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

MEDICAL MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ESGI

Facility ID: LTC0036

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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 **01/31/2019** (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:

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

* Code: **A1*** (L12)

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):

Friendship Village of Tempe found to be out of compliance with federal regulations based on annual survey conducted on 1/31/19. This facility is back in compliance with federal regulations based on allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 4/11/19, State Agency recommended recertification.

17. SURVEYOR SIGNATURE — Date:
for Ernest Cull, Surveyor — 04/15/2019 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Sandy Jan — 04/15/2019 (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
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

April 15, 2019

Important Notice - Please Read Carefully

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

Re: Provider Number 035074

Dear Mrs. Schmidt:

Your facility has just undergone its Federal/State recertification survey, as required for the Federal Title XVIII (Medicare) program. As the result of this survey, 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.

Please retain 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

April 15, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mrs. Schmidt:

On April 11, 2019, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

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

Sandy Farmer
LTC Customer Service Representative 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 _____ B. WING _____	R 04/11/2019

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 follow up Federal Recertification and complaint investigation survey was conducted on 4/11/19, there were no deficiencies cited.	{F 000}		

RECEIVED
APR 19 2019
By

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

Health Services Administrator 4-19-19

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 B. Wing Y2	4/11/2019 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 F0640	Correction	ID Prefix F0684	Correction	ID Prefix	Correction
Reg. # 483.20(f)(1)-(4)	Completed	Reg. # 483.25	Completed	Reg. #	Completed
LSC	04/11/2019	LSC	04/11/2019	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
☒	DA	4/11/19	Dale Coleman	4/11/19
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/31/2019	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

April 15, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mrs. Schmidt:

On April 5, 2019, an offsite **Life Safety Code** revisit was conducted at your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Life Safety Code**, 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

Sandy Farmer
LTC Customer Service Representative 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 **02 - MAIN BUILDING 01** B. WING _____	R **04/05/2019**

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 42 CFR 483.41(a) Nursing Home 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. The entire facility, was surveyed on January 31, 2019. The facility meets the standards, based on acceptance of a plan of correction.	{K 000}		

RECEIVED
APR 19 2019
By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Health Services Administrator	4/19/19

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	4/5/2019 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 K0372	04/05/2019	LSC K0920	04/05/2019	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
☒	RR	4/5/19	Tom Kelly	4/5/19
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 1/29/2019

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

April 15, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mrs. Schmidt:

On April 5, 2019, an offsite **Emergency Preparedness** revisit was conducted at your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that no deficiencies of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Emergency Preparedness 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

Sandy Farmer
LTC Customer Service Representative 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 04/05/2019

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
{E 000}	Initial Comments All noted deficiencies on the survey dated January 31, 2019, have been corrected. This is a NO ON SITE follow-up based on an approved plan of correction with allegations of correction and supporting documentation.	{E 000}		

RECEIVED
APR 18 2019
By

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

Health Services Administrator 4/19/19

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

April 4, 2019

Ms. Jadyne Schmidt, Administrator
Friendship Village Of Tempe NCI-2646
2525 East Southern Avenue
Tempe, AZ 85282

Dear Ms. Jadyne Schmidt,

Thank you for the documentation submitted with your request for informal dispute resolution regarding the Statement of Deficiencies for your survey # ESGI11 conducted on January 31, 2019.

The management review team has reviewed the citations and your documentation, and has made the following decisions:

Tag #F578. § 483.10(c)(6) will be deleted.

Tag #F684 § 483.25 will remain as written.

Tag #Y328. R9-10-403.C will be deleted.

Tag #Y1477. R9-10-414.B will remain as written.

Enclosed is a clean and amended copy of your Statement of Deficiencies reflecting these changes as determined by management review. Please copy your acceptable plan of correction onto the revised statement of deficiencies and return the original to our office within 10 days. Please retain a copy for your files. The original will be placed in your facility file.

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

Sincerely,

Colby Bower
Assistant Director

CB/pdh

Enclosure

cc: CMS
Ombudsman

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

March 20, 2019

Important Notice - Please Read Carefully

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

Dear Mrs. Schmidt:

Thank you for the documentation submitted with your request for informal dispute resolution regarding the Statement of Deficiencies for State compliance survey # ESGI21 conducted on January 29, 2019.

The management review team has reviewed the citations and your documentation, and has made the following decisions:

E006 will be deleted.

Enclosed is a clean and amended copy of your Statement of State and Medicare deficiencies reflecting these changes as determined by management review. Please copy your acceptable plan of correction onto the revised statement of deficiencies and return the original to our office. Please retain a copy for your files. The original will be placed in your facility file.

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

Sincerely,

Diane Eckles

Diane Eckles
Long Term Care Bureau Chief

Enclosure

cc: CMS
Ombudsman

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 27, 2019

Receipt Of This Notice Is Presumed To Be -02/27/2019
Important Notice - Please Read Carefully

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

Dear Mrs. Schmidt:

On **January 31, 2019**, a Medicare recertification 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. During this survey, complaints investigations may have also been conducted.

[] 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).

[X] This survey found the most serious deficiency(ies) in your facility to be a pattern of 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 (E).

[] This survey found the most serious deficiency(ies) in your facility to be widespread 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 (F).

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 **March 9, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **March 9, 2019** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

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.

- Please provide all in-service records to include:

    - What was taught
    - When it was taught
    - Sign-in sheets of those who attended
    - Any copies of monitoring aduits being done up to your Allegation of Compliance date

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 **02/27/19 .**

If, upon a 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 continue 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, effective January 31, 2019
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on January 31, 2019. 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 07/12/19.

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.

Notice for Statutory Denial of Payment for New Admissions (DPNA)

Based on deficiencies cited during this survey and as authorized by CMS San Francisco Regional Office, we are giving formal notice of imposition of statutory Denial of Payment for New Admissions effective 04/13/19. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.
This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the

finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A request for a hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at *https://dab.efile.hhs.gov* no later than 60 days from the date of receipt of this letter.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent

you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given during registration must be entered on the login screen at: *https://dab.efile.hhs.gov/user_sessions/new* to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: *https://dab.efile.hhs.gov/appeals/to_crd_instructions*. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

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. 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. **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.**

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **March 9, 2019**, licensure and/or 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
Bureau Chief

DE:sf

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 _____	01/31/2019

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
F 000	INITIAL COMMENTS The recertification survey was conducted on January 28, 2019 through January 31, 2019 in conjunction with the investigation of complaint #'s: AZ00146601, AZ00146207, and AZ00150531. The following deficiencies were cited:	F 000		
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for each resident in the facility: (i) Admission assessment. (ii) Annual assessment updates. (iii) Significant change in status assessments. (iv) Quarterly review assessments. (v) A subset of items upon a resident's transfer, reentry, discharge, and death. (vi) Background (face-sheet) information, if there is no admission assessment. §483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State. §483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:	F 640	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) It is the intention of Friendship Village of Tempe to ensure each Resident assessment is encoded completely and transmitted within 7 days and 14 days after Friendship Village of Tempe completes a Resident's assessment to CMS via MDS. 1. The four Resident's assessments were completed prior to survey, but not submitted within the required timeframe. MDS Coordinator transmitted the assessments once surveyors brought the concern to her attention. 2/1/2019 all assessments were transmitted to CMS. (see attached) 2. All residents, employees, volunteers, students and guests have the potential to affected by the facility's failure submit MDS assessments within the required time frame per requirements Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4).	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Health Services Administrator	03/07/2019

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.

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F 640	Continued From Page 1 (i)Admission assessment. (ii) Annual assessment. (iii) Significant change in status assessment. (iv) Significant correction of prior full assessment. (v) Significant correction of prior quarterly assessment. (vi) Quarterly review. (vii) A subset of items upon a resident's transfer, reentry, discharge, and death. (viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment. §483.20(f)(4) Data format. The facility must transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interview, and the Resident Assessment Instrument (RAI) manual, the facility failed to ensure MDS (Minimum Data Set) assessments were transmitted to the CMS (Centers for Medicare and Medicaid Services) QIES ASAP (Quality Improvement Evaluation System Assessment Submission and Processing) system for 4 residents (#2, 3, 4, and 5). Findings include: Review of the QIES ASAP system revealed the last submitted MDS assessments for the following residents were over 120 days old. -Resident #2 was readmitted on March 3, 2014 with diagnoses that included dementia, heart failure and hypertension.	F 640	3. Director of Nursing will ensure the MDS Coordinator continues to transmit Resident assessments timely. Director of Nursing will audit Resident charts monthly and report findings to Quarterly QAA (Quality Assurance Assessment) Committee. 4. Director of Nursing will be responsible for reporting to quarterly QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of page one.	

