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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: JYNH
Facility ID: LTC0031

1. MEDICARE/MEDICAID PROVIDER NO. (L1) 035145

2. STATE VENDOR OR MEDICAID NO. (L2) 748491

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 08/31/2012

6. DATE OF SURVEY 07/29/2016 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) 12/31

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

12. Total Facility Beds 312 (L18)

13. Total Certified Beds 312 (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	312			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Recertification survey for Devon Gables Rehabilitation Center. Annual survey was conducted on 07/29/2016 facility found to be out of compliance base on F tag #323. Devon Gables is back in compliance with federal regulations based on an acceptable plan of correction received 08/24/2016 revisit survey completed on 09/27/2016 State Agency recommended recertification.

17. SURVEYOR SIGNATURE Diane Eckles Date:
Christine Benson Simmons [signature] 10/27/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
[signature] 10/27/2016 (L20)

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

19. DETERMINATION OF ELIGIBILITY
_X_ 1. Facility is Eligible to Participate
___ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above:

22. ORIGINAL DATE OF PARTICIPATION
11/08/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions: (L44)
B. Rescind Suspension Date: (L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY 00
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

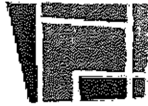
29. INTERMEDIARY/CARRIER NO.
03101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL



ARIZONA DEPARTMENT
OF HEALTH SERVICES
LICENSING

Public Health Licensing Services
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

October 27, 2016

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

Re: Provider Number 035145

Dear Ms. Friebus:

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

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

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE/bh

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DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

October 27, 2016

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

Dear Ms. Friebus:

Enclosed is the **Post-Certification Revisit Report** forms which indicates that the following deficiencies have been corrected on September 27, 2016. A copy will be filed in your public file.

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

Sincerely,

B Hernandez

Belinda Hernandez
Examine Technician II

\bh

Enclosure

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 035145 Y1	MULTIPLE CONSTRUCTION A. Building B. Wing Y2	DATE OF REVISIT 9/27/2016 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 F0241 Reg. # 483.15(a) LSC	Correction Completed 09/27/2016	ID Prefix F0281 Reg. # 483.20(k)(3)(i) LSC	Correction Completed 09/27/2016	ID Prefix F0323 Reg. # 483.25(h) LSC	Correction Completed 09/27/2016
ID Prefix F0366 Reg. # 483.35(d)(4) LSC	Correction Completed 09/27/2016	ID Prefix F0371 Reg. # 483.35(i) LSC	Correction Completed 09/27/2016	ID Prefix F0412 Reg. # 483.55(b) LSC	Correction Completed 09/27/2016
ID Prefix F0441 Reg. # 483.65 LSC	Correction Completed 09/27/2016	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS)	DATE 9/28/16	SIGNATURE OF SURVEYOR A. Farnsworth	DATE 9/28/16
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 7/29/2016		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

Public Health Licensing Services
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

September 22, 2016

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

Dear Ms. Friebus:

Thank you for the documentation submitted with your request for informal dispute resolution regarding the Statement of Deficiencies for Health Survey JYNH11 conducted on July 29, 2016.

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

> **F Tag-323 Free of Accident Hazards/supervision/devices - 483.25 (h)** will remain as written with the same scope and severity of "G."
>
> **Y Tag-2503 Environmental Standards R9-10-425.A.1.b.** will remain as written.

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

Sincerely,

Colby Bower
Assistant Director

CB:cmw

Enclosure

cc: CMS
Ombudsman

Public Health Licensing Services
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

October 27, 2016

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

Dear Ms. Friebus:

On July 29, 2016, a survey was conducted at your facility. You have alleged that the deficiencies cited on that survey have been corrected. We are accepting your allegation of compliance and presume that you have achieved substantial compliance. Based on this presumed compliance, we are not forwarding to the Centers for Medicare/Medicaid Services (CMS) Regional Office and/or the State Medicaid Agency our recommendation that the remedies we indicated in our letter to you of 08/10/2016 be imposed at this time.

