Medicare/Medicaid Public Records Documents Only

Survey event #JLF0

Facility: FRIENDSHIP VILLAGE OF TEMPE

Revised 7-2020

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: JLF0

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0036

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

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/15/2020** (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 **64** (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
64				
(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's Annual Recercitfication survey conducted on October 15, 2020. No Deficiencies cited in the State and Federal survey. Life Safety Code cited deficiencies; s/s-none. Life Safety code is back in compliance with federal regulations based on the acceptable plan of correction November 4, 2020. Revisit offiste survey completed on November 5, 2020. State Agency recommended recertification is effective November 5, 2020.

17. SURVEYOR SIGNATURE Date:
Carl Rehmar surveyor by M Miller 11/05/2020 (L19)
Sylvia Turner, HCFA

18. STATE SURVEY AGENCY APPROVAL Date:
Monica Miller 11/05/2020 (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

November 6, 2020

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/ST:mm

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 29, 2020

Receipt of This Notice is Presumed To Be 10/29/2020
Important Notice - Please Read

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

Dear Mrs. Schmidt:

On **October 15, 2020**, a 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/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaint investigations may have also been conducted.

The enclosed **Federal** deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please** retain a **copy** for your files.

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bk

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 _____	10/15/2020

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 annual recertification survey was conducted on October 13, 14, and 15, 2020 in conjunction with the investigation of complaint numbers AZ00163636 and AZ00163637. There were no deficiencies cited.	F 000		

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

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

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 29, 2020

Receipt of This Notice is Presumed To Be 10/29/2020
Important Notice - Please Read

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

Dear Mrs. Schmidt:

On **October 14, 2020**, a 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/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaint investigations may have also been conducted.

The enclosed **Emergency Preparedness** deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please** retain a **copy** for your files.

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bk

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 _____	10/16/2020

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. No apparent deficiences noted at the time of the survey.	E 000		

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

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035074 Y1	A. Building 02 - MAIN BUILDING 01 B. Wing Y2	11/5/2020 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. #	Completed	Reg. #	Completed
LSC K0355	11/05/2020	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	
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
☑	BER	11/5/2020	[signature]	5/11/2020
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
10/14/2020	☐ YES ☐ NO

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

November 6, 2020

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Mrs. Schmidt:

On November 5, 2020, an offsite **Life Safety Code/Emergency Preparedness,** revisit survey 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/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,

Monica Miller
Program Project Specialist II
\mm

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 11/05/2020

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 Surveyor: Rehman, Paul 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 All noted deficiencies on the survey dated October 16, 2020, 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 This Notice Is Presumed To Be 10/29/2020
Important Notice - Please Read Carefully

October 29, 2020

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

Dear Mrs Schmidt:

On October 14, 2020, 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. 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 **November 8, 2020**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **November 8, 2020**, 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 **November 30, 2020.**

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

Recommended Remedies

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

Recommending to CMS Civil Money, per day, per tag, effective October 14, 2020

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

Mandatory Remedies

Your current period of noncompliance began on October 14, 2020. 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 April 14, 2021.

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: 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 **11/08/2020**, 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\bk

Attachments

Friendship Village TEMPE

ARIZONA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
LICENSING

NOV 0 5 2020

LONG TERM CARE
150 N. 18TH AVE # 440
PHOENIX, AZ 85007

11/3/2020

rizona Department of Healt
Division of Public Health

NOV 0 4 2020

50 N. 18th Ave #40
Phoenix AZ 85007

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 Federal/State recertification survey conducted October 15.2020. The documents include the Life Safety Inspection 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

ARIZONA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
LICENSING

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: **02 – MAIN BUILDING 01** B. WING _____	**10/16/2020**

NOV 05 2020
LONG TERM CARE
150 N. 18TH AVE # 440
PHOENIX, AZ 85007

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
K 000	INITIAL COMMENTS 42CFR 483.70 (a) Nursing Homes The facility must meet the applicable provisions of the 2012 edition of the Life Safety Code of the National Fire Protection Association. This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing. The entire facility, was surveyed on October 14.2020. The facility meets the standards, based upon acceptance of a plan of correction.	K 000	rizona Department of Healt Division of Public Health NOV 04 2020 Reception Desk 50 N. 18th Ave #40 Phoenix AZ 85007	
K 355	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, Inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: (1) Based on observation it was determined the facility failed to conduct a visual inspection of three (3) ABC fire extinguishers on the Garden Level and document the visual inspection on the annual tag or keep separate records. Failing to have inspect and document on a monthly basis on the back of the annual fire extinguisher tag the visual monthly inspections, of all the ABC fire extinguishers could result in harm to the residents and/or staff in time of a fire. NFPA 101 Life Safety Code, 2012, Chapter 19,	K 355	It is the intention of the Health Care Center (HCC) at Friendship Village Tempe to ensure that all portable fire extinguishers are visually inspected monthly and documented in accordance with NFPA 10, Standard for Portable Fire (A) Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 and (B) NFPA 10, Chapter 7, Section 7.2.2 1. (A) Late entry inspection was completed 11/3/2020. Security officers who are responsible for fire extinguisher monthly inspections were re-trained on fire extinguisher inspections including clear access, locations, and Record keeping. This was partially accomplished on 10/31/2020 (Attachment A) Officers off duty or not available at that time will complete this by 11/07/2020. This information will then be reviewed yearly for current security officers and at the time of hire for new staff.	

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/16/2020

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 355	Continued From page 1 Section 19.3.5.12 "Portable fire extinguishers Shall be provided in all health care occupancies in accordance with 9.7.4.1" Section 9.7.4.1 "Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Standard for portable Fire Extinguishers." NFPA10, Chapter 7, Section 7.2.1 Frequency Section 7.2.1.2 Fire Extinguishers shall be inspected either manually or by means of an electronic monitoring device/ system at a minimum of 30 day intervals. Section 7.2.4 Inspection Record keeping Section 7.2.4.1 Personnel ,making the manual inspections shall keep records of all fire extinguishers inspected, including those found to corrective action. Findings include: Observations while on tour on October 14, 2020 revealed the facility failed to complete monthly visual inspections of the following fire extinguishers; One (1) ABC fire extinguisher in the Garden Level Pantry (HC13) One (1) ABC fire extinguisher in the Garden Level Fountain Pump room (G-89) One (1) ABC fire extinguisher in the Garden Level smoking area The monthly visual inspections were not completed for the month of September. During the exit conference on October 14, 2020 the above findings were again acknowledged by the management team.	K 355	(B) The fire extinguisher in the Garden Level smoking area foliage from a bush was trimmed providing clear access to the fire extinguisher on 11/2/2020. (Attachment B) 2. All residents, personnel, employees, volunteers, and students have the potential to affected by a fire extinguishers that are not inspected monthly or blocked and not visible. (A) Written maps and documentation of locations was provided to each security staff member responsible for fire extinguisher inspections. This information is now available at the security office as well as electronically. (B)Security officers who are responsible for fire extinguisher monthly inspections were re-trained on fire extinguisher inspections including clear access, locations, and Record keeping. This was partially accomplished on 10/31/2020 by Lead Security Officer. (See attached training log and training outline) Officers off duty or not available at that time will complete this by 11/07/2020. This information will then be reviewed yearly for current security officers and at the time of hire for new staff.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035074	A. BUILDING: 02 – MAIN BUILDING 01 B. WING _____	10/16/2020

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 355	Continued From page 2 (2) Based on observation it was determined the the facility failed to prevent an ABC fire extinguisher from being blocked and readily accessible in the Garden Level smoking area of the facility. Failing to have clear access to a fire extinguisher during an emergency could result in harm to the residents and/or staff. NFPA 1010 Life Safety Code, 2012, Chapter 19, Section 19.3.5.12 "Portable fire extinguishers shall be provided in all health care occupancies in accordance with 9.7.4.1" Section 9.7.4.1 "Where required by the provisions of another section of this Code, portable fire extinguishers shall be installed, inspected, and maintained in accordance with NFPA 10, Chapter 7, Section 7.2.2 Periodic inspections or electronic monitoring of fire extinguishers shall include a check of at least the following items: Findings include: Observation while on tour on October 14, 2020 revealed the facility failed to prevent an ABC fire extinguisher from being blocked and readily accessible in the Garden Level smoking are of the facility. The fire extinguisher cabinet was blocked by foliage from a bush. During the exit conference on October 14, 2020 the above finding was again acknowledged by management team.	K 355	3. (A) The Security Manager and Security Lead (Supervisory) Officers will conduct monthly checks of fire extinguishers to ensure inspections have taken place and are documented on the inspection tag. These monthly checks will also be documented by work orders in our internal work order system. (B) The Security Manager and Security Lead (Supervisory) Officers will conduct monthly checks of fire extinguishers to ensure extinguishers are not blocked, are visible and readily accessible. 4. (A) (B) Administrator, Security Manager and Security Lead Officers will conduct extinguisher inspections on a monthly basis and report findings to QAPI and quarterly to QAA. 5. (A) (B) See signature of Administrator at the bottom of the page.	

Attachment A

ARIZONA DEPARTMENT OF HEALTH
DIVISION OF PUBLIC HEALTH
LICENSING

NOV 05 2020

LONG TERM CARE
150 N. 18TH AVE # 440
PHOENIX, AZ 85007

Fire Extinguisher Monthly Inspection

All FVT fire extinguishers are checked each month by security officers. Maps to all extinguishers are below and can be found on the common drive (G:\Environmental Services\- - Floorplans and Maps\FIRE Plans). On each months workhub work order extinguishers are listed to ensure each is located and inspected. Lead officers are responsible to ensure checks are completed, tags are initialed and work orders are closed once the inspections are complete.

The monthly check shall include the following

Check tag for last stamped "certified" date. Month/Year. Date should not exceed 13 months since last "Certified" inspection.

Check Location and Visibility of extinguisher

Nothing should be blocking the view of the extinguisher. Extinguisher must be visible and easily found during an emergency (36 inch clearance is required). Nothing should be blocking easy access to the extinguisher. This includes things like furniture, and medical equipment. If the extinguisher is outside trees and shrubs should not block visibility or access either.

In proper cabinet or hanging properly on wall

FVT uses cabinets or brackets designed specifically for fire extinguishers. Extinguishers should never be outside of cabinets or off brackets unless they are secured in the keyroom as out of service.

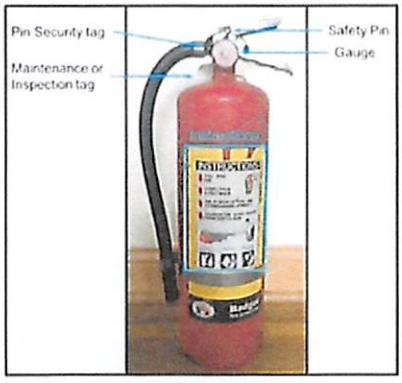
Gauge arrow is indicating "Good" or in the green



Operating instructions on the name plate legible and facing outward

safety seals and/or tamper indicators in place and functional

Extinguisher in good physical condition (No obvious damage, corrosion, leakage, or clogged nozzle).



Person conducting inspection shall initial back of the inspection tag

If you need to take fire extinguisher out of service, create a work order and replace the extinguisher with a spare (spares are in the keyroom).

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

A-1

DMWEST #8821736 v1
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)
10/13/2020	10/15/2020		

Name of Facility	Provider Number	Fiscal Year Ending: F5 (mm/dd/yyyy)
Friendship Village of Tempe	03-5074	12/31/2020

Street Address: 2525 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 ..... ○ 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 ..... ○ 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? ..... ● 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:		Waiver of 24 hr licensed nursing requirement:	
Date: F28 (mm/dd/yyyy)	Hours waived per week: F29	Date: F30 (mm/dd/yyyy)	Hours waived per week: F31
N/A	N/A	N/A	N/A

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

Name of Person Completing Form	Time
Jadyne Schmidt	10:50 am
Signature	**Date**
Jadyne Schmidt	10/13/2020

Form CMS-671 (06/2018)

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
	11 F75	0 F76	16 F77	27 F78

ADL	Independent		Assist of One or Two Staff		Dependent	
Bathing	F79	1	F80	18	F81	8
Dressing	F82	4	F83	20	F84	3
Transferring	F85	5	F86	20	F87	2
Toilet Use	F88	4	F89	21	F90	2
Eating	F91	25	F92	2	F93	0

A. Bowel/Bladder Status

F94 0 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission? 0

F96 17 Occasionally or frequently incontinent of bladder

F97 11 Occasionally or frequently incontinent of bowel

F98 0 On urinary toileting program

F99 0 On bowel toileting program

B. Mobility

F100 1 Bedfast all or most of time

F101 26 In chair all or most of time

F102 2 Independently ambulatory

F103 17 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 ? 0

C. Mental Status

F108-114-indicate the number of residents with:

F108 0 Intellectual and/or developmental disability

F109 25 Documented signs and symptoms of depression

F110 10 Documented psychiatric diagnosis (exclude dementias and depression)

F111 11 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 ?

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

D. Skin Integrity

F115-118-indicate the number of residents with:

F115 5 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? 4

F117 26 Receiving preventive skin care

F118 0 Rashes

Organization: Corp/MC/NC/FV-T - 2235/HC - FV-T
Created: 10/13/2020 1:01:37 PM

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 5 Respiratory treatment

F125 0 Tracheostomy care

F126 0 Ostomy care

F127 0 Suctioning

F128 7 Injections (exclude vitamin B12 injections)

F129 0 Tube feedings

F130 4 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 19 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 15 Any psychoactive medication

F134 2 Antipsychotic medications

F135 3 Antianxiety medications

F136 15 Antidepressant medications

F137 0 Hypnotic medications

F138 2 Antibiotics

F139 21 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 27 With advance directives

F144 6 Received influenza immunization

F145 20 Received pneumococcal vaccine

Signature of Person Completing the Form	Title	Date
[signature]	RN DON	10/14/2020

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 0 %

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CASPER Report 0003D
Provider History Profile
Report Selection Criteria

Run Date: 10/09/2020
Job # 93387304
Last Update: 10/08/2020

Criteria selected for this report:

Geographical Breakdown: State
State(s): AZ
Provider Categories: 04-Skilled Nursing Facility
Provider Lookup?: Y
Survey from: 10/09/2016
Survey thru: 10/09/2020
Provider Status: Active
Survey Selection: Current Survey
Print Survey Team Information?: N
Print Surveyor ID #'s?: N
CCNs: 035074
Sorted by: CCN

Any alteration to any page displaying the CMS logo is strictly prohibited.

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 - 04/11/2019

Prior 3 Survey 10/2015	S/S Code	Prior 2 Survey 11/2016	S/S Code	Prior 1 Survey 10/2017	S/S Code	Current Survey 01/31/2019	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	- -	-	-	REQ	F0252-SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	REQ	F0517-WRITTEN PLANS TO MEET EMERGENCIES/DISASTERS
-	-	-	-	-	-	- -	-	-	REQ	F0518-TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS
-	-	-	-	-	-	X C	E	04/11/2019	REQ	F0640-Encoding/Transmitting Resident Assessments
-	-	-	-	-	-	X C	D	04/11/2019	REQ	F0684-Quality of Care

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 10/2015	S/S Code	2012 HC Prior 2 Survey 11/2016	S/S Code	2012 HC Prior 1 Survey 10/2017	S/S Code	2012 HC Current Survey 01/31/2019	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	STD	K0291-Emergency Lighting
X	E	-	-	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	X	D	- -	-	-	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	- -	-	-	STD	K0363-Corridor - Doors
-	-	-	-	-	-	X C	D	04/05/2019	STD	K0372-Subdivision of Building Spaces - Smoke Barrie
-	-	X	D	-	-	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	- -	-	-	STD	K0379-Smoke Barrier Door Glazing
X	E	-	-	-	-	- -	-	-	STD	K0511-Utilities - Gas and Electric
-	-	-	-	X	D	- -	-	-	STD	K0712-Fire Drills
-	-	X	D	-	-	X C	D	04/05/2019	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	2	0	0	0
Health Total	2	0	0	0
Life Safety Code	2	2	2	2
Life Safety Code + Health	4	2	2	2

Complaint Survey Information

Survey Date	Status
01/31/2019	Substantiated
10/13/2017	Unsubstantiated
11/09/2016	Unsubstantiated
10/28/2015	Unsubstantiated

FRIENDSHIP VILLAGE OF TEMPE **CCN:** 035074

LTC Resident Census

Resident Census on 01/31/2019
Total: 23
Medicare: 18
Medicaid: 0
Other: 5

Total Certified Beds: 32

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

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

October 29, 2020

Important Notice - Please Read Carefully

John Hasselbalch
5015 Co Rd 19
Minnetrista, MN 55359

RE: Friendship Village Of Tempe
Complaint Intake #AZ00163636, #AZ00163637
Investigation #JLF011

Dear John Hasselbalch:

The Arizona Department of Health Services (Department) has concluded its investigation of the above referenced complaint. The Bureau of Long Term Care Licensing determined whether the issue(s) that were raised in your complaint corresponded to the rules or statutes that regulate Friendship Village Of Tempe.

Through the Department's investigation process, one or more surveyors conducted interviews with staff of the facility, residents that received services from the facility, and anyone else who may have been able to provide pertinent information. Surveyors also made observations during their time on site and reviewed records. The investigation may have also included the review of hospital, police, and other facility or state agency reports.

Unfortunately, the Department was not able to find enough evidence to verify your allegation(s); however, even though we were unable to substantiate your allegations there might be unrelated findings. You can search under azcarecheck.com. It is also appreciated that you took the time to make the Department aware of your concerns.

It may help you to know that, with few exceptions, each of our licensed facilities undergoes an unannounced annual inspection. During this inspection the facility is checked to see if they are following the rules that govern the Bureau of Long Term Care Licensing facilities. Since your complaint did pertain to the Bureau of Long Term Care Licensing facilities rules, this area will be checked during this annual inspection.

During the annual inspection, if the Surveyor finds rule violations, the Surveyor would cite the Facility. The Facility would then receive a report from the Department, known as a Statement of Deficiencies, which describes each violation(s) identified during this investigation. The Facility would then be required to submit a plan to the Department describing how they are going to correct the violation(s) and/or prevent it from occurring again.

If you would like to see a three year history of all of the inspection results (either annual or verified complaints) for this facility, as well as any enforcement actions, please visit our website at www.azcarecheck.com.

Thank you for bringing your concern(s) to the Department's attention. If you have any questions, please call the Bureau of Long Term Care Licensing at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/bk