

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			
	0 of 2 allegations were	1 of 13 bedroom doors do not contain a curtain for privacy			
Glendale N. 48th Ave	substantiated	4 of 13 bedrooms do not have the required square footage president			
Tucson N. Oracle	2 of 13 allegations were	No documentation of clinical oversight of a behavioral health tech			
rucson N. Oracle	substantiated	8 personnel records revealed late application for fingerprint clearance cards			
		1 of 30 personnel records do not contain evidence of freedom of tuberculosis			
Phoenix S. 7th Ave	1 of 6 allegations were substantiated	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	1 of 5 bedroom doors do not contain a curtain for privacy			
Peona 98th Lane	substantiated	1 of 4 bedrooms do not have enough space between the beds			
		Poisonous or toxic materials were unlocked; laundry chemicals; soaps			
Glendale W. Claremont	0 of 4 allegations were substantiated	2 of 4 bedrooms did not contain a door as required			
	Substantiated	1 of 4 bedrooms do not have the required square footage per resident			
Peoria 83rd Drive	0 of 4 allegations were	Poisonous or toxic materials were unlocked; laundry chemicals; soaps			
Peona Solu Drive	substantiated	1 of 4 bedrooms do not have the required square footage per resident			
		2 bathrooms do not have doors as required			
Glendale W. Myrtle	0 of 4 allegations were	Bedrooms do not have doors as required			
Gendale W. Myrtie	substantiated	1 bedroom does have the required square footage per resident			
Glendale W. San Miguel	0 of 4 allegations were	1 of 2 personnel records do not contain evidence of freedom of tuberculosis			
	substantiated	4 of 4 bedrooms do not have doors as required			
Mara I F 3 - 1 Ave	0 of 4 allegations were	Facility did not provide records to ADHS within the required 2- hour timeframe			
Mesa E. 2nd Ave	substantiated	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			

Douglas A. Ducey | Governor Cara M. Christ, MD, MS | Director

Governor Doug Ducey August 23, 2018 Page 3

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,

Governor Doug Ducey August 23, 2018 Page 4

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

racility Name: Southwest Key Programs	Lleense #: BH1936,	Facility ID#: BH1936.
STATE OF THE STATE	BH3534, BH2426,	B1(3534, B112426,
	B114460, B143662,	BH4460, BH3662,
	BH3661, BH3660,	BH3661, BH3660,
	BH4825, BH4474,	BH4825, BH4474,
	BH4486, BH4292,	BH4486, B114292,
	BH4051, BH4497	B144051, B114497
A STATE OF THE STA		

A meeting was held: August 14, 2018

The meeting was alto	inded by: Colby	Bower, Kathryn McC	Canna, Harmony	Duport, Shannon	Whitenker, &	: Nicole Morong
Provider Attendees:	Kelly Aiello, Sil	via Mendoza, Gerald	o Rivera, Elizabe	eth Schepel, & Ad	riana Saenz	

Provider Response:

Agreement:

(initials) XWAlthough 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) Ale 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.

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

Licensec/Director/Provider:

Burcou Chief:

Team Lend:

Attendee:

Attendee:

Attendee:

Date 8 | 18 | 18

Date 8 | 17 | 20 | 18

Date 8 | 17 | 20 | 18

Date 8 | 17 | 30 | 30 | 30

Date 8 | 17 | 30 | 30

Date 8 |

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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		BH1936	B. WING		1	C) <mark>3/2018</mark>
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
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	An on-site investigation was conducted on a	ation of complaint AZ00150181 August 3, 2018.				
	Three of three alleg substantiated and r	pations were unable to be no deficiencies were cited.				
	Abby Ziegler, RN, S Lauren Drucker, LE	Ed., State Licensing Surveyor State Licensing Surveyor SSW, State Licensing Surveyor , State Licensing Surveyor				
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



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

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	E CONSTRUCTION	(X3) DATE COMP	(X3) DATE SURVEY COMPLETED	
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		ons were unable to be no deficiencies were cited.					
	Alice Slaysman, M.	Ed., State Licensing Surveyor					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



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/O IDENTIFICATION NUM AL0001 or BH000		IBER:		CONSTRUCTION	DATE SURVEY COMPLETED 7/22/2015		
NAME OF PROVIDER OR SUPPLIER SAMPLE			EET ADDRESS	, CITY, STATE, ZIP COD			
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X16GE	R9-10-816. Medica	Authorities Check			See Attached Plan of Cor	rection	08/25/2015
	administration, a ma 3. A medication a	iving facility provides medi- nager shall ensure that: administered to a resident; d in compliance with a medi					
	the manager failed to	iew, observation, and intervoor ensure that a medication will pliance with an order for on	as				
el .	service plan included administration, and t written order from R 20 mg, one tablet eve 2. The Surveyor obse	medical record showed that I that R2 received medication the medical record included 2's medical practitioner for ery day at bedtime.	on a Lasix,				
	was no bottle of Lasi3. During an intervie not receiving the Lasthe facility ran out of	not contain Lasix, and that ix in R2's medications. EW, E1 acknowledged that R six as ordered, and reported f R2's Lasix a few days ago live had not yet brought more	2 was that , but				
					TITLE		(X6) DATE

John Smith, Manager

08/25/2015

XXXXII

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 (X1) PROVIDER/SUPPLIER/CLIA

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	was conducted on A with an off-site revie Four of four allegati	ation of complaint AZ00150185 August 3, 2018 and concluded ew on August 10, 2018. ons were unable to be the following deficiencies were				
	cited.	ne following deficiencies were				
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X 6FA	R9-10-706.F.1-2. Pe	ersonnel	X 6FA			
	member, or an emp student who has or than eight hours of with residents, provi from infectious tube 1. On or before the providing services a	date the individual begins it or on behalf of the sidential facility, and				
	administrator failed personnel members freedom from infect specified in R9-10-1	view and interview, the to ensure one of two sample provided evidence of ious tuberculosis (TB) as				
	Findings include:					
		ersonnel record revealed chest x-ray dated April 25,	2			

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

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	LE CONSTRUCTION	(X3) DATE	SURVEY PLETED
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X 6FA	Continued From pa	ge 1	X 6FA			
		ed E1 was free from TB. No d evidence of E1's freedom was available.				
	have annual documinfectious TB. O2 reneed for annual dochad a chest x-ray.	D2 acknowledged E1 did not present the content of E1's freedom from eported being unaware of the cumentation if the employee D2 explained O2 thought chest in was good for two years.				
X22EI	R9-10-722,B.8.c. P	hysical Plant Standards	X22EI			
To the state of th	following:	om complies with the hat opens into a hallway,				
	administrator failed	on and interview, the to ensure four of four resident d a door that opened into a				
	Findings include:					
	bedrooms on the se	served four resident econd floor of the facility. The oom had been removed.				-
the state of the s	had been removed residents during the aware of the require	3 acknowledged the doors in order to supervise the night. O3 reported being ment of doors on bedrooms process of contacting all compliance.		·		

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.

