the fingerprinting requirements of this section: 1. When under the direct visual supervision and in the presence of children's behavioral health program personnel who have a valid fingerprint clearance card: (a) Except as provided in subsection C of this section, parents, foster parents, kinship foster care parents and guardians who participate in group activities that include their children who are receiving behavioral health services from a children's behavioral health program if they are	B 043		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(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
B 043	Continued From page 2 not employees of the children's behavioral health program. (b) A volunteer who provides services to children receiving behavioral health services. (c) An employee or contractor who is eligible pursuant to section 41-1758.07, subsection C to petition the board of fingerprinting for a good cause exception and who provides documentation of having applied for a good cause exception pursuant to section 41-619.55 but who has not yet received a decision. (d) A person who is not providing medical services, nursing services, behavioral health services, health-related services, home health services or supportive services and who is either not an employee or contractor or not on the premises on a regular basis. 2. Hospital medical staff members, employees, contractors and volunteers who are not present in an area of the hospital authorized by the department for providing children's behavioral health services. C. A parent, foster parent, kinship foster care parent or guardian of a child who is receiving behavioral health services from a children's behavioral health program is not required to be fingerprinted or supervised for purposes of this section if the person is in the presence of or participating with only the person's own child. D. Applicants and employees who are fingerprinted pursuant to section 15-512 or 15-534 are exempt from the fingerprinting requirements of subsection A of this section.	B 043		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

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B 043	Continued From page 3 E. Children's behavioral health program personnel shall certify on forms that are provided by the department and notarized that they are not awaiting trial on or have never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. F. Forms submitted pursuant to subsection E of this section are confidential. G. Employers of children's behavioral health program personnel shall make documented, good faith efforts to contact previous employers of children's behavioral health program personnel to obtain information or recommendations that may be relevant to an individual's fitness for employment in a children's behavioral health program. H. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection B is prohibited from working in any capacity in a children's behavioral health program that requires or allows contact with children. I. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection C shall not work in a children's behavioral health program in any capacity that requires or allows the employee to	B 043		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4497	A. BUILDING: _____ B. WING _____	C 08/09/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(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
B 043	Continued From page 4 provide direct services to children unless the person has applied for and received the required fingerprint clearance card pursuant to title 41, chapter 12, article 3.1. J. The department of health services shall accept a certification submitted by a United States military base or a federally recognized Indian tribe that either: 1. Personnel who are employed or who will be employed and who provide services directly to children have not been convicted of, have not admitted committing or are not awaiting trial on any offense prescribed in subsection H of this section. 2. Personnel who are employed or who will be employed to provide services directly to children have been convicted of, have admitted committing or are awaiting trial on any offense prescribed in subsection I of this section if the personnel provide these services while under direct visual supervision. K. The employer shall notify the department of public safety if the employer receives credible evidence that a person who possesses a valid fingerprint clearance card either: 1. Is arrested for or charged with an offense listed in section 41-1758.03, subsection B. 2. Falsified information on the form required by subsection E of this section. L. For the purposes of this section: 1. "Children's behavioral health program" means	B 043		

ADHS LICENSING 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

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B 043	Continued From page 5 a program provided in a health care institution that is licensed by the department to provide children's behavioral health services. 2. "Children's behavioral health program personnel" means an owner, employee or volunteer who works at a children's behavioral health program. 3. "Direct visual supervision" means continuous visual oversight of the supervised person that does not require the supervisor to be in a superior organizational role to the person being supervised. This RULE is not met as evidenced by: Based on documentation review, record review and interview, the administrator failed to ensure two of 30 sample personnel members had documentation of the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03. Findings include: 1. A.R.S. § 36-425.03 states "A. Except as provided in subsections B, C and D of this section, children's behavioral health program personnel, including volunteers, shall submit the form prescribed in subsection E of this section to the employer and shall have a valid fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1 or, within seven working days after employment or beginning volunteer work, shall apply for a fingerprint clearance card...G. Employers of children's behavioral health program personnel shall make	B 043		

