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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: MBOZ

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0195

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **035258**
2. STATE VENDOR OR MEDICAID NO. (L2) **544032**
3. NAME AND ADDRESS OF FACILITY (L3) **HACIENDA NURSING FACILITY** (L4) **1402 EAST SOUTH MOUNTAIN AVENUE** (L5) **PHOENIX, AZ** (L6) **85040**
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 **12/13/2017** (L34)
7. PROVIDER/SUPPLIER CATEGORY **02** (L7)
   01 Hospital; 02 SNF/NF/Dual; 03 SNF/NF/Distinct; 04 SNF; 05 HHA; 06 PRTF; 07 X-Ray; 08 OPT/SP; 09 ESRD; 10 NF; 11 ICF/IID; 12 RHC; 13 PTIP; 14 CORF; 15 ASC; 16 HOSPICE; 22 CLIA
8. ACCREDITATION STATUS: __ (L10)
   0 Unaccredited; 1 TJC; 2 AOA; 3 Other
FISCAL YEAR ENDING DATE: (L35) **06/30**
11. LTC PERIOD OF CERTIFICATION
   From (a):
   To (b):
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: * Code: **A1*** (L12)
   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
12. Total Facility Beds **74** (L18)
13. Total Certified Beds **74** (L17)
14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	74			
(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):
Hacienda Nursing Facility found to be out of compliance with federal regulations based on an annual survey conducted on 12/13/207. 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 01/25/2018. State Agency recommended recertification.
17. SURVEYOR SIGNATURE DE Team Leader Date: 01/25/2018 (L19)
18. STATE SURVEY AGENCY APPROVAL DE Date: 01/25/2018 (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 **12/04/2000** (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. **03001** (L31)
30. REMARKS
31. RO RECEIPT OF CMS-1539 (L32)
32. DETERMINATION OF APPROVAL DATE (L33)
DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

January 25, 2018

Mr. Brian Henrie,
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Re: Provider Number 035258

Dear Mr. Henrie:

Your facility has just received its recertification survey for the Federal Title XVIII (Medicare) and Federal Title XIX (Medicaid/AHCCCS) program.

The facility's Medicare/Medicaid provider Agreement will be continuous, unless you are contacted by our Office or the Centers for Medicare/Medicaid Services to the contrary.

You should keep a copy of this notice with your signed provider agreement.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/bh

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

January 25, 2018

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Dear Mr. Henrie:

On December 13, 2017, a survey 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 12/27/2017 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 for Civil money penalty, effective December 13, 2017
Recommendation to CMS for 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

January 25, 2018

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Dear Mr. Henrie:

On January 25, 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 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.

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
	035258	A. BUILDING _____ B. WING _____	R 01/25/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 offsite Federal recertification and complaint investigation survey was conducted on January 25, 2018, 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.

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
035258 Y1	A. Building B. Wing Y2	1/25/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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 F0550	Correction	ID Prefix F0641	Correction	ID Prefix F0658	Correction
Reg. # 483.10(a)(1)(2)(b)(1)(2)	Completed	Reg. # 483.20(g)	Completed	Reg. # 483.21(b)(3)(i)	Completed
LSC	01/25/2018	LSC	01/25/2018	LSC	01/25/2018
ID Prefix F0755	Correction	ID Prefix F0812	Correction	ID Prefix F0838	Correction
Reg. # 483.45(a)(b)(1)-(3)	Completed	Reg. # 483.60(i)(1)(2)	Completed	Reg. # 483.70(e)(1)-(3)	Completed
LSC	01/25/2018	LSC	01/25/2018	LSC	01/25/2018
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
☒	DA	1/25/18	Dale Colon	1/25/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/13/2017

☐ 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

January 25, 2018

IMPORTANT NOTICE- PLEASE READ CAREFULLY

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Dear Mr. Henrie:

On January 12, 2018, an offsite **Life Safety Code/Emergency Preparedness,** revisit 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.

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,

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
	035258	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **01/12/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	**1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040**

(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 All noted deficiencies on the survey dated December 5, 2017, 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.

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
035258 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	1/12/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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 Reg. # NFPA 101 LSC K0211	Correction Completed 01/12/2018	ID Prefix Reg. # NFPA 101 LSC K0353	Correction Completed 01/12/2018	ID Prefix Reg. # NFPA 101 LSC K0920	Correction Completed 01/12/2018
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

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) RGR	DATE 1/12/18	SIGNATURE OF SURVEYOR [signature]	DATE 1/12/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/5/2017

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	R 01/12/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 All noted deficiencies on the survey dated December 5, 2017, 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.	{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
035258 Y1	A. Building B. Wing Y2	1/12/2018 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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 E0006 Reg. # 483.73(a)(1)-(2) LSC	Correction Completed 01/12/2018	ID Prefix E0024 Reg. # 483.73(b)(6) LSC	Correction Completed 01/12/2018	ID Prefix E0034 Reg. # 483.73(c)(7) LSC	Correction Completed 01/12/2018
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

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) PCR	DATE 1/12/18	SIGNATURE OF SURVEYOR [signature]	DATE 1/12/18
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/5/2017

☐ 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 12/27/2017 via email

December 27, 2017

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Dear Mr. Henrie:

On **December 13, 2017**, a Medicare 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 participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

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 **January 6, 2018**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by **January 6, 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.

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 **01/27/2018.**

If, upon a 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 continue 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, effective December 13, 2017

Mandatory Remedies

Your current period of noncompliance began on December 13, 2017. 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 06/13/2018.

