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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5L4C

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0031

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035145**
2. STATE VENDOR OR MEDICAID NO.
(L2) **748491**

3. NAME AND ADDRESS OF FACILITY
(L3) **DEVON GABLES REHABILITATION CENTER**
(L4) **6150 EAST GRANT ROAD**
(L5) **TUCSON, AZ** (L6) **85712**

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) **08/31/2012**

6. DATE OF SURVEY **08/10/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12. Total Facility Beds **312** (L18)
13. Total Certified Beds **312** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	312			
(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):
Devon Gables Rehabilitation found to be out of compliance with federal regulations based on annual survey conducted on 08/10/2017 This facility is back in compliance with federal regulations based on allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 09/18/2017. State Agency recommended recertification.

17. SURVEYOR SIGNATURE DE Date : 10/03/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL DE Date: 10/03/2017 (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
11/08/1987
(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.
03101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 3, 2017

Ms. Heather Friebus,
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Provider Number 035145

Dear Ms. Friebus:

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

DEVON GABLES
REHABILITATION CENTER

September 1, 2017

Diane Eckles, Bureau Chief
Bureau of Long Term Care
Arizona Department of Health Services, Licensing
150 N. 18th Avenue, Suite 440
Phoenix, AZ 85007-3245

RE: IDR for August 10th 2017 Federal Survey of NCI-2652

Dear Ms. Eckles:

We are writing to request that the Department remove Tag F224 from the Statement of Deficiencies (SOD) for the August 10, 2017state survey of Devon Gables Rehabilitation Center because the facility had appropriate policies in place (See exhibit# 1), trained staff on those policies (See exhibit# 2), and even recovered the wedding ring that was taken by Staff # 330.

Tag F224 (42 C.F.R.§483.12 (b) 42 C.F.R. §483.95) requires an administrator to ensure that a resident is not subjected to misappropriation of personal and private property by a nursing care institution's personnel members, employees, volunteers, or students." The SOD states that the facility did not meet this requirement because it "failed to ensure one resident (#132) was not subjected to misappropriation of resident property by a staff member. The documentation as summarized in the SOD, however, demonstrates that the facility had appropriate policies and training in place and the incident was caused by an employee who disregarded the policies and acted on their own free will. Furthermore, the SOD demonstrates that the facility restored the missing property so in essence her property was not misappropriated because the Facility followed their policy and procedures and in fact restored the property to the resident.

The SOD states that the incident with Resident #132 was a result of a fully trained CNA failing to follow the facility's policies. The facility immediately started an investigation and contacted the Tucson Police and appropriately investigated the misappropriation of property as part of its quality assurance process. Furthermore, the facility implemented appropriate corrective actions by, immediately suspending and then ensuring that Staff #330 was not employed at Devon Gables once she was found to have violated our abuse and misappropriation policy, reporting staff #330 to the board of nursing due to her CNA certification, and had a guest speaker, Sergeant Rick Rainsky From Tucson Police Department come on 10/18/2016 to ensure that all staff were re-trained on the Elder Justice Act and abuse and misappropriation of property. (see Exhibit #3)

DEVON GABLES
REHABILITATION CENTER

Staff#330's decision to ignore the training provided by the facility do not constitute a violation of the cited regulation. We therefore request that the Department delete Tag F224 from the SOD. Thank you for your time and attention. Please let me know if you have any questions or need further information.

Sincerely,

Heather Friebus

Heather Friebus, RD
Administrator, Devon Gables Rehabilitation Center

6150 E. Grant Rd., Tucson, Arizona 85712 • P: 520-296-6181 • F: 520-298-0997 • www.devongables.com

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

September 28, 2017

Ms. Heather Friebus,
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712
NCI-2652

Dear Ms. Friebus,

Thank you for the documentation submitted with your request for informal dispute resolution regarding the Statement of Deficiencies for your survey # 5L4C11 conducted on August 10, 2017.

The management review team has reviewed the citations and your documentation, and has made the following decisions:

Tag #F244. will remain as written.

Tag #Y1039. R9-10-410.B3.k will remain as written.