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F 640	Continued From page 2 Review of the QIES ASAP system revealed the last MDS assessment submitted was a quarterly MDS assessment dated August 22, 2018. -Resident #3 was admitted on November 30, 2013 with diagnoses that included anemia and hypertension. Review of the QIES ASAP system revealed the last MDS assessment submitted was an annual MDS assessment dated August 22, 2018. -Resident #4 was admitted on August 19, 2018 with diagnoses that included dementia and osteoporosis. Review of the QIES ASAP system revealed the last MDS assessment submitted was a SNF PPS (Skilled Nursing Facility Prospective Payment System) Part A Discharge (End of Stay) assessment dated September 11, 2018. -Resident #5 was admitted on August 9, 2018 with diagnoses that included dementia and hypertension. Review of the QIES ASAP system revealed the last MDS assessment submitted was a SNF PPS Part A Discharge (End of Stay) assessment dated September 26, 2018. An interview was conducted with the MDS coordinator (staff #122) on 01/31/19 at 11:02 AM. The MDS coordinator stated that assessments had been completed for the 4 residents but that they were not submitted to the QIES ASAP system. She stated that she would submit the assessments immediately. After reviewing the	F 640		

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F 640	Continued From page 3 RAI manual, the MDS coordinator admitted MDS assessments have to be submitted for a resident whose Medicare Part A stay has ended and the resident remains in a Medicare certified bed. The RAI manual instructs a discharge assessment is required if the resident is transferred from a Medicare-certified bed to a noncertified bed and is required if the resident's Medicare Part A stay ends, but the resident remains in the facility. The manual included when a resident's Medicare Part A stay ends but he/she remains in the facility in a Medicare certified bed with another payer source, the facility must continue with the OBRA (Omnibus Budget Reconciliation Act) schedule from the resident's original date of admission and must also complete a Part A PPS discharge assessment. The manual also included if the end date of the most recent Medicare stay occurs on the day of or one day before the discharge date, the OBRA discharge assessment and Part A PPS discharge assessment are both required and may be combined. The manual instructs MDS assessments must be transmitted (submitted and accepted into the MDS database) electronically no later than 14 calendar days after the MDS assessment completion date.	F 640		
F 684 SS=D	Quality of Care CFR(s) 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that the residents receive treatment and care in accordance with professional standards of	F 684	It is the intention of Friendship Village of Tempe to ensure each Resident has a care plan that includes nursing services that maintain the Resident's highest practicable well-being according to the Resident's comprehensive assessment. 1. The Resident impacted was already discharged. Friendship Village of Tempe will continue the protocol of the Primary Care Physician (PCP) responsible for reviewing and ultimately, ordering any recommendations made by Resident's specialist physicians if the PCP agrees with the recommendations. 2/1/2019 continue protocol for specialists visits with the relationship of the	

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F 684	Continued From page 4 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policy and procedures, the facility failed to ensure that one resident (#176) received diuretic medication as per a physician's recommendation. Findings include: Resident #176 was admitted to the facility on July 20, 2018 with diagnoses that included fracture of the upper right humerus (arm) and CKD (Chronic Kidney Disease) stage 4. Per the resident's weight record documented on July 21, 2019, the resident weighed 154 pounds. The admission MDS (Minimum Data Set) assessment dated July 27, 2018 revealed the resident scored a 13 on the BIMS (Brief Interview for Mental Status), indicating he was cognitively intact. Nursing notes from July 28 through July 31, 2018 indicated that the resident had bruising and edema to his right arm and had been encouraged to elevate it. Also noted, the resident had swelling of BLE (Bilateral Lower Extremities). There was no evidence that the physician was notified of the resident's edema. A physician's progress note dated July 31, 2018 revealed no comment regarding the resident's BLE edema. The physician recommended that the resident's right arm be elevated while in bed. Per the resident's weight record documented on	F 684	PCP directing comprehensive care for Resident at Friendship Village of Tempe. 2. All residents, employees, volunteers, students and guests have the potential to affected by the facility's failure to individually care plan a Resident's nursing services based on the comprehensive assessment, ultimately affecting timely and/or appropriate care for a Resident. 3. Administrator and Director of Nursing will continue to ensure the the PCP reviews specialists recommendations and writes orders for the Nursing staff to follow through with, if PCP is in agreement with the recommendations. Director of Nursing will audit Resident charts monthly and report findings to Quarterly QAA (Quality Assurance Assessment) Committee. 4. Director of Nursing will be responsible for reporting to quarterly QAA Committee to ensure compliance. 5. See signature of Administrator at the bottom of page one.	

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F 684	Continued From page 5 July 31, 2018, the resident's weight was 160.8 pounds. This was a 6.8 pound increase in 10 days. Nursing notes from August 1 through 5, 2018 continued to document that the resident had edema of BLE and the right arm. On August 5, the nursing notes documented that the resident's right foot did not fit into his brace that was used for foot drop because his foot was "too swollen". The resident was noted to be scheduled for a nephrologist appointment on August 6, 2018. Review of the progress note from the nephrology appointment dated August 6, 2018 revealed the resident was seen for follow-up and evaluation for CKD. The note stated that the edema of the resident's lower extremity was "much worse." The instructions the nephrologist provided were to start treating the resident with Lasix (a diuretic, also known as furosemide). The medication list from the nephrologist included an order dated August 6, 2018 for furosemide 40 milligrams (mg) per day. The residents physician at the facility signed his initials at the bottom of the page. Review of the physician orders revealed no order was written for furosemide. A nursing progress note dated August 8, 2018 stated the resident's foot brace did not fit because of foot swelling. Review of the MAR (Medication Administration Record) for August 1 through 17, 2018 revealed that furosemide was not administered. Review of the resident's care plan revealed no evidence that the resident's edema had been	F 684		

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F 684	Continued From page 6 addressed. Per the resident's weight record documented on August 17, 2018, the resident's weight was 160.4 pounds, indicating that the resident's weight was 6.4 pounds higher than on admission. A nursing progress note dated August 17, 2018 reported that the resident had edema to BLE and also had new order for furosemide. A physician's order dated August 17, 2018 was for furosemide 40 mg every day. Review of the August MAR revealed the furosemide was given as ordered starting on August 17, 2019. The resident's weight documented on August 21, 2018 was 149 pounds which is about 10 pounds of weight loss after the furosemide was ordered. An interview was conducted on January 30, 2019 at 08:32 a.m. with an RN (Registered Nurse/staff #165). She stated that when a resident goes to an appointment, the nurse will fill out a form that includes what time the resident left the facility, what time they return, who they went to see, and how they were transported. She said that when the resident returns, they usually have a progress note that they give to staff. She said that if the resident does not have any notes, either the unit clerk or a nurse will call the doctor's office in case there are new medication orders or other changes to the resident's care that need to be implemented. Staff #165 stated she wasn't working on the day of the appointment in question and that she wasn't familiar with the information concerning the furosemide.	F 684		

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F 684	Continued From page 7 An interview was conducted on January 30, 2019 at 09:16 a.m. with an RN (staff #209). She stated that she usually checks for resident appointments on the computer first thing in the morning on the days she works. She said that when a resident returns to the facility from an appointment, she reviews the paperwork to see if there are any new medication orders or changes to medications. She said she would then follow-up with the physician to report these changes. She said that regarding a resident with BLE edema or with a brace that wasn't fitting because of edema, she would check the resident's weight and notify the physician of these issues to determine if the physician wanted to implement interventions or reassess the resident. Staff #209 also stated she was not working on the day of the resident's appointment and did not know what happened with the recommendation for furosemide. On January 31, 2019 at 12:39 p.m. the DON (Director of Nursing/staff #10) was interviewed. She stated that when a resident has an outside appointment, her expectation is that the resident will return with paperwork from the appointment and that if they do not, there would be a phone call to the physician's office so that any recommendations can be sent to the facility. She said that this information would then be shared with the resident's physician who would then be responsible to respond to the recommendation. In response to why the furosemide was not given per the nephrologist's order, she said that it is up to the physician's discretion whether or not to implement any recommendations and write and sign any new orders. An interview was conducted with the resident's	F 684		

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F 684	Continued From page 8 physician (staff #255) on January 31, 2019 at 3:07 p.m. He stated that he did see the note from the nephrologist that was dated August 7, 2018 and that he did sign his initials to the note on August 8, 2018, but that he must have missed the information regarding the furosemide order from the nephrologist. He stated that he remembered that the resident's arm sling was too tight, but that he believed the resident had come from the hospital with it that way. He stated that he does remember thinking about the furosemide use for this resident, but did not implement at this time. The facility policy on transcription of physician orders stated that nursing staff immediately process/transcribe the order onto the medication administration record, fax it to the pharmacy, place a copy in the hospitality coordinator's folder, and enter into the electronic medical record all physician orders for residents including order diagnoses. Upon completion of a physician order the nursing staff completing the order will note the completion of all necessary steps and sign off with the location(s) of the transcribed order, their initials, and date. This ensures all steps have been completed.	F 684		

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 27, 2019

Receipt Of This Notice Is Presumed To Be -02/27/2019
Important Notice - Please Read Carefully

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

Dear Mrs. Schmidt:

On January 29, 2019, 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).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of 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 (E).

