

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 14, 2019

Important Notice - Please Read Carefully

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

Re: Provider Number 035145

Dear Ms. Friebus:

Your facility has just undergone its Federal/State recertification survey, as required by the Federal Title XVIII (Medicare) program and Federal Title XIX (Medicaid/AHCCCS) program. As the result of this survey, the facility's Medicare Provider Agreement will be continuous, unless you are contacted by our Bureau or the Centers for Medicare/Medicaid Services to the contrary.

Please retain a copy of this notice with your signed provider agreement.

Sincerely,

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

Diane Eckles
Bureau Chief

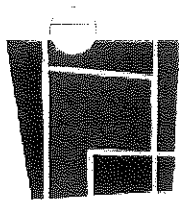
DE/sg

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

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Health and Wellness for all Arizonans



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 14, 2019

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On February 13, 2019, an offsite was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

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

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

Sincerely,

A handwritten signature in cursive script that reads "Shoalynn Gilliland".

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

Enclosure

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

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Health and Wellness for all Arizonans

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

PRINTED: 02/14/2019
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 R 02/13/2019
NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 follow up Federal Recertification and complaint investigation survey was conducted on 2/13/19, there were no deficiencies cited.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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

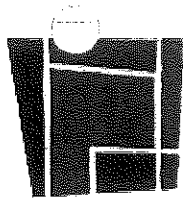
POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 035145	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	DATE OF REVISIT 2/13/2019	Y3
NAME OF FACILITY DEVON GABLES REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 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 F0600 Reg. # 483.12(a)(1) LSC	Correction Completed 01/23/2019	ID Prefix F0686 Reg. # 483.25(b)(1)(i)(ii) LSC	Correction Completed 01/23/2019	ID Prefix F0773 Reg. # 483.50(a)(2)(i)(ii) LSC	Correction Completed 01/23/2019
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 <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) DA	DATE 2/13/19	SIGNATURE OF SURVEYOR <i>Dahlan</i>	DATE 2/13/19
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 11/1/2018		<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO		



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 14, 2019

Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On November 1, 2018, 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.

A revisit may be conducted 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 November 1, 2018
Recommendation to CMS for Denial of Payment for New Admission

A civil money penalty, if imposed, will continue until you have achieved substantial compliance or your provider agreement is terminated.

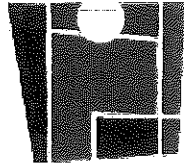
If you have any questions concerning the instructions contained in this letter, please call the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

A handwritten signature in cursive script that reads "Shoalynn Gilliland".

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

cc: State Ombudsman (with POC)



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

Receipt Of This Notice Is Presumed To Be 12/03/2018
Important Notice - Please Read Carefully

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

Dear Ms Friebus:

Included in this letter are instructions for your Directed Inservice training, effective December 28, 2018 (Code of Federal Regulations, CFR 488.425).

This inservice training must be done on the following areas of noncompliance which were identified at the time of the recertification survey conducted on November 1, 2018:

- **FED-F-658- Services Provided Meet Professional Standards**
- **FED-F-760- Residents Are Free of Significant Med Errors**

The inservice training must be a program developed by sources with an in-depth knowledge of the area(s) which require specific training. Facilities may choose to select:

1. Any training program developed by an established center of geriatric health services education, such as schools in the health sciences, including, but not limited to, medicine, nursing, pharmacy, social work, recreational therapy, occupational therapy, speech pathology, physical therapy, dietetics, and environmental health.
2. A training program provider who has demonstrated expertise in the relevant area, such as through a school in the health sciences, and has developed a training program that meets the criteria for continuing education from the appropriate accrediting body, e.g., the Arizona Nurses Association.
3. A training program provided by an area health education center which has established programs in geriatrics and geriatric psychiatry, centers for aging such as the Area Agency on Aging, or the Ombudsman program, for training in appropriate areas.

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

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Devon Gables Rehabilitation Center
December 3, 2018
Page Two

Documentation of the completion of the directed inservice training must be submitted to the Long Term Care Bureau Chief or designee by the effective date identified above.

Payment for the directed inservice training is the responsibility of the facility.

Action Following Training: After the staff has received inservice training, if the facility has not achieved substantial compliance, the State may impose one or more other remedies specified in CFR 488.406.

If you have any questions concerning this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

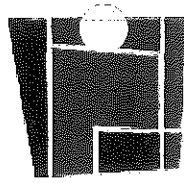
Sincerely,



Diane Eckles
Bureau Chief

DE\sg

Enclosure



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

Receipt Of This Notice Is Presumed To Be -12/03/2018
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On November 1, 2018, 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.

This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached CMS-2567 whereby significant corrections are required (G).

This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute actual harm that is not immediate jeopardy as evidenced by the attached CMS-2567 whereby significant corrections are required (H).

This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute actual harm that is not immediate jeopardy, as evidenced by the attached CMS-2567 whereby significant corrections are required (I).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A Plan of Correction (PoC) describing what corrective actions Devon Gables Rehabilitation Center will take to remedy the deficiencies identified during the **November 1, 2018**, survey (and listed on the Statement of Deficiencies) must be submitted by **December 13, 2018**.

As receipt of this notice and the enclosed Statement of Deficiencies has been sent to you via email, you must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **December 13, 2018** may result in the imposition of remedies, including termination of your facility's Medicare provider agreement. **Plans of correction sent by fax will not be accepted.**

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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;
- 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;
- 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;
- If the facility is in the process of implementing a PoC as a result of a survey completed by the State Survey Agency, you should reference this information in your PoC, with the current status of the correction and any revised correction dates.
- The dates when corrective action will be completed; and
- The signature and date you approve the Plan of Correction on the first page.

Recommended Remedies

Based on the deficiencies cited during this survey, we are recommending to the CMS Regional Office and/or State Medicaid Agency that the following remedies be imposed :

Recommending to CMS Civil Money, effective November 1, 2018
Directed In-Service Training for Tag# F658 and F760
Recommending to CMS Denial of Payment for New Admission

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, we will provide you with a separate formal notification of that determination.

The scope and severity of the deficiencies documented during this survey constitutes one or more findings of actual harm during the current certification period, **eliminating the opportunity to correct prior to imposition of the above remedies.**

Your current period of noncompliance began on November 1, 2018. We are also recommending to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **May 1, 2019**, if substantial compliance is not achieved by that time.

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

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

PRINTED: 12/03/2018
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 11/01/2018
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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F 686	<p>Continued From page 20</p> <p>nurse observed a change in the wound while providing the treatment, then the floor nurse would notify the provider that day and document the notification and any order obtained. She stated that the floor nurse would also notify her of the wound decline. The RN stated that on September 19, 2017, resident #470 wounds were assessed to be a mixture of moisture associated dermatitis with a fungal component. She stated that at the time of her observation on September 26, 2017, she classified the right ischium wound as a pressure related deep tissue injury and that the wound had declined. She also stated that the sacral coccyx area wounds were difficult to measure and that now there were three open areas, so she documented the overall size. The wound nurse stated that she notified the physician of the wound decline but she was unable to find any documentation of the notification.</p> <p>An interview was conducted with the DON (staff #241), who is wound care certified, on November 1, 2018 at 11:47 a.m. She stated that her expectation is that when a resident has a decline in skin integrity, the provider is notified of the decline and that staff document the provider notification by some means i.e. progress notes, obtaining an new order, treatment records, etc. She stated that a wound that changed from blanchable to non-blanchable to dark purple with a change in classification from moisture associated skin damage to a deep tissue injury and any new open areas would be considered a decline in the skin integrity. The DON stated that the facility policy of notifying the physician of a change in a resident's condition was not followed for this resident.</p>	F 686		

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F 686	Continued From page 21 Review of the facility's wound identification guidelines policy revealed that routine rounds are done by staff and with any new area of concern staff will follow the procedure for a change of condition to include notifications to the provider.	F 686		
F 760 SS=G	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to ensure one resident (#370) was free from a significant medication error, by failing to administer an anticoagulant medication per the admission orders. Findings include: Resident #370 was admitted from a hospital to the facility on 10/16/2017, with diagnoses that included chronic systolic congestive heart failure, prosthetic aortic heart valve, chronic obstructive pulmonary disease, prior myocardial infarction, chronic kidney disease and pacemaker. Review of the Admission Orders dated 10/16/17 from the hospital included for Warfarin	F 760	Past noncompliance: no plan of correction required.	