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

Sincerely,

Colby Bower
Assistant Director

CB/pdh

Enclosure

cc: CMS
Ombudsman

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 3, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

Enclosed is the **Post-certification Revisit Report** forms which indicate that the following deficiencies were found to be corrected on September 18, 2017 at the time of the follow-up investigation to Complaint #5L4C12. A copy will be filed in your public file.

Thank you for the time extended to us during the recent inspection of your facility. Please contact the Bureau of Long Term Care at (602) 364-2690 if we may be of assistance.

Sincerely,

B Hernandez

Belinda Hernandez,
CSR4/Licensing Certification Specialist

\bh

Enclosures

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	R 09/18/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 Federal offsite recertification and complaint investigation survey was conducted on September 18, 2017, there were no defeciencis 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
035145 (Y1)	A. Building B. Wing (Y2)	9/18/2017 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

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 F0224 Reg. # 483.12(b)(1)-(3) LSC	Correction Completed 09/18/2017	ID Prefix F0469 Reg. # 483.90(i)(4) LSC	Correction Completed 09/18/2017	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) DA	DATE 9/18/17	SIGNATURE OF SURVEYOR [signature]	DATE 9/18/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 8/10/2017	☐ 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

October 3, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

An **Life Safety Code** revisit was conducted on September 8, 2017, and the plan of correction was accepted for the Life Safety Code citations. Enclosed is the **Life Safety Code Post-Certification Revisit Report**. Please retain a copy for your files, a copy will be filed in our public file.

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
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	R 09/08/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 August 09, 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
035145 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	9/8/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

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		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0351	09/01/2017	LSC	K0353	09/01/2017	LSC	K0920	09/01/2017
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0923	09/01/2017	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		
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
				9/8/17
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO
8/9/2017	

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

October 3, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

On August 10, 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 08/23/2017 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 August 10, 2017

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

Receipt of Notice Presumed 08/23/2017 via email

August 23, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

On **August 10, 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 **September 2, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by **September 2, 2017** 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 **09/24/2017.**

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 August 10, 2017

Mandatory Remedies

Your current period of noncompliance began on August 10, 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 02/10/2018.

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

11/10/2017. 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 **September 2, 2017**, 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
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 August 7 through 10, 2017 in conjunction with the investigation of Complaint #'s: AZ142684, AZ140891, AZ137401, AZ139985 and AZ141416. The following deficiencies were cited.	F 000	RECEIVED Arizona Department of Health Division of Public Health Licensing Services SEP 1 2017 Reception Desk 150 N. 18th Ave #400 Phoenix, AZ 85007	
F 224 SS=D	483.12(b)(1)-(3) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. 483.12(b) The facility must develop and implement written policies and procedures that: (b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, (b)(2) Establish policies and procedures to investigate any such allegations, and (b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documentation, staff interviews and review of policies and procedures, the facility failed to ensure one resident (#132) was free from misappropriation of resident property. Findings include:	F 224	**F224** **Correct to the individual:** Resident #132 received her ring back. When the allegation of misappropriation was reported to the facility by the family of resident #132, the facility reported per regulation to DHS, notified the Tucson Police Department and initiated the investigation. The Facility provided the Police the name and date of birth of the CNA suspected of theft. Based on this the Tucson Police were able to confirm that the suspect in question had pawned a wedding ring that met the description of the ring of resident #132. The Tucson Police returned the wedding ring to the family and the resident was informed that her wedding ring was found.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Shelbus | TITLE: Administrator | (X6) DATE: 9/1/17