ADHS LICENSING 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS, INC	1201 SOUTH 7TH AVENUE, SUITE 120 PHOENIX, AZ 85007

(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
B 043	Continued From page 6 documented, good faith efforts to contact previous employers of children's behavioral health program personnel to obtain information or recommendations that may be relevant to an individual's fitness for employment in a children's behavioral health program." 2. Review of E11's (date of hire December 18, 2017) personnel record revealed no documentation to show good faith efforts were made to contact E11's previous employers. 3. Review of E27's (date of hire July 12, 2010) personnel record revealed a fingerprint clearance card was issued August 12, 2010 and expired August 12, 2016. Another fingerprint card was issued April 30, 2018 with an expiration date of April 30, 2024. There was a lapse of approximately 20 months when E27 was working without a valid fingerprint card. 4. In an interview, O1 acknowledged there was no documentation of the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03. O1 reported E11's references were being checked that day. O1 confirmed E27 did not have a lapse in employment and continued to work without a valid fingerprint clearance card.	B 043		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Alexia Rodriguez, Administrator
Southwest Key Programs
1601 North Oracle Road
Tucson, AZ 85704

RE: Southwest Key Programs - BH4486
Event ID: 0DLK11

Dear Ms. Rodriguez:

The purpose of this letter is to inform you that during a recent inspection of the facility on August 8, 2018, by the Arizona Department of Health Services, Public Health Licensing Services ("Department"), the Department substantiated at least one or more violations of Department statutes or rules. Due to the seriousness of the violations, this case has been referred to the Department's Enforcement Team (Enforcement Team) for further review.

Enclosed is a copy of the Statement of Deficiencies (SOD), which describes the violations the Department found at the facility. Because the case has been referred to the Enforcement Team, the Department is **not requesting or accepting a written plan of correction** for the violations at this time. However, the Department requires that you make immediate corrections of violations that present a threat to the health or safety of a client, resident, patient or agency personnel. Additionally, the Department urges correction of all deficiencies at the earliest possible date. The Department will notify you when a written plan of correction is required.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018.** The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call our office at (602) 364-2639.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4486	A. BUILDING: _____ B. WING _____	C 08/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	1601 NORTH ORACLE ROAD TUCSON, AZ 85704

(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
X 000	Initial Comment An on-site investigation of complaints AZ00150130 and AZ00150172 was conducted on August 7, 2018, and August 8, 2018. Two of thirteen allegations were substantiated and the following deficiencies was cited: Raquel Bravo-Clouzet, State Licensing Surveyor Seth Mackey, State Licensing Surveyor Coy Turner MS LISAC NCIT, State Licensing Surveyor	X 000		
X 6GO	R9-10-706.G.3.f. Personnel G. An administrator shall ensure that a personnel record is maintained for each personnel member, employee, volunteer, or student that includes: 3. Documentation of: f. If the individual is a behavioral health technician, clinical oversight required in R9-10-115; This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure the personnel file for each personnel member that was not a Behavioral Health Professionals (BHP) and who provided behavioral health services included documentation of clinical oversight, as required by R9-10-115. Findings include: 1. A review of E6's (date of hire February 13,	X 6GO		

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

ADHS LICENSING 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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X 6GO	Continued From page 1 2017) personnel file revealed E6 was hired as a "Clinician". 2. A review of E6's personnel file revealed a document titled "Job Title: Clinician" which stated, "The Clinician is responsible for providing mental health assessment and counseling intervention services..." 3. In an interview, E24 confirmed the facility job title of "Clinician" corresponded to the Department definition of Behavioral Health Technician (BHT) and reported E6 provided regular counseling services to several residents in group sessions and on an individual basis. 4. A review of E6's personnel file revealed no documentation of clinical oversight. 5. The medical record for R1 contained documentation of counseling progress notes for group counseling services provided by E6 on February 14, 2018, February 23, 2018, March 15, 2018, March 28, 2018, and an individual counseling session on June 13, 2018. 6. The medical record for R2 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 7. The medical record for R2 contained documentation of counseling progress notes for individual counseling services provided by E6 on December 21, 2017, February 20, 2018, and group counseling sessions on February 21, 2018, March 13, 2018, and March 28, 2018. 8. The medical record for R9 contained documentation of a counseling progress note for	X 6GO		