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Sincerely,

Harmony Duport Bureau Chief

HD:nm

Enclosures

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X 000	the Assisted Living conducted on July 2	iencies were found at the tir Facility's Compliance Inspe 2, 2015.					
X16GE	administration, a ma	S SATISFACE NO SAT			See Attached Plan of Corn	ection	08/25/2015
	the manager failed to administered in communication three sample resident Findings include: 1. A review of R2's service plan include administration, and written order from R20 mg, one tablet evenum and the Surveyor obsorganizer for R2 did was no bottle of Las. 3. During an interview of receiving the Latthe facility ran out of the same three same trees and the same trees and the same trees are same trees and the same trees are same trees administration.	icw, observation, and intervolve ensure that a medication valuation with an order for orals. medical record showed that d that R2 received medication the medical record included R2's medical practitioner for the rey day at bedtime. Merved that the medication and contain Lasix, and that ix in R2's medications. Lew, E1 acknowledged that F six as ordered, and reported f R2's Lasix a few days agotive had not yet brought mo	t R2's on la r Lasix, there		TITLE		

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

John Smith, Manager 08/25/2015

STATE FORM

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

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Attachments:

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	30 - 35	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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SOUTHV	EST KEY PROGRAM	ING	T MYRTLE			
0001111		GLENDAL	.E, AZ 8530			Simone
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE
X 000	Initial Comment		X 000			
	An on-site investigation was conducted on A	ation of complaint AZ00150175 August 3, 2018.				
		ons were unable to be he following deficiencies were				
		State Licensing Surveyor				
	Tiffany Slater, MPH	SW, State Licensing Surveyor , State Licensing Surveyor Ed., State Licensing Surveyor				
X22DJ	R9-10-722.B.5.a-c.	Physical Plant Standards	X22DJ			
	use and contains: a. A shatter-proof metreatment plan allow b. A window that opventilation; and c. Nonporous surfar and slip-resistant slip-resistant slip-resistant slip-resistant surfar and slip-resistant sl	om provides privacy when in hirror, unless the resident's				

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

TITLE

(X6) DATE

FORM APPROVED ADHS LICENSING SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: __ B. WING 08/03/2018 BH3534 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **5125 WEST MYRTLE AVENUE** SOUTHWEST KEY PROGRAM, INC GLENDALE, AZ 85301 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) X22DJ 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. X22EI R9-10-722.B.8.c. Physical Plant Standards X22EI 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. R9-10-722, B.8.g.ii.(2). Physical Plant Standards X22F0 X22FO

following: g. Is a:

B. An administrator shall ensure that: 8. A resident bedroom complies with the

FORM APPROVED ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: С B. WING BH3534 08/03/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5125 WEST MYRTLE AVENUE SOUTHWEST KEY PROGRAM, INC GLENDALE, AZ 85301 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) X22FO Continued From page 2 X22FO 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.



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

DEFICIEN	[17] [17] [17] [17] [17] [17] [17] [17]		DATE SURVEY COMPLETED 7/22/2015				
NAME OF	PROVIDER OR SUI	LE		ET ADDRESS	ET ADDRESS, CITY, STATE, ZIP CODE COPY		-
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X 000		iencies were found at the tin Facility's Compliance Inspe 2, 2015.				3	
X16GE	R9-10-816. Medica	1.50			See Attached Plan of Corr	ection	08/25/2015
	administration, a ma 3. A medication a b. Is administered order, and This RULE is not m Based on record rev the manager failed to administered in com three sample resident Findings include: 1. A review of R2's service plan include administration, and written order from R 20 mg, one tablet ev 2. The Surveyor obsorganizer for R2 did was no bottle of Las 3. During an intervient receiving the Latthe facility ran out of	iew, observation, and intervolve ensure that a medication with an order for orders. medical record showed that did that R2 received medicate the medical record included the medical practitioner for ery day at bedtime. erved that the medication not contain Lasix, and that ix in R2's medications. ew, E1 acknowledged that R six as ordered, and reported f R2's Lasix a few days agotive had not yet brought motive that the medication and reported f R2's Lasix a few days agotive had not yet brought motives.	R2's on a Lasix, there				
					TITLE		(X6) DATE

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

John Smith, Manager STATE FORM

XXXXII

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



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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and the second s	was conducted on a with an off-site review Four of four allegat	Ation of complaint AZ00150182 August 3, 2018 and concluded ew on August 10, 2018. Ions were unable to be				
	were cited.	no/the following deficiencies				
	Abby Ziegler, RN, S Lauren Drucker, LE	Ed., State Licensing Surveyor State Licensing Surveyor SW, State Licensing Surveyor , State Licensing Surveyor				
X21DU	R9-10-721.A.14, Er	nvironmental Standards	X21DU			
	program provided by residential facility, an administration of the facility of	ed containers in a locked area preparation and storage, ledications and are				
	Based on observati administrator failed	net as evidenced by: on and interview, the to ensure poisonous or toxic the facility was inaccessible to				
	Findings include:					
		served the door to the laundry contained Simply Green				

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LEIED
		BH3661	B, WING	AND THE RESERVE THE PROPERTY OF THE PROPERTY O	08/1	0/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 8	STATE, ZIP CODE		
		7580 WES	•	ONT STREET		
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<u>.</u>	2. In an interview, C toxic material would	D2 reported the poisonous or d be locked.				
X22EI	R9-10-722.B.8.c. P	hysical Plant Standards	X22EI			
	following:	om complies with the that opens into a hallway,				
	Based on observati administrator failed	net as evidenced by: ion and interview, the to ensure two of four resident d a door that opened into a irea or outdoors.				
	Findings include:				,	
	the second floor of	ed four resident bedrooms on the facility. The doors to two of m B and Dorm D) had been				
	had been removed residents during the aware of the require	D2 acknowledged the doors in order to supervise the enight. O2 reported being ement of doors on bedrooms exprocess of contacting all compliance.				,
X22FO	R9-10-722.B.8.g.ii.	(2). Physical Plant Standards	X22FO			
	B. An administrator 8. A resident bedro following: g. Is a: ii. Shared bedroom	om complies with the				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8	PLE CONSTRUCTION G:	(X3) DATE COMP	SURVEY
			A. BOILDING			5
		BH3661	B. WING			0/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAN	IS - C.I AREINGINI	ST CLAREN LE, AZ 853	IONT STREET 03		
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X22FO	contains at least 60 not including a closs occupying the share. This RULE is not measured on observation administrator failed bedroom contained floor space for each shared bedroom. Findings include: 1. The surveyors observed in the feet per individual or or measured 2 contained four beds capacity for three. 2. In an interview, O	ded in subsection (C), square feet of floor space, et, for each individual ed bedroom; and net as evidenced by: on and interview, the to ensure a shared resident at least 60 square feet of individual occupying the esserved one of four resident ave the required 60 square ccupying the bedroom. Dorm e14.3 square feet and when the room had a	X22FO	DEFICIENCY)		
	moved to other large required square foo	er rooms to accommodate the tage.				



