DEPARTMENT OF HEALTH AND HUMAN SERVICES — CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: IEJZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0036

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035074**
2.STATE VENDOR OR MEDICAID NO.
(L2)

3. NAME AND ADDRESS OF FACILITY
(L3) **FRIENDSHIP VILLAGE OF TEMPE**
(L4) **2525 EAST SOUTHERN AVENUE**
(L5) **TEMPE, AZ** (L6) **85282**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/13/2017** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **04** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **128** (L18)
13.Total Certified Beds **32** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
___ 6. Scope of Services Limit
___ 7. Medical Director
___ 8. Patient Room Size
___ 9. Beds/Room

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
32				
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

This facility is back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 11/17/17 State Agency recommended recertification.

Friendship Village Life Safety code is back in compliance with federal regulations based on the acceptable plan of correction 11/09/17. State Agency recommended recertification is effective 11/9/17.

17. SURVEYOR SIGNATURE
A for Michael Marck DE
Date : 12/14/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL
A. Jam DE
Date: 12/14/2017 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
11/12/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00511
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/15/2017
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

COPY

December 15, 2017

Mrs. Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Provider Number 035074

Dear Mrs. Schmidt:

Your facility has just received its recertification survey for the Federal Title XVIII (Medicare) program.

The facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

You should keep a copy of this notice with your signed provider agreement.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/sf

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

December 15, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On October 13, 2017, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and presume that you have achieved substantial compliance. Based on this presumed compliance, we are not forwarding to the Centers for Medicare/Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency our recommendation that the remedies we indicated in our letter to you of 10/26/17 be imposed at this time.

We may be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained. We will certify your facility in compliance if we find that your facility is in substantial compliance at the time of the revisit. If we find that your facility has failed to achieve or maintain substantial compliance, the following remedies (or revised, if appropriate) will be imposed:

Recommendation to CMS for Civil money penalty, effective October 13, 2017

A civil money penalty, if imposed, will continue until you have achieved substantial compliance or your provider agreement is terminated.

If you have any questions concerning the instructions contained in this letter, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
CSR IV

/sf

cc: State Ombudsman (with POC)

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 18, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

An offsite revisit was conducted on November 17, 2017, and the plan of correction was accepted for the Federal citations. Enclosed is the **Federal Post-Certification Revisit Report**. Please retain a copy for your files.

If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
CSR IV

\sf

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	R 11/17/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The offsite Federal recertification and complaint investigation survey was conducted on November 17, 2017, there were no deficiencies cited.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed 10/26/2017 via email

October 26, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, Arizona 85282

Dear Mrs Schmidt:

Enclosed is the Federal deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. These forms will become a part of our public file; please sign and return the first page with orginal signatures and retain a copy for your files.

If I may be of any further assistance please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\sf

Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING _____ B. WING _____	10/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The recertification survey was conducted October 10, 2017 through October 13, 2017 in conjunction with the investigation complaint #s AZ00143990, AZ00138407, AZ00140244, AZ00139112, and AZ00142671. No deficiencies were cited.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE: Health Services Administrator | (X6) DATE: 11/2/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

December 15, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

An **Life Safety Code** revisit was conducted on November 9, 2017, and the plan of correction was accepted for the Life Safety Code citations. Enclosed is the **Life Safety Code Post-Certification Revisit Report**. Please retain a copy for your files, a copy will be filed in our public file.

If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Sandy Farmer
CSR IV

\sf

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING **02 - MAIN BUILDING 01** B. WING _____	R **11/09/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	**2525 EAST SOUTHERN AVENUE** **TEMPE, AZ 85282**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS All noted deficiencies on the survey dated, October 11, 2017 have been corrected. This was an on site follow-up and based on an approved plan of correction with allegations of correction and supporting documentation.	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035074 Y1	A. Building 02 - MAIN BUILDING 01 B. Wing Y2	11/9/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 EAST SOUTHERN AVENUE TEMPE, AZ 85282

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0353	11/07/2017	LSC K0712	11/07/2017	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
				11/9/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
10/10/2017	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING **02 - MAIN BUILDING 01** B. WING _____	R **11/09/2017**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	**2525 EAST SOUTHERN AVENUE** **TEMPE, AZ 85282**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS All noted deficiencies on the survey dated, October 11, 2017 have been corrected. This was an on site follow-up and based on an approved plan of correction with allegations of correction and supporting documentation.	{K 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