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

03/13/2018. 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

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 **January 6, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	12/13/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 recertification survey was conducted on December 7 and 8, 2017 and from December 11 through 13, 2017, in conjunction with the investigation of Complaint #'s AZ00138194, AZ00140358 and AZ00144673. The following deficiencies were cited:	F 000		
F 550 SS=E	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.	F 550	F550 - SNF employees will treat residents with dignity and respect and protect and promote the rights of the resident. Staff #248 and #251 have been counseled on privacy during showering residents. All direct care staff will be in-serviced on Bathing with Dignity.The in-service will be completed by 1/22/2018 A ten percent sampling of the resident census witll be interviewed monthly by Teresa Dunlap, Nursing Qualtiy Assurance, to ensure that their dignity is being maintained during showering. Results of this interview will be doucmented and reviewed durng the monthly QAPI meeting (Attachment 1) RECEIVED JAN - 9 2018 By	12/28/2017

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

LNHA | 1/8/18

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 550	Continued From page 1 §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on clinical record review, resident and staff interviews and policy review, the facility failed to ensure one resident (#28) was treated in a dignified manner during the provision of showers. Findings include: Resident #28 was admitted to the facility on May 2, 2016, with diagnoses that included quadriplegia, trachea placement, ventilator dependence and anxiety. Review of the October 31, 2017 Minimum Data Set assessment revealed the resident was assessed to have a Brief Interview for Mental Status score of 15, which indicated there was no cognitive impairment. During an interview conducted with a Certified Nursing Assistant (CNA/staff #248) on December 11, 2017 at 8:14 a.m., she stated that she knows the resident well and has cared for him on many occasions. She stated that one day in November 2017, she was assisting the resident with a shower. She stated the resident's shower room is	F 550		

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F 550	Continued From page 2 between two adjoining resident rooms and there are two separate doors to enter and exit. Staff #248 stated she was giving the resident a shower, when another CNA entered the room and just wanted to talk with her. This CNA had full visual view of the resident, who was nude. She further stated that other staff enter and exit the shower rooms while residents are being showered. She stated it has now become a bad habit and is a dignity problem. She said that it would be degrading for a resident to have staff come and go, while a shower is being given. An interview was conducted with resident #28 on December 12, 2017 at 8:34 a.m. He stated that many staff have entered the shower room, while he was being given a shower and that it made him feel uncomfortable. He stated that he does not know why staff come and go in the shower room, when he does not have any clothes on. He stated it has happened on many occasions. An interview was conducted with a CNA (staff #251) on December 12, 2017 at 9:18 a.m. She stated that she has gone into the shower room while a resident was being showered, even though she was not asked to assist. She stated she has observed many staff enter a shower room, while a resident was being showered to either get to the adjoining room, or get some supplies (urinals) or dispose of something in the waste containers that are often stored in the shower rooms. Staff #251 also stated that she thought residents would feel really uncomfortable with so many people coming and going, as residents are sometimes completely nude when this happens. She stated this would be a dignity problem.	F 550		

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F 550	Continued From page 3 An interview was conducted with the Director of Nursing (staff #69) on December 12, 2017 at 10:41 a.m. She stated that staff had been entering the shower rooms to either get supplies, throw something into the waste receptacle, or use the shower area to get from one resident room to another. According to a facility policy regarding Quality of life-Dignity the following was included: Each resident shall be cared for in a manner that promotes and enhances quality of life and dignity. A policy regarding resident rights included that employees shall treat all residents with dignity. Federal and State laws guarantee certain basic rights to all residents of this facility and they include the right to a dignified existence and to be treated with dignity. Another policy regarding Employee-Resident interactions included that employees will contribute to the well-being of all residents by treating residents with dignity.	F 550		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews, Resident Assessment Instrument (RAI) manual, and policy and procedures, the facility failed to ensure the Minimum Data Set (MDS) assessments for two residents (#'s 15 and 31) were accurate.	F 641	Assessmets will accurately reflect the residents status. The MDS Nurse has sumbitted a correction to resident #15 and #31 section N of the MDS to accurately reflect the clients current medications An audit of Section N has been completed by the MDS/ Care Plan Nurse.Corrections have been made to section N of the MDS on all clients who are on Aspirin and/ or Melatonin to accurately reflect the classification of the medication. The MDS Nurse will be in-serviced on section N of the MDS. This in-service will be completed by 1/22/2018. A monthly audit of Section N will be completed monthly by Roxanne Rose, SNF Director of Nursing, on ten percent of the resident census. Audit results will be reviewed in the monthly QAPI meeting. (Attachment 2)	12/28/2017

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F 641	Continued From page 4 -Resident #15 was admitted on April 4, 2011, with diagnoses that included midbrain strokes and a subarachnoid hemorrhage. Review of the July and October 2017 MDS assessments revealed in Section N, Medications that the resident was assessed to have been administered an anticoagulant medication in the designated look back time period. Review of the physician's orders and medication records from July through December 2017 revealed the resident was receiving aspirin (non steroidal anti-inflammatory) 81 mg daily. However, there were no orders for any anticoagulant medications. An interview was conducted with the MDS nurse (staff #136) on December 11, 2017 at 10:41 a.m. She stated she had recently learned that aspirin was not considered an anti-coagulant and therefore, the MDS assessments for July and October 2017 were inaccurate. An interview was conducted with the Director of Nursing (staff #69) on Dec 12, 2017 at 10:41 a..m. She stated that she had no knowledge the MDS nurse had been coding aspirin as an anticoagulant on the MDS assessments. Staff #69 stated that the MDS assessments need to be accurate. -Resident #31 was admitted on March 31, 2014, with diagnoses that included respiratory failure, diabetes, endocrine abnormalities and panhypopituitarism. A quarterly MDS assessment dated November	F 641		