ADHS LICENSING 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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X 6GO	Continued From page 2 a group counseling service provided by E6 on June 27, 2018. 9. The medical record for R11 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 10. The medical record for R13 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 11. The medical record for R17 contained documentation of counseling progress notes for group counseling services provided by E6 on May 16, 2018, on July 4, 2018, and on July 11, 2018. 12. The medical record for R19 contained documentation of a counseling progress note for a group counseling service provided by E6 on July 4, 2018. 13. The medical record for R21 contained documentation of counseling progress notes for individual counseling services provided by E6 on February 7, 2018, February 21, 2018, and a group counseling session on August 1, 2018. 14. The medical record for R22 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 15. The medical record for R23 contained documentation of counseling progress notes for individual counseling services provided by E6 on July 10-12, 2018, July 15-19, 2018, July 25, 2018, August 1-2, 2018, family counseling sessions on July 11, 2018, July 15, 2018, July 30, 2018, and	X 6GO		

ADHS LICENSING 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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X 6GO	Continued From page 3 group counseling sessions on August 1, 2018, and August 8, 2018. 16. The medical record for R24 contained documentation of counseling progress notes for individual counseling services provided by E6 on July 3, 2018, July 10, 2018, July 17, 2018, July 23-24, 2018, July 31, 2018, August 7, 2018, and a family counseling session on July 3, 2018. 17. The medical record for R26 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 18. The medical record for R26 contained documentation of counseling progress notes for individual counseling services provided by E6 on May 2, 2018, and a group counseling session on June 6, 2018. 19. The medical record for R27 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 6, 2018. 20. The medical record for R29 contained documentation of a counseling progress note for a group counseling service provided by E6 on June 27, 2018. 21. The medical record for R35 contained documentation of counseling progress notes for individual counseling services provided by E6 on June 28, 2018, a group counseling session on July 7, 2018, and a family counseling session on July 7, 2018. 22. In an interview, E24 and E26 reported they were unaware the personnel file for all BHTs that	X 6GO		

ADHS LICENSING 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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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAMS	1601 NORTH ORACLE ROAD TUCSON, AZ 85704

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X 6GO	Continued From page 4 provide counseling must include documentation of clinical oversight as required in R9-10-115. E24 and E26 acknowledged documentation of clinical oversight was not included in the personnel file for E6.	X 6GO		
B 043	ARS§ 36-425.03 FINGERPRINTING A.R.S. § 36-425.03. Children's behavioral health programs;personnel; fingerprinting requirements; exemptions; definitions A. Except as provided in subsections B, C and D of this section, children's behavioral health program personnel, including volunteers, shall submit the form prescribed in subsection E of this section to the employer and shall have a valid fingerprint clearance card issued pursuant to title 41, chapter 12, article 3.1 or, within seven working days after employment or beginning volunteer work, shall apply for a fingerprint clearance card. B. The following persons are exempt from the fingerprinting requirements of this section: 1. When under the direct visual supervision and in the presence of children's behavioral health program personnel who have a valid fingerprint clearance card: (a) Except as provided in subsection C of this section, parents, foster parents, kinship foster care parents and guardians who participate in group activities that include their children who are receiving behavioral health services from a children's behavioral health program if they are not employees of the children's behavioral health program.	B 043		

ADHS LICENSING SERVICES

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B 043	Continued From page 5 (b) A volunteer who provides services to children receiving behavioral health services. (c) An employee or contractor who is eligible pursuant to section 41-1758.07, subsection C to petition the board of fingerprinting for a good cause exception and who provides documentation of having applied for a good cause exception pursuant to section 41-619.55 but who has not yet received a decision. (d) A person who is not providing medical services, nursing services, behavioral health services, health-related services, home health services or supportive services and who is either not an employee or contractor or not on the premises on a regular basis. 2. Hospital medical staff members, employees, contractors and volunteers who are not present in an area of the hospital authorized by the department for providing children's behavioral health services. C. A parent, foster parent, kinship foster care parent or guardian of a child who is receiving behavioral health services from a children's behavioral health program is not required to be fingerprinted or supervised for purposes of this section if the person is in the presence of or participating with only the person's own child. D. Applicants and employees who are fingerprinted pursuant to section 15-512 or 15-534 are exempt from the fingerprinting requirements of subsection A of this section. E. Children's behavioral health program	B 043		

