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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: OUUM11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

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) **AVALON SOUTHWEST HEALTH & REHABILITATION**
(L4) **2900 EAST MILBER STREET**
(L5) **TUCSON, AZ** (L6) **85714**

4. TYPE OF ACTION: **6** (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 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (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 **240** (L18)
13.Total Certified Beds **240** (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
	240			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Avalon Southwest Health Rehabilitation, Abbreviated survey was found to be out of compliance with federal regulations based S/S "E" conducted on 02/23/2018. This facility is back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 03/27/2018. State Agency recommended recertification

17. SURVEYOR SIGNATURE
Duke Ackerman Team Leader DE
Date : 03/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL
DE
Date: 03/29/2018 (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
02/05/1985
(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.
01101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

March 29, 2018

William Amoureux, Administrator
Avalon Southwest Health & Rehab
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Amoureux:

On February 23, 2018, complaint survey OUUM11 was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and presume that you have achieved substantial compliance. Based on this presumed compliance, we are not forwarding to the Centers for Medicare/Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency our recommendation that the remedies we indicated in our letter to you of 03/07/2018 be imposed at this time.

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

Recommendation to CMS Civil money penalty, effective February 23, 2018
Recommendation to CMS Denial of Payment for New Admission

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

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

Sincerely,

B Hernandez

Belinda Hernandez,
CSR4/Licensing Certification Specialist

/bh

cc: State Ombudsman (with POC)

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

March 29, 2018

IMPORTANT NOTICE- PLEASE READ CAREFULLY

William Amoureux, Administrator
Avalon Southwest Health & Rehab
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Amoureux:

On March 27, 2018, 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 at the time of the follow-up investigation to Complaint #OUUM12.

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.

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,

B Hernandez

Belinda Hernandez,
CSR4/Licensing Certification Specialist

\bh

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	R-C 03/27/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

(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 complaint investigation survey was conducted on March 27,2018, no deficiencies were 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.

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
035099 Y1	A. Building B. Wing Y2	3/27/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

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 F0584 Reg. # 483.10(i)(1)-(7) LSC	Correction Completed 03/27/2018	ID Prefix F0732 Reg. # 483.35(g)(1)-(4) LSC	Correction Completed 03/27/2018	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	DA	3/27/18	Dal Adam	3/27/18
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
2/23/2018	☐ 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

Receipt of Notice Presumed 03/14/2018 via email

March 14, 2018

Mr. William Amoureux, Administrator,
Avalon Southwest Health & Rehabilitation
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Amoureux:

Enclosed please find the Statement of Deficiencies and Plan of Correction for the Complaint Investigation # **OUUM11** conducted on February 23, 2018 which was submitted to the Bureau of Long Term Care on March 13, 2018.

The Plan of Correction is unacceptable for the following reasons:

F000: Please strike out the verbiage after "correctly cited…and it does not constitute an admission or agreement by the provider of the facts alleged or the conclusions set forth in the Statement of Deficiencies."

F732: Please send copies of posted staffing since 2/24/18. Please send a copy of twice weekly audit of staff posting since 2/24/18.

F584 & Y347: Please send a copy of purchase receipts and packing slips for linens delivered to the facility on 2/24/18. Please send copies of all audits conducted to date to monitor the supply of linen.

The requested documents are required to be returned to this office no later than **March 22, 2018**, please retain a copy for your files. If the requested documents for the Plan of Correction are not received by this office on or before **March 22, 2018**, licensure action and/or civil penalties may be assessed.