We may be conducting a revisit of your facility to verify that substantial compliance has been achieved and maintained. We will certify your facility in compliance if we find that your facility is in substantial compliance at the time of the revisit. If we find that your facility has failed to achieve or maintain substantial compliance, the following remedies (or revised, if appropriate) will be imposed:

Recommendation to CMS Civil money penalty,, effective July 29, 2016

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

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

Sincerely,

B Hernandez

Belinda Hernandez
Examine Technician II

DE/bh

cc: State Ombudsman (with POC)

ARIZONA DEPARTMENT
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DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

August 10, 2016

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

Dear Ms. Friebus:

On **July 29, 2016**, a Medicare recertification survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. During this survey, complaints investigations may have also been conducted.

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

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

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **August 24, 2016**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by **August 24, 2016** may result in the imposition of remedies. **Plans of correction sent by fax will not be accepted.**

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,

- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.

- The signature and date you approve the Plan of Correction on the first page.

Allegation of Compliance

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

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of **09/12/2016.**

If, upon a subsequent revisit, your facility has not achieved substantial compliance, the Bureau of Long Term Care will recommend that remedies be imposed by the CMS Regional Office or the State Medicaid Agency and continue until substantial compliance is achieved.

Recommended Remedies

The remedies which will be recommended if substantial compliance is not achieved include the following:

Civil money penalty of $250.00 per day, effective July 29, 2016

Mandatory Remedies

Your current period of noncompliance began on July 29, 2016. If you do not achieve substantial compliance within three months after the last day of the survey identifying noncompliance, the CMS Regional Office and/or State Medicaid Agency must deny payments for new admissions.

The CMS Regional Office must terminate your provider agreement if substantial compliance has not been reached by 01/29/2017.

Informal dispute resolution for the cited deficiencies will not delay the imposition of the enforcement actions recommended (or revised, as appropriate). A change in the seriousness of the deficiencies may result in a change in the remedy selected. When this occurs, you will be advised of any change in remedy.

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

10/29/2016. This remedy will be effectuated on the stated date unless you demonstrate substantial compliance with an acceptable plan of correction and subsequent revisit.

This notice in no way limits the prerogative of CMS to impose discretionary DPNA at any appropriate time. CMS Regional Office will notify your intermediary and the Medicaid Agency. If effectuated, denial of payment will continue until your facility achieves substantial compliance or your provider agreement is terminated. [Facilities are prohibited from billing those Medicare/Medicaid residents or their responsible parties during the denial period for services normally billed to Medicare or Medicaid} The Medicare and Medicaid programs will make no payment for residents whose plans of care begin on or after the DPNA effective date.

Appeal Rights

If you disagree with the determination of noncompliance (and/or substandard quality of care, if applicable), you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board. Procedures governing this process are set out in 42 CFR §498.40, et. seq. You may appeal the finding of noncompliance that led to an enforcement action, but not the enforcement action or remedy itself. A written request for hearing must be filed no later than (60 days from the date of receipt of this letter). Such written request should be made directly to:

Attention: Ms. Karen Robinson
Departmental Appeals Board
Civil Remedies Division
Cohen Building, Room G-644
330 Independence Avenue S.W.
Washington, D.C. 20201

A request for hearing should identify the specific issues, and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You may be represented at a hearing by counsel at your own expense.
Be sure to include a copy of this letter with your request to the Departmental Appeals Board. In addition, please forward a copy of your request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 1h Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Alternatively, you can file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he or she is a party or authorized representative. Once registered, you may file your appeal by:

-Clicking the File New Appeal link on the Manage Existing Appeals screen, then clicking Civil Remedies Division on the File New Appeal screen.
And,
-Entering and uploading the requested information and documents on the "File New Appeal-Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions on DAB E-File for CRD cases can be found by clicking the CRD E-File Procedures link on the File New Appeal Screen for CRD appeals.