ADHS LICENSING SERVICES

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B 043	Continued From page 6 personnel shall certify on forms that are provided by the department and notarized that they are not awaiting trial on or have never been convicted of or admitted in open court or pursuant to a plea agreement to committing any of the offenses listed in section 41-1758.03, subsection B or C in this state or similar offenses in another state or jurisdiction. F. Forms submitted pursuant to subsection E of this section are confidential. G. Employers of children's behavioral health program personnel shall make documented, good faith efforts to contact previous employers of children's behavioral health program personnel to obtain information or recommendations that may be relevant to an individual's fitness for employment in a children's behavioral health program. H. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection B is prohibited from working in any capacity in a children's behavioral health program that requires or allows contact with children. I. A person who is awaiting trial on or who has been convicted of or who has admitted in open court or pursuant to a plea agreement to committing a criminal offense listed in section 41-1758.03, subsection C shall not work in a children's behavioral health program in any capacity that requires or allows the employee to provide direct services to children unless the person has applied for and received the required	B 043		

ADHS LICENSING SERVICES

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B 043	Continued From page 7 fingerprint clearance card pursuant to title 41, chapter 12, article 3.1. J. The department of health services shall accept a certification submitted by a United States military base or a federally recognized Indian tribe that either: 1. Personnel who are employed or who will be employed and who provide services directly to children have not been convicted of, have not admitted committing or are not awaiting trial on any offense prescribed in subsection H of this section. 2. Personnel who are employed or who will be employed to provide services directly to children have been convicted of, have admitted committing or are awaiting trial on any offense prescribed in subsection I of this section if the personnel provide these services while under direct visual supervision. K. The employer shall notify the department of public safety if the employer receives credible evidence that a person who possesses a valid fingerprint clearance card either: 1. Is arrested for or charged with an offense listed in section 41-1758.03, subsection B. 2. Falsified information on the form required by subsection E of this section. L. For the purposes of this section: 1. "Children's behavioral health program" means a program provided in a health care institution that is licensed by the department to provide	B 043		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4486	A. BUILDING: _____ B. WING _____	C 08/08/2018

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B 043	Continued From page 8 children's behavioral health services. 2. "Children's behavioral health program personnel" means an owner, employee or volunteer who works at a children's behavioral health program. 3. "Direct visual supervision" means continuous visual oversight of the supervised person that does not require the supervisor to be in a superior organizational role to the person being supervised. This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure a personnel record maintained for each personnel member, employee, volunteer or student included documentation of the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03. Findings include: 1. A review of the personnel record for E1 (date of hire August 10, 2015) revealed a fingerprint card application was submitted on January 12, 2016, and a fingerprint card was issued to E1 on February 1, 2016. The application date was not within seven working days after the date of employment, as required. 2. A review of the personnel record for E3 (date of hire November 13, 2017) revealed a notarized crime-free attestation as required by A.R.S. § 36-425.03, subsection E, was included. However, the attestation was notarized on July	B 043		