[X] This survey found the most serious deficiency(ies) in your facility to be widespread 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 (F).

[] This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (G).

[] This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached form 2567 whereby significant corrections are required (H).

[] This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby significant corrections are required (I).

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 **March 9, 2019**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **March 9, 2019**, 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 **3/18/19.**

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 February 1, 2019

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 February 1, 2019. 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 7/31/19.

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 **March 9, 2019**, 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

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	035074	A. BUILDING: **02 – MAIN BUILDING 01** B. WING _____	**02/01/2019**

RECEIVED
MAR 11 2019
By

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 42 CFR 483.41 (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. The entire Skilled Nursing 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 372 SS=D	Subdivision of Building Spaces – Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces – Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a ½-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to fill penetration in two barriers in the facility. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.7.3 "Any required smoke barrier shall be constructed in accordance with Section	K 372	K372 Subdivision of Building Spaces – Smoke Barrie CFR(s): NFPA 101 It is the intention of Friendship Village of Tempe to ensure the facility does not have any penetrations in smoke barriers. 1. The Life Safety Facilitator fire caulked the two penetrations in the smoke barrier identified during survey on 2/1/2019 (see attached documentation dated 1/30/2019). The building is currently in compliance, but looking into a long-term solution for the areas where communication cables are ran as approved by Fire Marshall, who deferred to City Fire Inspector. The long-term project will require budgeting and may not occur until first quarter 2020. 2. All residents, employees, volunteers, students and guests have the potential to affected by facility's failure to ensure smoke barriers are in compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Health Services Administrator — (X6) DATE: 3/7/19

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.

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 _____	02/01/2019

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 372	Continued From page 1 8.5 and shall have a fire resistance rating of at least ½ hour. "Chapter 8, Section 8.5.6.2 Penetrations for cables cable trays, conduits, pipes, tubes, vents wires and similar items to accommodate electrical, plumbing and communications systems that pass through a wall , floor or /ceiling assembly constructed as a Smoke barrier , or through the ceiling membrane of the roof /ceiling of a smoke barrier assembly shall be protected by a system or material capable of restricting the transfer of smoke. Findings include: On January 29, 2019 the surveyor, accompanied by the Director of Maintenance and the Administrator observed unsealed penetrations in the smoke barriers in the following locations: 1. Above the fire door on 3 West, a cable run through uncaulked pipe. 2. Above the fire door 3 – 6 cable penetration through the wall which was unsealed. During the exit conference on January 29, 2019 the above findings were again acknowledged by the Director of Maintenance and Administrator. Failing seal the penetrations, holes and openings in the smoke barriers will allow smoke and heat to penetrate other wings or possibly the whole facility which could cause harm to the patients I time of a fire.	K 353	3. Security and Life Safety Manager and Chief Information Officer will inspect the work that is completed by vendors and their team to ensure compliance. Security and Life Safety Manager will report quarterly findings to the Quality Assurance and Assessment (QAA) Committee. 4. Security and Life Safety Manager and Chief Information Officer will inspect the work that is completed by vendors and their team to ensure compliance. 5. See signature of Administrator at the bottom of page one.	
K 920 SS=D	Electrical Equipment – Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment – Power Cords and	K920	Electrical Equipment – Power Cords and Extens CFR(s): NFPA 101 1. On 2/1/2019 the daisy chains in the two IT closets were removed immediately. The multiplug adapter was removed during survey (2/1/2019). The refrigerator in the Social Services Office was immediately plugged into the wall outlet (2/1/2019)	

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 _____	02/01/2019

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 920	Continued From page 2 Extension Cords Power strips in a patient care vicinity are only used for components of moveable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on Observation it was determined the facility allowed the use of a multiple outlet adapters, power strips and extension cords and did not use the wall outlet receptacles for appliances. NFPA 101, Life Safety Code, 2012. Chapter 2, Section 2.1 The following documents or portions thereof are referenced within this Code as mandatory requirements and shall be considered part of the requirements of this Code. Chapter 2 "Mandatory References" NFPA 99 "Standard for Health Care Facilities, " 2012 Edition. NFPA 99, Chapter 6, Section 6.3.2.2.6.2 , "All Patient Care	K 920	The Administrator has educated the IT Department, Nurse Supervisors and Social Worker regarding the daisy chains, multiplug adapters and plugging equipment directly in wall outlets verbally the day of survey (2/1/2019). Life Safety is educated annually by the Administrator and/or Administrator's designee. 2. All residents, employees, volunteers, students and guests have the potential to affected by facility's failure to manage daisy chains, multiplug adapters and failure to plug equipment directly in wall plugs potentially causing an overload of the electrical system and could cause a fire or an electrical hazards. A fire could cause harm to the residents, employees, volunteers, guests and students. All staff members, volunteers, residents, resident power of attorneys and students are educated upon hire/admission regarding Life Safety Code, monthly and annually by various members of the Interdisciplinary team.	

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 _____	02/01/2019

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 920	Continued From page 3 Areas, " Sections 6.3.2.2..6.2 (A) through 6.3.2.2.6.2 (E) Receptacles (2)" Minimum Number of Receptacles." "The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Finding include: On January 29, 2019 the surveyor, accompanied by the Administrator and Director of Maintenance, observed the following power strips in the facility and appliances not directly plugged in to the receptacle wall outlets as well as the use of a multiplug adapter. 1. A refrigerator plugged into a power strip in the Social Workers Office (2-13) 2. In the IT closet (2-16) 3 power strips daisy chained. 3. Multiplug adapter in the second floor Nurse Supervisors office. 4. In the IT closet (G-12B), battery backup/power strip daisy chain. During the exit conference on January 29, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance. The use of multiple outlet adapters could create an overload of the electrical system and could cause a fire or an electrical hazards. A fire could cause harm to the patients.	K 920	3. Continue to educate staff members, volunteers, residents, resident power of attorneys and students to ensure they are educated upon hire/admission regarding Life Safety Code, monthly and annually by various members of the Interdisciplinary team. 4. Security and Life Safety Manager, Housekeeping Manager and Life Safety Facilitator will monitor Resident rooms and employee offices quarterly to ensure compliance. Annual education of Life Safety expectations will continue to occur. Security and Life Safety Manager will report quarterly findings to the Quality Assurance and Assessment (QAA) Committee. 5. See signature of Administrator at the bottom of page one.	

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 27, 2019

Receipt Of This Notice Is Presumed To Be 02/27/2019
Important Notice - Please Read Carefully

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

Dear Mrs Schmidt:

On February 1, 2019, a Emergency Prepardness 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. Although the survey found that your facility was in substantial compliance with the participation requirements, some deficiencies exist.

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 **March 9, 2019.** You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **March 9, 2019** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

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,

Douglas A. Ducey | Governor Cara M. Christ MD, MS | Director
150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247 P | 602-364-2690 F | 602-324-0993
W | azhealth.gov
Health and Wellness for all Arizonans

- 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.

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, #440, Phoenix, Arizona 85007. 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.
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.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **March 9, 2019**, 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

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 _____	01/29/2019

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
E 000	Initial Comments 42 CFR 483.73 Long Term Care Facilities. The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016. The facility meets the standards, based on no deficiencies cited.	E 000		

RECEIVED
MAR 26 2019
By

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Health Services Administrator	03/08/2019

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 SERV.
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey: From: F1 (mm/dd/yyyy)	To: F2 (mm/dd/yyyy)	Extended Survey: From: F3 (mm/dd/yyyy)	To: F4 (mm/dd/yyyy)
1/28/2019	~~2/1/2019~~ 1/31/19		

Name of Facility	Provider Number	Fiscal Year Ending: F5 (mm/dd/yyyy)
Friendship Village of Tempe	03-5074	

Street Address: 2625 East Southern Avenue

City	County	State	Zip Code
Tempe	Maricopa	AZ	85282

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

F9: 01

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

Is this facility hospital based? F10 ..... O Yes ⊗ No

If yes, indicate Hospital Provider Number: F11

Ownership: F12: 05

For-Profit	Non-Profit	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
13 Limited Liability Corporation			

Owned or leased by Multi-Facility Organization: F13 ..... O 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 O No

Does the facility currently have an organized group of family members of residents? ..... ⊗ Yes O No

Does the facility conduct experimental research? F26 ..... O Yes ⊗ No

Is the facility part of a continuing care retirement community (CCRC)? F27 ..... ⊗ Yes O 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/yyyy)	Hours waived per week: F29	Waiver of 24 hr licensed nursing requirement: Date: F30 (mm/dd/yyyy)	Hours waived per week: F31
	n/a		n/a

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 ..... O Yes ⊗ No

Name of Person Completing Form	Time
Andrew M Schmidt	10:29 am
Signature	**Date**
Andrew M Schmidt	1-29-19

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
	18 F75	0 F76	5 F77	23 F78

ADL	Independent		Assist of One or Two Staff		Dependent	
Bathing	F79	0	F80	15	F81	8
Dressing	F82	0	F83	23	F84	0
Transferring	F85	1	F86	22	F87	0
Toilet Use	F88	1	F89	22	F90	0
Eating	F91	19	F92	3	F93	1

A. Bowel/Bladder Status

F94 1 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission? 1

F96 7 Occasionally or frequently incontinent of bladder

F97 3 Occasionally or frequently incontinent of bowel

F98 0 On urinary toileting program

F99 4 On bowel toileting program

B. Mobility

F100 0 Bedfast all or most of time

F101 15 In chair all or most of time

F102 2 Independently ambulatory

F103 14 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of total number of residents with restraints, how many were admitted or readmitted with orders for restraints? 0

F106 2 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission ? 2

C. Mental Status

F108-114-indicate the number of residents with:

F108 0 Intellectual and/or developmental disability

F109 2 Documented signs and symptoms of depression

F110 0 Documented psychiatric diagnosis (exclude dementias and depression)

F111 1 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 0 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an have an individualized care plan to support them 0 ?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118-indicate the number of residents with:

F115 1 Pressure ulcers (excluding Stage 1)

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

F117 14 Receiving preventive skin care

F118 0 Rashes

Organization: Corp/MC/NC/FV-T - 2235/HC-FV-T
Created: 1/28/2019 7:42:49 AM

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

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

E. Special Care

F119-132-indicate the number of residents receiving:

F119 1 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 0 Dialysis

F123 0 Intravenous therapy, IV nutrition, and/or blood tranfusion

F124 7 Respiratory treatment

F125 0 Tracheostomy care

F126 1 Ostomy care

F127 0 Suctioning

F128 5 Injections (exclude vitamin B12 injections)

F129 0 Tube feedings

F130 1 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 13 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 0 Assistive devices while eating

F. Medications

F133-139-indicate the number of residents receiving:

F133 0 Any psychoactive medication

F134 0 Antipsychotic medications

F135 2 Antianxiety medications

F136 6 Antidepressant medications

F137 0 Hypnotic medications

F138 3 Antibiotics

F139 11 On pain management program

G. Other

F140 0 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 12 With advance directives

F144 18 Received influenza immunization

F145 17 Received pneumococcal vaccine

Signature of Person Completing the Form	Title	Date
[illegible] RN	DON	1/28/2019

TO BE COMPLETED BY SURVEY TEAM

F146 Was ombudsman office notified prior to survey? ✓ Yes ____ No

F147 Was ombudsman present during any portion of the survey? ____ Yes ✓ No

F148 Medication error rate Ø %

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: 32

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 10/2014	S/S Code	Prior 2 Survey 10/2015	S/S Code	Prior 1 Survey 11/2016	S/S Code	Current Survey 10/13/2017	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
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	- -	-	-	REQ	F0456-ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION
X	E	-	-	-	-	- -	-	-	REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	-	-	- -	-	-	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 10/2014	S/S Code	2012 HC Prior 2 Survey 10/2015	S/S Code	2012 HC Prior 1 Survey 11/2016	S/S Code	2012 HC Current Survey 10/13/2017	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
X	D	-	-	-	-	- -	-	-	STD	K0291-Emergency Lighting

I = 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 - = No Data Entered

FRIENDSHIP VILLAGE OF TEMPE CCN: 035074

Edition of LSC Applied

2012 HC Prior 3 Survey 10/2014	S/S Code	2012 HC Prior 2 Survey 10/2015	S/S Code	2012 HC Prior 1 Survey 11/2016	S/S Code	2012 HC Current Survey 10/13/2017	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	X	E	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	X C	D	11/07/2017	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	- -	-	-	STD	K0363-Corridor - Doors
X	E	-	-	-	-	- -	-	-	STD	K0372-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	X	D	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
X	E	-	-	-	-	- -	-	-	STD	K0379-Smoke Barrier Door Glazing
X	F	X	E	-	-	- -	-	-	STD	K0511-Utilities - Gas and Electric
X	D	-	-	-	-	X C	D	11/07/2017	STD	K0712-Fire Drills
-	-	-	-	X	D	- -	-	-	STD	K0920-Electrical Equipment - Power Cords and Extens
-	-	-	-	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

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	0	6
Health Total	0	0	0	6
Life Safety Code	2	2	2	5
Life Safety Code + Health	2	2	2	11

Complaint Survey Information

Survey Date	Status
10/13/2017	Unsubstantiated
11/09/2016	Unsubstantiated
10/28/2015	Unsubstantiated
10/09/2014	Unsubstantiated

FRIENDSHIP VILLAGE OF TEMPE CCN: 035074

LTC Resident Census

Resident Census on 10/13/2017
Total: 28
Medicare: 15
Medicaid: 0
Other: 13

Total Certified Beds: 32

SNF	SNF/NF	NF	ICF/IID
32	0	0	0

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 27, 2019

Important Notice - Please Read Carefully

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

Re: Complaint Intake #AZ00146601
Investigation # ESGI11

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

02/27/2019

Important Notice - Please Read Carefully

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

Re: Complaint Intake #AZ00150531
Investigation # ESGI11

Dear Mrs. Schmidt:

Surveyors of the Arizona Department of Health Services (Department) 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 at least one of the allegations was found to be substantiated.

You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

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

Friendship Village
TEMPE



4/9/2019

Diane Eckles
Bureau Chief
Division of Licensing Services
Office of Long Term Care Licensing
150 N 18th Avenue, Suite 440
Phoenix, AZ 85007

Dear Ms. Eckles,

Please find enclosed signatures for our Medicare recertification survey conducted January 28, 2019.

On January 28, 2019, the annual survey was conducted. Enclosed you will find a signed copy of the amended Statement of State and Medicare deficiencies and plan of correction.

All of the pages of the documents have been dated and signed. Should you have any questions concerning the information, please do not hesitate to contact my office (480) 831-3107.

Sincerely,

Jadyne M. Schmidt, MHA NHA
Health Services Administrator
Friendship Village Tempe
480-831-3107

Enclosures

Friendship Village TEMPE

3/25/2019

Diane Eckles
Bureau Chief
Division of Licensing Services
Office of Long Term Care Licensing
150 N 18th Avenue, Suite 440
Phoenix, AZ 85007

Dear Ms. Eckles,

Please find enclosed signatures for our Medicare recertification survey conducted January 28, 2019.

On January 29, 2019, the Life Safety Code survey was also conducted. Enclosed you will find a signed copy of the amended Statement of State and Medicare deficiencies.

All of the pages of the documents have been dated and signed. Should you have any questions concerning the information, please do not hesitate to contact my office (480) 831-3107.

Sincerely,

Jadyne M. Schmidt, MHA NHA
Health Services Administrator
Friendship Village Tempe
480-831-3107

RECEIVED
MAR 26 2019
By

Enclosures

Friendship Village TEMPE

3/7/2019

Diane Eckles
Bureau Chief
Division of Licensing Services
Office of Long Term Care Licensing
150 N 18th Avenue, Suite 440
Phoenix, AZ 85007

Dear Ms. Eckles,

Please find enclosed signatures for our Medicare recertification survey conducted January 28, 2019.

On January 29, 2019, the Life Safety Code survey was also conducted. We have a plan of correction written for deficiencies cited on that date. You will also find this information enclosed.

All of the pages of the documents have been dated and signed. Should you have any questions concerning the information, please do not hesitate to contact my office (480) 831-3107.

Sincerely,

Jadyne M. Schmidt, MHA NHA
Health Services Administrator
Friendship Village Tempe
480-831-3107

Enclosures

RECEIVED
MAR 11 2019
By

Supplemental POC Documents

HCC > West > 3rd Floor

Not Applicable | NA

Due: Feb 18, 2019
Priority: Fire/Life Safety | Status: Complete
Requestor: fire marshall

add fire caulking in wall penetration above doors 3-6

Assigned To

Name	Assigned On	Est. Time	Work Date	Start Time	End Time	Time Spent	Type
Shane Winistorfer	Jan 30, 2019		Jan 30			0.30	Work by FVT Staff

Inventory Assigned

Description	Part #	Storage Location	Qty	Qty Used

Completion Information

Date / Time	Marked Complete By	Total Time	Additional Costs	Billable?	Bill Amount
Jan 30, 2019 11:37 AM	Shane Winistorfer	30m		Y / N	0.00

Completion Notes (notes about completion, extra inventory used, assets worked on, or other labor resources not identified above)

Jan 30 11:37 AM	Shane Winistorfer	fire caulked area
Jan 30 11:38 AM	Shane Winistorfer	Shane Winistorfer completed their portion on 1/30/2019 at 11:37 AM. Added note: fire caulked area.

Sign _____ Date _____

INTEGRITY - SERVICE - SAFETY

Compliance/Regulatory Work Order created on Jan 30, 2019 at 11:26 AM by Shane Winistorfer

Building Components >> Vista

HCC > West > 3rd Floor

Not Applicable | NA

Due: Jan 31, 2019
Priority: Fire/Life Safety | Status: Complete
Requestor: fire marshal

Fire caulk around wiring & add caulking to 2" conduit that has none

Assigned To

Name	Assigned On	Est. Time	Work Date	Start Time	End Time	Time Spent	Type
Shane Winistorfer	Feb 28, 2019		Jan 30			1:30	Work by FVT Staff

Inventory Assigned

Description	Part #	Storage Location	Qty	Qty Used

Completion Information

Date / Time	Marked Complete By	Total Time	Additional Costs	Billable?	Bill Amount
Jan 30, 2019 10:20 AM	Shane Winistorfer	1h 30m		Y / N	0.00

Completion Notes (notes about completion, extra inventory used, assets worked on, or other labor resources not identified above)

Jan 30 10:20 AM Shane Winistorfer Added fire caulking to conduit.

Sign Date

INTEGRITY - SERVICE - SAFETY

Compliance/Regulatory Work Order created on Feb 28, 2019 at 10:18 AM by Shane Winistorfer

Building Components >> Walls

Tempe Community Assessment Meeting

2/14/19 3:00PM

Name:	Dept:
DAVID FABOK	TEMPE FIRE MEDICAL RESCUE
ANDREA GLASS	TEMPE FIRE MEDICAL RESCUE
[redacted]	



David Fabok, IAAI-FIT
Lead Fire Inspector / Investigator
Community Risk Reduction

(480) 858-7236
(480) 253-2937 (cell)
(480) 858-7243 (fax)

david_fabok@tempe.gov

Tempe Fire Medical Rescue Department
1400 E. Apache Blvd., Tempe, Arizona 85281
www.tempe.gov/fire



Internationally
Accredited
Fire Department



Andrea Glass
Interim Assistant Chief
Community Risk Reduction

(480) 858-7201
(480) 600-6927 (cell)

andrea_glass@tempe.gov

Tempe Fire Medical Rescue Department
1400 E. Apache Blvd., Tempe, Arizona 85281
www.tempe.gov/fire



Internationally
Accredited
Fire Department

SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

1. Hazard Vulnerability Assessment

The Health Care Center at Friendship Village conducts a thorough Hazard Vulnerability Analysis to help determine what events or incidents may negatively impact its operations. While it is impossible to forecast every potential threat, it is important to identify as many potential threats as possible to adequately anticipate and prepare to manage a crisis or disaster situation.

The Health Care Center at Friendship Village utilizes a quantitative tool, the Hazard Vulnerability Assessment (HVA), which was developed by the American Society of Healthcare Engineering (ASHE) of the American Hospital Association (©2001). The HVA utilizes a rating system for the probability and risk of, as well as preparedness for, various hazards and situations.

Assumptions: For the purpose of this Emergency Management Plan, it is assumed that the following threats may potentially impact all facilities:

- Fire/Explosion
- Flood
- Bomb Threat
- Tornado/Hurricane/Severe Weather
- Power Failure/Utility Disruption
- Workplace Violence/Security Threat
- Law Enforcement Activity
- Missing Resident
- Internal Hazardous Materials Spill/Leak
- Pandemic Episode
- Unknown Acts of Terrorism

Unique Threats: Based on the facility's geographic location, history, proximity to other structures and operations, proximity to transportation corridors, and other unique factors, it is essential to identify all threats that can potentially impact the facility.

The Maricopa County Emergency Management Coordinator is contacted for guidance and assistance in determining hazards and vulnerabilities for the facility.

The following is a tool that aids in completing the Hazard Vulnerability Assessment, as it takes into consideration the proximity that The Health Care Center at Friendship Village is within specific probable hazardous areas. **The Health Care Center of Friendship Village is geographically less than a half mile from AZ-101 and US Route 60.**

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x will link with MSA

SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

Geographic Hazardous Areas	Proximity to Facility:	Potential Hazard Yes	No
Busy Roadways – **Elopement, Haz-Mat**	Less than 1mile, AZ-101, US-60	X	
Wooded Areas – **Elopement, Fire**			X
Bodies of Water – **Elopement**	.5 miles Canal	X	
Designated Truck Routes – **Haz-Mat**	Less than 1 mile, AZ-101, US-60	X	
Railroad – **Elopement, Haz-Mat**	2 mile	X	
Airport – **Terrorism Target, Mass Casualty**	9.7 miles	X	
Dam – **Terrorism Target, Mass Casualty,** flooding - storms			X
Military Bases/Installations – **Explosion, Hazmat, Terrorism Target**	10 miles, Army Reserve Center	X	
Pipelines – **Explosion, Haz-Mat** location gasline/Kinder Morgan		X	X
Gas Stations – **Explosion, Haz-Mat**	.5 miles	X	
Industrial Areas/Distribution Centers/Trucking Terminals – **Explosion, Haz-Mat**	1.9 Praxair Distributor	X	
Chemical Plants – **Explosion, Haz-Mat, Terrorism Target, Mass Casualty**	3.1 miles, American International Chemical, Accurate Chemical	X	
Nuclear Plants – **Explosion, Haz-Mat, Terrorism Target, Mass Casualty**	68.5 miles Palo Verde Nuclear Power Plant	X	
Bulk Fuel Storage/Tank Farms (Oil, Gasoline, Propane, Natural Gas, etc,) – **Explosion, Haz-Mat, Terrorism Target, Mass Casualty**			X
Refineries – **Explosion, Haz-Mat, Terrorism Target, Mass Casualty**			X
Sewage Treatment Plants – **Haz-Mat, Terrorism Target, Mass Casualty**			X
Agricultural Processing Plants/Storage Facilities (Grain Silos) – **Haz-Mat, Explosion**			X
Public Swimming Pools – **Elopement, Haz-Mat**			X
Schools – **Law Enforcement Activity**			X
Jails/Prisons – **Civil Unrest, Law Enforcement Activity**			X
Any Immediately Adjacent Operation posing a threat:			
Any Operation in the general area posing a threat:			

Council Dam - ems Rail system - Kpache/I-5 Broadway

APS power - ISR - gas line

2-3 water biological warfare

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

The Hazard Vulnerability Tool is completed to identify hazards and the direct/indirect effect these hazards could have for The Health Care Center at Friendship Village:

The following Hazard Vulnerability Analysis Tool was developed by the American Society for Healthcare Engineering of the American Hospital Association. The tool may be modified or changed in any way that is appropriate for individual facility use (Healthcare Facilities Management Series, February 2001, American Society for Healthcare Engineering of the American Hospital Association, page 5).

A. Instructions to Complete the Hazard Vulnerability Assessment Tool

1. Evaluate every potential event in each of the categories for probability, risk, and preparedness. Add events as necessary.
   Probability: Evaluate each event as the likelihood of it occurring. Issues to consider in determining probability are:
   - Known risk
   - Historical data
   - Manufacturer/vendor statistics

   Risk: Evaluate the potential impact that any given hazard may have on the facility. Issues to consider are:
   - Threat to life and/or health
   - Disruption of services
   - Damage/failure possibilities
   - Loss of community trust
   - Financial impact
   - Legal issues

   Preparedness: Evaluate the current level of preparedness to manage each disaster. Issues to consider are:
   - Status of current plans
   - Training status
   - Insurance
   - Availability of backup systems
   - Community resources

   Insurance: Determine whether the hazard is covered by insurance. This does not affect the rating

2. Multiply the ratings for each event in the area of probability, risk, and preparedness to give a total score for each hazard. A hazard that does not have a probability of occurring is scored zero and will result in a zero for the total score.

3. Listing the hazards in descending order of the total scores will prioritize the hazards most in need of attention and resources for emergency planning.

   The Health Care Center at Friendship Village evaluates the final prioritization and determines a cutoff value, where no action is taken for particular hazards. There are some risks for these hazards.

   The Hazard Vulnerability Assessment is reviewed at least annually.

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

Hazard Vulnerability Assessment

EVENT	PROBABILITY				RISK					PREPAREDNESS			INSURANCE		TOTAL
	HIGH	MEDIUM	LOW	NONE	LIFE THREAT	HEALTH/ SAFETY	HIGH DISRUPTION	MODERATE DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	COVERED	NOT COVERED	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	√	√	
NATURAL EVENTS															
Hurricane				X					X	X					4
Tornado/Microburst	X							X				X			6
Severe thunderstorm	X								X			X			5
Snowfall				X					X			X			2
Blizzard				X					X			X			2
Ice storm				X					X			X			2
Earthquake			X						X		X				4
Tidal wave/tsunami				X					X	X					4
Temperature extremes	X				X	X	X				X				17
Drought	X				X	X	X				X				17
Flood, external			X					X				X			4
Wildfire			X						X		X				4
Landslide			X						X			X			3
Volcano			X						X			X			3
Epidemic/pandemic	X				X	X	X					X			16
Dam failure			X						X			X			3
Explosion/munitions		X			X	X	X				X				16
Nuclear Power Plant Incident			X						X		X				5
HUMAN EVENTS															
Elopement	X				X	X		X				X			16
Workplace violence		X			X	X		X			X				15
Security threat		X			X	X		X			X				15

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

EVENT	PROBABILITY				RISK					PREPAREDNESS			INSURANCE		TOTAL
	HIGH	MEDIUM	LOW	NONE	LIFE THREAT	HEALTH/ SAFETY	HIGH DISRUPTION	MODERATE DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	COVERED	NOT COVERED	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	√	√	
Haz-Mat exposure, external	X				X	X	X				X				17
Terrorism, chemical			X				X				X				6
Terrorism, biological			X		X	X	X				X				15
Hostage situation		X			X	X	X				X				16
Civil disturbance/ community violence			X			X	X					X			9
Labor action			X						X			X			3
Bomb threat			X		X	X	X				X				15
TECHNOLOGICAL EVENTS															
Electrical failure	X				X	X	X				X				17
Generator failure	X				X	X	X				X				17
Transportation failure			X					X				X			4
Fuel shortage			X				X					X			5
Natural gas failure			X				X					X			5
Water failure		X			X	X	X				X				16
Sewer failure			X					X				X			4
Steam failure			X					X				X			4
Fire alarm failure			X		X	X	X					X			14
Communications failure			X					X			X				5
Medical gas failure			X						X			X			3
Medical vacuum failure			X						X			X			3
HVAC failure	X				X	X	X					X			17
Information systems failure		X				X		X			X				10
Fire, internal			X		X	X	X					X			14

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

EVENT	PROBABILITY				RISK					PREPAREDNESS			INSURANCE		TOTAL
	HIGH	MEDIUM	LOW	NONE	LIFE THREAT	HEALTH/ SAFETY	HIGH DISRUPTION	MODERATE DISRUPTION	LOW DISRUPTION	POOR	FAIR	GOOD	COVERED	NOT COVERED	
SCORE	3	2	1	0	5	4	3	2	1	3	2	1	√	√	
Flood, internal			X					X				X			4
Haz-Mat exposure, internal			X					X			X				5
Unavailability of supplies		X			X	X	X					X			15
Structural damage			X					X				X			4

© 2001. Based on the American Society for Healthcare Engineering of the American Hospital Association

2. Security Vulnerability Analysis

A. Security Vulnerability Assessment

The Health Care Center at Friendship Village conducts a thorough Security Vulnerability Analysis to help determine what vulnerabilities exist that may negatively impact or minimize its operations. While it is impossible to forecast every potential opportunity for a security breech, the goal is to identify as many potential opportunities as possible and to minimize the risk of a loss occurring.

Assumptions: For the purpose of this Emergency Management Plan, it is assumed that the following threats may potentially impact all facilities:

- Intruders
- Vandals
- Workplace Violence
- Neighborhood Crime
- Access Control
- Security Technology Systems
- Law Enforcement Activity
- Key Management
- Lack of Written Security Management Plan
- Training

Unique Threats: Based on the facility's geographic location, history, proximity to other structures and operations, proximity to transportation corridors, and other unique factors, it is essential to identify all threats that can potentially impact the facility..

A qualified health care security specialist can be contacted for guidance and assistance in determining the specific security vulnerabilities that exist in the facilities. Unlike other health care facilities, the security threats to long term care facilities, while often neglected, are much more challenging because of the nature of the client base and the unique settings and services provided.

The following is a tool that will aid in completing a Security Vulnerability Assessment, as it takes into consideration the common vulnerabilities identified in many long term care facilities. In assessing security vulnerabilities in any health care facility, including long term care, the P2T2® system is used. P2T2® recognizes that a health care facility security management program involves four critical areas:

- People
- Programs
- Training
- Technology

An effective security program must contain the right complement of these four basic elements. Every security program in a long term care facility must take the following into consideration:

1. People (hiring the right person)
   a. Selection Criteria
   b. Background Investigation
   c. Drug Screening
   d. Exit Interviews

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2. Programs (implementing the right programs)
   a. Policy and Procedure Development
   b. Staffing and Organization
   c. Crisis Management
3. Training (knowledge to do the job right)
   a. Security Staff
   b. Non-Security Staff
   c. Security Awareness
   d. Physical Protection of People and Property
   e. Security Services
4. Technology (proper tools to assist)
   a. Access Control
   b. CCTV
   c. Alarm Systems
   d. Communication Systems
   e. Lobby Management
   f. ID Systems

The Security Vulnerability Tool is completed to identify security risks and the direct/indirect impact these vulnerabilities could have for The Health Care Center at Friendship Village.

(Healthcare Facilities Management Series, February 2001, American Society for Healthcare Engineering of the American Hospital Association, page 5)

B. Instructions to Complete the Security Vulnerability Analysis Tool

1. Evaluate every vulnerability listed in each of the categories. Events marked "NO" indicate a potential vulnerability that should be included in a Strategic Plan for Security Improvement.
2. The Hazard Vulnerability Assessment is reviewed at least annually.

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

PROBE	YES	NO
EMERGENCY PREPAREDNESS PLANS		
The emergency preparedness plan includes a written security management plan that addresses both daily operations and emergency operations?	X	
Local police, fire, and EMS agencies have a copy of the facility emergency response plan?	X	
The facility has designated a "chief security officer" responsible for security operations on a daily basis and during an emergency?	X	
The written security management plan addresses the protection of facility assets as well as resident-owned property and staff property during normal operations and during emergency operations?	X	
Someone is assigned to cut off the power and the gas to the building, if possible, during emergencies that require it?	X	
The plan assigns backup personnel for all critical emergency response team functions?	X	
Someone is assigned to meet public safety (fire, police, and EMS) at the front of the building any time these agencies are called for an emergency?	X	
Someone is designated to check all offices, storage areas, utility rooms, and exterior doors at the end of the day to ensure that they are locked?	X	
EVACUATION AND TRAFFIC PATTERNS		
Staff are assigned to serve as enforcement officers to cover evacuation routes and vehicular travel lanes during all emergency drills and actual evacuations?	X	
Vehicles parked in a designated driving lane or in restricted areas are caused to be moved immediately?	X	
On each shift, there is a supervisor who is empowered to have unauthorized or illegally parked vehicles towed?	X	
MAIN OFFICE		
During an emergency, someone is assigned to secure all resident medications?	X	
During an evacuation, resident medications are evacuated and secured whenever possible?	X	
SURROUNDING NEIGHBORHOOD		
Staff are familiar with the known locations of drug- or gang-related activity near the facility?		X
Facility administrators have met with local police concerning neighborhood hazards and security risks that may affect the elderly?	X	
PERIMETER SECURITY		
Shrubs are trimmed so as to allow maximum visibility? (Shrubs trimmed to a three-foot height and low-hanging branches to a seven-foot height)	X	
Unauthorized vehicles are restricted from entering the staff parking areas and loading dock areas?	X	
Visitor parking spaces are clearly identified?	X	
There is adequate space for emergency response vehicles at the entrance?	X	
Staff parking spaces are marked in such a way that an attacker can easily locate their victims? (For example, if someone does not know the Administrator by sight and wants to attack him/her, the person can simply wait near the Administrator's designated parking spot)		X
All parking spaces, directional arrows, no-parking zones, handicapped-parking zones, fire zones, and restricted areas are clearly visible to first-time visitors to the facility?		X
All exterior doors to the facility are on a locking/unlocking schedule?	X	
Perimeter fencing is regularly cleared of vines and brush?	X	
All portable exterior buildings used as offices, storage, etc. have skirting?	N/A	N/A
Exterior lighting is checked regularly for burned out or damaged lights?	X	
Exterior light readings are conducted annually to assure that night lighting levels meet industry safety and security standards?	X	

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PROBE	YES	NO
Vehicles are kept separate from outdoor resident gardens or grotto areas?	X	
All exterior buildings such as portable offices, contractors' offices, or storage buildings have skirting?		N/A
EVACUATIONS		
Were evacuation routes and sites selected with input from fire, emergency management and law enforcement officials?	X	
A system is established to take roll at the evacuation site for accountability of residents, employees, and visitors?	X	
Evacuation routes are planned to include residents with mobility problems? (Especially important during a fire emergency)	X	
INTERIOR		
All mechanical rooms, boiler rooms, hazardous materials rooms, and other maintenance areas are kept locked at all times?	X	
All facility equipment is regularly inventoried?	X	
Unused areas such as conference rooms and offices are locked when not in use?	X	
A visitor check-in and identification procedure is in place, and is it clear for first-time visitors (including repair persons and vendors)?	X	
This procedure indicates the destination of each visitor as well as time and date of visit?	X	
Staff are required to wear a photo ID at all times they are in the building, even when not working?		X
The current verified collection of all facility telephone extensions and/or numbers is immediately available?	X	
Laptop and tabletop computers are secured?	X	
The facility has an established method of getting a master set of keys, alarm codes, a floor plan, a site plan, and emergency operations plans to public safety agencies for after-hours emergencies?	X	
The floor plan indicates sheltering locations for severe weather incidents?	X	
Records are kept for all serial numbers of all equipment present in the building, including computers?		
Dangerous and hazardous chemicals are securely stored when not in use?	X	
In the kitchen, foods are properly stored and secured when not in use?	X	
Foods are regularly inventoried and shrinkage monitored?	X	
Kitchen equipment is arranged in a way that staff can easily evacuate without obstructions in an emergency?	X	
Kitchen delivery doors are locked at all times except during a delivery?	X	
All kitchen-related deliveries are made at a scheduled time?	X	
The delivery area is properly supervised to prevent an attack?	X	
Evacuation plans and procedures are posted in the kitchen and dining areas?	X	
POLICIES AND PROCEDURES		
The facility has a formal emergency response team?	X	
Security management is a component of the emergency response team?	X	
There are specific plans to assist mobility, visually, or otherwise impaired staff and students during evacuations?	X	
There is a procedure to quickly notify residents' families of an emergency evacuation?	X	
Nurses' stations and resident wings are equipped with emergency panic buttons?		X
If so, are these buttons on a preventive maintenance test schedule?		
The names and assignments in the emergency response plan are updated at least semi-annually to reflect the current staff available to respond to an emergency?	X	
The employee handbook clearly explains the facility's policy on weapons, dress code, plain-view searches, and penalties associated with various offenses?	X	

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SECTION II: HAZARD AND SECURITY VULNERABILITY ASSESSMENT

PROBE	YES	NO
The employee handbook clearly explains search and seizure policies as they apply to employee personal items, lockers, and vehicles?	X	
The facility parking permit and/or registration form mentions vehicle search and seizure policies?	X	
Mechanisms are in place to advise agency employees of their role during an emergency?	X	
Within legal limits, paychecks of terminating or resigning employees are kept until return of facility keys?	X	
The facility shift supervisor has keys to all indoor and outdoor building locks in case of an emergency or need of immediate access?	X	
There is a plan of action for emergency lockdowns in cases of civil unrest, neighborhood violence, or domestic violence involving employees, residents, or families?	X	
All staff know proper procedures in a lockdown situation?	X	
TRAINING		
Ongoing staff training is conducted to review the district's emergency procedures?	X	
Emergency lockdown, severe weather sheltering, and Shelter-in-Place drills are regularly conducted?	X	
At least one tabletop or functional exercise has been conducted at the facility this year to allow staff to practice for emergency situations?	X	
All staff are trained in security awareness and vulnerabilities?	X	
Employees receive media communications training to deal with the media during or following a emergency situation?	X	
The facility regularly conducts lockdown drills?		X
The times of these drills are staggered to cover all shifts?	X	
Lockdown drills are designed so all staff (i.e., cafeteria workers, activities personnel, etc.) participate in the lockdown procedures?		X
SECURITY TECHNOLOGY		
The main campus entrance is easily viewed from the street?	X	
There is video surveillance in parking lots?	X	
The video surveillance system completely covers all parking spaces and walkways?	X	
Night lighting in parking lots, walkways, and point of ingress meet minimum lighting standards?	X	
All power boxes, gas exchanges, and satellite dish areas are protected from tampering	X	
All areas of the grounds are accessible to security and emergency vehicles?	X	
All door locks are in working condition?	X	
The exterior of the building has adequate lighting?	X	
All basement windows are secured with bars and locks?		N/A
Large windows in hallways and office are made of shatter-resistant safety glass or they have shatter-resistant film on them?	X	

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Arizona Coalition for Healthcare Emergency Response – Central Region

Community Hazard Vulnerability Assessment – 2018/2019

Introduction

The Assistant Secretary for Preparedness and Response (ASPR) requires as a condition of accepting Hospital Preparedness Program (HPP) funding that a coalition conduct a community hazard vulnerability assessment (CHVA) on an annual basis. In identifying the region's most significant risks – both natural and manmade – to the health care delivery service system, the assessment lends itself to an internal analysis of capacities and capabilities to address a medical surge, and subsequently is intended to determine resource needs and gaps.

Methodology

An online survey was administered to members through SurveyMonkey on October 11, 2018. All Designated Voting Representatives for healthcare organizations (n=183[1]) were instructed to 1) complete their facility HVA(s) for 2018 if one had not already been completed; and 2) complete the survey for each licensed facility reported on the AzCHER-Central Member Facilities Form. (See Appendix B for this communique.) Responses were due to be submitted no later than close of business on October 31, 2018. A reminder was sent on October 29th.

A total of 135 facility responses were received. While 84% of respondents were from Maricopa County, 14% were from Pinal County, and 2% were from Gila County. Facility types represented included hospitals (24%), LTC/SNF (18%), ambulatory surgery centers (14%), dialysis centers (11%), hospice (9%), rural health clinics (8%), home health agencies (7%), and nine percent "other."

The survey was constructed such that each facility was to select their top 10 identified risks from a pre-populated drop-down menu. Populated items were those included as options in the Kaiser Permanente HVA tool, which is reportedly the most frequently utilized tool for hazard assessment. This method of construction resulted in a series of 10 separate lists, with some items appearing across multiple lists. For example, the most common #1 risk was identified as Active Shooter. However, when calculations were applied to the raw data, this risk was moved to #4. Severe weather conditions rose to #1 and #2.

See tables below for explanation.

[1] A Designated Voting Representative (DVR) is the liaison to the member organization. Multiple facilities can be included under one organization. At the time the survey was administered, there were 201 member *organizations*, but only 183 receiving the survey because it was sent only to healthcare members (not EM, EMS, or PH). 135 *facilities* responded.

Table 1: Most Popular Risks

#1 Risk:

- Active Shooter – 23%
- Temperature Extremes – 20%
- External Fire – 10%
- Inclement Weather – 5%
- Communication/Telephone Failure – 4%
- IT System Outage – 4%
- Power Outage – 4%

#2 Risk:

- Workplace Violence/Threat – 19%
- Drought – 7%
- Inclement Weather – 7%
- Other Utility Failure – 7%
- External Fire 6%
- Power Outage – 6%
- Flood – 5%
- Patient Surge – 4%
- Temperature Extremes – 4%

This scoring mechanism did not allow for the identification of the top 10 *community* risks, and only provided a window into facilities' risk rankings. As such, the data were aggregated and the number of responses to each identified risk was weighted according to its ranking (i.e., highest priority #1 versus lowest priority #10) and then summed. For example:

Table 2: Weighted Rankings (2 examples)

Threat	**Ranking**, *Number of Responses per Rank*, and Weight										Total Score	Weighted Ranking
Active Shooter	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	454	4
	29	*2*	*6*	*3*	*0*	*5*	*4*	*7*	*5*	*5*		
	X	X	X	X	X	X	X	X	X	X		
	10	9	8	7	6	5	4	3	2	1		
Temp Extremes	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	515	1
	25	*5*	*7*	*4*	*13*	*8*	*4*	*9*	*4*	*1*		
	X	X	X	X	X	X	X	X	X	X		
	10	9	8	7	6	5	4	3	2	1		

In addition to the member survey, the counties represented in the coalition's service area were asked to share their own risk assessments to ensure alignment with member survey results. Maricopa County Department of Public Health and Maricopa County Department of Emergency Management responded with the following top 12 threats and hazards listed in alphabetical order: damaging wind, drought, dust storms, earth fissures and landslides, earthquakes, extreme heat, flooding, hazardous materials, monsoon storms, power outages, terrorism, and wildfires. Pinal County Public Health Services District and Pinal County Office of Emergency Management reported their top 10 threats, also listed in alphabetical order, as drought, dust storm, fissure, flooding, HazMat, health issues, power outage, severe wind, transportation accident, and wildfire. With significant alignment of identified county risks with facility risks, the Planning Committee came to a consensual agreement that the top 10 risks

identified in the survey would comprise those of the coalition. This was approved by the Leadership Team on December 7, 2018 and by General Membership on December 14, 2018.

Results

The top 10 risks identified by AzCHER-C membership (n=135 responses from individual facilities, not organizations) and their total weighted score are as follows:

1.	Temperature Extremes	515
2.	Inclement Weather	496
3.	Communication / Telephone Failure	470
4.	Active Shooter	454
5.	Fire (External)	377
6.	IT System Outage	375
7.	Workplace Violence / Threat	354
8.	Flood	351
9.	Power Outage	310
10.	Internal Fire	282

The 76-page survey report, the Excel file depicting computation of weighted scores, and other documents related to the 2018-19 CHVA, are available to members for download from the BaseCamp site.

Next Steps

Results of the 2018-29 CHVA will be utilized to complete the BP1S Resource Assessment; to direct coalition funds; to inform trainings and exercises; and to prioritize strategies to close or mitigate preparedness and response gaps within the coalition's boundaries.

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Appendix A: Members Participating in the 2018/19 CHVA

AdvisaCare Solutions of Arizona, LLC
AmSurg – Arizona Endoscopy Center
AmSurg – Phoenix Endoscopy
AmSurge/Envision – Gateway Surgery Center
Apache Junction Health Center
Arizona Autism United, Inc.
Arizona Department of Veteran Service – Arizona State Veterans Home – Phoenix
Bandera Group
Bandera Group
Banner Health – Banner Baywood Medical Center / Banner Heart Hospital
Banner Health – Banner Behavioral Health Hospital
Banner Health – Banner Boswell Medical Center
Banner Health – Banner Boswell Rehabilitation Center
Banner Health – Banner Casa Grande Medical Center
Banner Health – Banner Desert Medical Center – Cardon's Children
Banner Health – Banner Estrella Medical Center
Banner Health – Banner Gateway Medical Center
Banner Health – Banner Goldfield Medical Center
Banner Health – Banner Home Care AZ – Gilbert
Banner Health – Banner Home Care AZ – Payson
Banner Health – Banner Home Care AZ – Sun City/Meeker
Banner Health – Banner Hospice – Gilbert
Banner Health – Banner Hospice – Sun City
Banner Health – Banner Ironwood Medical Center
Banner Health – Banner Payson Medical Center
Banner Health – Banner Estrella Surgery Center LLC
Banner Health – Banner Mesa Surgery Center LLC
Banner Health – Banner Peoria Surgery Center LLC
Banner Health – Banner Phoenix Surgery Center LLC
Banner Health – Banner Sun City West Surgery Center LLC
Banner Health – Banner Thunderbird Medical Center
Banner Health – Banner Union Hills Surgery Center LLC
Banner Health – Banner University Medical Center – Phoenix
Baywood Medical Associates – Desert Pain Institute
Beatitudes Campus – Beatitudes Health Care Center
Beatitudes Home Health
Bella Vita Health and Rehab Center
Brookdale North Chandler
Cancer Treatment Centers of America
Canyon Surgery Center
Center for Advanced Surgery
Complete Hospice Care of Phoenix

Covenant Health Network – 17 facilities (unlisted)
Davita – Brookwood Dialysis Center
Davita – Central Mesa
Davita – Estrella
Davita – Gilbert Dialysis
Davita – Mountain Vista of Arizona
Davita – Ocotillo Dialysis
Davita – Papago
Davita – Phoenix
Davita – Phoenix Home Dialysis
Davita – Power Road Dialysis
Davita – Raven Dialysis
Davita – Sweetwater Ridge
Davita – Westbrook Dialysis
Davita – Wickenburg
Dignity Health – Arizona General Hospital, Mesa
Dignity Health – Chandler Regional Medical Center
Dignity Health – Mercy Gilbert Medical Center
Dignity Health – St. Joseph's Hospital and Medical Center
Dignity Health – St. Joseph's Westgate Medical Center
Elite Home Health Services
Encompass Health of East Valley Rehabilitation Hospital
Encompass Health Scottsdale Rehabilitation Hospital
Encompass Health Valley of the Sun Rehabilitation Hospital
Ensign – Sun West Choice Healthcare and Rehab
Estrella Home Healthcare 2, Inc.
Everest Hospice in Goodyear
Eye Surgery Center at the Biltmore
Focus Home Therapy & Medical Services, LLC – Sante Home Health
Friendship Village of Tempe
Genesis Health Care – Estrella Center
Gila River Health Care – Ak-Chin Clinic
Gila River Health Care – East Dialysis Center
Gila River Health Care – Hu Hu Kam Memorial Hospital
Gila River Health Care – Komatke Health Center
Gila River Health Care – Red Tail Hawk Health Center
Gila River Health Care – The Caring House
Gila River Health Care – Thwajik Ke Residential Treatment Center
Gila River Health Care – West Dialysis Center
HonorHealth Rehabilitation Hospital
Horizon Health and Wellness – Broadway - AJ
Horizon Health and Wellness – Florence
Horizon Health and Wellness - Kearny
Horizon Health and Wellness - Oracle
Horizon Health and Wellness - Oracle
Horizon Health and Wellness – Plaza - AJ

Horizon Health and Wellness - Queen Creek
Horizon Health and Wellness – 115 2nd Street – CG
Horizon Health and Wellness – 210 Cottonwood – CG
Horizon Health and Wellness – 222 Cottonwood CG
Horizon Health and Wellness – 415 Baseline - Gobe
ICSAVE
Inspiring Home Health
Integrity Hospice Care
Lavender Hospice
Lifestream Complete Senior Living – LifeStream at Sun Ridge
Maricopa Integrated Health System – Maricopa Medical Center
Maravilla Care Center
Mayo Clinic – Mayo Clinic Hospital
Mountain Park Health Centers
North Scottsdale Ambulatory Surgery Center, LLC
Peoria Post-Acute and Rehabilitation
Sante of Chandler
Sante of North Scottsdale
Sante of Mesa
Sante Hospice
Sante of Surprise
Scottsdale Eye Surgery Center
Serenity Hospice and Palliative Care
Shanti Hospice LLC
Solace Hospice, LLC
Sovereign Health Care – Biltmore Surgical Center
Springstone – Copper Springs Hospital
Steward Health Care – Mountain Vista Medical Center
Suncrest Health Care
Swagel Wootton Eye Center – Eye Surgery Center of Arizona
Tenet Healthcare – Abrazo Arizona Heart Hospital
Tenet Healthcare – Abrazo Arrowhead Campus
Tenet Healthcare – Abrazo West Campus
The Center at Val Vista
Unity Hospice
USPI – Desert Ridge Outpatient Surgery Center
USPI – Physician Surgery Center of Tempe
Valliant Hospice and Palliative Care
Veterans Health Administration – Phoenix VA Health Care System
Volunteers of America – Westchester Care Center
Wickenburg Community Hospital
Windsor – Palm Valley Rehabilitation and Care Center
Wellsprings Therapy Center of Phoenix
19th Avenue Operations LLC – The Rehabilitation Center at The Palazzo

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Appendix B: Email Requesting Survey Response

October 11, 2018

Designated Voting Representatives of AzCHER-Central,

As discussed in our General Body meeting last month, your health care coalition is requesting your participation in the community hazard vulnerability assessment (CHVA). Doing so may assist your organization in meeting regulatory requirements pertaining to sharing your HVAs with the community at-large.

Before you complete this survey, you will need to complete a hazard vulnerability assessment for each facility under your member Participation Agreement. Per CMS requirements, an HVA must be specific to each licensed facility – not the parent organization. Please use your most recent facility HVA, preferably one completed within the last 12 months.

When a facility's HVA is completed, use this survey tool (https://www.surveymonkey.com/r/18-19CHVA) to transfer the top 10 identified risks. If your identified risk is not listed in the drop-down menu, please select "Other" and specify that risk.

You, as the DVR, are tasked with distributing this survey to your facility managers IF your organization has multiple licensed facilities. This is easily done as a forward of this email with your custom introduction. You might also be responsible for completing this survey multiple times for multiple facilities; this survey will accommodate multiple submittals from one device.

Specified fields request the organization's name, the facility's name, and the facility's county and zip code. Once the survey closes, a report summarizing results as well as listing all participating facilities will be posted on BaseCamp. This report may be used to demonstrate regulatory compliance. The final "Thank You" page may also be printed to demonstrate compliance, but it will not list your facility's name.

The survey will close on Wednesday, October 31st. Due to time constraints imposed by completion of the regional HVA, the survey will NOT be reopened for those who miss this deadline.

Please let me now if you have any questions.

Thanks in advance for your participation!

Laura Dix
Director, AzCHER-Central