Thank you for your cooperation. If you have any questions, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bh

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

(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 A complaint (AZ146777) investigation was conducted on February 23, 2018. The following deficiencies were cited. F 584 Safe/Clean/Comfortable/Homelike Environment SS=E CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 000 F 584	This Plan of Correction Constitutes the facility's allegation of compliance for the deficiencies cited in the CMS-2567. However, the submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited. **F584** **How corrective action will be accomplished for those residents found to have been affected by deficient practice.** Linens were received and put into use on 2//24/2018. There are sufficient linens to supply the current level of residents. **How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this practice.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: William [illegible] | TITLE: Administrator | (X6) DATE: 03/09/2018

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 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and residents interviews, the facility failed to maintain an adequate supply of towels and washcloths for 150 residents. Findings include: A tour of the facility was conducted on February 23, 2018 with the housekeeping account manager/staff #156 to determine the availability of towels and washcloths for resident use. At 8:35 a.m. the linen cart on the C1 hallway had 3 bath towels, 5 hand towels, and 3 washcloths available for resident use. An interview was conducted with the housekeeping account manager on February 23, 2018 at 8:37 a.m.. The housekeeping account manager stated that linen carts are stocked two to three times per shift. The housekeeping account manager stated that the facility was waiting for a delivery of linen. The housekeeping account manager stated that towels and washcloths could be obtained from another hall if needed. At 8:40 a.m. the linen cart on the B1 hallway had 5 washcloths, 1 hand towel and 8 bath towels.	F 584	**What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not reoccur.** Laundry/Housekeeping account Manager will audit the linens weekly to ensure the appropriate supply of linen remains on hand. Linen will be re-ordered as need to keep a par level available. **How facility plans to monitor its performance to make sure solutions are sustained.** Findings will be reviewed in QAPI meeting monthly for a minimum of 3 months or until QAPI team determines a lesser frequency is deemed necessary. **Date of completion:** 2/24/2018	

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F 584	Continued From page 2 At 8:42 a.m. the linen cart on the A1 hallway had 2 washcloths, 5 hand towels and no bath towels. At 8:45 a.m. the linen cart on the C2 hallway had no washcloths, hand towels or bath towels. At 8:47 a.m. the linen cart on the B2 hallway had 5 washcloths, 13 bath towels and 3 hand towels. At 8:49 a.m. the linen cart on the A2 hallway had no washcloths, hand towels or bath towels. An interview was conducted with a laundry staff person/staff #157 on February 23, 2017 at 8:53 a.m. There were 11 bath towels, 8 hand towels, and 2 washcloths on a table in the laundry room. The laundry staff person stated there were more in the dryer but that she did not know how much. An interview was conducted with the housekeeping account manager/staff #156 on February 23, 2018 at 8:55 a.m.. The housekeeping account manager stated that the facility could use more linen. An interview was conducted with the central supply manager/staff #84 on February 23, 2018 at 9:00 a.m. The central supply manager stated that another housekeeping account manager thought the facility had enough washcloths. The central supply manager was only able to find 5 dozen more washcloths. The central supply manager provided the surveyor a requisition order which was placed on February 22, 2018 for 288 hand towels and 216 bath towels. The central supply manager stated that the towels were expected to be delivered on February 23, 2018.	F 584		

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F 584	Continued From page 3 An interview was conducted with the administrator/staff #6 on February 23, 2018. The administrator stated that he told central supply to double the order. An interview was conducted with a CNA (certified nursing assistant)/staff #141 on February 23, 2018 at 10:02 a.m. The CNA stated that sometimes there were no towels or washcloths available for resident use. The CNA stated that she used wipes to bathe the residents. The CNA stated that the facility has been short on linen for about two months. An interview was conducted with a CNA/staff #70 on February 23, 2018 at 10:06 a.m. The CNA stated that sometimes there were no towels or washcloths available for residents. The CNA stated that she used wipes to bathe the residents and bath blankets to dry the residents. The CNA stated that sometimes residents went without showers because of this. The CNA stated that she has asked laundry for more. The CNA further stated that her hallway was without bath blankets today. An interview was conducted with a CNA/staff #143 on February 23, 2018 at 10:08 a.m. The CNA stated that linen was not delivered to her hallway on time. The CNA stated that there was a lack of towels and washcloths. The CNA stated that she sometimes used hand towels to bathe the residents and bath blankets to dry the residents. The CNA further stated that sometimes the residents had to have their showers the next day because of the shortage of linen. An interview was conducted with a CNA/staff #98 on February 23, 2018 at 10:11 a.m. The CNA	F 584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 584	Continued From page 4	F 584		

stated that she always had to got to other hallways to get towels and washcloths. The CNA further stated that it was not fair to the residents as sometimes they had to go without showers.