ADHS LICENSING SERVICES

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B 043	Continued From page 9 31, 2018. The attestation date was not on or before the date of employment, as required. 3. A review of the personnel record for E9 (date of hire March 14, 2016) revealed a fingerprint card application was submitted on May 12, 2016, and a fingerprint card was issued to E9 on June 30, 2016. The application date was not within seven working days after the date of employment, as required. 4. A review of the personnel record for E10 (date of hire August 10, 2015) revealed a fingerprint card application was submitted on January 12, 2016, and a fingerprint card was issued to E10 on February 1, 2016. The application date was not within seven working days after the date of employment, as required. 5. A review of the personnel record for E12 (date of hire January 8, 2018) revealed no evidence of reference verification as required by A.R.S. § 36-425.03, subsection G was included. 6. A review of the personnel record for E13 (date of hire October 04, 2015) revealed a fingerprint card application was submitted on October 25, 2015, and a fingerprint card was issued to E13 on November 16, 2015. The application date was not within seven working days after the date of employment, as required. 7. A review of the personnel record for E21 (date of hire February 29, 2016) revealed a fingerprint card application was submitted on March 24, 2016, and a fingerprint card was issued to E21 on April 8, 2016. The application date was not within seven working days after the date of employment, as required.	B 043		

ADHS LICENSING SERVICES

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B 043	Continued From page 10 8. A review of the personnel record for E27 (date of hire April 30, 2018) revealed no evidence of a notarized crime-free attestation as required by A.R.S. § 36-425.03, subsection E was included. 9. In an interview, E24 and E26 acknowledged the personnel record maintained for each personnel member, employee, volunteer, or student did not include documentation of the individual's compliance with the fingerprinting requirements in A.R.S. § 36-425.03.	B 043		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 14, 2018

Ms. Alexia Rodriguez, Administrator
Southwest Key Program, Inc
723 East 2nd Avenue
Mesa, AZ 85204

Re: BH4825 - Event ID #OTWG11

Dear Ms. Rodriguez:

Thank you for the time spent with the Arizona Department of Health Services ("Department") staff during the recent inspection of your facility. Enclosed is the Statement of Deficiencies (SOD) for the inspection completed on August 10, 2018. The Department requires immediate correction of any deficiency that presents a threat to the health or safety of a client, resident, patient or agency personnel, and urges correction of all deficiencies at the earliest possible date.

The Plan of Correction (POC) must outline the specific steps taken to correct each deficiency noted, and must include the following:

1. How the deficiency is to be corrected, on both a temporary and permanent basis.
2. The date the correction will be completed.
3. The name, title, and/or position of the person responsible for implementing the corrective action.
4. A description of the monitoring system you will use to prevent the deficiency from recurring.
5. The signature, title, and date signed of the person responsible for the POC on the first page of the SOD.

An example of the type of information necessary for an acceptable POC is attached to this letter. Remember, this is a Plan of Correction, and future dates of correction are acceptable. The POC is a plan and can be submitted before the correction is made.

The POC must be returned to the Bureau of Residential Facilities Licensing by August 30, 2018. If this day falls on a Saturday, Sunday, or a holiday, these items must be submitted the business day after the weekend or holiday. If the POC is not received on or before this date, further action may be taken.

You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter, August 28, 2018**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision.

If you have any questions or need any additional information, please contact Abby Ziegler at the Bureau of Residential Facilities Licensing at (602) 364-2639 or via e-mail at Abby.Ziegler@azdhs.gov.

Sincerely,

Harmony Duport
Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETED
	AL0001 or BH0001	BUILDING _____ WING _____	**7/22/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SAMPLE	**COPY**

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)	COMPLETE DATE
X 000	INITIAL COMMENTS The following deficiencies were found at the time of the Assisted Living Facility's Compliance Inspection conducted on July 22, 2015. _____ State Licensing Surveyor Date			
X16GE	R9-10-816. Medication Services B. If an assisted living facility provides medication administration, a manager shall ensure that: 3. A medication administered to a resident: b. Is administered in compliance with a medication order, and This RULE is not met as evidenced by: Based on record review, observation, and interview, the manager failed to ensure that a medication was administered in compliance with an order for one of three sample residents. Findings include: 1. A review of R2's medical record showed that R2's service plan included that R2 received medication administration, and the medical record included a written order from R2's medical practitioner for Lasix, 20 mg, one tablet every day at bedtime. 2. The Surveyor observed that the medication organizer for R2 did not contain Lasix, and that there was no bottle of Lasix in R2's medications. 3. During an interview, E1 acknowledged that R2 was not receiving the Lasix as ordered, and reported that the facility ran out of R2's Lasix a few days ago, but that R2's representative had not yet brought more Lasix to the facility.		See Attached Plan of Correction	08/25/2015

