

MEDICAID CERTIFICATION AND TRANSFERAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

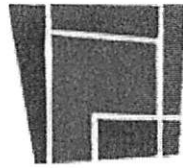
ID: 0VEQ11
Facility ID: LTC0053

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 035099
2. STATE VENDOR OR MEDICAID NO. (L2) 835118
3. NAME AND ADDRESS OF FACILITY (L3) SAPPHIRE OF TUCSON NURSING AND REHAB, LLC
4. TYPE OF ACTION: 9 (L8)
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY (L34)
8. ACCREDITATION STATUS: (L10)
7. PROVIDER/SUPPLIER CATEGORY (L7)
10. THE FACILITY IS CERTIFIED AS:
11. LTC PERIOD OF CERTIFICATION
12. Total Facility Beds (L18)
13. Total Certified Beds (L17)
14. LTC CERTIFIED BED BREAKDOWN
15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): YES (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
On 8/26/20 an onsite infection control survey was conducted at Sapphire of Tucson. No deficiencies were cited.
17. SURVEYOR SIGNATURE
18. STATE SURVEY AGENCY APPROVAL

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

19. DETERMINATION OF ELIGIBILITY
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
23. LTC AGREEMENT BEGINNING DATE
24. LTC AGREEMENT ENDING DATE
25. LTC EXTENSION DATE:
27. ALTERNATIVE SANCTIONS
26. TERMINATION ACTION:
28. TERMINATION DATE:
29. INTERMEDIARY/CARRIER NO.
30. REMARKS
31. RO RECEIPT OF CMS-1539
32. DETERMINATION OF APPROVAL DATE



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

September 1, 2020

Receipt of This Notice is Presumed To Be 09/01/2020  
Important Notice - Please Read

Brian Balliet, Administrator  
Sapphire Of Tucson Nursing And Rehab, Llc  
2900 East Milber Street  
Tucson, Arizona 85714

Dear Mr. Balliet:

On **August 26, 2020**, an Infection Control COVID-19 Focused 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 requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19.

The enclosed Federal deficiency form which indicates that no deficiencies were found at the time of the inspection. This form will become a part of your public file; 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,

A handwritten signature in cursive script that reads "Diane Eckles".

Diane Eckles  
Bureau Chief

DE\sf

Attachments

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

PRINTED: 09/01/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035099	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/26/2020
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NAME OF PROVIDER OR SUPPLIER  SAPPHIRE OF TUCSON NURSING AND REHAB, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2900 EAST MILBER STREET TUCSON, AZ 85714
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>A focused Infection Control survey was conducted on August 26, 2020. No deficiencies were cited.</p>	F 000		
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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.