Receipt of Notice Presumed on 10/26/2017 via email

October 26, 2017

Mrs. Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On October 10, 2017, a **Life Safety Code** survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **November 5, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 5, 2017**, may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

Allegation of Compliance

Your properly signed Plan of Correction constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of **11/27/17.**

If, upon the subsequent revisit, your facility has not achieved substantial compliance, The Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continuing until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Recommending to CMS Civil Money, per day, per tag, effective October 10, 2017

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

Mandatory Remedies

Your current period of noncompliance began on October 10, 2017. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by 4/13/18.

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Diane Eckles, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. **Please note: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies. An informal dispute resolution process will not delay the effective date of any enforcement action.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **November 5, 2017**, recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\sf

Attachments

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS 42CFR 483.70 (a) Nursing Homes The facility must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association. This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing of a Skilled Nursing Facility under Health Care. The entire skilled nursing portion of the facility was surveyed. The facility meets the standards, based upon acceptance of a plan of correction.	K 000	K000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 353 SS=D	NFPA 101 Sprinkler System – Maintenance and Testing Sprinkler System – Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This STANDARD is not met as evidenced by:	K 353	K353 NFPA 101 Sprinkler System – Maintenance and Testing It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure the standpipe testing is completed and tested per NFPA requirements, every 5 years. 1. The Assistant Environmental Services (ES) Director scheduled testing with Climatec (vendor) for 11/1/17 (see attached proposal) and additional invoice for repairs (see attached) accompanied by a letter from Climatec that repairs and testing will be completedy by 11/3/17 (see attached). The Assistant ES Director has ensured testing will be completed every 5 years by scheduling a PM in our WorxHub ES electronic work order management program.	