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F 641	Continued From page 5 11, 2017 included in Section N that the resident received 7 days of a hypnotic medication during the 7 day look back period. Review of the physician's orders for October and November 2017 revealed there were no hypnotic medications ordered. In addition, there was no documentation on the Medication Administration Record (MAR) from October 30 through November 5, 2017 that the resident received any hypnotic medications. An interview was conducted with the MDS nurse (staff #136) on December 12, 2017 at 11:10 a.m. She stated that to complete Section N of the MDS, she looks at the MAR and counts back 7 days from the assessment reference date (ARD) to determine how many times the resident received a specific medication. At this time, she reviewed the MAR and stated the resident received the hypnotic Melatonin (a dietary supplement which helps to maintain normal sleep patterns) for 7 days. She stated that on the MDS, they are to mark the medications based on their drug classification and not how it is being used. After looking up the medication electronically, she stated that Melatonin should not have been marked on the MDS as a hypnotic, as the medication is not classified as a hypnotic. An interview was conducted with the Director of Nursing (DON/staff #69) on December 12, 2017 at 1:09 p.m. She stated that the MDS nurses are to use the facility policy and the Resident Assessment Instrument (RAI) manual for direction in completing the MDS. She stated that the MDS should accurately reflect the resident's current status and care.	F 641		

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F 641	Continued From page 6 A review of Section N in the RAI manual indicated that when coding a hypnotic in the MDS, record the number of days a hypnotic medication was received by the resident at any time during the 7-day look-back period. It was further noted to code medications according to the medication's therapeutic category and/or pharmacological classification, not how it is used. The manual continued with the direction that herbal and alternative medicine products are considered to be dietary supplements by the Food and Drug Administration and should not be counted as medications. The RAI manual also included the importance of accurately completing and submitting the MDS assessment cannot be over emphasized. The MDS assessment is the basis for the development of an individualized care plan. According to a facility policy titled Certifying Accuracy of the Resident Assessment, all personnel who complete any portion of the MDS must sign and certify the accuracy of that portion of the assessment.	F 641		
F 658 SS=E	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to ensure one	F 658	Services provided will meet professional standards. The staff nurses who noted the Physician Orders for resident #13 have been counseled for services not meeting professional standards. Lantus 54 units subcutaneously at bedtime for diabetes has been added to the Physician Ordes for resident #13. An audit has been completed on all resident Physician Orders to ensure that ordered medications are on the Residents Medication Administration Record. An in-service will be completed for all SNF nurses on noting Physician Orders.This in-service will be completed by 1/26/2018. A monthly audit will be completed on a ten percent resident sampling of Physician Orders and the Medication Administration Record. This audit will be completed by Teresa Dunlap, Nursing Quality Assurance and the results will be reviewed in the monthly QAPI meeting. (Attachment 3)	12 /22/2017

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F 658	Continued From page 7 resident (#13) had physician orders for insulin. Findings include: Resident #13 was readmitted to the facility on December 1, 2017, with diagnoses that included ALS (amyotropic lateral sclerosis), diabetes and encephalopathy. Review of the resident's discharge orders from the hospital included for insulin gargine (Lantus) 54 units subcutaneous daily at bedtime A care plan dated December 7, 2017 included the resident had diabetes mellitus and was insulin dependent, with a potential for complications related to low blood sugar. Interventions included to administer gargine insulin as ordered and to perform accuchecks as ordered. However, review of the admission physician's orders revealed there were no orders for insulin. The admission orders were signed by the physician and two nurses. Review of the MAR (Medication Administration Record) for December 2017 revealed the following documentation: Lantus insulin 54 units subcutaneously at bedtime for diabetes. The documentation also showed that the resident was administered the insulin from December 1, through December 11. An interview was conducted with a registered nurse (RN/staff #141) on December 12, 2017 at 9:21 a.m. After reviewing the MAR, she stated the resident has been receiving insulin. Staff #141 stated that when a resident returns from the hospital, their discharge orders are compared to	F 658		

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F 658	Continued From page 8 their previous orders and the physician should be notified. She stated it is then up to the physician to approve the orders. In an interview with the Director of Nursing (DON/staff #69) on December 12, 2017 at 2:16 p.m., she stated that the insulin was not on the current physician's orders. She stated the computer system they use to print the MARs is based on the physician orders, so she was unsure as to how the order got printed on the MAR, when it was not on the physician orders. Review of a facility policy regarding Medication Orders revealed "Medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications in this state."	F 658		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed	F 755	Controlled substances will be accurately reconciled for all residents. Staff #184 has been counseled on proper documentation of Controlled Substances. The controlled substances log has been reconciled for resident #39 and #248. An audit has been completed on all SNF residents' controlled substance logs and documentation has been deemed accurate. An in-service will be completed for all SNF nurses on Controlled Substance Documentation. This in-service will be compelted by 1/26/2018. A monthly audit of the Controlled Substance Log will be completed by Roxanne Rose, SNF Director of Nursing, on ten percent of the resident census.Audit results will be reviewed in the monthly QAPI meeting. (Attachment 4)	12/22/2017

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F 755	Continued From page 9 pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record reviews, facility documentation, staff interviews and policy review, the facility failed to ensure that controlled substances were accurately reconciled for two residents (#39 and #248). Findings include: -Resident #39 was admitted on August 14, 2017, with diagnoses that included acquired encephalopathy, profound mental retardation and spastic quadriplegic cerebral palsy. Review of the physician's orders for October 2017 revealed an order for Clorazepate (sedative) 3.75 milligram (mg) tablet via gastrostomy tube every day for seizures. A review of the individual controlled substance record for Clorazepate 3.75 mg was conducted on December 8, 2017 at 12:31 p.m., with a Licensed Practical Nurse (LPN/staff #184) present. Per the individual controlled substance	F 755		