An interview was conducted with a CNA/staff #128 on February 23, 2018 at 10:14 a.m. The CNA stated that the facility ran out of towels and washcloths pretty often and sometimes staff stalled for showers because there is not enough. The CNA further stated that sometimes showers don't get done.

An interview was conducted with a CNA/staff #131 on February 23, 2018 at 10:17 a.m. The CNA stated that she was getting ready to give a resident a shower and there was no linen available.

An interview was conducted with a CNA/staff #59 on February 23, 2018 at 10:20 a.m. The CNA stated that about two days out of the week there is not enough linen. The CNA stated that she used wipes to give baths.

An interview was conducted with an LPN (licensed practical nurse)/staff #85 on February 23, 2018 at 10:23 a.m. The LPN stated that sometimes residents have to wait to get their showers until we get more linen but that they don't go without.

An interview was conducted with the DON (director of nursing)/staff #56 on February 23, 2018 at 10:31 a.m. The DON stated that she communicated with the housekeeping manager/staff #158 to ensure there were enough towels and washcloths. The DON stated that sometimes it was a timing issue as to when

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F 584	Continued From page 5 laundry delivered the linen to the units. The DON stated that if staff come to me if they can't find linen I get them some. The DON further stated that there were linen rooms on each hallway that had surplus linen stored. An immediate tour was conducted with the DON to determine how much linen was available in the linen rooms on each hallway. The linen rooms on C2, B2, A2, B1, and A1 hallways did not have any towels or washcloths available for resident use. The linen room on the C1 hallway had 8 hand towels, 6 washcloths and 4 bath towels. An interview was conducted with an LPN/staff #125 on February 23, 2018 at 1045 a.m. The LPN stated that it's a problem, we always have to go find linen. I know the CNA's have been using wipes because they don't have enough washcloths and towels. Multiple resident interviews were conducted on February 23, 2018. Most all of the residents interviewed stated they received their scheduled showers and staff were able to locate towels and washcloths for their showers. One resident stated that sometimes staff ran out of towels and then they used a blanket to dry him after his shower. The resident further stated that he didn't care as long as staff dried him with something. An interview was conducted with the DON/staff #56 on February 23, 2018 at 2:09 p.m. The DON stated that the facility did not have a policy on how much linen the facility should have.	F 584		
F 732	Posted Nurse Staffing Information	F 732		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 732 SS=B	Continued From page 6 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	**How corrective action will be accomplished for those residents found to have been affected by deficient practice.** The nurse Staffing information is updated and posted daily. The information will be current and updated as needed. **How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected. The DON/designee will educate regarding posting to ensure the information is current and posted before the start of the shift. **How facility plans to monitor its performance to make sure solutions are sustained.** Random audits at least 2x weekly will be completed to ensure posting are available daily, including weekends. Findings will be reviewed in QAPI meeting monthly for a minimum of 3 months or until QAPI team determines a lesser frequency is deemed necessary. **Date of completion:** 2/24/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	C 02/23/2018

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AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 732	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that nurse staffing information was posted on the weekends. Findings include: A review of the facility's Daily Staff Posting from February 9 through 23, 2018 was conducted on February 23, 2018. Further review of the Daily Staff Postings revealed no evidence that staffing information was posted on the weekends. An interview was conducted with the staffing coordinator/staff #106 on February 23, 2018 at 9:30 a.m. The staffing coordinator stated that he only posted nurse staffing information Monday through Friday and not on the weekends. An interview was conducted with the administrator/staff #6 on February 23, 2018 at 10:00 a.m. The administrator stated that he just heard that nurse staffing information was not posted on the weekends but that it will be from now on. A review of the facility's policy Posting Direct Care Staffing Numbers documented "Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents..."	F 732		

