





ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

July 29, 2020

Receipt of This Notice is Presumed To Be 07/29/2020  
Important Notice - Please Read

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

Dear Ms. Friebus:

On **July 21, 2020**, an Infection Control COVID-19 Focused Survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal/State requirements related to implementing proper infection prevention and control practices to prevent the development and transmission of COVID-19.

The enclosed Federal deficiency form which indicates that no deficiencies were found at the time of the inspection. This form will become a part of your public file; retain a **copy** for your files.

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

Sincerely,

A handwritten signature in cursive script that reads "Diane Eckles".

Diane Eckles  
Bureau Chief

DE\sf

Attachments

Douglas A. Ducey | Governor   Cara M. Christ MD, MS | Director

150 North 18th Avenue, Suite 440, Phoenix, AZ 85007-3247   P | 602-364-2690   F | 602-324-0993

W | [azhealth.gov](http://azhealth.gov)

*Health and Wellness for all Arizonans*

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

PRINTED: 07/29/2020  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/21/2020
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NAME OF PROVIDER OR SUPPLIER  DEVON GABLES REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712
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(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
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F 000	<p>INITIAL COMMENTS</p> <p>A focused Infection Control survey was conducted on July 21, 2020. No deficiencies were cited.</p>	F 000		
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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.