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

John Smith, Manager *08/25/2015*

PLAN OF CORRECTION ATTACHMENT

BRFL License # **AL0001** or **BH0001**
Rule Number: R9-10-816.B.3.b

Name, title, and/or position of the person responsible for implementing the corrective action:

John Smith, Manager

Date the correction will be completed: 08/25/2015

Correction on both a temporary and permanent basis:

John Smith, Manager, obtained the Lasix for R2 immediately after the survey, and reviewed all residents' medication orders and medications to ensure that the facility has a sufficient quantity of all ordered medications on hand. The Manager also updated the facility's medication policies and procedures (P&Ps) to include that caregivers will notify the Manager whenever a resident has less than a 7-day supply of medication, and the Manager will order medication refills at that time to ensure that a resident does not run out of medication. This P&P also includes that the facility will pay for any ordered medication if the resident's family does not provide the medication, and that the resident's responsible party will be billed for any medications the facility purchases on the resident's behalf. The Manager provided training on August 23 and 25, 2015 for all caregivers on the new P&Ps and the importance of ensuring that residents always have a sufficient supply of medication.

Monitoring System:

John Smith, Manager, will conduct a medication review on a monthly basis to ensure each resident has a sufficient quantity of medication. The Manager will document this review on each resident's medication administration record, which will be kept in the resident's file.

Attachments:

(A) Receipt from pharmacy showing purchase of Lasix for R2
(B) New medication P&Ps, signed by Jane Doe, RN, dated August 20, 2015
(C) Documentation of training for all caregivers dated August 23 and 25, 2015

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	BH4825	A. BUILDING: _____ B. WING _____	C 08/10/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOUTHWEST KEY PROGRAM, INC	723 EAST 2ND AVENUE MESA, AZ 85204

(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
X 000	Initial Comment An on-site investigation of complaint AZ00150124 was conducted on August 8, 2018 and concluded with an off-site review on August 10, 2018. Five of five allegations were unable to be substantiated and the following deficiencies were cited: Abby Ziegler, RN, State Licensing Surveyor Lauren Drucker, LBSW, State Licensing Surveyor	X 000		
X 3JI	R9-10-703.C.5.a. Administration C. An administrator shall ensure that: 5. Unless otherwise stated: a. Documentation required by this Article is provided to the Department within two hours after a Department request; and This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure documentation required by this Article is provided to the Department within two hours after a Department request. Findings include: 1. A review of E12's personnel record revealed the record did not include documentation of the verification of E12's skills and knowledge. 2. In an interview, O2 reported E1's skills and knowledge were verified through training conducted January 5-9, 2018. O2 acknowledged the documentation was not in E1's personnel record.	X 3JI		

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

ADHS LICENSING 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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X 3JI	Continued From page 1 3. In an electronic correspondence, O2 submitted documentation of the verification of E12's skills and knowledge at 4:47pm on August 10, 2018.	X 3JI		
X 6FA	R9-10-706.F.1-2. Personnel F. An administrator shall ensure that a personnel member, or an employee, a volunteer, or a student who has or is expected to have more than eight hours of direct interaction per week with residents, provides evidence of freedom from infectious tuberculosis: 1. On or before the date the individual begins providing services at or on behalf of the behavioral health residential facility, and 2. As specified in R9-10-113. This RULE is not met as evidenced by: Based on record review and interview, the administrator failed to ensure one of 21 sample personnel members provided evidence of freedom from infectious tuberculosis (TB) as specified in R9-10-113. Findings include: 1. A review of E6's personnel record revealed documentation from a QuantiFERON-TB Gold (QFT-G) test dated March 4, 2017, which documented E6 was free from TB. No current documented evidence of E6's freedom from infectious TB was found. 2. In an interview, O1 acknowledged E6 did not have annual documentation of E6's freedom from infectious TB. O1 explained there was a "mix-up" on their forms and E6 was confused with another	X 6FA		

ADHS LICENSING 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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X 6FA	Continued From page 2 employee.	X 6FA		