RECEIVED
NOV 7 - 2017
By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Health Services Administrator — (X6) DATE: 11/2/17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVENUE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	Continued From page 1 Based on record review with the Administrator, Plant Operations Manager and a phone call made too Climatec sprinkler and fire alarm company it was determined the facility failed to conduct a 5 year flow test of the sprinkler standpipes in the nursing home. Findings include: NFPA 101 Life Safety Code, 2012 Edition, Chapter 19, Section 19.1.1.1.3. General "The provisions of Chapter 4, General, shall apply." Chapter 4, Section 4.6.12.3 ,"Existing life safety features obvious to the public, if not required by the Code, shall be either maintained or removed." Section 4.6.12.4, "Any device, equipment, system, condition, arrangement, level of protection, fire-resistive construction, or any other feature requiring periodic testing, inspection, or operated as specified elsewhere in this Code or as directed by the authority having jurisdiction. NFPA 13, "Installation of Sprinkler Systems." Chapter 26, Section 26.1, General, "A sprinkler system installed in accordance with this standard shall be properly inspected, tested and maintained by the property owner or their authorized representative in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, to provide at least the same level of performance and protection as designed."NFPA 25, Chapter 6, Standpipe and Hose Systems Section 6.3.1 Flow Tests. Section 6.3.1.1 A flow test shall be conducted every 5 years at the hydraulically most remote hose connections of each zone of an automatic standpipe system to verify the water supply still provides the design pressure at the required flow.	K 353	2. All residents, personnel, employees, volunteers, and students have the potential to affected by not testing stand pipes every five years to ensure all pipes are functioning in in the event of a fire in accordance with NFPA 101 Life Safety Code, 2012, Chapter 19, Section 191.1.1.3. The Administrator and Assistant ES Director will ensure stand pipe testing is scheduled and occurs every 5 years. 3. The Assistant ES Director has assigned a PM in the electronic work order management program to ensure testing will be completed as required every 5 years. 4. Administrator and/or Administrator's Designee and Assistant ES Director will report to quarterly Quality Assurance and Assessment (QAA) Committee to ensure compliance. 5. See signature of Administrator at the bottom of the page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	Continued From page 2 On October 10, 2017 the surveyor accompanied by Administrator, Plant Operations Manager and Health Care Center Facilitator reviewed the automatic sprinkler inspection, testing, and maintenance documentation from Climatec since the last survey which did not indicate a 5 year flow tests for the standpipes was completed. A phone call was made while the surveyor was on site to Climatec by the Plant Operations Manager to verify if the 5 year flow tests was completed. Climatec could not verify at the time of the phone call and survey if it was completed. The Administrator e-mailed the surveyor on October 11, 2017 in the morning verifying it was not completed. During the exit conference on October 10, 2017 the above findings were again acknowledged by the Administrator, Plant Operations Manager and Health Care Center Facilitator. Failing to conduct the 5 year flow test of the sprinkler standpipes could cause harm to patients in time of a fire. Based on observation it was determined that the facility failed to maintain one or two sprinkler heads free from lint and grease in the kitchen cafe and main kitchen located in the basement. Findings include: NFPA 101 Life Safety Code, 2012 edition, Chapter 19, Section 19.3.5.1 "Buildings Containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." Chapter 9, Section 9.7.1 "Each automatic	K 353		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	Continued From page 3 Sprinkler system required by another section of this Code shall be in accordance with on of the following." "NFPA 13, Standard for the Installation of Sprinkler Systems." Chapter 26, Section 26.1 "General." "A sprinkler system installed in accordance with standard shall be properly inspected, tested, and maintained by the property owner or their authorized representative in accordance with NFPA 25. NFPA 25, Section 5.2.1 "Sprinklers, Section 5.2.1.1.1 "Sprinklers shall not show signs of leakage, shall be free of corrosion, foreign materials, paint and physical damage." Section 5.2.1.1.2 Any sprinkler that shows the signs of any of the following shall be replaced. 1. leakage 2. Corrosion 3. Physical damage 4. Loss of fluid in the glass bulb heat responsive element 5. *Loading See A.5.2.1.1.2 (5) In lieu of replacing sprinklers that are loaded with coating of dust, it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. 6. Painting unless painted by the manufacturer. Section 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage, is painted other than by the manufacturer, corroded, damaged, or loaded, is in the improper orientation. Annex E Examples of Classification of needed repairs Sprinklers and Escutcheon plates that are missing, painted or rusted. On October 10, 2017 the surveyor accompanied by one or all three staff, Administrator, Plant Operations Manager and Health Care Center Facilitator observed the kitchen cafe had lint and grease on two of two sprinkler heads and the main kitchen cooking area had one of approximately 15 sprinkler heads with lint and grease on the sprinkler head.	K 353	K353 NFPA 101 Sprinkler System – Maintenance and Testing It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure sprinkler heads are kept free from leakage, free of corrosion, foreign materials, paint and physical damage. 1. The Assistant Environmental Services Director scheduled the replacement of 3 sprinkler heads to be completed by 10/14/17 (see attached). 2. All residents, personnel, employees, volunteers, and students have the potential to affected by sprinkler heads that have a delayed response in the event of a fire. The Health Care Center Facilitator will observe sprinkler heads on a quarterly basis and report to quarterly QAA Committee. 3. Administrator, Plant Operations Manager and Health Care Center Facilitator will report findings to Quarter QAA Committee. 4. Administrator and/or Administrator's Designee, Plant Operations Manager and Health Care Center Facilitator will be responsible for reporting to quarterly QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of the page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 353	Continued From page 4 During the exit conference on October 10, 2017 the above findings were again acknowledged by the Administrator, Plant Operations Manager and Health Care Center Facilitator. Failing to maintain the sprinkler heads and escutcheon plated which are part of the entire sprinkler assembly could cause harm to the residents by allowing a fire to spread before the temperature is reached to set of the sprinkler head.	K 353		
K 712 SS=D	NFPA 101 Fire Drills Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This STANDARD is not met as evidenced by: Based on record review and interview with the Administrator and Plant Operations Manager it was determined the fire drills dated February 16, 2017 and August 01, 2017 both second shift fire drills. The fire alarm was not activated for two of twelve fire drills before nine pm. The facility has two twelve hour shifts for the fire drills. Findings include:	K 712	K712 NFPA 101 Fire Drills It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure audible alarms are sounded for fire drills between the hours of 0601 and 2059. 1. The Security and Transportation Manager created a Fire Drill Training and Outline (see attached) to review and educate with her evening Security Officers and revised the Fire Drill sheets (see attached) to include all 9 required elements. The evening Safety Officers signed off on the training they received (see attached) on 10/18/17 and 10/24/17 The Administrator and Safety Committee will review all drills for completeness every month.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 712	Continued From page 5 NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.7.1.1"The administration of every health care occupancy shall have, in effect and available to all supervisory personnel, written copies of a plan for the protection of all persons in the event of a fire, for their evacuation to areas of refuge, and from the evacuation from the building when necessary. All employees shall be periodically instructed and kept informed with respect to their duties under the plan. A copy of the plan shall be readily available at all times in the telephone operator's position or at the security center. NFPA 101, Life Safety Code, 2000, Chapter 19, Section 19.7.1.2 Fire exit drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. "When drills are conducted between 9:00 PM and 6:00 am a coded announcement shall be permitted to be used instead of audible alarms. NFPA 101 Life Safety Code Chapter 19, Section 19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: 1. Use of alarms	K 712	K 712 2. All residents, personnel, employees, volunteers, and students have the potential to affected by a fire if drills are not completed on a regular basis to ensure compliance. The Security and Transportation Manager and Safety Committee will review all drills for completeness and report to quarterly QAA Committee. 3. The Security Officers have been in-serviced on the new fire drill form, 9 elements required for a drill. New employees will receive the same training. Administrator and/or Administrator's Designee, Security and Transportation Manager will report findings to quarterly QAA Committee. 4. Administrator and/or Administrator's Designee and Security and Transportation Officer will be responsible for reporting to quarterly QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of the page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP VILLAGE OF TEMPE	2525 E SOUTHERN AVE TEMPE, AZ 85282