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F 755	Continued From page 10 record, 6 tablets remained of the Clorazepate 3.75 mg. However, an observation was then conducted of the medication card for Clorazepate 3.75 mg, which revealed there were 5 tablets remaining. -Resident #248 was admitted on November 15, 2017, with diagnoses that included dysphagia, gastrostomy tube, asthmaticus and severe encephalopathy. Review of the physician's orders for December 2017 revealed orders for Clobazam (sedative) 10 mg by mouth each morning for seizures and Clonazepam 1 mg by mouth 2 times daily for seizures. A review of the individual controlled substance records for Clobazam 10 mg and Clonazepam 1 mg tablet was conducted on December 8, 2017 at 12:31 p.m., with staff #184. Per the individual controlled substance record for Clobazam 10 mg, 19 tablets remained. However, an observation was then conducted of the medication card for Clobazam 10 mg, which revealed there were 18 tablets remaining. Per the individual controlled substance record for Clonazepam 1 mg, 3 tablets remained. However, according to the medication card for Clonazepam 1 mg revealed there were 2 tablets remaining. According to the Medication Administration Records for December 2017, the above medications were documented as being given at	F 755		

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F 755	Continued From page 11 8 a.m. on December 8, to both residents. An interview was conducted with a LPN (staff #184) during the above observation. He stated that he gave the scheduled medications at 8:00 a.m. on December 8, but he did not sign the medications out on the individual controlled substance records when he gave the medications to the residents. Another interview was conducted by telephone with staff #184 on December 12, 2017 at 9:00 a.m. He stated the medications should have been signed out on the controlled substance form, when they were administered. Staff #184 stated that he did not follow their policy, as he gave the medications and did not sign them out. An interview was conducted with the Director of Nursing (DON/staff #69) on December 12, 2017 at 1:04 p.m. She stated that when nurses give a controlled substance they are to sign out the medication on the controlled substance record at the time that they dispense the medication. She stated that it is never okay to wait until later in the shift to sign out the medication on the control substance record. Review of a facility policy regarding Controlled Substances revealed that nurses are to sign out controlled substances on the controlled substance record, when the controlled substance is removed.	F 755		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must -	F 812	The facility will procure food from sources approved or considered satisfactory by federal, local and state authorities. Employee #179 has been counseled on proper handling of resident's food. Employee #105 has been counseled on proper food preperation to prevent contamination. All Nurses and CNA staff will be in-serviced on the proper way to prepare and handle resident's food. This in-service will be completed by 1/26/2018.	12/28/2017

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 812	Continued From page 12 §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and policy review, the facility failed to ensure that staff did not touch ready to eat foods with their bare hands, and failed to ensure that a clean scoop was used in preparing pureed food. Findings include: -During a dining observation conducted on December 7, 2017 at 12:05 p.m., a licensed practical nurse (LPN/staff #179) was observed touching a resident's bread stick with her bare hands, while buttering it. An interview was conducted with staff #179 on December 12, 2017 at 12:43 p.m. She stated that she did touch the breadstick with her bare hands. Staff #179 stated that as long as she washed her hands, it should be fine to touch the food. She stated that she had washed her hands before	F 812	All dietary staff will be in-serviced on the proper food preperation to prevent contamination. This in-service will be completed by 1/26/2018. A monthly audit will be completed on a ten percent resident sampling of residents needing assistance with their food tray and on the preperation of client meals. This audit will be completed by Rosa Belcher, Infection Prevention, and the results will be reviewed in the monthly QAPI meeting. (Attachment 5)	

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HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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F 812	Continued From page 13	F 812		

delivering the tray to the resident, but since she had touched the tray, her hands were probably no longer clean. Staff #179 stated that she was not aware of the need to wear gloves when touching ready to eat foods. She further stated that she does not recall the policy on touching ready to eat foods.

An interview was conducted with a licensed nursing assistant (LNA/staff #206) on December 12, 2017 at 12:48 p.m. She stated that they wear gloves if they need to touch the food, as they can not touch the resident's food, with their bare hands.

An interview was conducted with a LPN (staff #175) on December 12, 2017 at 12:52 p.m. She stated that she would use gloves if she needed to touch a resident's food. She stated that she would not touch ready to eat foods, with her bare hands.

An interview was conducted with the Director of Nursing (DON/staff #69) on December 12, 2017 at 1:00 p.m. She stated that it is not okay to touch any resident's food with bare hands and that gloves should be worn if touching food.

Review of the handwashing and glove use policy revealed that gloves must be worn when touching any ready to eat food.

-An observation of the kitchen was conducted on December 12, 2017 at 10:22 a.m. The cook (staff #105) was observed preparing puree foods. During the observation, staff #105 was noted to take a scoop that was on a shelf which stored spices and used the scoop to obtain some powered thickener, which was in a can. Staff #105 then added the thickener to the pureed

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F 812	Continued From page 14 food. The shelf was observed to have residue from the dried spices on the surface. An interview was conducted immediately following the observation with staff #105. She stated that in preparing food, she should get a scoop from the clean utensil bin. She stated that the scoop she used for the thickener was not clean, as it was placed on an unclean surface. Immediately following the interview with the cook, the Dietary Manager (staff/#290) stated that if something is placed on an unclean surface it should not be reused until it is washed. He stated that this practice is to prevent contamination of the food.	F 812		
F 838 SS=E	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population	F 838	The facility will conduct and doucment what resources are necessary to care for it's residents competently. The facility assessment will be updated to inculde information reagrding the facility's operating budget, supplies, equipment and other services necessary to provide for the needs of the residents. It will also include all personnell, managers, staff (both employees and those who provide services under contract) and volunteers. The assessment will be completed by the SNF Administrator, Brian Henrie and Director of Nursing, Roxanne Rose by 1/22/2018 and reviewed in the next QAPI meeting.	1/22/2018

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 838	Continued From page 15 considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an	F 838		

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F 838	Continued From page 16 all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on facility documentation and staff interview, the facility failed to conduct a facility wide assessment, which included the facility's resources regarding the operating budget, supplies, and equipment which are necessary to care for residents competently during day to day operations and emergencies. Findings include: An entrance conference was conducted on December 7, 2017 at 8:30 a.m. At this time, a copy of the facility assessment was requested from the Director of Nursing (DON/staff #69). Review of the facility assessment was conducted on December 8, 2017. The assessment lacked information regarding the facility's operating budget, supplies, equipment and other services necessary to provide for the needs of residents. In addition, the assessment failed to include all personnel, managers, staff (both employees and those who provide services under contract) and volunteers. An interview was conducted with the Administrator (staff #286) on December 12, 2017 at 1:18 p.m. He stated that he had overlooked the instructions for determining the facility's resources. Regarding the lack of staffing information, he stated that he thought he was only to include the supervisory personnel. A policy was requested regarding the Facility Assessment, however, staff #286 stated they did not have a policy for this.	F 838		

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ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed on 12/27/2017 via email

December 27, 2017

Mr. Brian Henrie,
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Dear Mr. Henrie:

On December 5, 2017, 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.