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.

Sincevely,

Harmony Duport Bureau Chief

HD:nm

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER/SUPPLIER/C IDENTIFICATION NUMBER AL0001 or BH0001		BER:	BUILDING	CONSTRUCTION	DATE SURVEY COMPLETED 7/22/2015		
NAME OF	PROVIDER OR SU SAMP		STRE	ET ADDRESS	ET ADDRESS, CITY, STATE, ZIP CODE COPY		
ID PREFIX TAG	FIX FULL REGULATORY OR LSC IDENTIFYING		BY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE A SHOULD BE CROSS-RE THE APPROPRIATE DE	CTION FERENCED TO	COMPLETE DATE
X 000		iencies were found at the tir Facility's Compliance Inspe 2, 2015.					
X16GE	R9-10-816. Medical B. If an assisted I administration, a maderical administration, a maderical administered order, and This RULE is not maderical administered in computational administered in computational administration and written order from F20 mg, one tablet event administration and written order from F20 mg, one tablet event administration and written order from F20 mg, one tablet event administration and written order from F20 mg, one tablet event administration and written order from F20 mg, one tablet event amount of the Surveyor obsorganizer for R2 did was no bottle of Lassac and the facility ran out of the surveyor of the Lasta and the facility ran out of the surveyor of the Lasta and the facility ran out of the surveyor of the Lasta and the facility ran out of the surveyor of the Lasta and the facility ran out of the surveyor of the survey	ation Services iving facility provides medianager shall ensure that; administered to a resident; d in compliance with a mediate as evidenced by; iew, observation, and intervolvence that a medication vapliance with an order for orats. medical record showed that d that R2 received medicationer for early day at bedtime. the medical practitioner for early day at bedtime. the reved that the medication land contain Lasix, and that ix in R2's medications. ew, E1 acknowledged that F six as ordered, and reported if R2's Lasix a few days agotive had not yet brought mo	ication view, was ne of t R2's on a r Lasix, there R2 was that b, but		See Attached Plan of Corr	ection	08/25/2015
					TITLE		(X6) DATE

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

John Smith, Manager 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



	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	13.74.703 Ap-5000189	LE CONSTRUCTION :	(X3) DATE	SURVEY
		ВН3660	B. WING			C 10/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY	STATE, ZIP CODE		
		9663 NOR	TH 83RD D			
SOUTHW	EST KEY PROGRAM	PEORIA, A	AZ 85345			
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	was conducted on A	ation of complaint AZ00150177 August 3, 2018 and concluded ew on August 10, 2018.	2			
		ons were unable to be ne following deficiencies were				
	Tiffany Slater, MPH Abby Ziegler, RN, S	Ed., State Licensing Surveyor, State Licensing Surveyor State Licensing Surveyor SW, State Licensing Surveyor			ē	
X21DU	R9-10-721.A.14. En	vironmental Standards	X21DU			
	program provided b residential facility, an administr 14. Poisonous or to behavioral health re maintained in labele	ed containers in a locked area preparation and storage, edications and are				
	administrator failed	net as evidenced by: on and interview, the to ensure poisonous or toxic the facility were inaccessible				
	room was open and unlocked and acces	served the door to the laundry the following items were sible to residents: one bottle v soap, liquid detergent, and		*		

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

TITLE

(X6) DATE

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION		SURVEY PLETED
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	Simply Green.					
	2. In an interview, C locked.	02 reported the items would be				
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	following: g. Is a: ii. Shared bedroom (2) Except as provic contains at least 60 not including a close occupying the share This RULE is not m Based on observation	om complies with the that: led in subsection (C), square feet of floor space, et, for each individual ed bedroom; and				
	bedroom contained	at least 60 square feet of individual occupying the				1 T T T T T T T T T T T T T T T T T T T
	Findings include:					
	bedrooms did not he feet per individual o	served one of four resident ave the required 60 square ccupying the bedroom. Dorm 10.8 square feet and				
		2 reported the beds would be er rooms to accommodate the tage.				and the second s

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.

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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

DEFICIEN OF CORR	ICIES AND PLAN ECTION	AL0001 or BH000		BUILDING WING		7/22/2015	
NAME OF	PROVIDER OR SUI SAMP	LE		ET ADDRESS	, CITY, STATE, ZIP CO.	Z	
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X 000		iencies were found at the tin Facility's Compliance Inspec					
X16GE	State Licensing Surv R9-10-816. Medica				See Attached Plan of C	orrection	08/25/2015
	administration, a ma	iving facility provides medic mager shall ensure that: administered to a resident; d in compliance with a medi					
	the manager failed to administered in communication three sample resider. Findings include: 1. A review of R2's service plan include administration, and written order from R20 mg, one tablet ev. 2. The Surveyor obsorganizer for R2 did was no bottle of Las. 3. During an intervient receiving the Latthe facility ran out of the same communication.	iew, observation, and intervious ensure that a medication was pliance with an order for on ats. medical record showed that d that R2 received medication the medical record included R2's medical practitioner for tery day at bedtime. terved that the medication I not contain Lasix, and that six in R2's medications. ew, E1 acknowledged that R six as ordered, and reported of R2's Lasix a few days ago, tive had not yet brought more	R2's on a Lasix, there				
					TITLE		(X6) DATE

STATE FORM XXXXII

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



	AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
		ВН3662	B. WING	2/-2	08/0	03/2018
			la l		1 00/0	13/2010
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	S - NORTHERN 8398 NOR PEORIA, A	TH 98TH LA AZ 85345	ANE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
X 000	Initial Comment		X 000			
	was conducted on A with an off-site review	ation of complaint AZ00150184 August 3, 2018 and concluded ew on August 10, 2018.				
		ons were unable to be ne following deficiency was				
	Lauren Drucker, LB Abby Ziegler, RN, S	Ed., State Licensing Surveyor SW, State Licensing Surveyor state Licensing Surveyor, State Licensing Surveyor				
X22EU	R9-10-722.B.8.e. P	hysical Plant Standards	X22EU			
n g	following:	shall ensure that: om complies with the oor covers that provide				
	Based on observation administrator failed	net as evidenced by: on and interview, the to ensure a resident bedroom provided resident privacy.				
	Findings include:					
	in the house was be keep residents sepa door to this room, w did not have a solid	eserved one of five bedrooms being used as a bedroom to arated if they were ill. The which connects to the hallway, door. The door had ten clear byided direct view into the tovide privacy.				
		22 reported the isolation room dent becomes ill and needs to	_			

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

TITLE

FORM APPROVED ADHS LICENSING SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: _ B. WING BH3662 08/03/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 8398 NORTH 98TH LANE SOUTHWEST KEY PROGRAMS - NORTHERN PEORIA, AZ 85345 (X5) COMPLETE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) X22EU 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. X22FU 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.

