

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: UB6E11

Facility ID: LTC0053

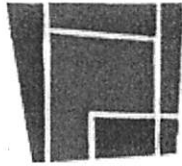
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|---|--|--|--|---|--|--|
| 1. MEDICARE/MEDICAID PROVIDER NO. (L1) 035099 | | 3. NAME AND ADDRESS OF FACILITY (L3) SAPPHIRE OF TUCSON NURSING AND REHAB, LLC (L4) 2900 EAST MILBER STREET (L5) TUCSON, AZ (L6) 85714 | | | 4. TYPE OF ACTION: <u>9</u> (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other 8. Full Survey After Complaint | |
| 2. STATE VENDOR OR MEDICAID NO. (L2) 835118 | | 7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7) 01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA 02 SNF/NF/Dual 06 PRIF 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) | |
| 5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) | | 6. DATE OF SURVEY (L34) | | | | |
| 8. ACCREDITATION STATUS: (L10) 0 Unaccredited 1 TJC 2 AOA 3 Other | | 10. THE FACILITY IS CERTIFIED AS: X A. In Compliance With Program Requirements Compliance Based On: <u>1. Acceptable POC</u> B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A* (L12) | | | And/Or Approved Waivers Of The Following Requirements: <u>2. Technical Personnel</u> 6. Scope of Services Limit <u>3. 24 Hour RN</u> 7. Medical Director <u>4. 7-Day RN (Rural SNF)</u> 8. Patient Room Size <u>5. Life Safety Code</u> 9. Beds/Room | |
| 11. LTC PERIOD OF CERTIFICATION From (a): To (b): | | 12. Total Facility Beds (L18) | | | 13. Total Certified Beds (L17) | |
| 14. LTC CERTIFIED BED BREAKDOWN | | | | | 15. FACILITY MEETS | |
| 18 SNF (L37) | | 18/19 SNF (L38) | | 19 SNF (L39) | | |
| ICF (L42) | | IID (L43) | | 1861 (e) (1) or 1861 (j) (1): YES (L15) | | |

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
An abbreviated infection control survey for Sapphire of Tucson Nursing and Rehab Event ID: #UB6E11 was conducted on 7/16/2020. No deficiencies were found at the time of the inspection.

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| 17. SURVEYOR SIGNATURE <u>for Julie Mortensen, Surveyor</u> Date: 07/20/2020 (L19) | 18. STATE SURVEY AGENCY APPROVAL <u>Daniel Cleman</u> Date: 07/20/2020 (L20) |
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

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|---|--|--|--|--|--|
| 19. DETERMINATION OF ELIGIBILITY <u>X</u> 1. Facility is Eligible to Participate <u> </u> 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: <u> </u> | |
| 22. ORIGINAL DATE OF PARTICIPATION (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) <u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure 05-Fail to Meet Health/Safety 02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal <u>OTHER</u> 07-Provider Status Change 00-Active | |
| 28. TERMINATION DATE: (L28) | | 29. INTERMEDIARY/CARRIER NO. 00000 (L31) | | 30. REMARKS | |
| 31. RO RECEIPT OF CMS-1539 (L32) | | 32. DETERMINATION OF APPROVAL DATE (L33) | | DETERMINATION APPROVAL | |



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

July 20, 2020

Receipt of This Notice is Presumed To Be 07/20/2020
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 **July 16, 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 State 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\dc

Attachments

ADHS LICENSING SERVICES

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|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2643 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED 07/16/2020 |
|--|---|---|---|

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|---|--|
| NAME OF PROVIDER OR SUPPLIER SAPPHIRE OF TUCSON NURSING AND REHAE | STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
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| Y 000 | <p>Initial Comments</p> <p>An onsite Infection Control focused survey was conducted on July 16, 2020. No deficiencies were cited.</p> | Y 000 | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE



Notice of Inspection Rights

Facility/Agency Name: Sapphire Of Tucson Nursing And Rehab, Llc

Address: 2900 East Milber Street City: Tucson Zip: 85714

Facility I.D.#: LTC0053 License #: NCI-2643 Medicare #: 035099 Date of Inspection: July 16, 2020

Survey Event ID: UB6E11

Inspector/Team Coordinator: Julie Mortensen

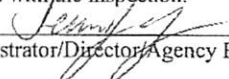
Accompanied By: Michelle Yeager

BUREAU OF LONG TERM CARE LICENSING

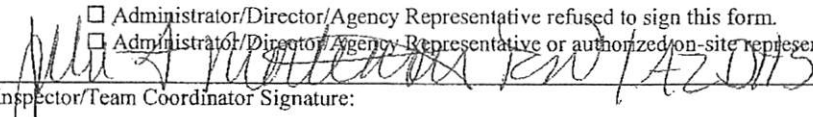
This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
 - Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
 - Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.


7-16-20
 Administrator/Director/Agency Representative Signature Date:

Administrator/Director/Agency Representative refused to sign this form.
 Administrator/Director/Agency Representative or authorized on-site representative is not present.


7-16-20
 Inspector/Team Coordinator Signature Date:

Copy left with Administrator/Director/Agency Representative