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 712	Continued From page 6 2. Transmission to the fire department 3. Emergency phone call to the fire department 4. Response to alarms 5. Isolation of fire 6. Evacuation of immediate area 7. Evacuation of smoke compartment 8. Preparation of floors and building for evacuation 9. Extinguishment of fire. Section 19.7.1.3 Employees of health care occupancies shall be instructed in life safety procedures and devices. On October 10, 2017 the surveyor accompanied by the Administrator and Plant Operations Manager reviewed the fire drills dated February 16, 2017 and August 01, 2017 these were noted as second shift fire drills. The fire alarm was not active for two of twelve fire drills before nine pm. 1. The fire drill dated February 16, 2017 indicated Method of Activation: All Call: This was also noted in the notes in the Fire Drill Evacuation Checklist Form and the written scenario which indicated the fire alarm was not not activated due being after hours and a cod 1000 was broadcast three times. The fire drill was initiated at 20:05 PM or (8:05 pm) 2. The fire drill dated August 01, 2017 Method of Activation: All Call. The written scenario indicated the fire alarm was not sounded due to the time residents were going to bed. The fire drill was initiated at 19:15 pm or (8:15 pm) During the exit conference on October 10, 2017 the above findings were again acknowledged by	K 712		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/10/2017

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K 712	Continued From page 7 the Administrator, Plant Operations Manager and Health Care Center Facilitator. Failing to conduct fire drills in accordance with the life safety code one per shift per quarter to familiarize staff with conditions under an actual fire can result in harm to patients and staff during a an actual fire or emergency situation.	K 712		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 10 16 17 (MM DD YY) To: F2 ☐☐ ☐☐ ☐☐ (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 (MM DD YY)
Friendship Village of Tempe	03-5074	12 31 07

Street Address	City	County	State	Zip Code
2525 East Southern Ave	Tempe	Maricopa	AZ	85282

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
480-831-3107	060	AZ

A. F9 ☐☐

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☑

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 05

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☐ No ☒

Name of Multi-Facility Organization: F14

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐☐ Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐☐☐ Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☒	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☒	No ☐
Does the facility conduct experimental research?	F26	Yes ☐	No ☒
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☒	No ☐

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F29 N/A
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31 N/A