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

Receipt Of This Notice Is Presumed To Be -03/07/2018
Important Notice - Please Read Carefully

March 7, 2018

William Amoureux, Administrator
Avalon Southwest Health & Rehabilitation
2900 East Milber Street
Tucson, AZ 85714

Dear Mr. Amoureux:

The purpose of this letter is to inform you that the Department of Health Services, Bureau of Long Term Care has investigated complaint #OUUM11 on February 23, 2018. During this investigation, some deficiency(ies) were found. A statement of Medicare deficiencies is attached to this letter.

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).

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 17, 2018**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Avalon Southwest Health & Rehabilitation failure to submit an acceptable PoC by **March 17, 2018** 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.

Mandatory Remedies

Your current period of noncompliance began on February 23, 2018. 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.

Recommended Remedies

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

Recommending to CMS Civil Money, effective February 23, 2018
Denial of Payment for New Admissions, effective May 23, 2018

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 05/23/2018. 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.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the 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 written request for hearing must be filed no later than (60 days from the date of receipt of this letter). Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for 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 be represented at a hearing by counsel at your own expense. Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 1h Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page;

(2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided 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 or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

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 **04/09/2018.**

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Office 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.

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 17, 2018,** 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

Diane Eckles
Bureau Chief

DE:sg

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F 000	INITIAL COMMENTS A complaint (AZ146777) investigation was conducted on February 23, 2018. The following deficiencies were cited.	F 000	This Plan of Correction constitutes the facility's allegation of compliance for the deficiencies cited in the CMS-2567. However, the submission of this Plan of Correction is not an admission that a deficiency existed or that one was correctly cited and it does not constitute an admission or agreement by the provider of the facts alleged or the conclusions set forth in the Statement of Deficiencies. We have implemented the Plan of Correction as stated below to correct the deficiencies cited.	
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas;	F 584	F584 **How corrective action will be accomplished for those residents found to have been affected by deficient practice.** Linens were received and put into use on 2//24/2018. There are sufficient linens to supply the current level of residents. **How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected by this practice.	

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

Administrator 3-9-18

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 584	Continued From page 1 §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and residents interviews, the facility failed to maintain an adequate supply of towels and washcloths for 150 residents. Findings include: A tour of the facility was conducted on February 23, 2018 with the housekeeping account manager/staff #156 to determine the availability of towels and washcloths for resident use. At 8:35 a.m. the linen cart on the C1 hallway had 3 bath towels, 5 hand towels, and 3 washcloths available for resident use. An interview was conducted with the housekeeping account manager on February 23, 2018 at 8:37 a.m.. The housekeeping account manager stated that linen carts are stocked two to three times per shift. The housekeeping account manager stated that the facility was waiting for a delivery of linen. The housekeeping account manager stated that towels and washcloths could be obtained from another hall if needed. At 8:40 a.m. the linen cart on the B1 hallway had 5 washcloths, 1 hand towel and 8 bath towels.	F 584	**What measures will be put into place or what systemic changes the facility will make to ensure the deficient practice does not reoccur.** Laundry/Housekeeping account Manager will audit the linens weekly to ensure the appropriate supply of linen remains on hand. Linen will be re-ordered as need to keep a par level available. **How facility plans to monitor its performance to make sure solutions are sustained.** Findings will be reviewed in QAPI meeting monthly for a minimum of 3 months or until QAPI team determines a lesser frequency is deemed necessary. **Date of completion:** 2/24/2018	