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
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 224	Continued From page 1 Resident #132 was admitted on June 9, 2016, with diagnoses that included altered mental status and anxiety disorder. An admission Minimum Data Set (MDS) assessment dated June 16, 2016 included the resident had a Brief Interview for Mental Status score of 5, which indicated severe cognitive impairment. The resident was also assessed to require limited to extensive assistance with activities of daily living. Review of a facility investigative report revealed that on August 19, 2016, a CNA (staff #330) reported that she was contacted on the evening of August 18, 2016, by the resident's family member asking if she had seen the resident's wedding rings. Per the CNA's statement, she had observed the resident wearing the rings and noticed that they were loose on her fingers, but could not remember when she had seen them last. The CNA stated that the rings may have slipped off of her finger during care. The report included that the facility was unable to locate the rings and the police were notified. The facility filed an online police report dated August 20, 2017, which included a family member reported that the resident's rings were missing, but was not alleging any misappropriation of property. The rings were described in the report as three yellow metal rings, with three clear stones. Review of the personnel records for staff #330 revealed a Counseling Action Form dated August 24, 2016, which documented that staff #330 had not shown up for her scheduled shift on August 23, 2016, and that staff #330 had resigned without notice.	F 224	**Correct to all others:** Staff is educated on abuse, neglect and misappropriation of resident property upon hire and at least annually. Staff #330 received education on abuse and misappropriation of property policy upon hire and 3 additional times during her employment. The Facility continues to do back ground checks, ensuring finger print clearance cards are in good standing, obtain references from previous employers, and verifies through the State Board that licenses and certifications are active and in good standing. On 10/18/16 Seargeant Rick Radinsky from Tucson Police Department did training for all staff on theft and misappropriation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 224	Continued From page 2 As part of the facility's investigation, the administrator (staff #91) contacted staff #330 on August 30, 2016, and questioned her regarding the rings. The report included that she denied taking the resident's rings. Continued review of the investigative report revealed that on September 15, 2016, a family member reported to the administrator that she suspected a CNA (staff #330) had stolen the wedding rings. On September 16, 2016, the facility called the police and reported the alleged theft. The family was able to provide police with a picture of the rings. The police were able to confirm that staff #330 had pawned the rings at a local pawn shop on August 26, 2016 and the rings were returned to the family. An interview was conducted on August 8, 2017 with staff #91. She stated the rings were reported missing on August 19, 2016, and on September 15, 2016, the family member alleged that staff #330 had taken the rings. Staff #91 stated the police were immediately informed. She stated that a police officer stated that according to their data, a person matching the name and date of birth of staff #330 had pawned jewelry at a local pawn shop on August 26, 2016. Review of a policy and procedure titled Abuse Prevention Program revealed that residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.	F 224	**System Correction:** Devon Gables followed our policy and procedure for education on abuse, neglect and misappropriation of resident property. The Facility reported, investigated and ultimately restored resident #132's wedding ring because of the investigation. The Facility will continue to do training on abuse, neglect, exploitation and misappropriation of property upon hire and at least annually. **Monitoring of System:** Concerns, grievances, allegations and investigations are reviewed at QAPI monthly with any follow-up as needed. **Correction Date:** 9/17/17 **Responsible Person:** Administrator or designee	
F 469 SS=E	483.90(i)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 469	Continued From page 3 (i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and policy and procedures, the facility failed to maintain an effective pest control program, by having multiple flies in the dining room and kitchen. Findings include: -A lunch meal observation was conducted on August 7, 2017 at 1:00 p.m., on the east hall assisted dining room. During this observation, multiple flies were observed on the residents' tables, eating utensils and on residents. Also during this observation, a resident was observed to be seated at a dining room table. The resident picked up her glass of chocolate milk and took a drink. The resident then placed the glass back on the dining table. Shortly thereafter, a fly landed on the inside of the glass of chocolate milk. A CNA (Certified Nursing Assistant/staff #144) who also observed this, removed the glass and replaced it with a fresh glass of chocolate milk. During this same observation, one resident was observed waving her hand in the air at flies and stated, "Somebody needs to get these flies, I just want to kill these flies." In addition, one CNA was observed standing in the middle of the dining room, waving her hand in the air to deter the flies from landing on the residents and the dining room tables.	F 469	**F469** **Correct to individual:** No individual residents identified. **Correct to all others:** Not Applicable as no residents identified. **System Correction:** Eco Lab, our Pest Control Company was out to spray for pest control on 8/7/17. Services are routinely provided monthly and upon request. Eco Lab did verify that the call volume regarding flies had doubled the week of August 7,2017 for the whole city of Tucson due to the extend monsoon season. Eco Lab delivered and installed Fly deterrent lights in multiple areas throughout the facility including the Dining Rooms, Kitchen and Hallways.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 469	Continued From page 4 Another CNA (staff #133) was observed to exit the dining room and then return with a fly swatter. Staff #133 swatted at the flies with the fly swatter and stated, "I got two." Additional observations were also conducted at this time on the east hall nursing unit. Multiple flies were observed on the outside of the lunch meal cart, which was stationed in the hallway. Staff were observed waving the flies away several times, while preparing to deliver the meal trays to the resident's rooms. A second meal observation was conducted on August 9, 2017 at 8:30 a.m., in the east hall dining room. During the breakfast meal, flies again were observed in the dining room. Following this observation, an interview was conducted with a resident who was seated in the east hall dining room. She stated the flies are always terrible in the dining room. She stated that the flies come in and you can not get rid of them. She further stated that the flies land on your food and you have to try and swat them away. An interview was conducted on August 9, 2017, with staff #144. She stated that the flies are a problem, but they seen to be seasonal and sometimes there are more than other times. Staff #144 confirmed that she had observed a fly in the resident's chocolate milk on August 7, and that she had removed the glass before the resident could drink from it. She stated that the resident was not alert enough to recognize that a fly was in her glass. An interview was conducted on August 9, 2017 with staff #133, who stated that the flies seem to	F 469	**Monitoring of System:** Department Managers have been instructed to report any concerns with flies at stand-up meeting so Eco Lab can be contacted as needed between routine visits. A Feedback log will be kept and reviewed in QAPI monthly to ensure that measures are effective in helping to prevent flies in the building. **Correction Date:** 9/17/17 **Responsible Person:** Administrator or Designee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 469	Continued From page 5 be more of a problem in the summer, because some residents open their patio doors and the hall door to the outside area is frequently left open. Staff #133 also confirmed that she had used a fly swatter during the lunch meal on August 7. On August 9, 2017, an interview was conducted with the administrator (staff #91). She stated that during the monsoon season the flies get worse, as the residents leave their patio room doors open. -A kitchen observation of the lunch meal preparation was conducted on August 9, 2017 at 9:24 a.m. Multiple flies were observed throughout the kitchen. At times, the flies landed on several of the food preparation surfaces and baking pans, used in meal preparation. During the observation, an interview was conducted with the Dietary Manager (staff #246), who stated that the flies have been a recent problem, since the monsoon rains. She further stated that she suspected the flies were getting into the kitchen from the multiple doors that open to the outside throughout the facility. An interview was conducted on August 10, 2017 with the maintenance director (staff #37). He stated that they use a commercial pest control company routinely, but the flies are due to the monsoon rain and are getting in through the open doors. Review of the facility's Food Policy revealed the facility should check for pest infestation regularly and if a there is a pest infestation problem, steps for eradicating the problem should be in place.	F 469		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 469	Continued From page 6 A facility policy titled, Pest Control included "Our facility shall maintain an effective pest control program." The policy also included the following: 1. This facility maintains an on-going pest control program to ensure that the building is kept free of insects and rodents.	F 469		

ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Receipt of Notice Presumed on 08/23/2017 via email

August 23, 2017

Ms. Heather Friebus,
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Dear Ms. Friebus:

On August 9, 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 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 **September 2, 2017**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **September 2, 2017**, 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 **09/24/20173.**

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 August 9, 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 August 9, 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 02/10/2018.

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 **September 2, 2017**, 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

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
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 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 facility was surveyed. The faciliyty meets ther standards based upon acceptance of a plan of correction.	K 000	RECEIVED Arizona Department of Health Division of Public Health Licensing Services SEP 1 2017 Reception Desk 150 N. 18th Ave #400 Phoenix, AZ 85007 K351 Boxes and Personal items within 18 inches of the sprinkler deflectors in the Business Office storage closet/ Office Manager storage closet, Lodge East Nurse Station Closet and walk in freezer and refrigerator in main kitchen were removed on 8/9/17.	8/11/17
K 351 SS=D	NFPA 101 Sprinkler System - Installation Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This STANDARD is not met as evidenced by: Based on Observation it was determined the the	K 351	The Facility will check and maintain 18 inch clearance from sprinkler deflectors in all storage areas. This will be monitored by the Director of Maintenance as part of the on-going preventative maintenance and quality assurance programs. The Director of Maintenance or designee will present the information to the QAPI committee that meets routinely. Director of Maintenance or Designee will be responsible.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Lubus | TITLE: Administrator | (X6) DATE: 9/1/17.