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☒

FACILITY STAFFING

	Tag Number	A			B	C	D
		Services Provided			Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
		1	2	3			
Administration	F33				00184	00018	00000
Physician Services	F34	Y	N	N			
Medical Director	F35				00000	00000	00020
Other Physician	F36				00000	00000	00000
Physician Extender	F37	N	N	N	00000	00000	00000
Nursing Services	F38	Y	N	N			
RN Director of Nurses	F39				00038	00000	00000
Nurses with Admin. Duties	F40				00236	00024	00000
Registered Nurses	F41				00660	00012	00000
Licensed Practical/ Licensed Vocational Nurses	F42				00006	00000	00000
					00000	00000	00000
Certified Nurse Aides	F43				01014	00192	00000
Nurse Aides in Training	F44				00000	00000	00000
Medication Aides/Technicians	F45				00000	00000	00000
Pharmacists	F46	Y	N	Y	00000	00000	00004
Dietary Services	F47	Y	N	Y			
Dietitian	F48				00000	00000	00004
Food Service Workers	F49				00487	00083	00000
Therapeutic Services	F50						
Occupational Therapists	F51	Y	N	Y	00000	00000	00168
Occupational Therapy Assistants	F52				00000	00000	00122
Occupational Therapy Aides	F53				00000	00000	00000
Physical Therapists	F54	Y	N	Y	00000	00000	00165
Physical Therapists Assistants	F55				00000	00000	00256
Physical Therapy Aides	F56				00000	00000	00156
Speech/Language Pathologist	F57	Y	N	Y	00000	00000	00104
Therapeutic Recreation Specialist	F58	N	N	N	00000	00000	00000
Qualified Activities Professional	F59	Y	N	N	00019	00000	00000
Other Activities Staff	F60	Y	N	N	00079	00002	00000
Qualified Social Workers	F61	Y	N	N	00040	00012	00000
Other Social Services	F62	N	N	N	00000	00000	00000
Dentists	F63	Y	N	Y	00000	00000	00000
Podiatrists	F64	Y	N	Y	00000	00000	00000
Mental Health Services	F65	Y	N	Y	00000	00000	00000
Vocational Services	F66	N	N	N			
Clinical Laboratory Services	F67	Y	N	Y			
Diagnostic X-ray Services	F68	Y	N	Y			
Administration & Storage of Blood	F69	N	N	N			
Housekeeping Services	F70	Y	N	N	00375	00000	00000
Other Chaplain	F71				00036	00000	00000

Name of Person Completing Form	Time
Signature	Date

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035074	15 F75	Ø F76	13 F77	28 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 26	F81 2
Dressing	F82 0	F83 26	F84 2
Transferring	F85 0	F86 26	F87 2
Toilet Use	F88 0	F89 26	F90 2
Eating	F91 26	F92 2	F93 0

A. Bowel/Bladder Status

F94 0 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission ____?

F96 14 Occasionally or frequently incontinent of bladder

F97 6 Occasionally or frequently incontinent of bowel

F98 Ø On urinary toileting program

F99 10 On bowel toileting program

B. Mobility

F100 Ø Bedfast all or most of time

F101 19 In a chair all or most of time

F102 1 Independently ambulatory

F103 16 Ambulation with assistance or assistive device

F104 Ø Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints Ø ?

F106 Ø With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission ___?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 Ø Intellectual and/or developmental disability

F109 12 Documented signs and symptoms of depression

F110 1 Documented psychiatric diagnosis (exclude dementias and depression)

F111 7 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 Ø Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them Ø ?

F114 Ø Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 Ø Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission Ø ?

F117 16 Receiving preventive skin care

F118 Ø Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 1 Hospice care

F120 Ø Radiation therapy

F121 Ø Chemotherapy

F122 Ø Dialysis

F123 Ø Intravenous therapy, IV nutrition, and/or blood transfusion

F124 Ø Respiratory treatment

F125 Ø Tracheostomy care

F126 Ø Ostomy care

F127 Ø Suctioning

F128 8 Injections (exclude vitamin B12 injections)

F129 0 Tube feedings

F130 2 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 14 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 0 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 6 Any psychoactive medication

F134 2 Antipsychotic medications

F135 2 Antianxiety medications

F136 2 Antidepressant medications

F137 0 Hypnotic medications

F138 3 Antibiotics

F139 12 On pain management program

G. Other

F140 1 With unplanned significant weight loss/gain

F141 0 Who do not communicate in the dominant language of the facility (include those who use American sign language)

F142 0 Who use non-oral communication devices

F143 ___ With advance directives

F144 26 Received influenza immunization

F145 20 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
[illegible] RN	Director of Nursing	10/10/17

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? X Yes ___ No

F147 Was ombudsman present during any portion of the survey? X Yes ___ No

F148 Medication error rate 0 %

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 09/26/2013 thru 09/26/2017
Arizona

FRIENDSHIP VILLAGE OF TEMPE
2525 EAST SOUTHERN AVENUE
TEMPE, AZ 85282
State's Region Code: AZ

CCN: 035074
Phone Number: (480)831-3184
Participation Date: 11/12/1980

Provider Beds
Total: 128
Certified: 128

Provider Category: SNF

Type Action: RECERTIFICATION
Type Ownership: NONPROFIT - CORPORATION

Compliance Status: Provider meets requirements based on an acceptable plan of correction

Program Requirements

Current Survey/Revisit Dates - None

Prior 3 Survey 07/2013	S/S Code	Prior 2 Survey 10/2014	S/S Code	Prior 1 Survey 10/2015	S/S Code	Current Survey 11/09/2016	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
		X	D						REQ	F0252-SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT
		X	E						REQ	F0253-HOUSEKEEPING & MAINTENANCE SERVICES
									REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
X	D								REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
									REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
		X	D						REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
									REQ	F0362-SUFFICIENT DIETARY SUPPORT PERSONNEL
									REQ	F0368-FREQUENCY OF MEALS/SNACKS AT BEDTIME
X	D								REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
									REQ	F0456-ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION
		X	E						REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
X	D								REQ	F0499-EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS
									REQ	F0511-RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN
									REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
		X	D						REQ	F0517-WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS
		X	D						REQ	F0518-TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 07/2013	S/S Code	2012 HC Prior 2 Survey 10/2014	S/S Code	2012 HC Prior 1 Survey 10/2015	S/S Code	2012 HC Current Survey 11/09/2016	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
		X	D						STD	K0291-Emergency Lighting

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 09/26/2013 thru 09/26/2017

FRIENDSHIP VILLAGE OF TEMPE CCN: 035074

Edition of LSC Applied

2012 HC Prior 3 Survey 07/2013	S/S Code	2012 HC Prior 2 Survey 10/2014	S/S Code	2012 HC Prior 1 Survey 10/2015	S/S Code	2012 HC Current Survey 11/09/2016	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
X	E			X	E				STD	K0321-Hazardous Areas - Enclosure
									STD	K0353-Sprinkler System - Maintenance and Testing
X	D								STD	K0363-Corridor - Doors
		X	E						STD	K0372-Subdivision of Building Spaces - Smoke Barrie
						X C	D	11/28/2016	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
		X	E						STD	K0379-Smoke Barrier Door Glazing
X	E	X	F	X	E				STD	K0511-Utilities - Gas and Electric
		X	D						STD	K0712-Fire Drills
						X C	D	11/28/2016	STD	K0920-Electrical Equipment - Power Cords and Extens
X	D								STD	K0923-Gas Equipment - Cylinder and Container Storag

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 09/26/2013 thru 09/26/2017

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	0	0	6	3
Health Total	0	0	6	3
Life Safety Code	2	2	5	4
Life Safety Code + Health	2	2	11	7

Complaint Survey Information

Survey Date	Status
11/09/2016	Unsubstantiated
10/28/2015	Unsubstantiated
10/09/2014	Unsubstantiated
07/10/2013	Substantiated

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 09/26/2013 thru 09/26/2017

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

LTC Resident Census

Resident Census on 11/09/2016
Total: 10
Medicare: 10
Medicaid: 0
Other: 0

Total Certified Beds: 128

SNF	SNF/NF	NF	ICF/IID
128	0	0	0

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 26, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Complaint Intake #AZ00142671
Investigation # IEJZ11

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

October 26, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Complaint Intake #AZ00143990
Investigation # IEJZ11

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 26, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Complaint Intake #AZ00140244
Investigation # IEJZ11

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

October 26, 2017

Jadyne Schmidt, Administrator
Friendship Village Of Tempe
2525 East Southern Avenue
Tempe, AZ 85282

Re: Complaint Intake #AZ00138407
Investigation # IEJZ11

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

If we may be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing