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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OC15

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0036

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

3. NAME AND ADDRESS OF FACILITY
(L3) **THE HEALTH CARE CENTER AT FRIENDSHIP VILLAGE**
(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 **11/09/2016** (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/HD	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 **128** (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
128				
(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):
The Health Care Center at friendship Village survey was conducted on 11/09/2016. There were No Deficiencies cited on the State and Federal survey. LSC has (S/S of D revisit survey completed on 12/01/2016 State Agency recommended recertification.

17. SURVEYOR SIGNATURE Diane Eckles Date:
for Brian Wachtendonk, Surveyor 03/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
[signature] 03/29/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00511
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

April 3, 2017

Mrs. Jadyne Schmidt, Administrator
The Health Care Center At Friendship Village
2525 East Southern Avenue
Tempe, AZ 85282

Re: Provider Number 035074

Dear Mrs. Schmidt:

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

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

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief
DE/ib

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

March 29, 2017

Jadyne Schmidt, Administrator
The Health Care Center At Friendship Village
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

Enclosed is the **Life Safety Code Post-Certification Revisit Report** form which indicates that the following deficiencies have been corrected on December 12, 2016. A copy will be filed in your public file.

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

Sincerely,

Shoalynn Gilliland McCleery

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

\SGM

Enclosure

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	12/1/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CARE CENTER AT FRIENDSHIP VILLAGE	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 K0374	11/28/2016	LSC K0920	11/28/2016	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
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 11/9/2016

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING **02 - MAIN BUILDING 01** B. WING _____	R **12/01/2016**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS All noted deficiencies on the survey dated November 09, 2016, 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.	{K 000}		

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

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

Receipt of Notice Presumed [11/17/2016 via email]

November 17, 2016

Jadyne Schmidt, Administrator
The Health Care Center At Friendship Village
2525 East Southern Avenue
Tempe, Arizona 85282

Dear Mrs Schmidt:

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

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

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Attachments

RECEIVED
NOV 28 2016
BY:

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 _____	11/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The recertification survey was conducted on November 7, 2016 through November 9, 2016, and there were no deficiencies cited.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Health Services Administrator	11/21/16

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed on [11/17/2016] via email

November 17, 2016

Mrs. Jadyne Schmidt, Administrator
The Health Care Center At Friendship Village
2525 East Southern Avenue
Tempe, AZ 85282

Dear Mrs. Schmidt:

On November 9, 2016, a **Life Safety Code** survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

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

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

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **November 27, 2016**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 27, 2016**, 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 **12/24/2016.**

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 November 9, 2016

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 November 9, 2016. 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 05/09/2017.

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 Joel Bunis, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. **Please note: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

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

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **November 27, 2016**, 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

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Attachments

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 _____	11/09/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS 42CFR 483.70 (a) Nursing Homes The facility must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association. This is a recertification survey for Medicare under LSC 2012, Chapter 19 Existing of a Skilled Nursing facility under Health Care. The entire skilled nursing portion of the facility was surveyed. The facility meets the standards, based upon acceptance of a plan of correction.	K 000	K000 Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.	
K 374 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke Barrie Subdivision of Building Spaces – Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid Bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This STANDARD is not met as evidenced by: Based on Observation it was determined the Facility failed to maintain a few 1/1/2 hour rated double doors on the second floor.	K 374	K374 NFPA 101 LIFE SAFETY CODE STANDARD It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure that all fire rated doors are in proper working condition (astragals and latching mechanisms) to ensure effective smoke resistance as a smoke barrier. 1. Both doors on the 2nd Floor were fixed 11/10/2016. (See attached work order documentation 176027 and 176026) Lanmor recertified the repaired doors 11/21/2016 (see attached).	

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

Health Services Administrator 11/21/16

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 _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CARE CENTER AT FRIENDSHIP VILLAGE	**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 029	Continued From page 1 NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.7.3 "Any required smoke barrier Shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1 hour. (1/2 hour for existing) Findings include: On November 09, 2016 the surveyor, accompanied by the Administrator, Assistant Director of Environmental Services and Plant Operations, Plant Operations Manager and Maintenance observed 1/1/2 fire rated doors located on the second floor in the following locations either the astragals on the doors or the latching mechanisms caused the doors to prop back open and not close together during the testing done by the maintenance staff. 1.2 East, 2-260, and 2 West. These were all on the second floor. During the exit conference on November 09, 2016 the above findings were again acknowledged by the Administrator, Assistant Director of Environmental Services, Plant Operations, Plant Operations Manager and Maintenance Technicians Failing to maintain the 1/1/2 hour fire rated doors during a fire could cause harm to the patients.	K 374	2. All residents, personnel, employees, volunteers, and students have the potential to affected by a fire if a door doesn't maintain 1/1/2 hour rating. All doors are inspected quarterly by Administrator and designees. Lanmor is contracted on an annual basis to ensure all doors are functioning in accordance with NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.7.3. 3. Administrator and designees will continue to monitor doors on a quarterly basis with the Maintenance Technician and report findings to Quarter QAPI. 4. Administrator, Administrator's designee, Plant Operations Manager and Maintenance Technician will be responsible for reporting to quarterly QAPI to ensure compliance. 5. See signature of Administrator at the bottom of the page.	
K 920 SS=D	NFPA 101 Electrical Equipment – Power Cords And Extens Electrical Equipment – Power Cords and Extension Cords Power strips in a patient care vicinity are only	K 920	K920 NFPA 101 LIFE SAFETY CODE STANDARD It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure that electrical safety is maintained and to prohibit the use of multiple outlet adapters or extension cords in all resident care areas.	

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 _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CARE CENTER AT FRIENDSHIP VILLAGE	**2525 E SOUTHERN AVE** **TEMPE, AZ 85282**

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K 920	Continued From page 2 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 STANDARD is not met as evidenced by: Based on Observation it was determined the facility allowed the use of a multiple outlet Adapter, a power strip for appliances 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 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	K 920	1. The Administrator plugged the refrigerator and microwave directly into the outlet at the time of inspection on 11/9/2016. All employee and resident care areas were checked on 11/10/2016 to ensure compliance. 2. All residents, personnel, employees, volunteers, and students have the potential to affected by an electrical fire. All resident care areas are inspected on a quarterly basis by Administrator and designees to ensure compliance. 3. Administrator and designees will continue to monitor doors on a quarterly basis with the Maintenance Technician and report findings to Quarter QAPI. 4. Administrator, Administrator's designee, Plant Operations Manager and Maintenance Technician will be responsible for reporting to quarterly QAPI to ensure compliance. 5. See signature of Administrator at the bottom of the page.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: **02 – MAIN BUILDING 01** B. WING _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE HEALTH CARE CENTER AT FRIENDSHIP VILLAGE	**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 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. Findings include: On November 09, 2016 the surveyor, accompanied by the Administrator, Assistant Director of Environmental Services and Plant Operations, Plant Operations Manager and Maintenance Technicians observed the Therapy Rehabilitation Office Rom 6-67 had both microwave and refrigerator connected into a power strip and not directly plugged in to the receptacle wall outlets in the office. During the exit conference on November 09, 2016 the above findings were again acknowledged by the Administrator, Assistant Director of Environmental Services, Plant Operations, Plant Operations Manager and Maintenance Technicians The use of multiple outlet adapters could create an overload of the electrical system and could cause a fire or an electrical hazard. A fire could cause harm to patients.	K 920		

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 [ ][ ] [ ][ ] [ ][ ] To: F2 [ ][ ] [ ][ ] [ ][ ]
MM DD YY MM DD YY

Extended Survey
From: F3 [ ][ ] [ ][ ] [ ][ ] To: F4 [ ][ ] [ ][ ] [ ][ ]
MM DD YY MM DD YY

Name of Facility	Provider Number	Fiscal Year Ending: F5
Tempe Life Care Village Inc dba The Healthcare Center at Friendship Village	03-5074	[ ][ ] [ ][ ] [ ][ ] MM DD YY

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

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

A. F9 [01]

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

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

If yes, indicate Hospital Provider Number: F11 [ ][ ][ ][ ][ ][ ]

Ownership: F12 [05]

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

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

Name of Multi-Facility Organization: F14

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

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

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

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

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

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

FACILITY STAFFING

	Tag Number	A Services Provided 1	2	3	B Full-Time Staff (hours)	C Part-Time Staff (hours)	D Contract (hours)
Administration	F33				00214	0001 6	00000
Physician Services	F34	Y	N	N			
Medical Director	F35				00000	00000	0004
Other Physician	F36				00000	00000	00000
Physician Extender	F37	N	N	N	00000	00000	00000
Nursing Services	F38	Y	N	Y			
RN Director of Nurses	F39				00040	00000	00000
Nurses with Admin. Duties	F40				00268	00000	00000
Registered Nurses	F41				00648	0036	00000
Licensed Practical/ Licensed Vocational Nurses	F42				00004	00000	00000
					00000	00000	00000
Certified Nurse Aides	F43				01050	0018	00000
Nurse Aides in Training	F44				00000	00000	00000
Medication Aides/Technicians	F45				00000	00000	00000
Pharmacists	F46	Y	N	Y	00000	00000	00004
Dietary Services	F47	Y	N	Y			
Dietitian	F48				00000	00000	00004
Food Service Workers	F49				00483	0090	00020
Therapeutic Services	F50						
Occupational Therapists	F51	Y	N	Y	00000	00000	00071
Occupational Therapy Assistants	F52				00000	00000	00062
Occupational Therapy Aides	F53				00000	00000	00000
Physical Therapists	F54	Y	N	Y	00000	00000	00165
Physical Therapists Assistants	F55				00000	00000	00104
Physical Therapy Aides	F56				00000	00000	00000
Speech/Language Pathologist	F57	Y	N	Y	00000	00000	00114
Therapeutic Recreation Specialist	F58	N	N	N	00000	00000	00000
Qualified Activities Professional	F59	Y	N	N	00018	00000	00000
Other Activities Staff	F60	Y	N	N	00080	00000	00000
Qualified Social Workers	F61	Y	N	N	00040	00000	00000
Other Social Services	F62	N	N	N	00000	00000	00000
Dentists	F63	Y	N	Y	00000	00000	00000
Podiatrists	F64	Y	N	Y	00000	00000	00000
Mental Health Services	F65	Y	N	Y	00000	00000	00000
Vocational Services	F66	N	N	N			
Clinical Laboratory Services	F67	Y	N	Y			
Diagnostic X-ray Services	F68	Y	N	Y			
Administration & Storage of Blood	F69	N	N	N			
Housekeeping Services	F70	Y	N	Y	00351	00000	00000
Other Chaplain	F71				00040	00000	00000

Name of Person Completing Form	Time 8:37a
Signature	Date 11/9/16

Form CMS-671 (12/02)

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
0350774	11 F75	Ø F76	Ø F77	11 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 Ø	F80 3	F81 1
Dressing	F82 Ø	F83 4	F84 Ø
Transferring	F85 Ø	F86 4	F87 Ø
Toilet Use	F88 Ø	F89 4	F90 Ø
Eating	F91 Ø	F92 4	F93 Ø

A. Bowel/Bladder Status

F94 Ø With indwelling or external catheter

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

F96 2 Occasionally or frequently incontinent of bladder

F97 1 Occasionally or frequently incontinent of bowel

F98 Ø On urinary toileting program

F99 2 On bowel toileting program

B. Mobility

F100 Ø Bedfast all or most of time

F101 4 In a chair all or most of time

F102 Ø Independently ambulatory

F103 4 Ambulation with assistance or assistive device

F104 Ø Physically restrained

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

F106 Ø With contractures

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

C. Mental Status

F108-114 – indicate the number of residents with:

F108 Ø Intellectual and/or developmental disability

F109 5 Documented signs and symptoms of depression

F110 1 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 Ø Behavioral healthcare needs

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

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

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 Ø Pressure ulcers (exclude Stage 1)

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

F117 4 Receiving preventive skin care

F118 Ø Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 Ø Hospice care

F120 Ø Radiation therapy

F121 Ø Chemotherapy

F122 Ø Dialysis

F123 1 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 1 Respiratory treatment

F125 Ø Tracheostomy care

F126 Ø Ostomy care

F127 Ø Suctioning

F128 1 Injections (exclude vitamin B12 injections)

F129 Ø Tube feedings

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

F131 4 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 Ø Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 2 Any psychoactive medication

F134 Ø Antipsychotic medications

F135 Ø Antianxiety medications

F136 1 Antidepressant medications

F137 1 Hypnotic medications

F138 4 Antibiotics

F139 3 On pain management program

G. Other

F140 Ø With unplanned significant weight loss/gain

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

F142 Ø Who use non-oral communication devices

F143 5 With advance directives

F144 Ø Received influenza immunization

F145 4 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
Brittny Hindley	RN DON	11/8/16

TO BE COMPLETED BY SURVEY TEAM

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

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

F148 Medication error rate 0 %

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 11/04/2012 thru 11/04/2016
Arizona

THE HEALTH CARE CENTER AT FRIENDSHIP
2525 EAST SOUTHERN AVENUE
TEMPE, AZ 85282
State's Region Code: AZ

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

Provider Beds
Total: 128
Certified: 128

Provider Category: SNF

Type Action: RECERTIFICATION
Type Ownership: NONPROFIT - CORPORATION

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

Program Requirements

Current Survey/Revisit Dates - None

Prior 3 Survey 04/2012	S/S Code	Prior 2 Survey 07/2013	S/S Code	Prior 1 Survey 10/2014	S/S Code	Current Survey 10/28/2015	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
				X	D				REQ	F0252-SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT
				X	E				REQ	F0253-HOUSEKEEPING & MAINTENANCE SERVICES
									REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
		X	D						REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
									REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
				X	D				REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
									REQ	F0362-SUFFICIENT DIETARY SUPPORT PERSONNEL
									REQ	F0368-FREQUENCY OF MEALS/SNACKS AT BEDTIME
X	D	X	D						REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
									REQ	F0456-ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION
				X	E				REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
		X	D						REQ	F0499-EMPLOY QUALIFIED FT/PT/CONSULT PROFESSIONALS
									REQ	F0511-RADIOLOGY FINDINGS-PROMPTLY NOTIFY PHYSICIAN
									REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
				X	D				REQ	F0517-WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS
				X	D				REQ	F0518-TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 04/2012	S/S Code	2012 HC Prior 2 Survey 07/2013	S/S Code	2012 HC Prior 1 Survey 10/2014	S/S Code	2012 HC Current Survey 10/28/2015	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
				X	D				STD	K0291-Emergency Lighting

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

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 11/04/2012 thru 11/04/2016

THE HEALTH CARE CENTER AT FRIENDSHIP **CCN:** 035074

Edition of LSC Applied

2012 HC Prior 3 Survey 04/2012	S/S Code	2012 HC Prior 2 Survey 07/2013	S/S Code	2012 HC Prior 1 Survey 10/2014	S/S Code	2012 HC Current Survey 10/28/2015	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
		X	E			X C	E	11/12/2015	STD	K0321-Hazardous Areas - Enclosure
X	E								STD	K0353-Sprinkler System - Maintenance and Testing
X	D	X	D						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	D	X	E	X	F	X C	E	11/12/2015	STD	K0511-Utilities - Gas and Electric
				X	D				STD	K0712-Fire Drills
		X	D						STD	K0923-Gas Equipment - Cylinder and Container Storag

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 11/04/2012 thru 11/04/2016

THE HEALTH CARE CENTER AT FRIENDSHIP **CCN:** 035074

Deficiency Summary

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

Complaint Survey Information

Survey Date	Status
10/28/2015	Unsubstantiated
10/09/2014	Unsubstantiated
07/10/2013	Substantiated
04/18/2012	Unsubstantiated

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 11/04/2012 thru 11/04/2016

THE HEALTH CARE CENTER AT FRIENDSHIP **CCN:** 035074

LTC Resident Census

Resident Census on 10/28/2015
Total: 15
Medicare: 10
Medicaid: 0
Other: 5

Total Certified Beds: 128

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

Friendship Village TEMPE

ADHS CONTROLLER'S OFFICE
CASH RECEIPTS UNIT
NOV 23 2016
RECEIVED

November 21, 2016

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 November 7, 2016.

On November 9, 2016, 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