;			

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE COMP	(X3) DATE SURVEY COMPLETED		
		BH4051	B. WING		08/0	08/07/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
southv	VEST KEY PROGRAN	18	RTH 14TH S' (, AZ 85014	TREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
X 000	Initial Comment		X 000				
	was conducted on A	ation of complaint AZ00150178 August 7, 2018. ions were unable to be no deficiencies were cited.					
		ate Licensing Surveyor Licensing Surveyor	-	www.		a a constructive de la construct	
77.7		e e e e e e e e e e e e e e e e e e e					
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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/C IDENTIFICATION NUMB AL0001 or BH0001		BER:	MULTIPLE CONSTRUCTION BUILDING COMPLETED WING 7/22/2015				
NAME OF	PROVIDER OR SUI		STRE	ET ADDRESS	, CITY, STATE, ZIP CODE		
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X 000		iencies were found at the tir Facility's Compliance Inspe 2, 2015.					ø.
X16GE	R9-10-816. Medica	, a - 7 min a a a a a a a a a a a a a a a a a a a			See Attached Plan of Corr	ection	08/25/2015
	administration, a ma 3. A medication a	iving facility provides medi nager shall ensure that: administered to a resident: d in compliance with a med				i	
	the manager failed to administered in com three sample residen Findings include: 1. A review of R2's service plan included administration, and twritten order from R 20 mg, one tablet ev. 2. The Surveyor obsorganizer for R2 did was no bottle of Las. 3. During an intervien treceiving the Last the facility ran out o	iew, observation, and intervolve ensure that a medication villance with an order for orts. medical record showed that d that R2 received medication the medical record included 2's medical practitioner for	R2's on a Lasix, there		TITLE		(X6) DATE

STATE FORM

XXXXII

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 (X:

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
/ / / Bill	or contribution	IDENTIFICATION NOMBER.	A. BUILDING		COMPLETED	
		BH4292	B. WING		C 08/10/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	IS - HACIENDA D	RTH 113TH DWN, AZ 85			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
X 000	Initial Comment		X 000	180		
	was conducted on A	ition of complaint AZ00150135 August 10, 2018. ons were unable to be				
		ne following deficiency was				
		ate Licensing Surveyor ate Licensing Surveyor				
X22EU	R9-10-722.B.8.e. P	hysical Plant Standards	X22EU			
5h	B. An administrator 8. A resident bedroof following:	shall ensure that: om complies with the				
		oor covers that provide		•		
æ	administrator failed	net as evidenced by: on and interview, the to ensure a resident bedroom at provided resident privacy.				
	Findings include:					
2	several bedrooms h center of the doors.	served the entry doors to ad large glass windows in the The surveyors observed the s did not have covers to vacy.				
	several bedrooms we ten glass panels fro	served the entry doors to vere french style doors with m the top of the door to the ors observed the doors did not ide resident privacy.	e e	V		
	3. In an interview, O	1 acknowledged the doors				

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

TITLE

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER;** COMPLETED A. BUILDING: _ B. WING BH4292 08/10/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 12030 NORTH 113TH AVENUE SOUTHWEST KEY PROGRAMS - HACIENDA D YOUNGTOWN, AZ 85363 (X5) COMPLETE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) X22EU 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.



August 1, 2018

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

Re:

BH4460 - Event ID #EUIPI1

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.

Harmony Duport Bureau Chief

HD:nm

Sincer

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

R-1 X M.Z-MIY.II.J		ACCEL KADILE I	. A.// A.	104 00.	CCC CONTON		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER AL0001 or BH0001		IBER:	BUILDING COMPLE		DATE SURVEY COMPLETED 7/22/2015	7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7 7	
NAME OF	PROVIDER OR SU		STRE	ET ADDRESS,	CITY, STATE, ZIP CODE		
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 (EACH CORRECTIVE A SHOULD BE CROSS-RE THE APPROPRIATE DE	CTION FERENCED TO	COMPLETE DATE	
X 000	INITIAL COMMEN	NTS					
		iencies were found at the tir Facility's Compliance Inspe 2, 2015.					- Andrews - Andr
	State Licensing Sur	veyor Date					
X16GE	R9-10-816. Medic	ation Services			See Attached Plan of Corr	ection	08/25/2015
	administration, a magnification	iving facility provides medi anager shall ensure that: administered to a resident: d in compliance with a med				i	
	This RULE is not m	et as evidenced by:			,		
	the manager falled t	riew, observation, and intervo ensure that a medication vapilance with an order for or its.	Vas				
ı	Findings include:						
	service plan include administration, and	medical record showed that id that R2 received medicati the medical record included R2's medical practitioner for very day at bedtime.	on I a				
	organizer for R2 die	served that the medication I not contain Lasix, and that six in R2's medications.	there				
	not receiving the La	ew, E1 acknowledged that I islx as ordered, and reported if R2's Lasix a few days ago tive had not yet brought mo	l that o, but				
				1	TITLE		(X6) DATE

R

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

John Smith, Manager_ STATE FORM

08/25/2015

XXXXII

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

Unofficial Document Information Only

ADHS LICENSING SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: C B. WING 07/30/2018 BH4460 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 7022 NORTH 48TH AVENUE SOUTHWEST KEY PROGRAMS GLENDALE, AZ 85301 SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE DATE PROVIDER'S PLAN OF CORRECTION ID PREFIX (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG · DEFICIENCY) X 000 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 Slavsman, M.Ed., State Licensing Surveyor X 8BV 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