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
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 351	Continued From page 1 facility failed to assure that all parts of the facility were provided sprinkler system coverage. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.5.1, "Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." ." Chapter 9, Section 9.7.1.1, " Each automatic sprinkler system required by another section of this Code shall be installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems." NFPA 13, Chapter 8, Section 8.5.6 Clearance to Storage. Section 8.5.6.1 Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4. or 8.5.6.5 are met a clearance between the deflector and the storage shall be 18 inches. (457mm) or greater. Findings include: On August 09, 2017 the surveyors, accompanied by the Director of Maintenance observed personal items or food boxes within the18 inches of the sprinkler deflectors in the following areas of the facility. 1. Business Office/Office Managers storage closet. 2. Nurses station East Lodge closets. 3. Walk in freezer and refrigerator in the main kitchen. During the exit conference on August 09, 2017 the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to provide sprinkler coverage in storage areas by blocking the sprinkler heads could	K 351		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 351	Continued From page 2 result in harm to the patients in time of a fire.	K 351		
K 353 SS=E	NFPA 101 Sprinkler System - Maintenance and Testing Sprinkler System - Maintenance and Testing 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 STANDARD is not met as evidenced by: Based on observation it was determined that the facility failed to maintain the sprinkler system, sprinkler heads and escutcheon plates which are part of the entire sprinkler frame and assembly in several 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	K 353	**K353** The sprinkler head in room 1 C/D bathroom with lint on frame and assembly, Lodge North entire sprinkler head with lint on frame and assembly, and the sprinkler head in room 4B with sheet rock or paint over spray were cleaned on 8/25/17. The facility will complete an audit of all painted escutcheon plates in patient rooms and other locations in the building offices. The Facility will devise a plan to replace painted escutcheon plates over the next year. Sprinkler heads will be maintained according to code and will be monitored by the Director of Maintenance as part of the on-going preventative maintenance and quality assurance programs. The Director of Maintenance or designee will present the information to the QAPI committee that meets routinely. Director of Maintenance or Designee will be responsible.	8/25/17 9/17/17 9/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 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 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 August 09, 2017 the surveyors accompanied by the Director of Maintenance observed sprinkler heads with dust/lint, paint or sheetrock spray on the sprinkler heads or escutcheon plates in patient rooms, offices or corridors of the nursing home. 1. Room 1 C/D lint on the entire sprinkler head	K 353		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 frame and assembly in the bathroom. 2. Lodge North lint on the entire sprinkler head frame and assembly in the bathroom. 3. Sheetrock or paint overspray on one of two sprinklers in room 46. 4. Painted escutcheon plates in all the corridors of the nursing home. Patient escutcheon plates in patient rooms. This was one of two or one of three in patient rooms and one of one or one of two in other locations in the building offices etc:. During the exit conference on August 09, 2017 the above findings were again acknowledged by the Administrator and Director and the Maintenance. 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=E	NFPA 101 Electrical Equipment - Power Cords and Extens 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	K 920	**K920** The six way multi outlet adapters were removed from rooms 22 and 198 on 8/25/17. The oxygen concentrators in room 198 and 1 C/D were plugged directly into outlets, and the auxiliary power unit in the server room was disconnected and removed on 8/25/17.	8/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 (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 This STANDARD is not met as evidenced by: Based on Observation it was determined the facility allowed the use of a multiple outlet adapters connected to power strips for different appliances. The appliances 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 August 09, 2017 the surveyors, accompanied	K 920	The Facility will check to ensure that only UL listed power strips ad circuit breakers are used, and that all appliances are plugged directly into outlets, not power strips. This will be monitored by the Director of Maintenance as part of the on-going preventative maintenance and quality assurance programs. The Director of Maintenance or designee will present the information to the QAPI committee that meets routinely Director of Maintenance or Designee will be responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 by the Director of Maintenance observed the following: 1. Room 22 and room 198 a six way multi-outlet adapter was connected into a power strip. 2. Oxygen concentrators plugged into power strips in room 198 and room 1 C/D. 3. (APU) Auxiliary Power Unit in the server room was connected into a power strip. During the exit conference on August 09, 2017 the above findings were again acknowledged by the Administrator and Director of the Maintenance. 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		
K 923 SS=D	NFPA 101 Gas Equipment - Cylinder and Container Storag Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet	K 923	K923 Re-educate all staff who handle E- oxygen tanks of proper storage and handling. Random audits of oxygen storage will be completed weekly. The Administrator or designee will present the information to the QAPI committee that meets routinely Administrator or Designee will be responsible.	9/17/17 9/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 923	Continued From page 7 In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation the facility failed to secure one medical gas E-type oxygen cylinder in a stand or cart. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 11 Section 11.6.2.3 (11) Free standing cylinders shall be properly chained or supported in a proper cylinder stand or cart." Findings include: On August 09, 2017 the surveyor accompanied by the Director of Maintenance observed one unsecured medical gas oxygen cylinder E-type	K 923	The facility will not store full and empty oxygen cylinders together. There will be a segregated storage area for empty oxygen cylinders and a segregated storage area for full oxygen cylinders. Random audits of oxygen storage will be completed weekly. The Administrator or designee will present the information to the QAPI committee that meets routinely. Administrator or Designee will be responsible.	9/17/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 923	Continued From page 8 located in the Central Courtyard was not secured in a rack or stand. During the exit conference on August 09, 2017 the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to secure compressed medical gas cylinders could cause harm to the patients and staff. Based on observation the facility failed to segregate empty and full oxygen E- type cylinders in a separate storage rack or stand. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 11 Section 11.6.5.2 If empty and full cylinders are stored within the same enclosure, empty cylinders shall be segregated from full cylinders. Findings include: On August 09, 2017 the surveyor accompanied by the Director of Maintenance observed one storage rack of twelve oxygen E type cylinders. Four of twelve oxygen cylinders were empty and being stored in the same rack as eight full oxygen cylinders. These were observed not segregated as empty or full oxygen cylinders being stored in a separate rack or stand. During the exit conference on August 09, 2017 the above findings were again acknowledged by the Administrator and Director of Maintenance.	K 923		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	08/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6150 EAST GRANT ROAD TUCSON, AZ 85712

(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 923	Continued From page 9 Failing to segregate compressed gas medical cylinders could cause harm to the patients if a full bottle is needed in a hurry for the patients.	K 923		

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 08 01 17 (MM DD YY) To: F2 08 10 17 (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)
Devon Gables Rehabilitation Center	035145	☐☐ ☐☐ ☐☐

Street Address	City	County	State	Zip Code
6150 E. Grant Rd.	Tucson	Pima	AZ	85712

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
520-296-6181		

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 03

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
Altitude Health Services

Dedicated Special Care Units (show number of beds for all that apply)

F15 ☐☐☐ AIDS
F16 ☐☐4 Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐32 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_____
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ (MM DD YY) Hours waived per week: F31_____

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				1200	0	0
Physician Services	F34	Y	N	Y			
Medical Director	F35				0	0	24
Other Physician	F36				0	0	18
Physician Extender	F37	N	N	N	0	0	0
Nursing Services	F38	Y	N	N			
RN Director of Nurses	F39				80	0	0
Nurses with Admin. Duties	F40				639	0	20
Registered Nurses	F41				809	235	0
Licensed Practical/ Licensed Vocational Nurses	F42				2163	378	0
					0	0	0
Certified Nurse Aides	F43				6094	1524	0
Nurse Aides in Training	F44				0	0	0
Medication Aides/Technicians	F45				0	0	0
Pharmacists	F46	Y	N	Y	0	0	32
Dietary Services	F47	Y	N	N			
Dietitian	F48				79	42	35
Food Service Workers	F49				1388	455	0
Therapeutic Services	F50						
Occupational Therapists	F51	Y	N	N	132	19	0
Occupational Therapy Assistants	F52				66	67	0
Occupational Therapy Aides	F53				8	0	0
Physical Therapists	F54	Y	N	N	284	26	0
Physical Therapists Assistants	F55				80	7	0
Physical Therapy Aides	F56				0	0	0
Speech/Language Pathologist	F57	Y	N	N	80	0	0
Therapeutic Recreation Specialist	F58	Y	N	N	0	0	0
Qualified Activities Professional	F59	Y	N	N	80	0	0
Other Activities Staff	F60	Y	N	N	922	619	0
Qualified Social Workers	F61	Y	N	N	160	0	0
Other Social Services	F62	Y	N	N	66	0	0
Dentists	F63	N	N	N	0	0	0
Podiatrists	F64	Y	N	Y	0	0	4
Mental Health Services	F65	Y	N	Y	0	0	30
Vocational Services	F66	N	N	N			
Clinical Laboratory Services	F67	N	N	N			
Diagnostic X-ray Services	F68	N	N	N			
Administration & Storage of Blood	F69	N	N	N			
Housekeeping Services	F70	Y	N	N	1973	136	0
Other	F71				478	188	0

Name of Person Completing Form	Heather Friebus	Time	10:12am
Signature	Heather Friebus.	Date	8/9/17

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035145	9 F75	184 F76	44 F77	237 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 2	F80 197	F81 38
Dressing	F82 24	F83 152	F84 61
Transferring	F85 26	F86 148	F87 63
Toilet Use	F88 22	F89 141	F90 74
Eating	F91 132	F92 69	F93 36

A. Bowel/Bladder Status

F94 21 With indwelling or external catheter

F95 Of total number of residents with catheters, 18 were present on admission.

F96 152 Occasionally or frequently incontinent of bladder

F97 132 Occasionally or frequently incontinent of bowel

F98 196 On individually written bladder training program

F99 139 On individually written bowel training program

B. Mobility

F100 2 Bedfast all or most of time

F101 186 In chair all or most of time

F102 11 Independently ambulatory

F103 65 Ambulation with assistance or assistive device

F104 9 Physically restrained

F105 Of total number of residents restrained, Ø were admitted with orders for restraints.

F106 14 With contractures

F107 Of total number of residents with contractures, 8 had contractures on admission.

C. Mental Status

F108 4 With mental retardation

F109 76 With documented signs and symptoms of depression

F110 138 With documented psychiatric diagnosis (exclude dementias and depression)

F111 135 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type

F112 97 With behavioral symptoms

F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 97.

F114 Ø Receiving health rehabilitative services for MI/MR

D. Skin Integrity

F115 14 With pressure sores (exclude Stage I)

F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? 8.

F117 92 Receiving preventive skin care

F118 8 With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119 28 Receiving hospice care benefit

F120 Ø Receiving radiation therapy

F121 Ø Receiving chemotherapy

F122 5 Receiving dialysis

F123 5 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion

F124 80 Receiving respiratory treatment

F125 Ø Receiving tracheostomy care

F126 7 Receiving ostomy care

F127 Ø Receiving suctioning

F128 73 Receiving injections (exclude vitamin B12 injections)

F129 4 Receiving tube feedings

F130 90 Receiving mechanically altered diets including pureed and all chopped food (not only meat)

F131 42 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)

F132 31 Assistive devices while eating

F. Medications

F133 170 Receiving any psychoactive medication

F134 72 Receiving antipsychotic medications

F135 60 Receiving antianxiety medications

F136 140 Receiving antidepressant medications

F137 10 Receiving hypnotic medications

F138 33 Receiving antibiotics

F139 159 On pain management program

G. Other

F140 10 With unplanned significant weight loss/gain

F141 14 Who do not communicate in the dominant language of the facility (include those who use sign language)

F142 1 Who use non-oral communication devices

F143 237 With advance directives

F144 158 Received influenza immunization

F145 195 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
Kendra Rooney	RN	8/7/2017

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 0 %

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/26/2013 thru 07/26/2017
Arizona

DEVON GABLES REHABILITATION CENTER
6150 EAST GRANT ROAD
TUCSON, AZ 85712
State's Region Code: TUC
Compliance Status: Provider meets requirements

CCN: 035145
Phone Number: (520)296-6181
Participation Date: 11/08/1987

Provider Beds
Total: 312
Certified: 312

Provider Category: SNF/NF (DUAL)
Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - CORPORATION

Program Requirements

Current Survey/Revisit Dates - 09/27/2016

Prior 3 Survey 12/2012	S/S Code	Prior 2 Survey 02/2014	S/S Code	Prior 1 Survey 04/2015	S/S Code	Current Survey 07/29/2016	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
									REQ	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
									REQ	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
X	E								REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
				X	D				REQ	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
X	D			X	D				REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
X	D			X	D				REQ	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
X	E					X C	E	09/27/2016	REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
									REQ	F0246-REASONABLE ACCOMMODATION OF
X	D								REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
									REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
				X	D	X C	D	09/27/2016	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
				X	E				REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
									REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
		X	G			X C	G	09/27/2016	REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
									REQ	F0356-POSTED NURSE STAFFING INFORMATION
									REQ	F0365-FOOD IN FORM TO MEET INDIVIDUAL NEEDS
						X C	D	09/27/2016	REQ	F0366-SUBSTITUTES OF SIMILAR NUTRITIVE VALUE
X	E					X C	E	09/27/2016	REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
									REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
						X C	E	09/27/2016	REQ	F0412-ROUTINE/EMERGENCY DENTAL SERVICES IN NFS
X	D	X	E						REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
						X C	D	09/27/2016	REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
									REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
									REQ	F0502-ADMINISTRATION
									REQ	F0504-LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN

! = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSES X = Deficient
* = Regional Office Flag (Includes COPs) ELE = Element STD = Standard COP = Condition REQ = Requirement

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/26/2013 thru 07/26/2017

DEVON GABLES REHABILITATION CENTER CCN: 035145

Prior 3 Survey	S/S Code	Prior 2 Survey	S/S Code	Prior 1 Survey	S/S Code	Current Survey	S/S Code	Plan/Date of Correction		Requirement
12/2012		02/2014		04/2015		07/29/2016				
									REQ	F0505-PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS
									REQ	F0507-LAB REPORTS IN RECORD - LAB NAME/ADDRESS
X	D								REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
X	E								REQ	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey	S/S Code	2012 HC Prior 2 Survey	S/S Code	2012 HC Prior 1 Survey	S/S Code	2012 HC Current Survey	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
12/2012		02/2014		04/2015		07/29/2016				
				X	D				STD	K0232-Aisle, Corridor, or Ramp Width
									STD	K0271-Discharge from Exits
									STD	K0281-Illumination of Means of Egress
									STD	K0291-Emergency Lighting
									STD	K0293-Exit Signage
X	D			X	D				STD	K0321-Hazardous Areas - Enclosure
X	E								STD	K0324-Cooking Facilities
X	D								STD	K0353-Sprinkler System - Maintenance and Testing
									STD	K0363-Corridor - Doors
		X	E						STD	K0374-Subdivision of Building Spaces - Smoke Barrie
									STD	K0511-Utilities - Gas and Electric
									STD	K0753-Combustible Decorations
		X	D						STD	K0923-Gas Equipment - Cylinder and Container Storag

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/26/2013 thru 07/26/2017

DEVON GABLES REHABILITATION CENTER **CCN:** 035145

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	7	5	2	9
Health Total	7	5	2	9
Life Safety Code	0	2	2	3
Life Safety Code + Health	7	7	4	12

Complaint Survey Information

Survey Date	Status
07/29/2016	Substantiated
04/30/2015	Unsubstantiated
06/18/2014	Unsubstantiated
02/27/2014	Substantiated

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/26/2013 thru 07/26/2017

DEVON GABLES REHABILITATION CENTER **CCN:** 035145

LTC Resident Census

Resident Census on 07/29/2016
Total: 233
Medicare: 6
Medicaid: 183
Other: 44

Total Certified Beds: 312

SNF	SNF/NF	NF	ICF/IID
0	312	0	0

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 23, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Complaint Intake #AZ00140891
Investigation # 5L4C21

Dear Ms. Friebus:

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 23, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Complaint Intake #AZ00141416
Investigation # 5L4C21

Dear Ms. Friebus:

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 23, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Complaint Intake #AZ00142684
Investigation # 5L4C21

Dear Ms. Friebus:

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

08/23/2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Complaint Intake #AZ00137401
Investigation # 5L4C21

Dear Ms. Friebus:

Surveyors of the Arizona Department of Health Services (Department) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that at least one of the allegations was found to be substantiated.

You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

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

Sincerely,

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

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

August 23, 2017

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, AZ 85712

Re: Complaint Intake #AZ00139985
Investigation # 5L4C21

Dear Ms. Friebus:

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