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F 584	Continued From page 2 At 8:42 a.m. the linen cart on the A1 hallway had 2 washcloths, 5 hand towels and no bath towels. At 8:45 a.m. the linen cart on the C2 hallway had no washcloths, hand towels or bath towels. At 8:47 a.m. the linen cart on the B2 hallway had 5 washcloths, 13 bath towels and 3 hand towels. At 8:49 a.m. the linen cart on the A2 hallway had no washcloths, hand towels or bath towels. An interview was conducted with a laundry staff person/staff #157 on February 23, 2017 at 8:53 a.m. There were 11 bath towels, 8 hand towels, and 2 washcloths on a table in the laundry room. The laundry staff person stated there were more in the dryer but that she did not know how much. An interview was conducted with the housekeeping account manager/staff #156 on February 23, 2018 at 8:55 a.m.. The housekeeping account manager stated that the facility could use more linen. An interview was conducted with the central supply manager/staff #84 on February 23, 2018 at 9:00 a.m. The central supply manager stated that another housekeeping account manager thought the facility had enough washcloths. The central supply manager was only able to find 5 dozen more washcloths. The central supply manager provided the surveyor a requisition order which was placed on February 22, 2018 for 288 hand towels and 216 bath towels. The central supply manager stated that the towels were expected to be delivered on February 23, 2018.	F 584		

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F 584	Continued From page 3 An interview was conducted with the administrator/staff #6 on February 23, 2018. The administrator stated that he told central supply to double the order. An interview was conducted with a CNA (certified nursing assistant)/staff #141 on February 23, 2018 at 10:02 a.m. The CNA stated that sometimes there were no towels or washcloths available for resident use. The CNA stated that she used wipes to bathe the residents. The CNA stated that the facility has been short on linen for about two months. An interview was conducted with a CNA/staff #70 on February 23, 2018 at 10:06 a.m. The CNA stated that sometimes there were no towels or washcloths available for residents. The CNA stated that she used wipes to bathe the residents and bath blankets to dry the residents. The CNA stated that sometimes residents went without showers because of this. The CNA stated that she has asked laundry for more. The CNA further stated that her hallway was without bath blankets today. An interview was conducted with a CNA/staff #143 on February 23, 2018 at 10:08 a.m. The CNA stated that linen was not delivered to her hallway on time. The CNA stated that there was a lack of towels and washcloths. The CNA stated that she sometimes used hand towels to bathe the residents and bath blankets to dry the residents. The CNA further stated that sometimes the residents had to have their showers the next day because of the shortage of linen. An interview was conducted with a CNA/staff #98 on February 23, 2018 at 10:11 a.m. The CNA	F 584		

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F 584	Continued From page 4 stated that she always had to got to other hallways to get towels and washcloths. The CNA further stated that it was not fair to the residents as sometimes they had to go without showers. An interview was conducted with a CNA/staff #128 on February 23, 2018 at 10:14 a.m. The CNA stated that the facility ran out of towels and washcloths pretty often and sometimes staff stalled for showers because there is not enough. The CNA further stated that sometimes showers don't get done. An interview was conducted with a CNA/staff #131 on February 23, 2018 at 10:17 a.m. The CNA stated that she was getting ready to give a resident a shower and there was no linen available. An interview was conducted with a CNA/staff #59 on February 23, 2018 at 10:20 a.m. The CNA stated that about two days out of the week there is not enough linen. The CNA stated that she used wipes to give baths. An interview was conducted with an LPN (licensed practical nurse)/staff #85 on February 23, 2018 at 10:23 a.m. The LPN stated that sometimes residents have to wait to get their showers until we get more linen but that they don't go without. An interview was conducted with the DON (director of nursing)/staff #56 on February 23, 2018 at 10:31 a.m. The DON stated that she communicated with the housekeeping manager/staff #158 to ensure there were enough towels and washcloths. The DON stated that sometimes it was a timing issue as to when	F 584		