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

TITLE

ADHS L	<u>ICENSING SERVICI</u>	<u> </u>		CONOTRIBATION	(X3) DATE	SURVEY	
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	COMPLETED		
AND PLAN	OF CORRECTION	ADEM III IOATION NOMBER.	A. BUILDING:				
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		ВН4460	B. WING		07/3	0/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
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SOUTHW	SOUTHWEST KEY PROGRAMS GLENDA						
,			1	PROVIDER'S PLAN OF CORRECT	ion	(X5)	
(X4) ID	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOU	LD BE	COMPLETE	
PREFIX TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
X 88V	Continued From pa	ige 1	X 8BV		l		
		•					
	the date signed.						
	Findings include:						
	T MARINO HOMAN						
	1. A review of R1's	medical record (date: May 27,]				
	2018) revealed R1	was a minor and required a]				
	guardian. The reco	rd contained an undated		•			
	document titled "In-	dividual Services Plan." This					
	document did not d	ontain R1's presenting issue,	i i			- !	
	the signature of the	resident's guardian, a date of t plan would be reviewed, or					
	the clanature of the	personnel member who					
	developed the trea	tment plan. The bottom of the					
	document containe	d signature lines; however	ļ				
	they were blank.						
	2. A review of R2's	medical record (admit date:					
	May 30, 2018) reve	ealed R2 was a minor and					
	required a guardial	n, The record contained an tilled "Individual Services	1				
	Dian This document	ent dld not contain R1's				İ	
	nresenting issue t	he signature of the residents	Ì				
	nuardian a date of	when the treatment plan					
	would be reviewed	, or the signature of the	Į			<u> </u>	
	personnel member	who developed the treatment	1				
	plan. The bottom o	f the document contained					
	signature lines; ho	wever they were blank.					
	D. A. anada at DOI-	medical record (admit data:					
	3. A review of R3's	medical record (admit date: ealed R3 was a minor and	<u> </u>			 	
	regulted a guardie	n. The record contained an				•	
	undated document	titled "Individual Services					
	Pian." This docum	ent did not contain R1's		•			
	presenting issue, t	he signature of the residents					
	guardian, a date of	f when the treatment plan	1 1				
	would be reviewed	, or the signature of the	1				
	personnel member	who developed the treatment		·			
	plan. The bottom o	of the document contained					
	signature lines; no	wever they were blank.					
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AND PLAN OF CORRECTION	IDENTIFICATION NUMBER		CONSTRUCTION	COMPLETED
596	F114400	B, WING		C 07/30/2018
	Bl-14460	D, 11110		07/30/2010
NAME OF PROVIDER OR SUPPLIER	manufacture some some services	DRESS, CITY, ST	NA VINCENT AND	
SOUTHWEST KEY PROGRAMS		TH 48TH AVE E, AZ 85301	INUE .	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
titled, "Treatment Plai "3. Within 24 hours Mental Health Screen development of the of Plan (ISP), which is the mechanism used information obtained and/or case manager develop an appropriat 5 days of the MHS, the Services Plan (ISP) de allneeds8,the updated a minimum of thereafter9. The pr that the MHS and ISP under the supervision another qualified beha 10. The assigned clin and if applicable, the designated represent the treatment plan. 5. In an interview, O1 was done electronica	entation revealed a policy nning Policy," which stated, is of arrivingundergo a ning (MHS)will asssit in he dient's Individual Service the treatment planning 5. In addition to any during the MHS, the clinician is shall collect alland atte treatment plan7. Within the client will have n individual developed to address to ISP is required to be of every 30 days rogram director shall ensure process is conducted in of a lead clinician or eavioral health professional. IncidenInclude the client, parents, guardian or tative in the development of the reported most paperwork ally and acknowledged the not have all the required	X 8BV		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION S:	(X3) DATE SURVEY COMPLETED		
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		BH4474	B. WING		08/0	6/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

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

STATEME DEFICIEN OF CORR	ICIES AND PLAN	PROVIDER/SUPPLIER/ IDENTIFICATION NUM AL0001 or BH000	ABER:	1	CONSTRUCTION	DATE SURVEY COMPLETED 7/22/2015	
NAME OF	PROVIDER OR SUI SAMP		STRE	ET ADDRESS	, CITY, STATE, ZIP CODE COPY	;	
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X 000		encies were found at the tir Facility's Compliance Inspe 2, 2015.					
X16GE	R9-10-816. Medica B. If an assisted li administration, a ma 3. A medication a b. Is administered order, and	tion Services ving facility provides medi nager shall ensure that: idministered to a resident: I in compliance with a med			See Attached Plan of Corr	ection	08/25/2015
	the manager failed to administered in communication three sample resident Findings include: 1. A review of R2's service plan included administration, and the written order from R 20 mg, one tablet even 2. The Surveyor obserganizer for R2 did was no bottle of Lasi to treceiving the Last the facility ran out of	ew, observation, and intervolvensure that a medication volumes with an order for or	R2's on a Lasix, there			· · · · · · · · · · · · · · · · · · ·	
					TITLE		(X6) DATE

If continuation sheet 1 of 1

STATE FORM XXXXII

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



	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE :	
					С	;
		BH4460	B. WING		08/1	0/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	a	TH 48TH A' .E, AZ 8530			
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	was conducted on A	tion of complaint AZ00150180 August 3, 2018 and concluded w on August 10, 2018.				
	Two of two allegatio substantiated and the cited.	ns were unable to be ne following deficiencies were				
		Ed., State Licensing Surveyor SN, State Licensing Surveyor				***
		SW, State Licensing Surveyor State Licensing Surveyor			***************************************	
X22EU	R9-10-722.B.8.e. Ph	nysical Plant Standards	X22EU	v:·		
	B. An administrator 8. A resident bedroo following: e. Has window or do resident privacy;				1	and the second s
	Findings Include:			,	-	
	resident bedrooms was not a solid door glass panes that pro room and did not pro					
	2. In an interview, O	3 reported the isolation room				

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

TITLE

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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X22EU	Continued From pa	ige 1	X22EU			
	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.					
X22FO	R9-10-722.B.8.g.ii.	(2). Physical Plant Standards	X22FO			
	following: g. Is a: ii. Shared bedroom (2) Except as provid contains at least 60	om complies with the that: ded in subsection (C), square feet of floor space, et, for each individual				
	Based on observati administrator failed bedroom contained	net as evidenced by: on and interview, the to ensure a shared resident at least 60 square feet of n individual occupying the				
	The surveyors of resident bedrooms	oserved four of thirteen did not have the required 60 vidual occupying the				
	contained three bed square feet and con measured 177 square	red 176 square feet and ds. Room B3 measured 177 ntained three beds. Room B5 are feet and contained three asured 175 square feet and ds.				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 3:	(X3) DATE	SURVEY PLETED			
		BH4460	B. WING			C 10/2018			
	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7022 NORTH 48TH AVENUE								
SOUTHV	VEST KEY PROGRAM		E, AZ 8530						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE			
X22FO	Continued From page	ge 2	X22FO						
	3. In an interview, C moved to other large required square foo	3 reported the beds would be er rooms to accommodate the tage.							
The state of the s		THE PT (1997) IN THE BACKET COMPANY AND ADDRESS.				-			

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

3	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
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	An on-site investiga was conducted on A	ition of complaint AZ00ˌ149710 August 9, 2018.				
	six allegations were	ns was substantiated, five of unable to be substantiated, oficiencies were cited.				
	Abby Ziegler, RN, S	Ed., State Licensing Surveyor state Licensing Surveyor , State Licensing Surveyor				
X 6FA	R9-10-706.F.1-2. P	ersonnel	X 6FA			
	member, or an emp student who has or than eight hours of with residents, provi from infectious tube 1. On or before the providing services a	date the individual begins It or on behalf of the sidential facility, and				
	administrator failed personnel members	view and interview, the to ensure one of 30 sample s provided evidence of ious tuberculosis (TB) as			- CONTRACTOR - CON	
THE STATE OF THE S	Findings include:					
	TB skin test was do the result was negative	personnel record revealed a ne on March 28, 2017, and tive. No current documented eedom from infectious TB			and the state of t	

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

TITLE

PRINTED: 08/14/2018 FORM APPROVED ADHS LICENSING SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: С B. WING 08/09/2018 BH4497 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SOUTH 7TH AVENUE, SUITE 120 SOUTHWEST KEY PROGRAMS, INC PHOENIX, AZ 85007 (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID COMPLETE DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) X 6FA 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. B 043 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

HY8P11

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED				
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NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
SOUTHV	VEST KEY PROGRAM	IS INC.	TH 7TH AVE , AZ 85007	ENUE, SUITE 120					
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B 043	Continued From pa	ge 2	B 043	The state of the s					
	not employees of the program.	ne children's behavioral health							
	(b) A volunteer who receiving behaviora	provides services to children I health services.							
77	pursuant to section	contractor who is eligible 41-1758.07, subsection C to f fingerprinting for a good d who provides							
	documentation of his	aving applied for a good rsuant to section 41-619.55 received a decision.							
	services, nursing se services, health-rela services or supporti	not providing medical ervices, behavioral health ated services, home health we services and who is either contractor or not on the lar basis.							
	contractors and volu- an area of the hosp	staff members, employees, unteers who are not present in ital authorized by the riding children's behavioral							
	parent or guardian of behavioral health se behavioral health pr fingerprinted or sup section if the person	parent, kinship foster care of a child who is receiving ervices from a children's rogram is not required to be ervised for purposes of this in is in the presence of or ally the person's own child.							
	15-534 are exempt	mployees who are ant to section 15-512 or from the fingerprinting osection A of this section.		(II)		.8			

PRINTED: 08/14/2018 FORM APPROVED ADHS LICENSING SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION **IDENTIFICATION NUMBER:** COMPLETED AND PLAN OF CORRECTION A, BUILDING: R WING 08/09/2018 **BH4497** NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SOUTH 7TH AVENUE, SUITE 120 SOUTHWEST KEY PROGRAMS, INC PHOENIX, AZ 85007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) B 043 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 iurisdiction. 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

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
,	7, 33,11,12,7,3,1	[5=(1)), 15.(1.5](1.15)(1.5)(1.5)	A. BUILDING				
		BH4497	B. WING		I	୦ ୨୭/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE			
SOUTHV	VEST KEY PROGRAN	IS. INC	TH 7TH AVI , AZ 85007	ENUE, SUITE 120		,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETE DATE	
B 043	Continued From pa	ge 4	B 043				
	person has applied	ces to children unless the for and received the required e card pursuant to title 41, 3.1.					
	a certification subm	of health services shall accept itted by a United States derally recognized Indian tribe					
	employed and who children have not be admitted committing	re employed or who will be provide services directly to een convicted of, have not g or are not awaiting trial on ped in subsection H of this					
	employed to provide have been convicte committing or are a prescribed in subse	waiting trial on any offense ction I of this section if the hese services while under					
The Access of the Control of the Con	public safety if the e	all notify the department of employer receives credible son who possesses a valid e card either:					
	1. Is arrested for or in section 41-1758.0	charged with an offense listed 03, subsection B.					
	2. Falsified informat subsection E of this	ion on the form required by section.					
	L. For the purposes	of this section:					
	1. "Children's behav	vioral health program" means					

FORM APPROVED ADHS LICENSING SERVICES (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: C B. WING 08/09/2018 BH4497 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SOUTH 7TH AVENUE, SUITE 120 SOUTHWEST KEY PROGRAMS, INC PHOENIX, AZ 85007 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) B 043 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

PRINTED: 08/14/2018 FORM APPROVED

ADHS LICENSING SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: B. WING BH4497 08/09/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 SOUTH 7TH AVENUE, SUITE 120 SOUTHWEST KEY PROGRAMS, INC PHOENIX, AZ 85007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE DATE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) B 043 Continued From page 6 B 043 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.

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

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING	COMPLETED					
BH4486		B. WING		C 08/08/2018				
		***************************************			00/00/2010			
NAME OF I	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
SOUTHV	VEST KEY PROGRAM	S	TH ORACL AZ 85704	= ROAD				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE			
X 000	Initial Comment		X 000					
	August 7, 2018, and Two of thirteen alleg	Z00150172 was conducted on		2				
	Raquel Bravo-Clouz	zet, State Licensing Surveyor						
Seth Mackey, State Licensing Surveyor								
Coy Turner MS LISAC NCIT, State Licensing Surveyor								
X 6GO	record is maintained	shall ensure that a personnel d for each personnel member, r, or student that includes: f: a behavioral health	X 6GO					
	administrator failed for each personnel I Behavioral Health P provided behavioral	net as evidenced by: view and interview, the to ensure the personnel file member that was not a rofessionals (BHP) and who health services included inical oversight, as required						
	Findings include:							
	1. A review of E6's (date of hire February 13,						