This survey found the most serious deficiency(ies) in your facility to be isolated 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 (D).

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 **January 6, 2018**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **January 6, 2018**, 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 **01/27/2018.**

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 December 5, 2017

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 December 5, 2017. 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 06/13/2018.

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: 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.**

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 **January 6, 2018**, 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

Attachments

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed 12/27/2017 via email

December 27, 2017

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, Arizona 85040

Dear Mr Henrie:

On December 5, 2017, a Emergency Prepardness 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 **January 6, 2018.** You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **January 6, 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.

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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.

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Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\SG

Attachments

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
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HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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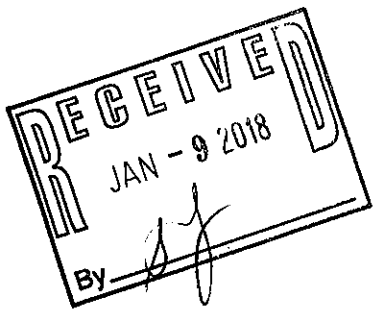
K 000	INITIAL COMMENTS 42CFR 483.70 (a) Nursing Homes The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association. This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing of a Skilled Nursing Facility under Health Care. The entire skilled nursing facility and basement was surveyed. The facility meets the standards based upon acceptance of a plan of correction.	K 000		
K 211 SS=D	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to maintain a safe exit access from the area of refuge from the second floor to the first floor. NFPA 101, Life Safety Code, 2012, Chapter 19, Section 19.2.1 "Every aisle, passageway, corridor, exit discharge, exit location, and access	K 211	The facility will ensure that aisles, passageways, corridors, exit discharges, exit locations, and accessess are clear and free from obstruction. The stairwell has been cleared and lockers and lock cabinets have been relocated. An in-service will be conducted with the Maintenance department staff regarding the need for aisles, passageways, corridors, exit discharges, exit locations, and accessess are clear and free from obstruction. This in-service will be completed by 1/26/2018. A weekly audit will be conducted by Dave Mills, Environmental Services Director to ensure that pathways and stairwells remain clear and free from obstruction. This audit will be reviewed during the monthly QAPI meeting. (Attachment 1)	12/22/2017

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

LNHA 1/8/18

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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K 211	Continued From page 1 shall be in accordance with Chapter 7. Chapter 7 Section 7.2.2.5 Enclosures and Protection of Stairs, Section 7.2.2.5.3 Usable Space. Enclosed usable spaces within exit enclosures shall be prohibited, including under stairs, unless otherwise permitted by 7.2.2.5.3.2. Section 7.2.2.5.3.2 Enclosed usable space shall be permitted under stairs provided that both of the following are met. (1) The usable space shall be separated from stair enclosure by the same fire resistance as the exit enclosure. (2) Entrance to the enclosed usable space shall not be from within the stair enclosure. (See 7.1.3.2.3) Section 7.1.3.2.3 An exit enclosure shall not be used for any purpose that has potential to interfere with its use as an exit and if so designated as an area of refuge. On December 05, 2017 the surveyors, accompanied by the Administrator, Director of Maintenance and Director of Nursing observed the main exit egress from the second floor to the first floor had wooden locker cabinets and metal locker cabinets being stored in the atrium portion (area of refuge) of the stairwell. During the exit conference on December 05, 2107 the above findings were again acknowledged by the Administrator, Director of the Maintenance and Director of Nursing. Failure to provide a clear and unimpeded means of egress could cause harm to the patients and staff in a fire emergency.	K 211		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing	K 353	Sprinkler system will be maintained and tested in accordance with NFPA 25. The sprinkler head in stairwell #2 has had the paint removed from it. In room #213 and the laundry room, the sprinkler heads have been cleaned and dusted.	12/22/2017

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K 353	Continued From page 2 Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the facility failed to maintain the sprinkler system, sprinkler heads free from paint and lint which are part of the entire sprinkler frame and assembly in three areas of the nursing home. NFPA 101 Life Safety Code, 2012 edition, Chapter 19, Section 19.3.5.1 "Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." Chapter 9, Section 9.7.1 "Each automatic sprinkler system required by another section of this Code shall be in accordance with on of the following." " NFPA 13, Standard for the Installation of Sprinkler Systems." Chapter 26, Section 26.1 "General." "A sprinkler system installed in accordance with standard shall be properly inspected, tested, and maintained by the	K 353	An in-service will be completed for all Maintenance staff regarding the maintaince of automatice sprinkler and stand pipe systems. This in-service will be completed by 1/26/2018. A weekly audit will be completed by Dave Mills, Environmental Services Director to ensure automatic sprinkler system is maintained. This audit will be reviewed in the monthly QAPI meeting. (Attachment 1)	