If you choose to file your appeal electronically, please also send a copy of the hearing request to:

Attention: Paula Perse, Manager
Long Term Care Branch
Division of Survey and Certification
Centers for Medicare & Medicaid Services
90 7th Street, Suite 5-300 (5W)
San Francisco, CA 94103-6707

Informal Dispute Resolution

In accordance with §488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request, along with the specific deficiencies being disputed, an explanation of why you are disputing those deficiencies along with supporting information that shows that the facility was in compliance at the time of the survey to Joel Bunis, Bureau Chief, Bureau of Long Term Care, 150 North 18th Avenue, Suite 440, Phoenix, Arizona 85007. This request must be sent during the same 10 days you have for submitting a PoC for the cited deficiencies.

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: Effective July 1, 2007, facilities requesting an Informal Dispute Resolution must submit separate requests, one for State deficiencies cited and one for Federal deficiencies cited, if applicable.**

Retain a copy of the PoC for your files. If the PoC is not received by this Office by **August 24, 2016**, licensure and/or recertification may be denied. **Plans of correction sent by fax will not be accepted.** If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bh

Attachments

APOC 9.27.16
POC 8.24.16

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

PRINTED: 08/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The recertification survey was conducted on July 25 through 29, 2016, in conjunction with the following Complaint investigations: AZ135498, AZ135300, AZ134229, AZ134046, AZ134198, AZ133274, AZ133181, AZ132384, AZ131064, AZ130815, AZ130782, AZ130197, AZ135826, AZ135973, AZ136002, AZ135919, AZ135974, AZ136158, and AZ136305. The following deficiencies were cited.	F 000	Arizona Department of Health, Division of Public Health, Licensing Services AUG 24 2016 Receptionist Dept 150 N. 18th Ave #400 Phoenix, AZ 85007	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and policies and procedures, the facility failed to promote care in a manner that maintains each resident's dignity, by failing to ensure that staff were seated while assisting residents with eating, by failing to ensure residents were offered desserts and condiments with meals, and by failing to assist residents with their meals in a timely manner. Findings include: -An observation of the lunch meal was conducted on July 25, 2016 in the Lodge East assisted dining room. There were two horseshoe shaped tables with four residents at each table and one CNA (Certified Nursing Assistant) was seated at	F 241	F241 Correction to the individual: No individual resident's were cited Resident's will have staff members seated while assisting them to eat. Resident's will have condiments and desserts offered at meal times. Resident's will be assisted in a timely manner with their meals. Correct to all others: Staff will receive re-education on promoting care in a manner that maintains each resident's dignity, including to be seated while assisting residents to eat, offering	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Imebus — TITLE: Administrator — (X6) DATE: 8/24/16.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 each table. During the observation, a covered food plate was placed in front of each resident at the two tables. The two CNAs, who were seated at the tables, were observed to only uncover one meal plate at a time and assist that resident, while the other residents sat with their covered meals in front of them. One resident waited 30 minutes with her covered lunch in front of her and was then observed to be able to fed herself, once her food was uncovered. An interview was conducted on July 27, 2016 at 10:40 a.m., with CNA (staff #201). Staff #201 stated that it was his routine to assist and/or feed one resident at a time and that the resident who was last to have her food uncovered was able to feed herself. -An observation of the breakfast meal in the Lodge East assisted dining room was conducted on July 27, 2016. One resident was observed to have a bowl of rice krispies, without any milk. The resident had milk in front of her, however, no staff members were observed to assist the resident in pouring the milk into her cereal. This resident was not observed to eat the dry cereal. An interview was conducted on July 27, 2016 at 10:15 a.m., with a Certified Nursing Assistant (staff #225). Staff #225 stated that the resident likes milk and staff should have assisted the resident to pour the milk on her cereal. Further observations during the breakfast meal on July 27, revealed that there were four residents who were seated at each of the two horseshoe shaped tables, with a CNA seated at each table. At this time, the food was uncovered	F 241	desserts and condiments and ensuring that all residents receive timely assistance with their meals **System Correction:** Random observations and audits of dining service for all meal times will be completed 3 times weekly for 90 days and weekly thereafter. **Monitoring of System:** The analysis of the audits will be taken to QAPI for review monthly and follow-up as needed. **Correction Date:** **Responsible Person:** Director of Nursing or Designee.	9/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 2	F 241		

and placed in front of the four residents at each table. The CNAs proceeded to assist the residents with feeding, one at a time. The last resident who was provided assistance with her breakfast had her uncovered meal in front of her for 30 minutes.