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F 760	<p>Continued From page 22</p> <p>(anticoagulant) 3 mg (milligram) tablet orally every Monday, Tuesday, Thursday, Friday and Sunday and Warfarin 5 mg tablet orally every Wednesday and Sunday. On the Admission Orders these two medication orders were crossed through and it was handwritten in for Warfarin 3.5 mg daily and for INR (International Normalized Ratio) lab tests on Mondays and Thursdays.</p> <p>However, the recapitulation of physician orders for October 2017 did not include an order for Warfarin or for the INR lab tests to be done.</p> <p>Review of the Medication Administration Record (MAR) for October 2017 did not reveal any documentation that the resident was administered Warfarin.</p> <p>The MAR further showed that 24-hour chart checks were conducted daily, without recognition of the missed medication. As a result the resident did not receive the anticoagulant medication from the time of admission on 10/16/17 to the time of the discovered missed medication on 11/20/17 (for a total of 34 days). In addition, no INR lab tests were obtained.</p> <p>A physician's order dated 11/20/17 now included for Warfarin 5 mg orally daily and for INR lab tests on Tuesday and Friday for a diagnosis of prosthetic heart valve.</p> <p>Review of the MAR for November 2017 revealed the resident was administered Warfarin on 11/20/17, 11/21/17 and 11/22/17.</p> <p>According to the INR lab test dated 11/21/17, the INR result was 1.2 (sub-therapeutic level).</p>	F 760		

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F 760	Continued From page 23 Further review of the clinical record revealed there was no documentation that the physician was notified of the sub-therapeutic level for the INR. A nurse progress note dated 11/22/17 revealed that around 7:30 p.m., the resident appeared to be confused. The note included the resident's vital signs were stable, but her blood sugar was elevated at 447 and was administered insulin. The note also included that a family member requested the resident be sent to the hospital, so 911 was called and the resident was transported to the hospital at 9:00 p.m. Review of the emergency department physician note dated 11/22/17 revealed the resident presented with altered mental status. Diagnoses included confusion, delirium, cerebral vascular accident, hypoglycemia, intracranial hemorrhage and metabolic encephalopathy. The resident was admitted to the Telemetry Unit in stable condition. A hospital physician's note dated 11/27/17 revealed the chief complaint of the patient was "new CVA (cerebral vascular accident) with dysarthria (difficulty speaking)." The History of Present Illness included, "she has now suffered a CVA after being sub-therapeutic on her Warfarin." Review of the hospital course summary dated 11/29/17 revealed the resident was on chronic anticoagulation, due to mechanical aortic valve replacement. The resident presented to the emergency department due to progressive worsening of altered mental status, lethargy, and recent somnolence. In addition to confusion, the patient was having difficulty talking. The summary	F 760			

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F 760	<p>Continued From page 24</p> <p>included the resident's INR level was 1.6, "which is sub-therapeutic and given the patient's mechanical aortic valve, the resident should have a goal INR of 3." The documentation further included the patient was found, on repeat Computerized Tomography (CT) imaging to have an "acute stroke, and this is thought to be embolic given her subacute therapeutic INR. Per neurology recommendations, we will continue Warfarin with up-titration still as to get her INR back in to range..at a goal of 3.0."</p> <p>An interview was conducted on 10/31/18 at 1:48 p.m., with a Licensed Practical Nurse (LPN/staff #214). Staff #214 stated that when a resident is admitted from the hospital, the hospital sends admissions orders, which are reviewed with the facility's physician, usually by reading them over the phone, and then entering them into the electronic chart. Staff #214 stated that after the orders are entered, the order recap is printed and the physician will review and sign the order recap. He stated that a chart check process is also completed every 24 hours by the night nurse which includes checking for new orders and verifying that the order recap is correct. Staff #214 stated that if there are medications that were on the hospital admission orders that were not on the order recap, the nurse should review the clinical record for documentation as to why the medications are not on the orders or call the physician to find out why. He stated that if the medications were missed when adding them to the electronic record, it should have been caught by the 24 hour chart check process. The LPN said that he would expect a resident on long term anticoagulants would continue on the medication while at the facility. He further stated that if a resident is on long term anticoagulants that were</p>	F 760			

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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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F 760	<p>Continued From page 25</p> <p>suddenly stopped it could result in coagulation of the blood leading to clots, pulmonary embolism, deep vein thrombosis and stroke.</p> <p>During an interview conducted on 11/01/18 at 9:15 a.m. with the Director of Nursing (DON/staff #241), the DON stated the admitting department obtains the resident information and orders from the hospital. She stated that when she became aware of the missed Warfarin and labs for resident #370, she started a Performance Improvement Plan (PIP) for their Quality Assurance Process Improvement (QAPI) committee. She said the PIP was designed to identify how this occurred and to ensure there is a process in place so that it does not happen again. The DON stated that in the case of resident #370, the hospital admission orders had Warfarin on them, it just got missed and fell through all of the safety checks. The DON stated that the 24-hour chart check missed it, the physician did a History and Physical the next day and missed it, and the pharmacy review conducted their review 2 days later and missed it.</p> <p>An interview was conducted on 11/01/18 at 9:41 a.m. with the Administrator (staff #87). The Administrator stated that the facility has initiated the following measures:</p> <ul style="list-style-type: none"> -Chart audits were conducted on 100% of new admissions and randomly on other charts and any discrepancies are reported to the Administrator and none were identified -Staff education was initiated and completed -Physicians and the Pharmacy now review the hospital orders for medications and the facility orders when they come in to see a new resident -All facility physicians and NPs were alerted to 	F 760			

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

PRINTED: 12/03/2018
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 11/01/2018
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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F 760	<p>Continued From page 26</p> <p>what occurred and their role in reviewing new admission orders.</p> <ul style="list-style-type: none"> -The medical director and the pharmacy consultant review and sign off on all medication errors. -The PIP was completed in February 2018 and the issue was then turned to ongoing QAPI quality audits. <p>Review of the facility's PIP and ongoing QAPI audits revealed the following:</p> <ul style="list-style-type: none"> -QAPI Action Plan initiated on 11/28/17 with the root cause, tasks, and reporting process for findings -Notes of ongoing review identified no new concerns on 12/15/17, 12/29/17, 1/11/18, 1/25/18, 2/8/18, and 2/22/18 -Action Plan did not note any concerns since the staff education and the plan then transitioned to monthly updates at the QAPI Committee meeting -Staff education materials and education sign-in sheets -Admission audit sheet results <p>Review of the facility's policy titled, Admission Orders: Reconciliation Procedures revealed the facility will take measures to obtain accurate admission orders. The policy included that the nurse receiving the resident shall review the orders and make recommendations to the provider after observation of the resident. All admitting orders are to be reviewed by a licensed nurse. The nurse will document that the admission orders were reconciled for accuracy and will notify the provider of any discrepancies. The nurse will then fax the admission orders and transcribed orders to the pharmacy. The policy also included the 24-hour chart check nurse will</p>	F 760		

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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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F 760	<p>Continued From page 27 review transfer orders against admission orders and against the MAR for accuracy.</p> <p>Review of the facility's policy titled, Anticoagulation - Clinical Protocol revealed that as part of the initial assessment, the physician will help identify individuals who are currently anticoagulated and assess for any signs or symptoms of adverse drug reactions and evidence of effects related to the sub-therapeutic or greater than therapeutic drug level. The policy included the nurse shall assess and document/report current drug and dosage of anticoagulation therapy, lab results and monitoring, active diagnoses, and other current medications. The physician will verify underlying causes of conditions requiring anticoagulation therapy and will prescribe the therapy in accordance with recognized guidelines and will order appropriate lab testing to monitor the therapy.</p> <p>The facility's policy titled, 24-Hour Chart Checks stated that the 24-hour chart checks will be completed by the night shift. The policy included that each chart is checked for new orders and if any error is noted it is reported to the unit manager and corrected immediately. The policy included that if clarification of orders are needed, it must be followed-up promptly and reported. Staff will initial on the 24-hour chart check sheet located in the front of the physician's orders in the clinical record, after the chart check is completed.</p>	F 760		
F 773 SS=D	<p>Lab Svcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii)</p> <p>§483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when</p>	F 773		

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F 773	<p>Continued From page 28</p> <p>ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws.</p> <p>(ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, staff and resident interviews, and policy review, the facility failed to promptly notify the provider of abnormal laboratory results for one resident (#61).</p> <p>Findings include:</p> <p>Resident #61 was admitted to the facility on May 21, 2018, with diagnoses that included congestive heart failure, repeated falls, and urinary tract infection.</p> <p>Review of a quarterly Minimum Data Set (MDS) assessment dated August 23, 2018, revealed a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident was cognitively intact. The assessment also included the resident had a urinary tract infection (UTI) within the last 30 days.</p> <p>A nursing progress note dated October 22, 2018, revealed the resident complained of pain when voiding and had a history of frequent UTIs. The note included the provider was notified and that an order was obtained for a urinalysis (UA) with a culture and sensitivity (c&s). The note also</p>	F 773	<p>F773</p> <p>Correct to Individual: Resident #61's Provider was notified of the results of her UA C&S and it was documented in the Medical Record.</p> <p>Correct to all others: Has the potential to affect all Residents that have lab orders. Licensed Nurses will receive re-education on procedure for notifying the Provider of abnormal lab results and document the results in the medical record accordingly.</p> <p>System Correction: Audits of abnormal lab results reported to the Provider and documented in the medical record will be completed 2 times weekly for 90 days and then weekly thereafter.</p> <p>Monitoring System: The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed.</p> <p>Correction Date:</p> <p>Responsible Person: DON or Designee</p>	12/16/18	