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HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 353	Continued From page 3 property owner or their authorized representative in accordance with NFPA 25. NFPA 25, Section 5.2.1 "Sprinklers, Section 5.2.1.1.1 "Sprinklers shall not show signs of leakage, shall be free of corrosion, foreign materials, paint and physical damage." Section 5.2.1.1.2 Any sprinkler that shows the signs of any of the following shall be replaced. 1. leakage 2. Corrosion 3. Physical damage 4. Loss of fluid in the glass bulb heat responsive element 5. * Loading See A.5.2.1.1.2 (5) In lieu of replacing sprinklers that are loaded with a coating of dust , it is permitted to clean sprinklers with compressed air or by a vacuum provided that the equipment does not touch the sprinkler. 6. Painting unless painted by the manufacturer. Section 5.2.1.1.4 Any sprinkler shall be replaced that has signs of leakage, is painted other than by the manufacturer, corroded, damaged, or loaded, is in the improper orientation. Annex E Examples of Classification of needed repairs Sprinklers and Escutcheon plates that are missing, painted or rusted. Findings Include: On December 05, 2017 the surveyor accompanied by the Assistant Director of maintenance observed sprinkler heads with dust/lint, paint on the sprinkler heads in the following locations: 1. Stairwell number two, paint on one sprinkler head. 2. Room 213 lint on the entire sprinkler head frame and assembly. 3. Main laundry lint on one sprinkler head frame and assembly.	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 353	Continued From page 4 During the exit conference on December 05, 2107 the above findings were again acknowledged by the Administrator, Director of the Maintenance and Director of Nursing. Failing to maintain the sprinkler heads and escutcheon plates which are part of the entire sprinkler assembly could cause harm to the residents by allowing a fire to spread before the temperature is reached to set of the sprinkler head.	K 353		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5	K 920	The facility will ensure proper use of power and extension cords. The extension cord in #214 was removed and TV was plugged in to an appropriate outlet.The power strip in the Admin office was removed and the A/C unit was plugged in to an appropriate outlet. An facility walk thru was completed to ensure the appropriate use of power strips and extension cords. A monthly audit will be conducted by Dave Mills, Environmental Service Director, to ensure the appropriate use of power strips and extension cords. The results of this audit will be presented in the monthly QAPI meeting. (Attachment 1)	12/22/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 920	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility allowed the use of a six way multiple outlet adapter for an air conditioner and an extension cord for a TV and appliances. These were not plugged directly into the wall receptacle outlets for all the appliances observed during the survey. NFPA 101, Life Safety Code, 2012. Chapter 2, Section 2.1 The following documents or portions thereof are referenced within this Code as mandatory requirements and shall be considered part of the requirements of this Code. Chapter 2 "Mandatory References" NFPA 99 "Standard for Health Care Facilities, " 2012 Edition. NFPA 99, Chapter 6, Section 6.3.2.2.6.2 , "All Patient Care Areas," Sections 6.3.2.2..6.2 (A) through 6.3.2.2.6.2 (E) Receptacles (2)" Minimum Number of Receptacles." "The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Findings include: On December 05, 2017 the surveyor, accompanied by the Assistant Maintenance staff observed the use of a six way multiple outlet adapter for an air conditioner in use in the Administrators office and an extension cord for a TV was in use in room 214. These were not plugged directly into the wall electrical receptacle outlets for all the appliances observed during the survey. During the exit conference on December 05,	K 920		

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
	035258	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

(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 920	Continued From page 6 2017 the above findings were again acknowledged by the Administrator, Director of the Maintenance and Director of Nursing. The use of multiple outlet adapters could create an overload of the electrical system and could cause a fire or an electrical hazard. A fire could cause harm to the patients.	K 920		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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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. The facility meets the standards, based on acceptance of a plan of correction	E 000	RECEIVED JAN - 9 2018 By	
E 006 SS=F	Plan Based on All Hazards Risk Assessment CFR(s): 483.73(a)(1)-(2) [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do the following:] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.* *[For LTC facilities at §483.73(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing residents. *[For ICF/IIDs at §483.475(a)(1):] (1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach, including missing clients. (2) Include strategies for addressing emergency events identified by the risk assessment.	E 006	The facility will develop and maintain an emergency preparedness plan. The emergency prepardness plan will include a community risk assessment. This assessment will be completed by Brian Henrie, SNF Administrator by 1/26/2018 and will be reviewed in the next QAPI meeting.	1/26/2018

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

LNHA — 1/8/18

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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E 006	Continued From page 1 * [For Hospices at §418.113(a)(2):] (2) Include strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility record review the facility failed to perform a community risk assessments prior to developing the facility's emergency plan. Findings include: On December 5, 2017 the surveyors, along with the Administrator, Director of the Maintenance and Director of Nursing reviewed the facility's Emergency Plan. The plan did not include risk assessments for the community in developing the facility's plan. During the exit conference on December 5, 2017, the above finding was again acknowledged by the Administrator, Director of the Maintenance and Director of Nursing. Failure to develop emergency plans based on community and facility risk assessments may cause harm to the residents during an emergency.	E 006		
E 024 SS=C	Policies/Procedures-Volunteers and Staffing CFR(s): 483.73(b)(6) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency	E 024	The facility will develop and implement an emergencypreparedness plan. This plan will include the policy and procedure for the use of volunteers in an emergency. This plan will be updated by Brian Henrie, SNF	1/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	12/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HACIENDA NURSING FACILITY	1402 EAST SOUTH MOUNTAIN AVENUE PHOENIX, AZ 85040

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E 024	Continued From page 2 plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (6) [or (4), (5), or (7) as noted above] The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of State and Federally designated health care professionals to address surge needs during an emergency. *[For RNHCIs at §403.748(b):] Policies and procedures. (6) The use of volunteers in an emergency and other emergency staffing strategies to address surge needs during an emergency. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to develop and implement policy and procedures for the use of volunteers in an emergency. Findings include: On December 5, 2017 the surveyors, along with the Administrator, Director of the Maintenance and Director of Nursingreviewed the facility's Emergency Plan. The plan did not include policies and procedures to address the use of volunteers in an emergency or other staffing strategies, including the use of State and Federally designated health care professional during an emergency.	E 024	Administrator and approved in the next QAPI meeting.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035258	A. BUILDING _____ B. WING _____	12/05/2017