At this time, the CNA was interviewed and was asked if the resident's breakfast was still warm. The CNA was observed to place her hand above the resident's food and then stated that the meal was now "cold."

The food temperatures were obtained at this time by nursing staff and each hot food item temperature was between 80 and 88 degrees.

An interview was conducted on July 27, 2016 at 10:15 a.m. with staff #225, who confirmed that the resident's breakfast foods were cold and that she should have re-heated them, before she attempted to feed the resident.

On July 27, 2016 at 11:10 a.m., an interview was conducted with CNA team lead (staff #36). She stated that the CNA's seated at the horseshoe shaped tables were suppose to assist more than one resident at a time, and that the residents should not have to wait to eat while their food was in front of them.

Another observation during the breakfast meal on July 27, revealed that one resident who was seated alone with her breakfast on a bedside table, was observed to have her uncovered breakfast in front of her for 35 minutes. Although a staff member had past the resident twice and suggested that she eat, no staff member was observed to assist the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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-A lunch observation was conducted on July 25, 2016 and a breakfast observation was conducted on July 27, 2016, in the Lodge East assisted dining room.

During these observations, staff were not observed to offer any condiments, inclusive of salt/pepper and butter/jelly, nor offer any desserts after the lunch meal to the residents.

An interview was conducted on July 27, 2016 at 10:15 a.m. with a staff #225. She stated that the residents are not offered any condiments because, "we know what they like." However, she agreed that for those residents in the assisted dining room who could make a decision, they were not offered the opportunity. Staff #225 further stated that the residents in the assisted dining room should be offered dessert after lunch.

On July 27, 2016 at 11:10 a.m., an interview was conducted with staff #36. She stated that condiments and desserts were suppose to be offered to residents in the assisted dining room.

Posted on the wall outside of the assisted dining room on the Lodge East unit was the following: "If you would like a dessert with your lunch meal you may ask your server for one. They will have an assortment of items stocked on the nurses station/dining room for you to choose from." These items are: ice cream, sherbet, popsicles and cookies.

A facility policy titled, Nursing Department Responsibilities at Mealtime included the following: 2. The Nursing Department is responsible for preparing residents for

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meals...assisting residents who are unable to feed themselves. 7. The Total Assist tables should have 4 residents who need total dining assistance or cueing and one CNA on a roller stool can appropriately feed them. (Clarified by Administrative staff (#98) that "appropriately" meant to assist or feed more than one resident at a time).

-During a breakfast observation on July 27, 2016 at 8:15 a.m., a CNA (certified nursing assistant/staff #48) was observed feeding three residents at a horseshoe shaped table. Two of the residents were seated in Geri-chairs and the other resident was seated in a wheelchair. A stool was observed inside of the horseshoe table, however, staff #48 was observed standing inside of the horseshoe table, while feeding the residents.

An interview was conducted with staff #48 on July 27, 2016. Staff #48 stated that she used to sit while feeding the residents, but one of the residents got new foot pedals on her wheelchair and she felt like she was leaning too much, while she fed the residents. Staff #48 further stated that she found it easier to stand while she fed the residents.

An interview was conducted with the DON (Director of Nursing/staff #276) on July 28, 2016. She stated that staff should be seated while feeding residents, so they could talk to the residents while they ate.