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F 773	<p>Continued From page 29 included that the sample was collected and sent to the laboratory (lab).</p> <p>Review of the physician's order dated October 22, 2018, revealed an order for a urinalysis with culture and sensitivity if indicated.</p> <p>The results of the UA, c&s dated October 24, 2018 revealed the following abnormal results: -nitrite positive -3+ leukocyte esterase -slight cloudy -white blood cell >50 -White blood cell clumps -many bacteria -squamous epithelial -mucous threads</p> <p>However, no documentation was found that the results of this abnormal lab test were communicated to the provider.</p> <p>The final report of the urine lab dated October 27, 2018 revealed: ->100,000 gram negative rods/ escheria coli Again, no documentation was found that this final report of the urine lab was communicated to the provider.</p> <p>A nursing progress note dated November 1, 2018 at 2:37 p.m. revealed the UA results read positive for an UTI and that the provider was notified.</p> <p>Review of the physician's orders dated November 1, 2018, revealed an order for Keflex (antibiotic) 500 milligrams capsule by mouth every 12 hours for an UTI.</p> <p>An interview was conducted with the resident (#61) on October 29, 2018 at 11:16 a.m. She</p>	F 773			

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F 773	<p>Continued From page 30</p> <p>stated that she thinks she has an UTI and stated that her urine was sent to the lab "last week". She stated that she does not think the results are back yet because no one has told her the results or started her on a treatment. The resident stated that she has severe pressure and pain when she urinates and that it has made her cry. She also stated that she has a spastic urethra.</p> <p>An interview was conducted with a Licensed Practical Nurse (LPN/staff #44) on November 1, 2018 at 1:35 p.m. She stated that it is the nurse's responsibility to be on the lookout the laboratory results. She stated that she had not seen the laboratory report. The LPN stated that as soon as she reviews a lab report, she will call the provider if the laboratory results were abnormal or ordered STAT. She stated that a delayed notification of an abnormal UA to the provider could put the resident at risk of discomfort or sepsis. The LPN stated that their procedure was not followed in this instance because the provider was not notified of the lab results when the facility received the report.</p> <p>During an interview conducted with the unit manager (LPN/staff #187) on November 1, 2018 at 1:38 p.m., she stated that the lab results are faxed to the fax machine on "south" and that they are sorted and put in the individual folder for each unit. She stated that as far as she knows, her unit did not receive the lab report of the urine results for resident #61.</p> <p>An interview was conducted with the Family Nurse Practitioner (FNP/#326) for this resident on November 1, 2018 at 1:39 p.m. She stated that normally the provider is notified of laboratory reports as soon as the facility receives them. The</p>	F 773		

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

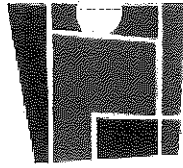
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F 773	<p>Continued From page 31</p> <p>FNP stated that she would review the resident's symptoms and the culture results and then decide on what interventions to implement. She stated that she was not notified of the UA or c&s results for resident #61. She also stated that if the physician had been notified of the results; the physician would have asked her to follow up. The FNP stated that it was concerning to her that it was over 48 hours before the provider was notified. She further stated that this delay in notification and treatment puts the resident at risk for sepsis or a kidney infection.</p> <p>During an interview conducted with a laboratory customer service representative (#325) on November 1, 2018 at 2:00 p.m., she stated that the initial report of the UA was faxed to the facility on October 24, 2018 at 2:30 p.m. and that the final c&s was faxed to the facility on October 27, 2018 at 9:30 a.m.</p> <p>During an interview conducted with the receptionist (staff #130) on November 1, 2018 at 2:10 p.m., she confirmed that the fax number the lab customer service representative stated was used to fax the lab reports was the correct fax number.</p> <p>An interview was conducted with the Director of Nursing (DON/staff #241) on November 1, 2018 at 2:13 p.m. She stated that when an order is received for a lab, a slip is filled out and sent to the laboratory. She stated that the laboratory will fax the results to the facility and that if the labs results are abnormal, the provider is notified on the shift that the lab results were received. She stated that if the provider gives an order, it will be reflected in the orders and a progress note. After reviewing the UA and c&s results for resident</p>	F 773		

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F 773	Continued From page 32 #61, the DON stated that the provider should have been notified of the results within the receiving nurse's shift. She stated that delaying to notify the provider of the lab results puts the resident at risk for sepsis. The facility's policy regarding laboratory ordering and monitoring revealed that each day the carbon copy of the previous day's lab log will be retrieved from each unit, the results obtained, and returned to the nursing staff. The policy included that the provider will be notified of results as needed, and that when the provider is notified verbally, the nurse is to date and sign/initial the lab slip, and include the name of the provider contacted.	F 773			



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

Receipt of This Notice is Presumed To Be 12/03/2018
Important Notice - Please Read

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

Dear Ms. Friebus:

On **November 6, 2018**, a 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/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaint investigations may have also been conducted.

The enclosed Life Safety Code deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please sign and return the original** and retain a **copy** for your files.

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

Sincerely,

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

Diane Eckles
Bureau Chief

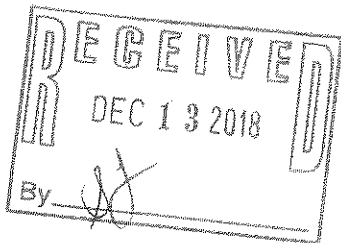
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Attachments

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

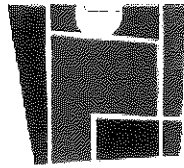
PRINTED: 11/08/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/06/2018
NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>INITIAL COMMENTS</p> <p>42 CFR 483.41(a) Nursing Home</p> <p>The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association.</p> <p>This is a Recertification survey for Medicare under LSC 2012, Chapter 19 Existing Nursing Home. The entire building was surveyed.</p> <p>The facility meets the standards, based upon compliance with all the provisions of the standards.</p> <p>No apparent deficiencies were found during the survey.</p>	K 000	<p>Arizona Department of Health Division of Public Health Reception Center DEC 13 2018 150 N. 18th Ave #401 Phoenix AZ 85007</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Heather Muebis* TITLE: *Administrative* (X6) DATE: *12/4/18*

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



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

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Important Notice - Please Read

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

Dear Ms. Friebus:

On **November 6, 2018**, a 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/State participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaint investigations may have also been conducted.

The enclosed Emergency Preparedness deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. This form will become a part of your public file; **please sign and return the original** and retain a **copy** for your files.

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

Sincerely,

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

Diane Eckles
Bureau Chief

DE\sg

Attachments

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

PRINTED: 11/08/2018
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E 000	<p>Initial Comments</p> <p>42 CFR 483.73 Long Term Care Facilities.</p> <p>The facility must meet all applicable Federal, State and local emergency preparedness requirements as outlined in the Medicare and Medicaid Programs: Emergency Preparedness Requirements of Medicare and Medicaid Participating Providers and Suppliers Final Rule (81 FR 63860) September 16, 2016.</p> <p>No apparent deficiencies noted at the time of the survey.</p>	E 000	<p>Arizona Department of Health Division of Public Health Training Center</p> <p>DEC 13 2018</p> <p>RECEIVED 150 N. 18th Ave #40 Phoenix AZ 85007</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Heather Krebs* TITLE *Administrative* (X6) DATE *12/4/18*

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

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey: From: F1 (mm/dd/yyyy) <i>10/29/18</i> To: F2 (mm/dd/yyyy) <i>11/1/18</i>		Extended Survey: From: F3 (mm/dd/yyyy) To: F4 (mm/dd/yyyy)	
Name of Facility Devon Gables Rehabilitation Center		Provider Number 035145	Fiscal Year Ending: F5 (mm/dd/yyyy) 12/31/2018

Street Address
6150 E. Grant Rd.