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E 024	Continued From page 3 During the exit conference on December 5, 2017 the above finding was again acknowledged by the Administrator, Director of the Maintenance and Director of Nursing. Failure to address the use of volunteers in an emergency could adversely impact resident care during an emergency.	E 024		
E 034 SS=C	Information on Occupancy/Needs CFR(s): 483.73(c)(7) [(c) The [facility] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (7) [(5) or (6)] A means of providing information about the [facility's] occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For ASCs at 416.54(c)]: (7) A means of providing information about the ASC's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. *[For Inpatient Hospice at §418.113:] (7) A means of providing information about the hospice's inpatient occupancy, needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee. This REQUIREMENT is not met as evidenced by:	E 034	The facility will develop and maintain an emergency preparedness plan. This will include a method to show occupany levels, and facility needs to other faciliites or to the authority having jurisdiction or the incident command center. This will be updated by Brian Henrie, SNF Administrator by 1/26/2018 and will be reviewed in the next QAPI meeting.	1/26/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 034	Continued From page 4 Based on observation, staff interview and record review, the facility failed to develop a means to sharing information on occupancy and needs. Findings include: On December 5, 2017 the surveyors, along with the Administrator, Director of the Maintenance and Director of Nursing reviewed the facility's Emergency Plan. The Emergency Plan did not include a method to share occupancy levels and/or facility needs to other facilities or to the authority having jurisdiction or the Incident Command Center. During the exit interview on December 5, 2017, the above finding was again acknowledged by the Administrator, the Director of Nursing and the Director of Maintenance. Failure to develop a means to report occupancy levels and/or needs may result in residents not receiving care and services as needed.	E 034		

HACIENDA NURSING FACILITY
1402 EAST SOUTH MOUNTAIN AVENUE
PHOENIX, AZ 85040
State's Region Code: AZ

CCN: 035258
Phone Number: (602)243-4231
Participation Date: 12/04/2000

Provider Beds
Total: 74
Certified: 74

Provider Category: SNF/NF (DUAL)

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 - 11/10/2016

Prior 3 Survey 04/2013	S/S Code	Prior 2 Survey 06/2014	S/S Code	Prior 1 Survey 07/2015	S/S Code	Current Survey 10/07/2016	S/S Code	Plan/Date of Correction		Requirement
				X	E				REQ	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
									REQ	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
				X	D				REQ	F0157-NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
X	E								REQ	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
									REQ	F0271-ADMISSION PHYSICIAN ORDERS FOR IMMEDIATE CARE
									REQ	F0272-COMPREHENSIVE ASSESSMENTS
									REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
				X	D				REQ	F0280-RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP
X	D					X C	E	11/08/2016	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
X	D								REQ	F0282-SERVICES BY QUALIFIED PERSONS/PER CARE PLAN
									REQ	F0285-PASRR REQUIREMENTS FOR MI & MR
				X	D				REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
X	G								REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
X	D								REQ	F0315-NO CATHETER, PREVENT UTI, RESTORE BLADDER
X	D					X C	E	11/08/2016	REQ	F0318-INCREASE/PREVENT DECREASE IN RANGE OF MOTION
									REQ	F0319-TX/SVC FOR MENTAL/PSYCHOSOCIAL DIFFICULTIES
									REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
X	E								REQ	F0329-DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS
									REQ	F0334-INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS
						X C	E	11/08/2016	REQ	F0353-SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS
									REQ	F0372-DISPOSE GARBAGE & REFUSE PROPERLY
X	D					X C	E	11/08/2016	REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
						X C	D	11/08/2016	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
X	E								REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
X	E								REQ	F0492-COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF
									REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

HACIENDA NURSING FACILITY CCN: 035258

Prior 3 Survey 04/2013	S/S Code	Prior 2 Survey 06/2014	S/S Code	Prior 1 Survey 07/2015	S/S Code	Current Survey 10/07/2016	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0518-TRAIN ALL STAFF-EMERGENCY PROCEDURES/DRILLS
X	E					X C	E	11/08/2016	REQ	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 04/2013	S/S Code	2012 HC Prior 2 Survey 06/2014	S/S Code	2012 HC Prior 1 Survey 07/2015	S/S Code	2012 HC Current Survey 10/07/2016	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
									STD	K0133-Multiple Occupancies - Construction Type
									STD	K0271-Discharge from Exits
									STD	K0281-Illumination of Means of Egress
									STD	K0321-Hazardous Areas - Enclosure
		X	D						STD	K0324-Cooking Facilities
									STD	K0352-Sprinkler System - Supervisory Signals
									STD	K0353-Sprinkler System - Maintenance and Testing
									STD	K0363-Corridor - Doors
X	E								STD	K0374-Subdivision of Building Spaces - Smoke Barrie
X	D	X	D						STD	K0511-Utilities - Gas and Electric
									STD	K0711-Evacuation and Relocation Plan
X	C								STD	K0914-Electrical Systems - Maintenance and Testing
									STD	K0915-Electrical Systems - Essential Electric Syste
									STD	K0923-Gas Equipment - Cylinder and Container Storag

HACIENDA NURSING FACILITY CCN: 035258

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	6	4	0	11
Health Total	6	4	0	11
Life Safety Code	0	0	2	3
Life Safety Code + Health	6	4	2	14

Complaint Survey Information

Survey Date	Status
06/05/2014	Substantiated
03/12/2014	Unsubstantiated
04/18/2013	Substantiated
11/16/2012	Unsubstantiated