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F 584	Continued From page 5 laundry delivered the linen to the units. The DON stated that if staff come to me if they can't find linen I get them some. The DON further stated that there were linen rooms on each hallway that had surplus linen stored. An immediate tour was conducted with the DON to determine how much linen was available in the linen rooms on each hallway. The linen rooms on C2, B2, A2, B1, and A1 hallways did not have any towels or washcloths available for resident use. The linen room on the C1 hallway had 8 hand towels, 6 washcloths and 4 bath towels. An interview was conducted with an LPN/staff #125 on February 23, 2018 at 1045 a.m. The LPN stated that it's a problem, we always have to go find linen. I know the CNA's have been using wipes because they don't have enough washcloths and towels. Multiple resident interviews were conducted on February 23, 2018. Most all of the residents interviewed stated they received their scheduled showers and staff were able to locate towels and washcloths for their showers. One resident stated that sometimes staff ran out of towels and then they used a blanket to dry him after his shower. The resident further stated that he didn't care as long as staff dried him with something. An interview was conducted with the DON/staff #56 on February 23, 2018 at 2:09 p.m. The DON stated that the facility did not have a policy on how much linen the facility should have.	F 584		
F 732	Posted Nurse Staffing Information	F 732		

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AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

(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) F732	(X5) COMPLETION DATE
F 732 SS=B	Continued From page 6 CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 732	**How corrective action will be accomplished for those residents found to have been affected by deficient practice.** The nurse Staffing information is updated and posted daily. The information will be current and updated as needed. **How facility will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.** All residents have the potential to be affected. The DON/designee will educate regarding posting to ensure the information is current and posted before the start of the shift. **How facility plans to monitor its performance to make sure solutions are sustained.** Random audits at least 2x weekly will be completed to ensure posting are available daily, including weekends. Findings will be reviewed in QAPI meeting monthly for a minimum of 3 months or until QAPI team determines a lesser frequency is deemed necessary. **Date of completion:** 2/24/2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035099	A. BUILDING _____ B. WING _____	C 02/23/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AVALON SOUTHWEST HEALTH & REHABILITATION	2900 EAST MILBER STREET TUCSON, AZ 85714

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F 732	Continued From page 7 This REQUIREMENT is not met as evidenced by: Based on staff interviews, review of facility documentation, and review of facility policies and procedures, the facility failed to ensure that nurse staffing information was posted on the weekends. Findings include: A review of the facility's Daily Staff Posting from February 9 through 23, 2018 was conducted on February 23, 2018. Further review of the Daily Staff Postings revealed no evidence that staffing information was posted on the weekends. An interview was conducted with the staffing coordinator/staff #106 on February 23, 2018 at 9:30 a.m. The staffing coordinator stated that he only posted nurse staffing information Monday through Friday and not on the weekends. An interview was conducted with the administrator/staff #6 on February 23, 2018 at 10:00 a.m. The administrator stated that he just heard that nurse staffing information was not posted on the weekends but that it will be from now on. A review of the facility's policy Posting Direct Care Staffing Numbers documented "Our facility will post, on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents..."	F 732		

AVALON SOUTHWEST
HEALTH & REHAB

March 12, 2018

RECEIVED
MAR 13 2018
BY:

Ms. Diane Eckles, Bureau Chief
Bureau of Long Term Care Licensing
150 N. 18th Ave., Ste. 440
Phoenix, AZ 85007-3242

Dear Ms. Eckles:

Enclosed please find our Plans of Correction for the complaint survey that was conducted at Avalon Southwest Health & Rehab on February 23, 2018. Both the state and the federal plans of correction are enclosed. Please accept these plans of correction as our credible allegation of substantial compliance effective 2-24-2018.

Please contact me if you have any questions.

Sincerely,

William P. Amoureux, Administrator
Avalon Southwest Health & Rehab

RECEIVED
MAR 13 2018
By

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

March 07, 2018

William Amoureux, Administrator
Avalon Southwest Health & Rehabilitation
2900 East Milber Street
Tucson, AZ 85714

Re: Complaint Intake #AZ00146777
Investigation # OUUM11

Dear Mr. Amoureux:

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