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

TITLE

	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		D114400	B. WING		0010	
		BH4486	D. 11110		1 08/0	8/2018
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE FROAD		
SOUTHV	VEST KEY PROGRAM	8	AZ 85704			
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X 6GO	Continued From pa	ge 1	X 6GO			
	2017) personnel file "Clinician".	revealed E6 was hired as a				
	document titled "Joi "The Clinician is res	personnel file revealed a o Title: Clinician" which stated, sponsible for providing mental and counseling intervention				
	title of "Clinician" co Department definition Technician (BHT) at regular counseling s	24 confirmed the facility job viresponded to the on of Behavioral Health and reported E6 provided services to several residents and on an individual basis.		·		
	A review of E6's personnel file revealed no documentation of clinical oversight.					
	documentation of co group counseling se February 14, 2018,	ord for R1 contained bunseling progress notes for ervices provided by E6 on February 23, 2018, March 15, 18, and an individual on June 13, 2018.				
		ord for R2 contained counseling progress note for service provided by E6 on				
	individual counselin December 21, 2017	ounseling progress notes for g services provided by E6 on , February 20, 2018, and essions on February 21, 2018,				
	8. The medical reco	ord for R9 contained counseling progress note for				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	et 1945-1970/histopalkestates an	E CONSTRUCTION	(X3) DATE	SURVEY
			71. BOILDING.			3
		BH4486	B, WING		08/0	08/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	IS	TH ORACLE AZ 85704	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
X 6GO	Continued From pa	ge 2	X 6GO			
	a group counseling June 27, 2018.	service provided by E6 on				
	documentation of a	ord for R11 contained counseling progress note for service provided by E6 on				
	documentation of a	cord for R13 contained counseling progress note for service provided by E6 on				
	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.					
	documentation of a	cord for R19 contained counseling progress note for service provided by E6 on				
	documentation of co individual counselin February 7, 2018, F	cord for R21 contained ounseling progress notes for g services provided by E6 on february 21, 2018, and a ession on August 1, 2018.				
	documentation of a	cord for R22 contained counseling progress note for service provided by E6 on				
	documentation of coindividual counselin July 10-12, 2018, Ju August 1-2, 2018, fa	cord for R23 contained ounseling progress notes for g services provided by E6 on uly 15-19, 2018, July 25, 2018, amily counseling sessions on 15, 2018, July 30, 2018, and				

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		BH4486	8. WING			C 08/2018	
MAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	TATE ZIP CODE	, ,,,		
		1601 NOF	RTH ORACLE			,	
SOUTHV	VEST KEY PROGRAM	S TUCSON,	AZ 85704				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
X 6GO	Continued From pa	ge 3	X 6GO				
	group counseling se and August 8, 2018	essions on August 1, 2018,	:				
	documentation of co individual counselin July 3, 2018, July 10 23-24, 2018, July 3 a family counseling	cord for R24 contained counseling progress notes for g services provided by E6 on 0, 2018, July 17, 2018, July 1, 2018, August 7, 2018, and session on July 3, 2018.					
	documentation of a	counseling progress note for service provided by E6 on					
	documentation of co individual counselin	cord for R26 contained ounseling progress notes for g services provided by E6 on group counseling session on					
	documentation of a	cord for R27 contained counseling progress note for service provided by E6 on					
	documentation of a	cord for R29 contained counseling progress note for service provided by E6 on					
	documentation of co individual counselin June 28, 2018, a gr	cord for R35 contained counseling progress notes for g services provided by E6 on oup counseling session on family counseling session on			,		
		E24 and E26 reported they ersonnel file for all BHTs that					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
	BH4486	B. WING	· · · · · · · · · · · · · · · · · · ·	08/0) 8/2018
NAME OF PROVIDER OR SUPPLIER SOUTHWEST KEY PROGRAMS	1601 NOR	TH ORACLI	STATE, ZIP CODE E ROAD		
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
of clinical oversight and E26 acknowled	ge 4 must include documentation as required in R9-10-115. E24 ged documentation of clinical cluded in the personnel file	X 6GO			
programs; personnel exemptions; definition A. Except as provide of this section, childred program personnel, submit the form pressection to the employing fingerprint clearance 41, chapter 12, article working days after evolunteer work, shall clearance card. B. The following personnel work in the presence of chapter program personnel working the program personnel	Children's behavioral health ; fingerprinting requirements;	B 043			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
AND FLAN	OF CORRECTION	(DENTA JOM FOR HOMBER)	A, BUILDING:			
		BH4486	B. WING		08/0) <mark>8/2018</mark>
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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		TUCSUN,	AZ 85704			1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
B 043	Continued From pa	ge 5	B 043	,		
	receiving behaviora	provides services to children al health services. contractor who is eligible				
	pursuant to section petition the board o cause exception an	41-1758.07, subsection C to fingerprinting for a good of who provides				
	cause exception pu	aving applied for a good rsuant to section 41-619.55 t received a decision.				
	services, nursing so services, health-rel services or support	not providing medical ervices, behavioral health ated services, home health ive services and who is either contractor or not on the lar basis.				
	contractors and vol an area of the hosp	staff members, employees, unteers who are not present in bital authorized by the viding children's behavioral				
	parent or guardian behavioral health so behavioral health p fingerprinted or sup section if the perso	parent, kinship foster care of a child who is receiving ervices from a children's rogram is not required to be pervised for purposes of this in the presence of or half the person's own child.				
	15-534 are exempt	employees who are ant to section 15-512 or from the fingerprinting bsection A of this section.				
	E. Children's behav	rioral health program	control by controls, designed			

0DLK11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			Value and the second	E CONSTRUCTION	(X3) DATE COMP	SURVEY
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NAME OF PROVID	DER OR SUPPLIER	STREET ADI	ORESS, CITY,	STATE, ZIP CODE		
SOUTHWEST	KEY PROGRAM	IS	TH ORACLI AZ 85704	E ROAD		
	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
pers by the away or an agree lister this juris. F. For this. G. E. proggood of che to obtain any empty proggood with the all with l. A proggood with the all with linear court company and the all capacity proving the all th	ne department a iting trial on or admitted in open bement to commod in section 41-state or similar diction. orms submitted section are considered of charam personnel defaith efforts to admitted be relevant to a charam. operson who is a convicted of c	tify on forms that are provided and notarized that they are not have never been convicted of court or pursuant to a plea nitting any of the offenses 1758.03, subsection B or C in offenses in another state or	B 043	DETIGIENTI		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF I	PROVIDER OR SUPPLIER		-	STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	S	TH ORACLE AZ 85704	E ROAD		
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(X5) COMPLETE DATE
B 043	Continued From pa	ge 7	B 043			:
	fingerprint clearance chapter 12, article 3	e card pursuant to title 41, s.1.				
-	a certification subm	of health services shall accept itted by a United States derally recognized Indian tribe				
	employed and who children have not be admitted committing	re employed or who will be provide services directly to een convicted of, have not g or are not awaiting trial on ped in subsection H of this				
	employed to provide have been convicted committing or are at prescribed in subse	walting trial on any offense ction I of this section if the nese services while under				
	public safety if the e	all notify the department of employer receives credible son who possesses a valid e card either:				
	1. Is arrested for or in section 41-1758.0	charged with an offense listed 03, subsection B.				
	2. Falsified informat subsection E of this	ion on the form required by section.				
	L. For the purposes	of this section:				
	a program provided	rioral health program" means in a health care institution ne department to provide				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			Sen Indiana Managara Managara	E CONSTRUCTION	(X3) DATE COMP	SURVEY
			A. BOILDING.	<u> </u>	С	
		BH4486	B. WING			8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY,	STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	S	TH ORACLI AZ 85704	E ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
B 043	children's behaviora 2. "Children's behaviora personnel" means a volunteer who work health program. 3. "Direct visual sup visual oversight of ti does not require the		B 043			
	administrator failed maintained for each employee, voluntee documentation of the the fingerprinting read-425.03. Findings include: 1. A review of the penire August 10, 201 application was sub and a fingerprint car February 1, 2016. within seven working employment, as require November 13, 2 crime-free attestation 36-425.03, subsections.	view and interview, the to ensure a personnel record personnel member, or or student included e individual's compliance with quirements in A.R.S. § ersonnel record for E1 (date of 5) revealed a fingerprint card mitted on January 12, 2016, or dwas issued to E1 on The application date was not g days after the date of uired. ersonnel record for E3 (date of 2017) revealed a notarized on as required by A.R.S. §				

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1601 NORTH ORACLE ROAD TUCSON, AZ 85704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM-	STATEMENT OF DEFICIENC AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 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) B 043 Continued From page 9 31, 2018. The attestation date was not on or before the date of employment, as required.		BH4486 B. WING	C 08/08/2018
SOUTHWEST KEY PROGRAMS TUCSON, AZ 85704 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B 043 Continued From page 9 31, 2018. The attestation date was not on or before the date of employment, as required.	IAME OF PROVIDER OR S		, 33,332
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) B 043 Continued From page 9 31, 2018. The attestation date was not on or before the date of employment, as required.	OUTHWEST KEY PR	S ,	
31, 2018. The attestation date was not on or before the date of employment, as required.	PREFIX (EACH DE	MUST BE PRECEDED BY FULL PREFIX (EACH CORF	TIVE ACTION SHOULD BE COMPLETE DED TO THE APPROPRIATE DATE
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. § 36-426,03, 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.	31, 2018. before the dispersion of the March application of a fingerprint 2016. The working day required. 4. A review of hire August card application application of the August card application of hire Januareference of the March application of the Octo card application of the Octo card application of the Octo card application of the March appl	station date was not on or employment, as required. ersonnel record for E9 (date of) revealed a fingerprint card mitted on May 12, 2016, and as issued to E9 on June 30, ion date was not within seven he date of employment, as ersonnel record for E10 (date of	

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
			A. BUILDING			С	
		BH4486	B. WING			08/2018	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE			
SOUTHV	VEST KEY PROGRAM	S	TH ORACL AZ 85704	E ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
B 043	of hire April 30, 201 notarized crime-free A.R.S. § 36-425.03, 9. In an interview, E the personnel recorpersonnel member, student did not include.	ersonnel record for E27 (date 8) revealed no evidence of a e attestation as required by subsection E was included. 24 and E26 acknowledged d maintained for each employee, volunteer, or ade documentation of the noce with the fingerprinting	B 043				



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.

Harmony Duport Bureau Chief

HD:nm

Singerely,

Enclosures

EXAMPLE OF AN ACCEPTABLE PLAN OF CORRECTION

DEFICIEN	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION PROVIDER/SUPPLIER/ IDENTIFICATION NUM AL0001 or BH000		1BER:		CONSTRUCTION	DATE SURVEY COMPLETED 7/22/2015	
NAME OF	PROVIDER OR SUI		STRE	ET ADDRESS	, CITY, STATE, ZIP CODE COPY		
ID PREFIX TAG	(EACH DEFICIEN	EMENT OF DEFICIENCIE CY MUST BE PRECEDED RY OR LSC IDENTIFYIN	BY	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE A SHOULD BE CROSS-RE THE APPROPRIATE DE	CTION FERENCED TO	COMPLETE DATE
X 000		iencies were found at the tin Facility's Compliance Inspe 2, 2015.					
X16GE	administration, a ma 3. A medication a b. Is administered order, and This RULE is not m	iving facility provides medi- mager shall ensure that: administered to a resident: d in compliance with a medi	lcation		See Attached Plan of Corr	ection	08/25/2015
	the manager failed to	o ensure that a medication v pliance with an order for on	vas				
	service plan include administration, and	medical record showed that d that R2 received medication the medical record included 12's medical practitioner for ery day at bedtime.	on a				
	organizer for R2 did was no bottle of Las	erved that the medication not contain Lasix, and that ix in R2's medications.					
	not receiving the La the facility ran out o	ew, E1 acknowledged that R six as ordered, and reported f R2's Lasix a few days ago tive had not yet brought mo	that , but				
					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



AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED
		BH4825	B. WING		1	0
		БП4623			1 08/	10/2018
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
SOUTHV	VEST KEY PROGRAM	I, INC 723 EAST MESA, AZ	2ND AVEN 2 85204	UE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
X 000	Initial Comment		X 000			
	was conducted on A	tion of complaint AZ00150124 August 8, 2018 and concluded ew on August 10, 2018.				
		ns were unable to be ne following deficiencies were				
		tate Licensing Surveyor SW, State Licensing Surveyor				
X 3JI	R9-10-703.C.5.a. A	dministration	X 3JI			
		stated: equired by this Article is artment within two hours after				
	administrator falled required by this Artic	view and interview, the to ensure documentation				
	Findings include:	oct from a gamen				
	the record did not in	personnel record revealed clude documentation of the skills and knowledge.		·		
	knowledge were ver conducted January	2 reported E1's skills and ified through training 5-9, 2018. O2 acknowledged vas not in E1's personnel			***************************************	
					1	

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

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED				
			A. 8UILDING:		С				
		BH4825	B. WING		08/10/2018				
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE					
SOUTHWEST KEY PROGRAM, INC 723 EAST 2ND AVENUE									
(X4) ID	IVIESA, AZ 832U4								
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	(EACH CORRECTIVE ACTION SHOULD BE CONCROSS-REFERENCED TO THE APPROPRIATE				
X 3JI	Continued From page 1		X 3JI						
	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 6FA	R9-10-706.F.1-2. Personnel		X 6FA						
	member, or an emp student who has or than eight hours of with residents, provi from infectious tube	date the individual begins at or on behalf of the sidential facility, and							
	administrator failed personnel members	view and interview, the to ensure one of 21 sample s provided evidence of ious tuberculosis (TB) as				TO THE PROPERTY OF THE PROPERT			
o were about to device	-								
	documentation from (QFT-G) test dated documented E6 was	personnel record revealed a QuantiFERON-TB Gold March 4, 2017, which is free from TB. No current ce of E6's freedom from bund.		-					
	have annual docume infectious TB. O1 ex	1 acknowledged E6 did not entation of E6's freedom from colained there was a "mix-up" E6 was confused with another				7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED						
			A. BOILDING;		C						
		BH4825	B, WING		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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE						
X 6FA	Continued From page 2		X 6FA								
	employee.										
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