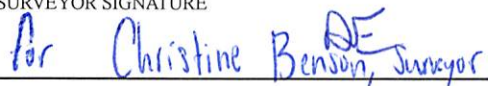
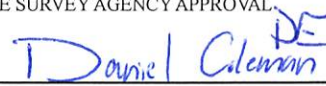


MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7E9011

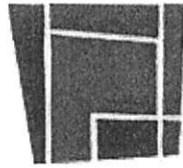
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0222

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 035288		3. NAME AND ADDRESS OF FACILITY (L3) COPPER HEALTH ORO VALLEY			4. TYPE OF ACTION: <u>9</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2)		(L4) 1119 EAST RANCHO VISTOSO BLVD			1. Initial	
		(L5) ORO VALLEY, AZ (L6) 85755			2. Recertification	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>04</u> (L7)			3. Termination	
6. DATE OF SURVEY (L34)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			4. CHOW	
8. ACCREDITATION STATUS: ___ (L10)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			5. Validation	
0 Unaccredited 1 TJC		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			6. Complaint	
2 AOA 3 Other		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			7. On-Site Visit	
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:			8. Full Survey After Complaint	
From (a):		X A. In Compliance With			FISCAL YEAR ENDING DATE: (L35)	
To (b):		Program Requirements				
		Compliance Based On:				
12.Total Facility Beds (L18)		___ 1. Acceptable POC				
13.Total Certified Beds (L17)		B. Not in Compliance with Program				
		Requirements and/or Applied Waivers: * Code: A* (L12)				
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 Copper Health Oro Valley Event ID: #7E9011 was conducted on 5/20/2020. No deficiencies were found at the time of the inspection.						
17. SURVEYOR SIGNATURE			Date :		18. STATE SURVEY AGENCY APPROVAL	
			05/29/2020 (L19)			
					Date: 05/29/2020 (L20)	

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)	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate				2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)	
<input type="checkbox"/> 2. Facility is not Eligible (L21)				3. Both of the Above : _____	
22. ORIGINAL DATE OF PARTICIPATION (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		26. TERMINATION ACTION: (L30)	
		24. LTC AGREEMENT ENDING DATE (L25)		<u>VOLUNTARY</u> <u>00</u> <u>INVOLUNTARY</u>	
				01-Merger, Closure	
				02-Dissatisfaction W/ Reimbursement	
				03-Risk of Involuntary Termination	
				04-Other Reason for Withdrawal	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		<u>OTHER</u>	
		A. Suspension of Admissions: (L44)		05-Fail to Meet Health/Safety	
		B. Rescind Suspension Date: (L45)		06-Fail to Meet Agreement	
28. TERMINATION DATE:		29. INTERMEDIARY/CARRIER NO. 00000		07-Provider Status Change	
		(L28) (L31)		00-Active	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE (L33)		30. REMARKS	
				DETERMINATION APPROVAL	



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

May 29, 2020

Receipt of This Notice is Presumed To Be 05/29/2020
Important Notice - Please Read

Fred Randolph, Administrator
Copper Health Oro Valley
1119 East Rancho Vistoso Blvd
Oro Valley, Arizona 85755

Dear Mr. Randolph:

On **May 20, 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; **please sign and return the original** and 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

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

PRINTED: 05/29/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035288	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/20/2020
NAME OF PROVIDER OR SUPPLIER COPPER HEALTH ORO VALLEY			STREET ADDRESS, CITY, STATE, ZIP CODE 1119 EAST RANCHO VISTOSO BLVD ORO VALLEY, AZ 85755		
(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 focused infection control survey was conducted on May 20, 2020. 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.