Statement of Deficiencies	**(X1) Provider/Supplier/CLIA Identification Number**	**(X3) Date Survey Completed**
	03P001	05/21/2026
Name of Provider or Supplier	**Street Address, City, State**	
Donor Network Of Arizona	2010 West Rio Salado Parkway, Tempe, AZ	

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

(X4) ID Prefix Tag	**Summary Statement of Deficiencies** (Each deficiency should be preceded by full regulatory or LSC identifying information)
Z0121	STAFFING CFR(s): 486.326(b)(1) The OPO must provide sufficient coverage, either by its own staff or under contract or arrangement, to assure both that hospital referral calls are screened for donor potential and that potential donors are evaluated for medical suitability for organ and/or tissue donation in a timely manner. This STANDARD is not met as evidenced by: Based on interview, record review, and policy review, the facility failed to ensure the Organ Procurement Organization (OPO)'s staff member arrived at the donor hospital within two hours of the initial referral time for one of ten donors (Brain Death Donor (BDD) 4, UNOS (United Network for Organ Sharing) ID#: AMFU382) donor records reviewed. This failure could negatively impact the OPO's ability to procure viable donor organs. Findings include: Review of BDD4's "Progress Notes" tab of the electronic medical record (EMR) revealed a progress note which indicated, ". . . Organ Initial Referral06/13/25 at 06:41 [6:41 AM] MST [Mountain Standard Time] Spoke with BSRN (Bachelor of Science Registered Nurse) . . . who called in the initial referral . . . Dx [Diagnosis]: Respiratory failure 06/13/25 @ 06:22 [6:22 AM] . . ." Review of BDD4's "Progress Notes" tab of the EMR revealed a progress note which indicated, ". . . Assignment Organ Coordinator, 06/13/25 at 0654 [6:54 AM] MST

Notified Organ Donation Coordinator [ODC3] . . . [ODC3] to see, Thank you."

Review of BDD4's "Progress Notes" tab of the EMR revealed a progress note which indicated, ". . . Organ Following [ODC3] 06/13/25 at 1033 [10:33 AM] MST . . . Onsite with BSRN . . . patient is a GCS [Glasgow Coma Scale)]3 + cough . . ."

Review of the OPO's "Staff Tracking" sheet for UNOS#: AMFU382 under the "Staff Logs" section indicated ODC3 arrived at the donor hospital on 06/13/25 at 10:05 MST and departed on 06/13/25 at 10:36 MST. This was greater than two hours after the initial referral was received by the OPO.

During an interview on 05/20/26 at 2:15 PM, Referral Optimization Charge (ROC) 2 stated the typical OPO staff member arrival time to the donor hospital, after donor referral, was within two hours. ROC2 explained if the arrival time was greater than two hours, he/she would document the reason for the delay in a delayed onsite note in the donor's EMR. ROC2 reviewed BDD4's EMR and stated the referral time for that case was at 6:22 AM, and the OPO staff member's documented arrival time to the donor hospital was 10:33 AM. ROC2 confirmed she was the ROC for this referral. ROC2 stated normally she would have documented why there was a delay with staff arrival, but without the documentation she would be guessing the cause of the delay.

During an interview on 05/21/26 at 8:40 AM, the Assistant Vice President of Clinical Services (AVPCS) 1 confirmed there was a delay with the initial staff arrival time to the donor hospital for BDD4's case. AVPCS1 explained the response teams were arranged by regions and it normally should not take a staff member four hours to arrive at a donor hospital. ASVPCS1 stated the two-hour response period was the goal for the OPO staff assigned to a donor referral case.

Review of the OPO's policy titled, "Referral Intake and Monitoring," effective date 06 /23/25, indicated, "1. Purpose: 1.1. This policy will define Donor Network of Arizona (DNA)'s preparation for, response to and continual monitoring of organ referrals . . . 2.2. Organ Referral and Donation Optimization staff are responsible for responding to referrals in a prompt, professional manner that facilitates the evaluation . . . 6. Procedure: . . . 6.3.2. Excluding situations described in 6.2.1, the ORO (Organ Referral Optimization) staff will respond on-site to provide professional consultation of the referred candidate as soon as possible. Any delays in an onsite being performed > 2 hours of the initial referral should be documented by the ROC (Referral Optimization Charge) . . ."