HACIENDA NURSING FACILITY **CCN:** 035258

LTC Resident Census

Resident Census on 10/07/2016
Total: 60
Medicare: 0
Medicaid: 56
Other: 4

Total Certified Beds: 74

SNF	SNF/NF	NF	ICF/IID
0	74	0	0

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F2 ☐☐ ☐☐ ☐☐ (MM DD YY)

Extended Survey
From: F3 ☐☐ ☐☐ ☐☐ (MM DD YY) To: F4 ☐☐ ☐☐ ☐☐ (MM DD YY)

Name of Facility	Provider Number	Fiscal Year Ending: F5 (MM DD YY)
Hacienda HealthCare SNF	035258	06 30 00

Street Address	City	County	State	Zip Code
1402 E. South Mountain Ave	Phoenix	Maricopa	AZ	85042

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
(602) 243-4231		

A. F9 ☐☐
01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

B. Is this facility hospital based? F10 Yes ☐ No ☑

If yes, indicate Hospital Provider Number: F11 ☐☐☐☐☐☐

Ownership: F12 05

For Profit	NonProfit	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

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?	F25	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. Date: F28 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F29 n/a
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31 n/a

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 Yes ☐ No ☒

FACILITY STAFFING

	Tag Number	A Services Provided 1	2	3	B Full-Time Staff (hours)	C Part-Time Staff (hours)	D Contract (hours)
Administration	F33	Y			267		
Physician Services	F34	Y					
Medical Director	F35	Y					
Other Physician	F36	Y					8
Physician Extender	F37	Y					
Nursing Services	F38	Y					
RN Director of Nurses	F39	Y			80		
Nurses with Admin. Duties	F40	Y			231	86	
Registered Nurses	F41	Y			801	110	
Licensed Practical/ Licensed Vocational Nurses	F42	Y			965	395	
Certified Nurse Aides	F43	Y			3083	1057	
Nurse Aides in Training	F44	N					
Medication Aides/Technicians	F45	N					
Pharmacists	F46	N					20
Dietary Services	F47	Y					
Dietitian	F48	Y			~~5~~ BH		20
Food Service Workers	F49	Y			545		
Therapeutic Services	F50	Y					
Occupational Therapists	F51	Y			40		
Occupational Therapy Assistants	F52	N					
Occupational Therapy Aides	F53	N					
Physical Therapists	F54	Y			18		
Physical Therapists Assistants	F55	N					
Physical Therapy Aides	F56	N			~~20~~ BH		
Speech/Language Pathologist	F57	Y			26		
Therapeutic Recreation Specialist	F58	Y			75		
Qualified Activities Professional	F59	Y			110		
Other Activities Staff	F60	N					
Qualified Social Workers	F61	Y			76		
Other Social Services	F62	N					
Dentists	F63	N					
Podiatrists	F64	N					
Mental Health Services	F65	N					10
Vocational Services	F66	N					
Clinical Laboratory Services	F67	Y					8
Diagnostic X-ray Services	F68	Y					1 ~~8~~ BH
Administration & Storage of Blood	F69	N					
Housekeeping Services	F70	Y			1980		
Other	F71	Y			2309		

Name of Person Completing Form: Brian Henvit	Time: 0935
Signature:	Date: 12/8/17

Form CMS-671 (12/02)

1345

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
	1 F75	49 F76	0 F77	50 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 0	F80 0	F81 50
Dressing	F82 0	F83 2	F84 48
Transferring	F85 0	F86 3	F87 47
Toilet Use	F88 0	F89 3	F90 47
Eating	F91 2	F92 5	F93 43

A. Bowel/Bladder Status

F94 13 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 13 ?

F96 35 Occasionally or frequently incontinent of bladder

F97 35 Occasionally or frequently incontinent of bowel

F98 3 On urinary toileting program

F99 3 On bowel toileting program

B. Mobility

F100 8 Bedfast all or most of time

F101 40 In a chair all or most of time

F102 0 Independently ambulatory

F103 2 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0 ?

F106 48 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 48 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 11 Intellectual and/or developmental disability

F109 8 Documented signs and symptoms of depression

F110 4 Documented psychiatric diagnosis (exclude dementias and depression)

F111 1 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 14 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 14 ?

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

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 3 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 3 ?

F117 50 Receiving preventive skin care

F118 1 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119-132 – indicate the number of residents receiving:

F119 0 Hospice care

F120 0 Radiation therapy

F121 0 Chemotherapy

F122 1 Dialysis

F123 3 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 28 Respiratory treatment

F125 27 Tracheostomy care

F126 5 Ostomy care

F127 28 Suctioning

F128 10 Injections (exclude vitamin B12 injections)

F129 30 Tube feedings

F130 10 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 6 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 5 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 32 Any psychoactive medication

F134 4 Antipsychotic medications

F135 13 Antianxiety medications

F136 13 Antidepressant medications

F137 2 Hypnotic medications

F138 3 Antibiotics

F139 2 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 1 Who use non-oral communication devices

F143 50 With advance directives

F144 47 Received influenza immunization

F145 30 Received pneumococcal vaccine

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form	Title	Date
Sharon Frown LPN	RN	12/11/17

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 _____%

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 27, 2017

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Re: Complaint Intake #AZ00144673
Investigation # MBOZ11

Dear Mr. Henrie:

Surveyors of the Arizona Department of Health Services (Long Term Care) 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 the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

December 27, 2017

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Re: Complaint Intake #AZ00138194
Investigation # MBOZ11

Dear Mr. Henrie:

Surveyors of the Arizona Department of Health Services (Long Term Care) 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 the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

December 27, 2017

Brian Henrie, Administrator
Hacienda Nursing Facility
1402 East South Mountain Avenue
Phoenix, AZ 85040

Re: Complaint Intake #AZ00140358
Investigation # MBOZ11

Dear Mr. Henrie:

Surveyors of the Arizona Department of Health Services (Long Term Care) 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 the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

Shoalynn Gilliland

Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing