Medicare/Medicaid

Public Records Documents Only

Survey event #5416

Facility: DEVON GABLES REHAB CTR

Revised 7-2020

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 541612

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: **9** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds (L18)

13. Total Certified Beds (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
(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):
On offsite revisit focus survey event #541612 for Focused Infection Control-COVID19 was conducted on Februrary 24, 2021. No deficiencies were cited.

17. SURVEYOR SIGNATURE Date:
Matt Connolly, HCCM. by DE 02/24/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
DE 02/24/2021 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 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 (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.
00000 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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	2/24/2021 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 F0880 Reg. # 483.80(a)(1)(2)(4)(e)(f) LSC	Correction Completed 02/24/2021	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	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) [illegible]	DATE 2/23/21	SIGNATURE OF SURVEYOR [illegible]	DATE 2/23/21
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
1/25/2021	☐ 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

February 24, 2021

Receipt Of This Notice Is Presumed To Be 02/23/2021
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On February 24, 2021, an offsite revisit survey was conducted for your facility by the Arizona Department of Public Health, Licensing and Certification Bureau, to determine if your facility was in compliance with federal requirements at the time of the focused infection control survey **#541612**.

The enclosed Center for Medicare and Medicaid Services (CMS) form, entitled "Statement of Deficiencies and Plan of Correction" (CMS 2567), documents that **no deficiencies** of participation requirements were identified during this revisit. The plan of correction was accepted for the Federal citations.

Enclosed is the **Federal Post-Certification Revisit Report**, please retain a copy for your files. If we can be of further assistance, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Monica Miller
Program Project Specialist II
Bureau of Long Term Care Licensing

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Enclosure

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 02/24/2021

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 An offsite follow-up survey was conducted on February 23, 2021. No deficiencies were cited.	{F 000}		

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

February 9, 2021

Receipt Of This Notice Is Presumed To Be -02/09/2021
Important Notice - Please Read Carefully
NO HARD COPY TO FOLLOW

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

Dear Ms. Friebus:

On **January 25, 2021**, an Infection Control COVID-19 Focused Survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19. The survey revealed that your facility was not in substantial compliance with the most serious deficiency cited below:

- F880 - S/S: E - §483.80 Infection Control

The finding(s) from the survey is enclosed with this letter on from CMS-2567. Also enclosed is a list of the "resident identifiers" used in writing the statement of Deficiencies. The "resident identifiers" will enable you to identify any specific residents referred to in the CMS 2567.

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 **February 19, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **February 19, 2021** may result in the imposition of additional 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.

- Any copies of monitoring audits being done up to your Allegation of Compliance date

Your properly signed PoC constitutes your credible allegation of compliance. We may accept the Plan of Correction and presume compliance until substantiated by a revisit or other means.

The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

Ltc.licensing@azdhs.gov
SUBJECT LINE: the name of your facility and POC

SUMMARY OF ENFORCEMENT REMEDIES

Imposition of Discretionary Denial of Payment for New Admissions (DDPNA):

Payment will be denied for all NEW Medicare and Medicaid admissions, beginning March 26, 2021, in accordance with the statutory provisions at §1819(h)(2)(D) and §1919(h)(2)(C) and Federal regulations at 42 CFR §488.417. CMS will notify your Medicare payer the date the denial of payment begins. DDPNA will continue until the day before your facility achieves substantial compliance or your provider agreement is terminated. [*You may not bill new Medicare/Medicaid residents or their responsible parties for services normally covered by Medicare, Medicaid or Medicare Managed Care Organizations during DDPNA.]*

Directed Plan of Correction (DPOC)

In accordance with Federal regulations at 42 CFR §483.424, a Directed Plan of Correction is imposed on the facility. In accordance with 42 CFR §488.402(f), this remedy is effective 15 calendar days from the date of the enforcement letter. The DPOC may be completed before or after that date. The effective date is not the deadline for completion of the DPOC. However, the State Agency will not conduct a revisit prior to receipt of documentation confirming the DPOC was completed in accordance with the specifications described in this notice. Please send all documentation to ADHS at the following:

Diane Eckles, Bureau Chief
Email: Diane.eckles@azdhs.gov

Imposition of this DPOC does not replace the requirement that the facility must submit a complete POC for all cited deficiencies (including F880) within 10 days after receipt of the Form CMS 2567. Please see the attached instructions for detailed guidance.

Elements of an Effective DPOC:

- The corrective action to be implemented and an appropriate infection prevention and intervention plan consistent with the requirement of §483.80 for the affected identified in the deficiency.
- Governing Body
- Specific staff involved in implementing the corrective action (such as the Staff Development Coordinator, Infection Preventionist, Nursing Home Administrator, Director of Nursing, and Medical Director)
- Systemic changes and actions that need to be taken
- Monitoring of approaches to ensure infections are controlled going forward.
- Plan of Correction Completion date with 30 days of survey exit date.

Elements of an Effective Root Cause Analysis (RCA):

- Identify the root cause resulting in the facilities Failure. This includes asking the Who, What, Where, When and Why questions which can be done by conduction internal investigations.
- Develop solutions and systemic changes that need to be taken to address the root cause.
- Implement the solution.

TERMINATION PROVISION

If your facility has not attained substantial compliance by 07/25/2021, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the ACT at § § 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and § 489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirement for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XV111 of the Social Security Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR § 489.57 will apply.

INFORMAL DISPUTE RESOLUTION (IDR)

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, Diane.eckles@azdhs.gov. 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: Facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.

FILING AN APPEAL

If you disagree with the determination to impose remedies made on the basis of noncompliance identified at the survey, you or your legal representative may request a hearing before an administrative law judge of the U.S. Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 CFR §498.40, et. seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than 60 days from the date of receipt of this letter.

We request that you provide and electronic copy of the request for appeal to ROEnforcements@cms.hhs.gov SUBJECT LINE: Appeal ATTN: Sahana Sanyal and to the CMS Regional Chief Counsel Femi.Johnson@hhs.gov and the Bureau of Long Term Care Licensing.

If you elect to dispute deficiencies through the Informal Dispute Resolution (IDR) process this will not extend the 60-day period to file your appeal before the Departmental Appeals Board. Filing an appeal will not stop the imposition of any enforcement remedy.

If you experience problems with, or have questions about DAB e-File, please contact e-file System Support at OSDABImmediateOffice@hhs.gov about using the DAB e-file System, please visit https://dab.efile.hhs.gov/login?locale=en

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. If, upon the subsequent revisit, your facility has not achieved substantial compliance, a civil money penalty may be imposed by the CMS Regional Office or State Medicaid Agency beginning on January 25, 2021 and continuing until substantial compliance is achieved. The CMS Regional Office or State Medicaid Agency may also impose additional remedies at that time if appropriate.

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **February 19, 2021**, 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:sf

COVID-19 Directed Plan of Correction
2/18/2021

Corrective Action and Identification of others:

All staff will be re-trained on the screening process for COVID-19 including symptom review, actively taking temperature, exposure to suspected or confirmed COVID-19 infection, and post vaccine side effects if applicable.

CDC video "Keeping COVID-19 out" will be utilized to train staff. Post education quiz will be completed.

Staff conducting screenings will be re-trained on the screening process to ensure that they are competent to conduct a thorough screening including any follow up that is indicated before the staff leaves the screening area. Post education quiz will be completed.

System Changes:

Problem Statement: Major outbreak of COVID-19 in our building

Goal: Prevent the spread of COVID-19

Root Cause: The main reason(s) why something happened or did not happen. It is a systematic approach to get to the true root cause of a process problem. It is important to look at barriers to success. Methods to get to the root cause-1) 5 Why's (Keeping asking why)

We utilized the 5 Why's
-Why did this outbreak occur? (Probably have an asymptomatic employee who is infecting residents)
-Staff have been testing twice a week per CMS guidelines so why would we have not caught the infected staff member.
-On 1/14/2021 C.N.A from unit where outbreak had occured notified IP at 1430 that she thinks she is the one who is making the residents sick because she was not feeling well and attributed her symptoms to the side affects from the vaccine and had not reported them to the facility.
-C.N.A was immediately PCR tested on 1/14/2021 at 1430 and sent home. The PCR came back positive on 1/16/2021 even though the C.N.A did have a negative antigen test on 1/14/2021 at 0933.
-The why was identified as the C.N.A not reporting her vaccine side affects as symptoms.
-PHI report ran to identify residents who C.N.A may have had contact with. It was identified that she had floated to another unit on 1/9/2021 as well.
-Residents were tested and moved to COVID-19 unit if positive, and if negative they were placed on isolation. All exposed residents being tested daily and upon symptoms worsening.
- Staff education regarding outbreak, and symptom reporting.

-Monoclonal antibodies were obtained from HHS and TMC, and started on all COVID-19 positive residents that were eligible to help prevent further decline.
-Working closely with Pima County Health Department to do further testing on the C.N.A's PCR specimen to identify what strain we have etc.
-Infection control Nurse from ADHS & Epidemiologist from Pima County/Uofa will be doing walk thru of Facility on 01/18/2021 to monitor infection control practices and give feedback.
-Realized that we need to do all house education on reporting ANY SYMPTOMS even if they feel the symptoms are because of the vaccine 1/20/2021
-ICAR survey completed with ADHS and Pima County Health Department on 1/23/2021
-As recommended in the ICAR survey updated screening tool on 1/23/2021 to include question regarding post vaccine side effects.
-Additional follow up was done with 3 team members from the CDC "Experts in infection control" onsite from 2/1/2021-2/10/2021.

Systemic changes and actions taken:
-One staff member was not aware that they should be reporting, what they believed to be side affects from the vaccine as symptoms.
-Re-training was completed with the one staff member as well as entire staff to ensure that a thorough screening is completed at all times. Question regarding when employee has had vaccine and if they are experiencing any side affects was added to screening form.
-Outside experts engaged to assist in monitoring infection control practices.

Monitoring:
--The analysis of the audits conducted will be taken to QAPI meeting for review and follow-up as needed.
-The IP's and DON will conduct on-going audits via monitoring, observation and review on all shifts to ensure staff are complying with the requirements for screening of staff for COVID-19.
-After 12 weeks of monitoring, provided that such monitoring demonstrates expectations are met, monitoring may be reduced to monthly. Monthly monitoring will continue for no less than 3 months.
-Monitoring will not be discontinued until the facility completes 3 consecutive rounds of monthly monitoring which demonstrate sustained compliance as approved by the QAPI committee and Medical Director.

Heather Friebus Administrator 2/18/21

John Wadleigh DO Medical Director 2/18/21

Kendra Rogney RN Director of Nursing 2/18/21

Darunee Armenta RN IP 2/18/21

Stephanie Pogue RN IP SDC 2/18/21

COVID-19 Directed Plan of Correction
2/18/2021

Watch the Video: "Keeping COVID-19 Out"

https://www.cdc.gov/coronavirus/2019-ncov/hcp/long-term-care.html

The symptoms of COVID-19 include **Fever, cough, new shortness of breath or difficulty breathing, fatigue, nausea, vomiting, diarrhea, sore throat, chills, muscle pain, headache, new loss of taste or smell, new congestion or a runny nose.**

Always Report Symptoms regardless of what you may feel the cause may be. Call Da Armenta 520-904-2306 or designee and follow their instructions. Also notify your supervisor of the outcome.

As a healthcare worker, you should be self screening at home. You are responsible for reporting symptoms regardless of the cause.

If you develop symptoms during your shift, you should report your symptoms to your supervisor and IP immediately and leave the building to await further direction.

Thank you for all You do to Keep COVID-19 out!!!

DEVON GABLES
REHABILITATION CENTER

Dear AZDHS Licensing,

Attached you will find

-2567 Federal SOD
-Staff #6 on SOD education sign in sheet and quiz
-COVID-19 Directed Plan of Correction Outline including System changes, Problem Statement, goal, Root cause analysis utilizing 5 why's, systemic changes and actions taken and monitoring signed by Administrator, Director of Nursing, both IP's and Medical Director
-COVID-19 Directed Plan of Correction for all staff including CDC video "Keeping COVID out", symptoms of COVID-19, Reporting Instruction etc Handout
-Sample Quiz given for all staff to show competency of education listed above.
-Sign in sheets for the directed plan of correction listed above
-Actual quizzes with staff signatures

-COVID-19 Directed Plan of Correction for all Screeners- "Screener Education Handouts"
-Sample Employee Screening Competency Quiz
-Sign in sheets for the directed plan of correction listed above
-Actual quizzes with staff signatures

-Audits performed for compliance with system correction

If you have any questions, please let me know.

Heather Friebus.

Heather Friebus R.D., LNHA
Administrator
Devon Gables Rehabilitation Center
6150 E. Grant Rd. Tucson, Az 85712
(520) 296-6181 x 5011
(520) 298-0997 fax
hfriebus@devongables.com

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 _____	01/25/2021

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 A focused infection control survey was conducted on January 25, 2021. The following deficiency was cited:	F 000	ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH LICENSING FEB 23 2021 LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880	**F880** **Correct to all residents:** All residents were tested for COVID-19 and placed in appropriate cohorts. **Identification and correction for other residents potentially affected:** Outbreak testing for residents and staff continues until outbreak resolution. The facility continues to follow CMS requirement for testing based on county positivity rate and outbreak status. The facility added additional screening question on 01/23/2021 to include inquiring regarding potential vaccination side effects. Staff were re-educated on policy and procedure for reporting COVID-19 like symptoms regardless of their belief of the cause. **System Correction:** Audits will be completed twice per week to ensure staff understands COVID-19 symptoms and reporting procedure. Audits of screening will be completed twice per week to ensure thorough screening was completed on staff and visitors for COVID-19 symptoms.	

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

Heather Knehus | Administrator | 2/19/202

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 _____	01/25/2021

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 880	Continued From page 1 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on facility documentation, staff interviews, policy review, and the Centers for Disease Control (CDC), the facility failed to ensure the screening for COVID-19 was thorough for one staff (staff #6). The deficient practice could result	F 880	**Monitoring of System/ Quality Assurance Program** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** Infection Preventionist or Designee	2/24/2021

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	035145	A. BUILDING _____ B. WING _____	01/25/2021

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F 880	Continued From page 2 In the spread of infection, including COVID-19 to residents and staff. Findings include: During the entrance conference conducted with the facility administrator (staff #28) and the Director of Nursing (DON/staff #56) on January 25, 2021 at 9:15 am, the administrator stated one staff member (staff #6) reported to the facility Infection Preventionist (IP/staff #32) on January 14, 2021 that she had been experiencing COVID-19 symptoms since January 7, 2021. The administrator stated the symptoms were not reported on the screening for COVID-19. The Start of Shift Employee Screening logs for the month of January 2021 revealed staff #6 was screened and that no COVID-19 symptoms were documented on January 1, 4, 5, 7, 8, 9, 10, 12, 13, and 14, 2021. The facility's employee routine testing records for the month of January 2021 revealed staff #6 was tested for COVID-19 using the facility's rapid antigen test on January 5, 8, 12, and 14, 2021, all with negative results. Review of the facility's line list tracking for COVID-19 revealed staff #6 received a COVID-19 polymerase chain reaction (PCR) test on January 14, 2021 and the positive result was reported on January 15, 2021. In the interview conducted with the administrator and the DON on January 25, 2021 at 9:15 a.m., the administrator stated that education was provided to staff regarding reporting symptoms and that a question was added to the screening	F 880		

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F 880	Continued From page 3 for COVID-19. On January 25, 2021 at 2:40 pm, an attempt was made to interview staff #6 via phone, a voicemail was left. An interview was conducted with the IP (staff #32) via facetime on January 25, 2021 at 3:50 pm. Staff #32 stated staff #6 reported to her on January 14, 2021 that she had been experiencing fatigue and muscle aches since January 7, 2021 and had developed a cough on January 14, 2021. The IP stated that staff #6 said that she thought her symptoms were side effects from the COVID-19 vaccine she had received at the facility on January 5, 2021. Staff #32 stated staff #6 was tested at the facility at that time (January 14, 2021) using the facility's rapid antigen test and that the test was negative. The IP stated staff #6 was sent home and a sample was sent for PCR testing. The IP stated the PCR test result was positive for COVID-19. Review of the facility's document titled Education 1/20/2021 revealed to "always report symptoms no matter if you think they are side effects from the vaccine etc." The facility's policy COVID-19 Clinical Protocol for Visitor and Employee Screening included that as part of routine practice, health care personnel (HCP) will be asked to regularly monitor themselves for fever, respiratory symptoms and COVID-19 like symptoms. It also included that HCP should be reminded to stay home when they are ill, and if HCP develop COVID-19 like symptoms while at work, they should immediately put on a facemask (if not already wearing), inform their supervisor, and leave the workplace. The	F 880		

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F 880	Continued From page 4 policy was revised January 25, 2021, for screening to include questioning all HCP if they have symptoms related to COVID-19 vaccine. The CDC guidance Preparing for COVID-19 in Nursing Homes Updated Nov. 20, 2020 stated to screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. Facilities should reinforce sick leave policies, and remind HCP not to report to work when ill. The CDC Post Vaccine Considerations for Healthcare Personnel updated December 13, 2020, revealed strategies are needed for healthcare facilities to appropriately evaluate and manage post-vaccination signs and symptoms among healthcare personnel (HCP). Systemic signs and symptoms, such as fever, fatigue, headache, chills, myalgia, and arthralgia, can occur following COVID-19 vaccination. Preliminary data from mRNA COVID-19 vaccine trials indicate that most systemic post-vaccination signs and symptoms are mild to moderate in severity, occur within the first three days of vaccination, resolve within 1-2 days of onset, and are more frequent and severe following the second dose and among younger persons compare to those who are older (>55 years). Inform HCP about the potential for short-term systemic signs and symptoms post-vaccination. Develop a strategy to provide timely assessment of HCP with systemic signs and symptoms post-vaccination. Evaluate the HCP with signs and symptoms that may be from either the COVID-19 vaccination, SARS-CoV-2 infection, or	F 880		

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F 880	Continued From page 5 another infection. Offer nonpunitive sick leave options (e.g., paid sick leave) for HCP with systemic signs and symptoms post-vaccination to remove barriers to reporting these symptoms.	F 880		

Employee Screening Competency Quiz

1. True or False As a Healthcare worker you should self screen while off duty?

2. Please list 5 symptoms of COVID-19:
   a.
   b.
   c.
   d.
   e.

3. True or False I am responsible to report any and all symptoms I have regardless of what I think the cause is.

4. You have come to work and screened in and began your shift, two hours in to your shift you begin to have a headache and a runny nose

   a. Do nothing, its probably the weather

   b. Report your symptoms to your supervisor and IP immediately and leave the building to await further direction.

   c. Report your symptoms to co-workers, they will know what to do.

5. According to the video, "Keeping COVID-19 out", what is the number one thing you do if you are sick?

   a. Do not come to work, Report your symptoms to IP

   b. Take some medicine and hope you feel better

   c. Come to work and don't report your symptoms.

_____ _____

Printed Name Signature

_____

Date

2/19/21

On this date, I did a 30 minute observation of screening inclusive of 18 employees.
There were no omissions noted. The symptom review included covid -19 vaccination information, covering side effects.
There were no missed items for the screenings I observed.

Debbie Friebus RN, BSN
Nurse Consultant
Devon Gables Rehab Center