City Tucson	County Pima	State Az	Zip Code 85712
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Telephone Number: F6 (520) 296-6181	State/County Code: F7	State/Region Code: F8
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F9 <input type="checkbox"/> 0 <input type="checkbox"/> 3 01 Skilled Nursing Facility (SNF) - Medicare Participation 02 Nursing Facility (NF) - Medicaid Participation 03 SNF/NF - Medicare/Medicaid	Is this facility hospital based? F10 <input type="radio"/> Yes <input checked="" type="radio"/> No If yes, indicate Hospital Provider Number: F11 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
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Ownership: F12 <input type="checkbox"/> 1 <input type="checkbox"/> 3	For-Profit 01 Individual 02 Partnership 03 Corporation 13 Limited Liability Corporation	Non-Profit 04 Church Related 05 Nonprofit Corporation 06 Other Nonprofit	Government 07 State 08 County 09 City 10 City/County 11 Hospital District 12 Federal
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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 <input type="text"/> 0 <input type="text"/> <input type="text"/>	F16 Alzheimer's Disease <input type="text"/> 2 <input type="text"/> 4 <input type="text"/>	F17 Dialysis <input type="text"/> 9 <input type="text"/> <input type="text"/>
F18 Disabled Children/Young Adults <input type="text"/> 0 <input type="text"/> <input type="text"/>	F19 Head Trauma <input type="text"/> 0 <input type="text"/> <input type="text"/>	F20 Hospice <input type="text"/> 1 <input type="text"/> 7 <input type="text"/>
F21 Huntington's Disease <input type="text"/> 1 <input type="text"/> <input type="text"/>	F22 Ventilator/Respiratory Care <input type="text"/> 0 <input type="text"/> <input type="text"/>	F23 Other Specialized Rehabilitation <input type="text"/> 3 <input type="text"/> 2 <input type="text"/>

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? 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/yyyy) Hours waived per week: F29	Waiver of 24 hr licensed nursing requirement: Date: F30 (mm/dd/yyyy) Hours waived per week: F31
---	---

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

Name of Person Completing Form Heather Friebus	Time 15:00
Signature <i>Heather Friebus</i>	Date 10/29/2019

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035145	7	178	41	226
ADL	Independent		Assist of One or Two Staff	Dependent
Bathing	F79 3	F80 117	F81 106	
Dressing	F82 21	F83 190	F84 15	
Transferring	F85 23	F86 125	F87 78	
Toilet Use	F88 17	F89 157	F90 52	
Eating	F91 100	F92 114	F93 12	

A. Bowel/Bladder Status

- F94 18 With indwelling or external catheter
- F95 Of total number of residents with catheters, 15 were present on admission.
- F96 170 Occasionally or frequently incontinent of bladder
- F97 158 Occasionally or frequently incontinent of bowel
- F98 171 On individually written bladder training program
- F99 162 On individually written bowel training program

B. Mobility

- F100 4 Bedfast all or most of time
- F101 196 In chair all or most of time
- F102 11 Independently ambulatory
- F103 90 Ambulation with assistance or assistive device
- F104 0 Physically restrained
- F105 Of total number of residents restrained, 0 were admitted with orders for restraints.
- F106 124 With contractures
- F107 Of total number of residents with contractures, 68 had contractures on admission.

C. Mental Status

- F108 2 With mental retardation
- F109 99 With documented signs and symptoms of depression
- F110 124 With documented psychiatric diagnosis (exclude dementias and depression)
- F111 134 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type
- F112 80 With behavioral symptoms
- F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 80.
- F114 0 Receiving health rehabilitative services for MI/MR

D. Skin Integrity

- F115 13 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? 7
- F117 170 Receiving preventive skin care
- F118 6 With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119 17 Receiving hospice care benefit
 F120 0 Receiving radiation therapy
 F121 0 Receiving chemotherapy
 F122 9 Receiving dialysis
 F123 1 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion

F127 0 Receiving suctioning
 F128 67 Receiving injections (exclude vitamin B12 injections)
 F129 3 Receiving tube feedings
 F130 78 Receiving mechanically altered diets including pureed and all chopped food (not only meat)

F124 50 Receiving respiratory treatment
 F125 0 Receiving tracheostomy care
 F126 5 Receiving ostomy care

F131 29 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)
 F132 31 Assistive devices while eating

F. Medications

F133 172 Receiving any psychoactive medication
 F134 73 Receiving antipsychotic medications
 F135 53 Receiving antianxiety medications
 F136 148 Receiving antidepressant medications
 F137 11 Receiving hypnotic medications
 F138 8 Receiving antibiotics
 F139 154 On pain management program

G. Other

F140 1 With unplanned significant weight loss/gain
 F141 9 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 26 With advance directives
 F144 178 Received influenza immunization
 F145 146 Received pneumococcal vaccine

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

Signature of Person Completing the Form <i>Keudia Rogney</i>	Title DON	Date 10/29/2018
---	--------------	--------------------

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 10/25/2014 thru 10/25/2018
Arizona

Run Date: 10/25/2018
 Job # 74379309
 Last Update: 10/24/2018
 Page 1 of 4

DEVON GABLES REHABILITATION CENTER
 6150 EAST GRANT ROAD
 TUCSON, AZ 85712
 State's Region Code: TUC

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

Compliance Status: Provider meets requirements based on an acceptable plan of correction

Program Requirements

Current Survey/Revisit Dates - 09/18/2017

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
02/2014	-	04/2015	-	07/2016	-	08/10/2017	-	-	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
-	-	-	-	-	-	-	-	-	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
-	-	-	-	-	-	-	-	-	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
-	-	-	-	-	-	-	-	-	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
-	-	X	D	-	-	-	-	-	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
-	-	X	D	-	-	X	C	09/18/2017	F0224-PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN
-	-	X	D	-	-	-	-	-	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
-	-	X	D	-	-	-	-	-	F0226-DEVELOP/IMPLEMENT ABUSE/NEGLECT, ETC POLICIES
-	-	-	-	X	E	-	-	-	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	-	-	-	F0246-REASONABLE ACCOMMODATION OF
-	-	-	-	-	-	-	-	-	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	-	-	-	F0279-DEVELOP COMPREHENSIVE CARE PLANS
-	-	X	D	X	D	-	-	-	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	X	E	-	-	-	-	-	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
-	-	-	-	-	-	-	-	-	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
X	G	-	-	X	G	-	-	-	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	-	-	-	F0356-POSTED NURSE STAFFING INFORMATION
-	-	-	-	-	-	-	-	-	F0365-FOOD IN FORM TO MEET INDIVIDUAL NEEDS
-	-	-	-	X	D	-	-	-	F0366-SUBSTITUTES OF SIMILAR NUTRITIVE VALUE
-	-	-	-	X	E	-	-	-	F0371-FOOD PROCURE; STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	-	-	-	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
-	-	-	-	X	E	-	-	-	F0412-ROUTINE/EMERGENCY DENTAL SERVICES IN NFS
X	E	-	-	-	-	-	-	-	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
-	-	-	-	X	D	-	-	-	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	-	-	-	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	-	-	X	C	09/18/2017	F0469-MAINTAINS EFFECTIVE PEST CONTROL PROGRAM

I = 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 - = No Data Entered



CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 10/25/2014 thru 10/25/2018

Run Date: 10/25/2018
 Job # 74379309
 Last Update: 10/24/2018
 Page 2 of 4

DEVON GABLES REHABILITATION CENTER CCN: 035145

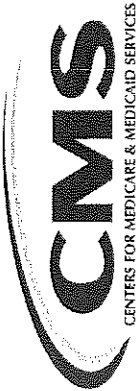
Prior 3 Survey	S/S Code	Prior 2 Survey	S/S Code	Prior 1 Survey	S/S Code	Current Survey	S/S Code	Plan/Date of Correction	Requirement
02/2014	-	-	-	-	-	08/10/2017	-	-	REQ F0502-ADMINISTRATION
	-	-	-	-	-		-	-	REQ F0504-LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN
	-	-	-	-	-		-	-	REQ F0505-PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS
	-	-	-	-	-		-	-	REQ F0507-LAB REPORTS IN RECORD - LAB NAME/ADDRESS
	-	-	-	-	-		-	-	REQ F0514-RES RECORDS-COMLETE/ACCURATE/ACCESSIBLE
	-	-	-	-	-		-	-	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
02/2014	-	-	-	-	-	08/10/2017	-	-	K0232-Aisle, Corridor, or Ramp Width
	-	-	-	-	-		-	-	K0271-Discharge from Exits
	-	-	-	-	-		-	-	K0281-Illumination of Means of Egress
	-	-	-	-	-		-	-	K0291-Emergency Lighting
	-	-	-	-	-		-	-	K0293-Exit Signage
	-	-	-	-	-		-	-	K0321-Hazardous Areas - Enclosure
	-	-	-	-	-		-	-	K0324-Cooking Facilities
	-	-	-	-	-		-	-	K0351-Sprinkler System - Installation
	-	-	-	-	-		-	-	K0353-Sprinkler System - Maintenance and Testing
	-	-	-	-	-		-	-	K0363-Corridor - Doors
	X	-	-	-	-		-	-	K0374-Subdivision of Building Spaces - Smoke Barrie
	-	-	-	-	-		-	-	K0511-Utilities - Gas and Electric
	-	-	-	-	-		-	-	K0753-Combustible Decorations
	-	-	-	-	-		-	-	K0920-Electrical Equipment - Power Cords and Extens
	X	-	-	-	-		-	-	K0923-Gas Equipment - Cylinder and Container Stora

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CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 10/25/2014 thru 10/25/2018

Run Date: 10/25/2018
 Job # 74379309
 Last Update: 10/24/2018
 Page 3 of 4

DEVON GABLES REHABILITATION CENTER CCN: 035145

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	2	7	5	2
Health Total	2	7	5	2
Life Safety Code	4	0	2	2
Life Safety Code + Health	6	7	7	4

Complaint Survey Information

Survey Date	Status
03/08/2018	Unsubstantiated
08/10/2017	Substantiated
07/29/2016	Substantiated
04/30/2015	Unsubstantiated

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**CASPER Report 0003D
Provider History Profile**

Based on Current Surveys from 10/25/2014 thru 10/25/2018

Run Date: 10/25/2018
Job # 74379309
Last Update: 10/24/2018
Page 4 of 4

DEVON GABLES REHABILITATION CENTER

CCN: 035145

LTC Resident Census

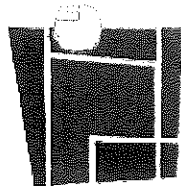
Resident Census on 08/10/2017

Total: 237
Medicare: 9
Medicaid: 184
Other: 44

Total Certified Beds: 312

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

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ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00144571
Investigation # AKMC11**

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,

A handwritten signature in black ink that reads "Shoalynn Gilliland-McCleery".

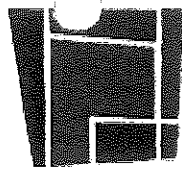
Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

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

Health and Wellness for all Arizonans



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

December 3, 2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00150091
Investigation # AKMC11**

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,

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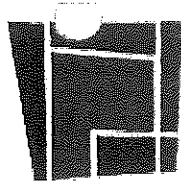
Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

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Health and Wellness for all Arizonans



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

12/03/2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00152452
Investigation # AKMC11**

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,

A handwritten signature in black ink that reads "Shoalynn Gilliland-McCleery".

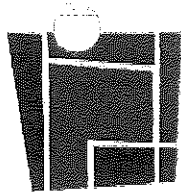
Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

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Health and Wellness for all Arizonans



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

12/03/2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00148231
Investigation # AKMC11**

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.

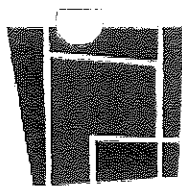
You are in receipt of a Statement of Deficiencies that reflect the finding of this survey.

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

Sincerely,

A handwritten signature in black ink that reads "Shoalynn Gilliland-McCleery".

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



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

12/03/2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00148231
Investigation # AKMC11**

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,

A handwritten signature in black ink, appearing to read 'Shoalynn Gilliland-McCleery'.

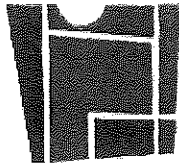
Shoalynn Gilliland-McCleery
Program Project Specialist II
Bureau of Long Term Care Licensing

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Health and Wellness for all Arizonans



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

12/03/2018

Important Notice - Please Read Carefully

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

**Re: Complaint Intake #AZ00149315
Investigation # AKMC11**

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.

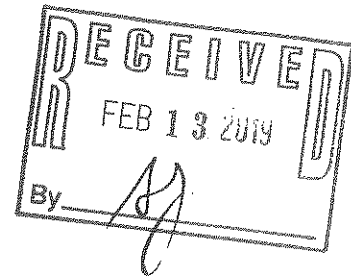
Sincerely,

A handwritten signature in black ink, appearing to read 'Shoalynn Gilliland-McCleery'.

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



COPY



Dear Shoalynn Gilliland,

Attached is our plan of correction for the state tags.
Please let me know if you need anything further.

Sincerely,

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

**ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES
BUREAU OF LONG TERM CARE FACILITIES LICENSING
ENFORCEMENT MEETING NOTIFICATION OF RIGHTS**

Facility Name: Devon Gables Rehabilitation Center

License # NCI-2652

Fac ID LTC0031

Please initial after each section.

1. I understand that I have the right to reject the proposed resolution and may refuse to sign this Agreement.

2. This Agreement has been reviewed and approved by the Assistant Director. If this agreement is changed, it will be returned to the Assistant Director for approval. _____
3. I understand that if I do not enter into an Agreement at this time, the Program will refer this matter to Public Health Licensing Services ("Licensing") Enforcement Team and a legal order may be prepared and sent to me.

4. I understand that I have due process rights and can request a hearing before the Office of Administrative Hearings regarding any legal order issued by the Department's Director. _____

I hereby acknowledge that I have discussed the above statements with the Department and understand my rights with regard thereto.

Licensee/Director/Provider: _____ Date: _____

Licensee/Director/Provider: _____ Date: _____

ENFORCEMENT MEETING AGREEMENT FORM

Facility Name: Devon Gables Rehabilitation Center

License # Nci-2652

Fac ID: LTC0031

A meeting was held on

A survey was conducted on November 1, 2018

The following Department concerns were discussed:

Agreement:

(initials) _____ Licensee agrees to pay civil fines in the amount of \$500.00.

(initials) _____ Licensee understands to not be in substantial compliance could result in further enforcement action up to and including denial of the renewal application.

(initials) _____ Licensee will return the original Statement of Deficiencies with the signed and dated acceptable Plan of Correction to the Department within 10 working days of receipt of this agreement.

- Meeting held in person
 Meeting held by teleconference
 Enforcement agreement mailed

	PLEASE PRINT NAME	SIGNATURE	TITLE	DATE
Licensee/Director/ Provider:		X		
Licensee/Director/ Provider:		X		
Bureau Chief (or designee):	Diane Eckles		Bureau Chief	
Assistant Director:	Colby Bower		Assistant Director	
Program & Project Specialist	Shoalynn Gilliland-McCleery		Program & Project Specialist II	
Team Leader:			Team Leader	
Surveyor:			Surveyor	
Surveyor:			Surveyor	
Surveyor:			Surveyor	
Attendee:				
Attendee:				
Attendee:				
Attendee:				

**ARIZONA DEPARTMENT OF HEALTH SERVICES
PUBLIC HEALTH LICENSING SERVICES
BUREAU OF LONG TERM CARE FACILITIES LICENSING**

[Full Facility Address (Name, Address, City, St, Zip)()]
License # Nci-2652

CIVIL FINES

Statute/Rule	Violations	Penalty Assessment	Penalty Amount
Y0339 R9-10-403.C.2.b. An administrator shall ensure that: C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: C.2.b. Cover the provision of physical health services and behavioral health services	Based on clinical record review, staff interviews, facility documentation and policy and procedures, the facility failed ensure services provided met professional standards of quality, by failing to ensure that one resident (#370) received anticoagulant medication per the admission orders	Date of survey 11/01/2018	\$250.00
Y2109 R9-10-421.A.I.b.i. An administrator shall ensure that policies and procedures for medication services: A.1. Include: A.1.b. Procedures for preventing, responding to, and reporting: A.1.b.i. A medication error,	Based on clinical record review, staff interviews, facility documentation and policies and procedures, the facility failed to implement their policy to ensure one resident (#370) was free from a significant medication error, by failing to administer an anticoagulant medication per the admission orders.	Date of survey 11/01/2018	\$250.00
Total			\$500.00

Licensee agrees to pay the Department civil fines, pursuant to A.R.S. § 36-431.01, in the total amount of five hundred dollars (\$500.00) without interest for all violations set forth on this Civil Fines Form.

Please remit a **credit card or e-check** payable to the Arizona Department of Health Services. Payment needs to be made via the Division of Licensing Services Online Website: <https://licensing.azdhs.gov/LicensingOnline/Account/Login>.

If the Entity is sold on or after the execution date of this Agreement, Licensee shall pay the civil fines.

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 **February 1, 2019**. 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 **February 1, 2019**.

FILING AN APPEAL

If you disagree with the determination of noncompliance (and/or substandard quality of care resulting in the loss of your Nurse Aide Training and Competency Evaluation Program (NATCEP), if applicable), 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. 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 request for a 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 have counsel represent you at a hearing (at your own expense). Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted unless you do not have access to a computer or internet service. **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.**

When using DAB E-File for the first time, you will need to create an account by a) clicking Register on the DAB E-File home page; b) entering the requested information on the Register New Account form; and c) clicking Register Account at the bottom of the form. Each representative authorized to represent you must register separately to use the DAB E-File on your behalf.

The e-mail address and password given 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/she is a party or an authorized representative. You can file a new appeal by a) clicking the *File New Appeal* link on the Manage Existing Appeals screen; then b) clicking *Civil Remedies Division* on the File New Appeal screen; and c) entering and uploading the requested information and documents on the File New Appeal-Civil Remedies Division form.

The Civil Remedies Division (CRD) requires all hearing requests to be signed and accompanied by the notice letter from CMS that addresses the action taken and your appeal rights. All submitted documents must be in Portable Document Format (PDF). Documents uploaded to DAB E-File on any day on or before 11:59p.m. ET

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

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December 3, 2018

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will be considered to have been received on that day. You will be expected to accept electronic service of any appeal-related documents filed by CMS or that the CRD issues on behalf of the Administrative Law Judge (ALJ) via DAB E-File. Further instructions are located at: https://dab.efile.hhs.gov/appeals/to_crd_instructions. Please contact the Civil Remedies Division at (202) 565-9462 if you have questions regarding the DAB E-Filing System. If you experience technical issues with the DAB E-Filing System, please contact E-File System Support at OSDABImmediateOffice@hhs.gov or call (202) 565-0146 before 4:00p.m. ET.

If you do not have access to a computer or internet service, you may call the Civil Remedies Division at (202) 565-9462 to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter by mailing to the following address:

**Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201**

In addition, please email a copy of your request to Western Division of Survey and Certification-San Francisco at ROSFEnforcements@cms.hhs.gov.

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 **November 1, 2018** 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.

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: facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

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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 **December 13, 2018**, licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,



Diane Eckles
Bureau Chief

DE\sg
Attachments

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

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

PRINTED: 12/03/2018
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 11/01/2018
NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6160 EAST GRANT ROAD TUCSON, AZ 85712	
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F 000	INITIAL COMMENTS The recertification survey was conducted on October 29 through November 1, 2018, in conjunction with the following Complaint investigations: AZ00144571, AZ00148231, AZ00149315, AZ00150091, and AZ00152452. The following deficiencies were cited. Past non compliance was also identified and cited.	F 000	Arizona Department of Health Services Division of Public Health Inspector Tom Gage DEC 13 2018 RECEPTION DESK 150 N. 18th Ave #400 Phoenix, AZ 85007	
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation 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 medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff and resident interviews, facility documentation, and review of policies and procedures, the facility failed to ensure resident #35 was free from abuse by resident #91, and failed to ensure that resident #47 was free from abuse by resident #152. Findings include: -Resident #35 was admitted to the facility on	F 600	F600 Correct to the individual: Immediately following the incident on 10/29/2018, Resident #91 was placed on 1:1 monitoring and the Physician ordered to send resident to emergency room for stabilization. Resident #91 has been discharged from the facility. Resident #152 was immediately separated from resident #47 and upon evaluation of resident #47 there were no identified injuries and she felt safe. There were no adverse outcomes to the residents involved in either of the events cited.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Heather Krebs* TITLE *Administrator* (X6) DATE *12/13/18*

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

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F 600	<p>Continued From page 1</p> <p>August 1, 2018 with diagnoses that included vascular dementia with behavioral disturbance, major depressive disorder, aphasia, cerebral infarction, and post-traumatic stress disorder.</p> <p>Review of a nursing note dated August 7, 2018 revealed "Admission MDS (Minimum Data Set) interview attempted. (Name of resident) has clear speech with aphasia, fluctuating inattention and was unable to answer BIMS (Brief Interview for Mental Status) assessment questions appropriately. He said multiple times that he wants to go home..."</p> <p>A behavioral symptoms care plan dated August 14, 2018 revealed "(Name of resident) has socially/inappropriate/disruptive behaviors related to dementia. He has target behavior for monitoring for physical aggression, verbal aggression, and restlessness/agitation..." An approach included was "...Avoid over-stimulation with noise, crowding, and other verbally/physically aggressive residents..."</p> <p>-Resident #91 was admitted to the facility on August 17, 2018 with a diagnosis of unspecified dementia with behavioral disturbance.</p> <p>A nursing note dated August 17, 2018 revealed "...Resident has a history of homicidal ideation, combative with family..."</p> <p>An admission MDS assessment dated August 24, 2018 revealed a BIMS (Brief Interview for Mental Status) score of 3 which indicated the resident had severely impaired cognition.</p> <p>A behavioral symptoms care plan dated August 29, 2018 revealed "(Name of resident) has</p>	F 600	<p>Correct to all others: All residents have the potential to be affected. Direct Care staff will receive re-education on de-escalating techniques and ways to help prevent resident to resident altercations from occurring.</p> <p>System Correction: Visual audits of resident to resident interactions will be made weekly to help ensure that residents are safe.</p> <p>Monitoring of System: The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed.</p> <p>Correction Date:</p> <p>Responsible Person: DON or Designee</p>	12/16/18

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F 600	<p>Continued From page 2</p> <p>undesirable behaviors related to dementia..." An approach included was "...Assess whether (name of resident) behaviors endanger himself or others. Intervene as needed..."</p> <p>A nursing note dated September 25, 2018 revealed "BHT (behavioral health team) Review: Resident presented for new psychiatric consult for mental health managements. Resident has been pacing up and down the hall, non-redirectable. Target Behaviors monitored: hallucinations, wandering in unit..."</p> <p>A nursing note dated October 14, 2018 revealed "Resident in and out of other resident room. Yelling he needs to go pick up his wife. This nurse notified NP (nurse practitioner) and order obtained to reinstate IM (intramuscular) and PO (by mouth) Ativan."</p> <p>Another nursing note dated October 27, 2018 revealed "Resident observed on the floor with another resident. Appears to have wandered into another resident's room. This resident escorted him out, during this they both fell to the floor...no apparent injury..."</p> <p>A nursing note dated October 29, 2018 at 6:25 a.m. revealed "...resident medicated during the night with Ativan for increased behaviors. Resident trying to go out back door and in and out of residents room. Resident not easily redirected. Will continue to provide calm quiet environment."</p> <p>Another nursing note dated October 29, 2018 at 11:42 a.m. revealed "Resident involved in resident to resident altercation. Resident agitated and combative this morning. Multiple attempts at redirection unsuccessful. Resident medicated</p>	F 600		

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F 600	<p>Continued From page 3</p> <p>with PRN (as needed) Ativan with no helpful results. Resident wandered into peer's (resident #35) room, when approached by male peer, resident became aggressive striking peer with rolled up magazine to the face. Staff immediately intervened and redirected away from each other. Resident placed on 1:1. Provider contacted and new order received to send resident to emergency room for stabilization. Family notified..."</p> <p>The resident's clinical record revealed the resident (#91) was transferred to the emergency room at 12:27 p.m. on October 29, 2018.</p> <p>Review of resident #35's clinical record revealed the resident sustained slight redness to the right side of his cheek.</p> <p>A Witness Statement Form dated October 29, 2018 revealed "I was on the hallway by my cart and I heard yelling so I looked over to my left and I saw (resident #91) had a rolled up magazine in his hand and hit (resident #35) in the face. And then (resident #35) grabbed (resident #91) by the arms and I told him not to do anything to him as a CNA (certified nursing assistant) came to separate them since she was closer. (Resident #91) looked very upset even after being separated."</p> <p>An interview was conducted with a CNA (staff #272) on October 31, 2018 at 11:00 a.m. Staff #272 stated that she heard in report that resident #91 hit resident #35 with a magazine. Staff #272 further stated resident #91 is very busy and is everywhere.</p> <p>An interview was conducted with resident #35 on</p>	F 600			

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F 600	<p>Continued From page 4</p> <p>October 31, 2018 at 11:20 a.m. The resident had difficulty expressing himself. When asked about the incident which occurred on October 29, 2018 with resident #91, resident #35 clearly stated "I don't like that guy, he is an a--hole." Resident #35 further stated "I was sitting right here (as he pointed to his chair by his bed) and Bam (made a gesture that resident #91 hit him on the side of the face)." When asked what resident #91 hit him with, resident #35 stated "He is an a--hole." When asked if resident #91 use a magazine to hit him in the face, resident #35 stated "yes."</p> <p>During an interview conducted with an environmental services assistant (staff #300) on October 31, 2018 at 1:54 p.m. Staff #300 stated that she was cleaning the bathroom when she heard a noise and that it was a fight. Staff #300 stated that she did not see resident #91 hit resident #35.</p> <p>An interview was conducted with an LPN (licensed practical nurse/staff #29) on October 31, 2018 at 3:03 p.m. Staff #29 stated a CNA had attempted to redirect resident #91 closer to activities but that the resident would not follow along. Staff #29 stated that resident #91 "was on a roll" that day in and out of rooms so she ended up administering Ativan prior to the incident. Staff #29 further stated that she did not witness the incident but heard that resident #91 was "messaging" with resident #35's wet floor sign in his room and that he (resident #91) "whacked" resident #35 with a rolled up magazine.</p> <p>During an interview conducted with the administrator (staff #87) on October 31, 2018 at 3:16 p.m. Staff #87 stated that staff receive training in CPI (crisis prevention intervention) and</p>	F 600			

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F 600	<p>Continued From page 5 de-escalation of behaviors.</p> <p>An interview was conducted with a housekeeper (staff #45) on November 1, 2018 at 9:15 a.m. Staff #45 stated that she was in another resident's room when she heard residents #'s 35 and 91 talking loudly. Staff #45 stated that she turned around and saw resident #91 hit resident #35's face with a magazine. Staff #45 stated that resident #35 did not hit resident #91 back but tried to get him out of his room.</p> <p>-Resident #47 was admitted to the facility on February 6, 2009, with diagnoses that included obstructive hydrocephalus, diabetes type II, and Schizophrenia.</p> <p>A quarterly MDS assessment dated May 17, 2018, revealed a BIMS score of 4, which indicated the resident had severely impaired cognition.</p> <p>-Resident #152 was admitted to the facility on April 4, 2016 with diagnoses that included cellulitis, major depressive disorder, pain, and schizoaffective disorder.</p> <p>Review of the annual MDS assessment dated June 21, 2018, revealed a BIMS score of 15, which indicated the resident was cognitively intact.</p> <p>Review of the facility's investigation report revealed a resident to resident altercation occurred on June 23, 2018 between roommates resident #152 and resident #47. Staff overheard resident #152 yell at resident #47. When staff started walking toward the room a slapping sound</p>	F 600			

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F 600	<p>Continued From page 6</p> <p>was heard. Resident #152 verbalized that resident #47 was in the way and was repeatedly asking her questions. The report included resident #152 admitted she slapped her roommate and that no injuries were noted.</p> <p>The facility's investigation report included a written witness statement from a CNA (staff #205). Staff #205 stated that while on break in the dining room, she heard resident #152 yell at resident #47 and that before she could find out what was going, she heard a slap. The CNA stated that resident #47 was asking why did resident #152 hurt her. The CNA stated that she told resident #152 that she cannot do that, but that resident #152 said that she can slap resident #47.</p> <p>Another CNA (#273) written witness statement was included in the report. CNA #273 stated that she heard resident #152 yell at resident #47 because she was exiting the room while resident #152 was trying to enter. She stated as she was leaving the room that she was in, she heard resident #152 slap resident #47. The CNA stated that CNA #205 ran from the break area and asked resident #152 if she had slapped resident #47 and that resident #152 admitted she that hit resident #47.</p> <p>During an interview conducted with CNA #205 on October 31, 2018 at 8:47 a.m., she stated that she remembered the incident between the residents. The CNA stated that she heard a slapping sound coming from the doorway of the residents' room. She stated that she asked resident #152 if she had hit resident #47 and that resident #152 stated that she did hit resident #47.</p>	F 600			

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F 600	<p>Continued From page 7</p> <p>An interview was conducted with CNA #273 on October 31, 2018 10:34 a.m. She stated that she heard a loud slapping coming from the residents' room. The CNA stated that the residents were separated and another staff member asked resident #152 if she had slapped resident #47 and that the resident stated that she did slap resident #47.</p> <p>During an interview conducted on November 1, 2018 at 12:42 p.m. with the Director of Nursing (DON #241), she stated that she was familiar with the resident to resident altercation and that neither resident was injured.</p> <p>The facility's policy regarding Behavior Changes/Combative/Aggressive Behavior (Resident) revealed "...Every effort is made to have all staff trained in CPI (nonviolent crisis intervention program). The program educates and trains staff in identification of escalating behaviors and strategies in deceleration using supportive and/or directive approaches..."</p>	F 600		
F 658 SS=G	<p>Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i)</p> <p>§483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-</p> <p>(i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by:</p>	F 658		

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F 658	<p>Continued From page 8</p> <p>Based on clinical record review, staff interviews, facility documentation and policy and procedures, the facility failed ensure services provided met professional standards of quality, by failing to ensure that one resident (#370) received anticoagulant medication per the admission orders.</p> <p>Findings include:</p> <p>Resident #370 was admitted to the facility on 10/16/2017 and readmitted on 11/29/17, with diagnoses that included chronic systolic congestive heart failure, prosthetic aortic heart valve, chronic obstructive pulmonary disease, prior myocardial infarction (MI), chronic kidney disease and pacemaker.</p> <p>Review of the Admission Orders received from the referring hospital dated 10/16/17 revealed for Warfarin (anticoagulant) 3 mg (milligram) tablet orally every Monday, Tuesday, Thursday, Friday and Sunday and Warfarin 5 mg tablet orally every Wednesday and Saturday. On the Admission Orders, these two medication orders were crossed through and it was handwritten in for Warfarin 3.5 mg daily and for INR (International Normalized Ratio) lab tests on Mondays and Thursdays.</p> <p>However, the recapitulation of physician orders (recap) for October 2017 did not include an order for Warfarin or for the INR lab tests to be done.</p> <p>Review of the Medication Administration Record (MAR) for October 2017 did not reveal any documentation that the resident was administered Warfarin.</p>	F 658	Past noncompliance: no plan of correction required.	

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F 658	<p>Continued From page 9</p> <p>The MAR for October 2017 revealed documentation that a 24 hour chart check was completed for accuracy of daily new orders on 10/16/17, however, there was no documentation that the Warfarin and INR orders were identified as being missed from the recap and the MAR.</p> <p>Review of the Nurse Practitioner (NP) Initial Comprehensive Evaluation (H&P) dated 10/17/17, revealed the resident had HCVD (hypertensive cardiovascular disease) with CHF/CAD/AVR (congestive heart failure/coronary artery disease/aortic valve replacement).</p> <p>A baseline cardiovascular care plan dated 10/17/17 included under Cardio-output that the resident had a history of MI and Aortic Valve. The section to include the potential for bleeding related to anticoagulants was not selected and there were no interventions related to the use of anticoagulants.</p> <p>An Interim Medication Regimen Review was conducted on 10/18/17, which included documentation that no medication related issues were found.</p> <p>An admission Minimum Data Set (MDS) assessment dated 10/23/17 included the resident had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident was cognitively intact.</p> <p>Additional physician and NP notes dated 10/25/17, 10/27/17, 10/31/17, 11/01/17 contained documentation that the resident had a history of MI and AVR, however, there was no mention of any anticoagulant therapy.</p>	F 658		

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F 658	<p>Continued From page 10</p> <p>Review of recap for 10/16/17 through 11/16/17 revealed no orders for Warfarin or INR lab tests, however the orders were signed by a staff member and a Registered Nurse (RN) who noted the orders on 10/17/17. The recap was also signed by the physician.</p> <p>A review of the MARs from 10/16/17 through 11/20/17 revealed the resident's chart was checked on the night shift every 24 hours for accuracy of daily new orders.</p> <p>A physician's order was obtained on 11/20/16 for Warfarin 5 mg orally once each day and for INR's to be done on Tuesday and Friday, for a diagnosis of prosthetic aortic heart valve.</p> <p>An INR lab test was completed on 11/21/17 and the lab result was 1.2 which was a sub-therapeutic level. (Therapeutic INR levels for secondary prevention after a myocardial infarction or for patients with high-risk mechanical prosthetic heart valves is 2.5 to 3.5.</p> <p>There was no clinical record documentation that the physician was notified of the sub-therapeutic INR result.</p> <p>A nurse progress note dated 11/22/17 revealed that around 7:30 p.m., the resident appeared to be confused. The resident's vital signs were stable, but her blood sugar was elevated at 447 and was administered insulin. The note also included that a family member requested the resident be sent to the hospital, so 911 was called and the resident was transported to the hospital at 9:00 p.m.</p> <p>Review of the emergency department physician</p>	F 658			

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F 658	<p>Continued From page 11</p> <p>note dated 11/22/17 revealed the resident presented with altered mental status. Diagnoses included confusion, delirium, cerebral vascular accident, hypoglycemia, intracranial hemorrhage and metabolic encephalopathy. The resident was admitted to the Telemetry Unit in stable condition.</p> <p>A hospital physician's note dated 11/27/17 revealed the chief complaint of the patient was "new CVA (cerebral vascular accident) with dysarthria (difficulty speaking)." The History of Present Illness included, "she has now suffered a CVA after being sub-therapeutic on her Warfarin."</p> <p>Review of the hospital course summary dated 11/29/17 revealed the resident was on chronic anticoagulation, due to mechanical aortic valve replacement. The resident presented to the emergency department due to progressive worsening of altered mental status, lethargy, and recent somnolence. In addition to confusion, the patient was having difficulty talking. The summary included the resident's INR level was 1.6, "which is sub-therapeutic and given the patient's mechanical aortic valve, the resident should have a goal INR of 3." The documentation further included the patient was found, on repeat Computerized Tomography (CT) imaging to have an "acute stroke, and this is thought to be embolic given her subacute therapeutic INR. Per neurology recommendations, we will continue Warfarin with up-titration still as to get her INR back in to range..at a goal of 3.0."</p> <p>In an interview conducted on 10/31/18 at 1:48 p.m. with a Licensed Practical Nurse (LPN/staff #214), who stated that the medication orders are supplied by the hospital and signed by the hospital physician or NP. Staff #214 said that on</p>	F 658			

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F 658	<p>Continued From page 12</p> <p>admission, the orders are reviewed with the physician, usually by reading them over the phone, and then the orders are entered into the electronic chart. He stated that after the orders are entered, the order recap is printed, reviewed and signed by the physician at the facility. He said they also have a chart check process which is completed every 24 hours by the night nurse and includes a check of the new orders and verification that the order recap is correct. Staff #214 stated if there are medications that were on the hospital orders and not on the order recap, the nurse should look for a note as to why or call the physician. Staff #214 stated he would expect a resident with clinical indications for long term anticoagulants would continue on that medication while at the facility. He also stated that if the medications were missed when adding them to the electronic record, he would expect them to be caught during the chart check process. He said if a resident is on long term anticoagulants and they were suddenly stopped, it could result in coagulation of the blood leading to clots, pulmonary embolism, deep vein thrombosis and stroke.</p> <p>An interview was conducted on 11/01/18 at 9:15 a.m. with the Director of Nursing (DON/staff #241), who stated that the admitting department works on getting the resident information and orders from the hospital. The DON stated when she became aware of the missed Warfarin and labs for resident #370, she started a Performance Improvement Plan (PIP) for our Quality Assurance Process Improvement (QAPI) committee, which was designed to identify how this occurred and ensure there is a process in place so it does not happen again. The DON stated there was some confusion on the new</p>	F 658		

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F 658	<p>Continued From page 13</p> <p>admission orders regarding which list would be used to reconcile the orders and transcribe them into the electronic record. The DON said that now staff make a note as to which order list was used for reconciliation and they continue to do random audits on orders and 100% audits on all admission charts. The DON stated all staff were re-educated on the process. She said in the case of resident #370, all of the hospital orders had Warfarin on them, and that it just got missed, and fell through all of their safety checks. She said the 24-hour chart checks missed it, the physician did a History and Physical the next day and missed it, and the pharmacy review did a review 2 days later and it was missed. The DON stated the Unit Manager brought it to her attention that the Warfarin was missed since admission and the physician was contacted and orders were obtained for the medication and lab tests on 11/20/18. The DON stated the INR was drawn on 11/21/17 and the result was 1.2, and the physician should have been notified, because it was at a sub-therapeutic level. The DON stated that as part of the PIP, a section was added to the MAR where the nurses document the result and that the provider was notified.</p> <p>An interview was conducted on 11/01/18 at 9:41 a.m. with the Administrator (staff #87), who stated the facility has initiated the following measures:</p> <ul style="list-style-type: none"> -The nurse managers and weekend supervisors are completing chart audits and notify the Administrator if any discrepancies are identified -Staff education was initiated when this event was identified -Chart audits were completed on 100% of new admissions and randomly on other charts and no medication reconciliation issues were identified 	F 658			

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F 658	<p>Continued From page 14</p> <ul style="list-style-type: none"> -Physicians are now asked to review the hospital orders for medications and the facility transcribed orders when they come in to see a new resident -The facility sends the hospital orders and the facility transcribed orders to the pharmacy for review -The pharmacy consultant reviews all medications errors and assists with identifying any process concerns and remedies -The medical director and the pharmacy consultant sign off on all medication errors. -The PIP was completed in February 2018 and the issue was then turned to ongoing QAPI quality audits. <p>Review of the facility PIP and ongoing QAPI documentation revealed the following:</p> <p>QAPI Action Plan was initiated on 11/28/17 with the root cause identified as multiple medication lists received from the hospital, causing confusion and changes to physician verified orders, which caused confusion with the chart checks. The tasks included education for licensed nurses on admission order transcription and 24-hour chart check process, updates to the admission audit process to ensure hospital orders and facility orders are reconciled and noted by the admission nurse, DON and Unit Managers will review all admission audits. All reports on activity for QAPI Action Plan will be reviewed every 2 weeks.</p> <p>The QAPI Action Plan also included the following:</p> <ul style="list-style-type: none"> -Notes of ongoing review identified no new concerns on 12/15/17, 12/29/17, 1/11/18, 1/25/18, 2/8/18 and 2/22/18 -Action Plan did not note any concerns since staff 	F 658		

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F 658	<p>Continued From page 15</p> <p>education and the plan then transitioned to monthly updates at the QAPI Committee meeting</p> <ul style="list-style-type: none"> -Staff education materials included 24-hour chart check steps and responsibilities, how to check orders for all admissions, and the procedure for admission order transcription and verification -Sign in sheets for 65 staff members between 11/28/17 and 1/9/18 -Admission audit sheets -Audits completed since beginning of PIP with no identified concerns <p>Review of the facility's investigation and actions in response to the event included:</p> <ul style="list-style-type: none"> -QAPI plan -Medication error report for the nurse that admitted resident #370 and reconciled the initial orders which were signed by the staff member, supervisor, DON, Medical Director, Administrator and Pharmacy Consultant. -Components of the clinical record that included the admission order sheet with handwritten notes, the transcribed orders appearing on the order recap, Interim Medication Regimen Review, H&P, and all documents from the QAPI plan -Chronological summary of events that included how the medication was missed at multiple check points during the first few days of admission to the facility, the description of events on the 11/20/17 when it was discovered that the medication was not administered, the events on 11/22/17 when the resident's condition changed and was transported to the hospital, and the resident's return to the facility following a stroke on 11/29/17. <p>Review of the facility's policy titled, Admission Orders: Reconciliation Procedures revealed the</p>	F 658		

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F 658	<p>Continued From page 16</p> <p>facility will take measures to obtain accurate admission orders. The policy included that the nurse receiving the resident shall review the orders and make recommendations to the provider after observation of the resident. All admitting orders are to be reviewed by a licensed nurse. The nurse will document that the admission orders were reconciled for accuracy and will notify the provider of any discrepancies. The nurse will then fax the admission orders and transcribed orders to the pharmacy. The policy also included the 24-hour chart check nurse will review transfer orders against admission orders and against the MAR for accuracy.</p> <p>Review of the facility's policy titled, Anticoagulation - Clinical Protocol revealed that as part of the initial assessment, the physician will help identify individuals who are currently anticoagulated and assess for any signs or symptoms of adverse drug reactions and evidence of effects related to the sub-therapeutic or greater than therapeutic drug level. The policy included the nurse shall assess and document/report current drug and dosage of anticoagulation therapy, lab results and monitoring, active diagnoses, and other current medications. The physician will verify underlying causes of conditions requiring anticoagulation therapy and will prescribe the therapy in accordance with recognized guidelines and will order appropriate lab testing to monitor the therapy.</p> <p>The facility's policy titled, 24-Hour Chart Checks stated that the 24-hour chart checks will be completed by the night shift. The policy included that each chart is checked for new orders and if any error is noted it is reported to the unit</p>	F 658			

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F 658	Continued From page 17 manager and corrected immediately. If clarification of orders are needed, it must be followed-up promptly and reported. Staff will initial on the 24-hour chart check sheet located in the front of the physician's orders in the clinical record, after the chart check is completed.	F 658	F686 Correct to individual: Resident #470 was discharged from the facility on 9/28/17. Correct to all others: Has the potential to affect any residents with existing alterations in skin integrity. Licensed Nurses will be re- educated on the requirement to document that a Provider is notified of a decline in wound status. System Correction: Audits will be completed for any wounds weekly to ensure that the Provider is notified of a declining wound. Monitoring of System: The analysis of the audits will be taken to QAPI for review monthly and follow up as needed.		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and policies and procedures, the facility failed to ensure that the physician was notified of changes in the condition of two wounds for one resident (#470). Findings include: Resident #470 was admitted on May 11, 2017, with diagnoses that included encounter for other orthopedic aftercare, muscle weakness, incomplete quadriplegia, and spinal stenosis of the cervical region.	F 686		12/16/18	

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F 686	Continued From page 18 The care plan initiated June 1, 2017, revealed the resident was at risk for pressure ulcers. Interventions included reporting any signs of skin breakdown. Review of a significant change in status Minimum Data Assessment (MDS) assessment dated August 17, 2017, revealed a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident was cognitively intact. The MDS assessment further included the resident had no pressure ulcers. A nursing progress note dated September 19, 2017, revealed that the resident was assessed during a shower and was observed to have open areas to the right ischium and coccyx that were pink/red in color. A skin integrity event form dated September 19, 2017 revealed that the injury to the right ischium measured 6.5 centimeters (cm) x 7.6 cm x 0.2 cm and that the skin impairment to the coccyx measured 1 cm x 0.5 cm x 0.1 cm. and that they were open, pink/red, and blanchable. The documentation also included that the physician was notified on September 19, 2017 at 2:00 p.m. Review of the care plan initiated September 19, 2017, revealed the resident had open areas to the right ischium and coccyx related to moisture associated skin damage. Review of a nursing progress note dated September 26, 2017, revealed the area to the right ischium had darkened in color to a dark purple and was no longer blanchable and measured 4.5 cm x 5.5 cm x 0.1 cm. and that	F 686			

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F 686	<p>Continued From page 19</p> <p>there a small amount of drainage. The note also revealed the peri wound was intact and blanched well and that the treatment continued as ordered.</p> <p>The note further included the wound bed to the coccyx region was pink/red in color and had increased in size to 1.4 cm x 3.7 cm x 0.1 and now consisted of three small areas with attached edges with a scant amount of drainage. The note also included that the areas and the peri wound continued to blanch and that the treatment continued as ordered.</p> <p>However, further review of the clinical record did not reveal documentation that the physician was notified of the changes in the wounds' condition. The resident was discharged on September 28, 2017.</p> <p>During an interview conducted with a Licensed Practical Nurse (LPN/staff #44) on November 1, 2018 at 9:35 a.m., she stated that the floor nurse, the wound team, the Director of Nursing (DON), and the unit manager follow a resident with an existing wound. The LPN stated that if a wound worsens, the nurse would notify the physician and the wound team and document the notification in the nursing progress notes.</p> <p>An interview was conducted with the Wound Care Certified (WCC) Registered Nurse (RN/staff #253) on November 1, 2018 at 9:58 a.m. She stated that the wound care team, sometimes with the Nurse Practitioner, rounds on existing wounds once a week. The RN stated that if there was a change in the wound she would notify the provider and document the provider notification in her notes, progress notes, or by presence of a new physician order. She stated that if the floor</p>	F 686			