A review of the facility's policy regarding Nursing Department Responsibilities at Meal Time revealed the total assistance tables should have four residents who need total assistance or

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F 241	Continued From page 5 cueing with dining. The CNA on a roller stool can appropriately feed the residents. Residents in Geri-chairs can be fed two at a time with two trays on a bedside table set between them, and the aide in a chair feeding both residents. Appropriate interaction with Nursing and the resident is important, for example, the nurse should be at eye level, not standing while feeding..."	F 241		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, staff interviews and policy and procedures, the facility failed to ensure that medications were administered as physician ordered for two residents (#s 407 and 412). Findings include: -Resident #407 was admitted on January 15, 2015, with diagnoses that included gastro-esophageal reflux disease, chronic embolism and thrombosis. The resident was discharged on February 20, 2015 to home. A nursing note dated February 16, 2015, included the resident complained of having a hard bowel movement, with some bleeding and the physician was notified. A physician's order dated February 16, 2015	F 281	F281 **Correct to the individual:** Resident# 412 had Pantoprazole DR/EC time corrected to follow the Physician's order. Resident # 407 discharged, system change will correct the cited deficiency. **Correct to all others:** Re-education on the procedure for changing times of medication and ensuring medications are documented when administered was initiated and will be completed with nurses and Unit Clerks.	

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F 281	Continued From page 6 included for Lactulose (laxative) 30 ml (milliliters) by mouth every night for constipation. Review of the February 2015 MAR (Medication Administration Record) revealed the Lactulose order, however; the MAR did not include any documented evidence that the Lactulose had been administered from February 16, through 19. The February 2015 nursing note entries also did not include any documentation that the Lactulose had been administered. An interview was conducted on July 28, 2016 with the Director of Nursing (staff #276), who stated that the MAR should have been signed by licensed staff when the Lactulose was administered. She stated that she was unable to locate any documented evidence that the Lactulose had been administered as physician ordered. A facility policy titled, Medication Administration included "All medications ordered for a resident by the Medical provider shall be documented by time, name of drug and signature of Nurse administering the medications." -Resident #412 was admitted to the facility on July 19, 2016, with diagnoses that included hepatic failure, encephalopathy, and protein-calorie malnutrition. A physician's order dated July 19, 2016 included for Pantoprazole DR/EC (Proton pump inhibitor) 40 mg at 9:00 a.m. each day. A medication pass observation was conducted on July 27, 2016 at 8:55 a.m., with a registered	F 281	System Correction: MAR/TAR audits will be completed 2 times weekly for 90 days and weekly thereafter. Monitoring of System: The analysis of the audits will be taken to QAPI for review and follow-up as needed. Correction Date: Responsible Person DON or Designee.	9/12/16

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F 281	Continued From page 7 nurse (RN/staff #309). During the observation, the Pantoprazole was not included in the medications which were administered to resident #412. Review of the Medication Administration Record for July 2016 revealed the physician's order for the Pantoprazole. However, the pre-printed administration time of 9:00 a.m. had been crossed off and a new time of 9:00 p.m. had been entered. However, review of the clinical record revealed there were no physician orders to change the administration time from 9:00 a.m. to 9:00 p.m. In an interview conducted with staff #309 on July 27, 2016 at 10:00 a.m., she stated it looks like someone crossed out the original time and put in 9 p.m. She said that they should have gotten an order to change the time. An interview was conducted with the Ward Clerk/Licensed Practical Nurse (LPN/staff #73). Staff #73 stated the charts are checked every evening shift for new orders and accuracy. She stated this should have been caught and the order updated. In an interview conducted with the RN/Unit Manager (staff #289) on July 27, 2016, staff #289 stated the order should have been updated and that it was missed. A facility policy titled Medication Administration included, "The nurse administering the medications must review all medication sheets to see that the administration frequency is the same as ordered by the medical provider..."	F 281		

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F 281	Continued From page 8 A facility policy titled 24-Hour Chart Checks included the nurse should check all components of the order and if an error is noted, it must be reported to the unit manager and corrected immediately.	F 281	F323 **Correct to the Individual:** Resident #168 was sent to the hospital for evaluation of laceration to the back of her head on June 26, 2016. Two staples were placed to the resident's head and the CT scan was negative for internal injuries. The resident returned to the facility the same day. **Correct to all others:** House wide education was completed for all CNA's on hoyer safety, including a return demonstration and quiz. **System Correction:** Visual audits of CNA's performing hoyer lifts will be done 2 times per week for 90 days and weekly thereafter. A policy for hoyer lifts was in place and given to survey team at the time of survey.	
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff and resident interviews, and hospital documentation, the facility failed to ensure the resident's environment remained free of accident hazards, by failing to ensure one resident (#168) was transferred safely using a hoyer lift. Findings include: Resident #168 was admitted to the facility on October 19, 2011, with diagnoses that included vascular dementia, depressive disorder and right sided hemiplegia. Review of the annual Minimum Data Set (MDS) assessment dated May 26, 2016 revealed a Brief Interview for Mental Status score of 11, which indicated the resident had moderate cognitive	F 323		

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F 323	Continued From page 9 impairment. Under functional status, the resident was assessed to be totally dependent with transfers and required the assistance of two persons. Review of a falls care plan revealed the resident was at risk for falls. The goal included that the resident will remain free from injury due to falls. An approach included for a two person transfer using the hoyer lift. A nursing note dated June 26, 2016 indicated a Licensed Practical Nurse (LPN/staff #96), heard a noise in the room of resident #168. Upon entering, the resident was on the floor and two CNAs (staff #18 and 181) were in the room. Staff #96 asked what happened and one of the CNAs stated "something popped off." The LPN then observed that the "top left top strap unhooked from the hoyer." The note further included that 911 was called, as the resident's head was bleeding. Another nursing note dated June 26, 2016 included that the resident returned to the facility and had 2-3 staples to the back of her head. Review of the facility's investigative report revealed the resident was alert and oriented times two, had expressive aphasia and right sided hemiplegia. On June 26, 2016, the resident "was being assisted out of bed by two staff members via hoyer transfer when it appears a strap slipped off a loop and she fell to her right side landing on her buttocks then falling back hitting her head." The resident sustained a laceration to the back of her head and was transported to the hospital for an evaluation. The report indicated two staples were placed to the	F 323	Hoyer Policy reviewed. Facility will continue with Preventative maintenance plan, Fall risk observations, and therapy screens. **Monitoring of System:** The analysis of the audits will be taken to QAPI for review and follow-up as needed. Correction Date: Responsible Person: Director of Nursing or Designee	9/12/16

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F 323	Continued From page 10 laceration on the resident's head and the CT scan was negative for internal injuries. The resident returned to the facility the same day. The report further included that the hoyer lift and the sling straps were immediately checked for failure and no faulty equipment was found. The report also noted "It appears that as the hoyer was lifted a strap slipped of (sic) the hook on the hoyer." In an interview conducted with resident #168 on July 27, 2016 at 11:40 a.m., the resident stated she was getting transferred from the bed to her wheelchair by two CNAs (Certified Nursing Assistant) using the hoyer lift. She stated she was being lifted up and the left upper sling strap slipped off and she fell. She further stated she hurt the left side of her body and cut her head and had to go to the hospital. An interview was conducted with CNA (staff #313) and CNA (staff #303) on July 27, 2016 at 11:50 a.m. The CNAs stated they always used two staff to transfer a resident when using the hoyer lift and that they had training on the use of the lift, as part of the initial and ongoing training at the facility. An interview was conducted with a LPN (staff #96) on July 27, 2016 at 3:05 p.m. Staff #96 stated that on June 26, 2016, she was passing medications when she heard a loud noise. She stated she ran in the room and there were two CNAs (staff #18 and #181). She said she asked what happened and CNA #181 said she was guiding the hoyer by the feed and heard a pop and the resident fell to the floor. She stated she looked at the straps of the sling and nothing was wrong with them. She said the resident's head was bleeding, so 911 was called. She stated that	F 323		

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she didn't want to move the resident, because of how high she was when she fell. She stated the resident was approximately 4-5 feet off the floor when she fell.

An interview was conducted with CNA (staff #18) on July 28, 2016 at 7:55 a.m. Staff #18 stated that staff #181 hooked up the top of the sling and she hooked up the bottom of the sling. Staff #18 stated her role during the transfer was to guide the resident. She stated staff #181 voiced that there was resistance when moving the hoyer and thought the hoyer might be caught on a cord from under the bed. She said at that moment the hook on the top right of the hoyer came undone and the resident fell to the floor. Staff #18 stated she looked at the equipment following the fall and there were no tears, rips, or defects on the sling. She also stated the resident was not moving or flailing during the transfer.

In an interview conducted with CNA (staff #181) on July 28, 2016 at 8:00 a.m., staff #181 stated that staff #18 was the one who hooked up the upper sling loops and she hooked the lower sling loops, and that her role in the transfer was to raise the hoyer and guide the lift out from under the bed to position it for transfer to the wheelchair. She stated that staff #18 was to guide the resident, however, staff #18 left the head of the resident and went to move the wheelchair, so she was not near the resident's head to watch the sling loops, as she was supposed to do. She stated that is when the upper right loop slipped and the resident fell to the floor. Staff #181 stated she looked at the equipment and sling following the incident and there were no defects identified. She also stated the resident was not moving or flailing during the transfer.

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F 323	Continued From page 12 In an interview conducted with the Director of Nursing (DON/staff #276) on July 28, 2016 at 10:15 a.m., the DON stated that during the transfer a sling strap slipped off the hook on the hoyer lift. A policy regarding the use of hoyer lifts was requested, however, the facility did not have a policy related to the use of hoyer lifts.	F 323		
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and a review of policy and procedures, the facility failed to ensure that two residents were offered an alternative meal, after refusing to eat the food served. Findings include: A lunch observation was conducted on July 25, 2016, in the Lodge East assisted dining room. During this observation, two residents who were seated at the horseshoe shaped tables, refused to eat their meal. Although a CNA (Certified Nursing Assistant) was seated at each of the horseshoe shaped tables, neither CNA offered either resident an alternative meal. At the end of the lunch observation, neither resident had consumed any food.	F 366	F366 Correct to the individual: Resident #36 will be offered substitutes when not eating food served. Correct to all others: Staff will receive re-education on offering substitutes/alternates when residents are not eating the food served. System Correction: Audits of staff offering substitutes/alternates during meal service if residents are not eating the food served will be completed 2 times per week for 90 days and weekly thereafter.	

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F 366	Continued From page 13 An interview was conducted on July 27, 2016 at 10:15 a.m., with a CNA, who stated that the residents who had refused their lunch should have been offered an alternative. Another interview was conducted on July 27, 2016 at 11:10 a.m., with the CNA team lead (staff #36). She stated that if a resident refuses a meal, an alternative meal was suppose to be offered. A facility policy titled Menu Alternatives included, "An alternative meat or entree and vegetable should be provided at every meal in the event of personal food preferences or refusals." The policy also included the following: 1...The alternative must be offered to the resident within 15 minutes of refusal of the main course. 2. In addition, the following should always be available to the residents if they refuse the scheduled alternative: A. Soup B. Cheese C. Cottage cheese D. Peanut butter and or jelly E. Juice and fruit	F 366	**Monitoring of System:** The analysis of the results of the audits will be taken to QAPI for review and follow-up as needed. **Correction Date:** **Responsible Person:** Administrator or Designee	9/12/16
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	**F371** **Correct to Individual:** No individual residents were cited.	

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This REQUIREMENT is not met as evidenced by:
Based on observations, staff interviews and review of policy and procedures, the facility failed to ensure food was stored, prepared and served in a sanitary manner, by failing to ensure that staff washed their hands properly, by staff touching ready to eat foods with their bare hands, by failing to ensure multiple glasses and utensils were air dried, by failing to ensure food items were dated when opened, and by failing to ensure food was covered when transported in a resident hallway.

Findings include:

-Dining observations were conducted in the main dining room at 12:02 p.m. on July 25, 2016. One dietary staff member (staff #293) was observed serving food on the tray line. Staff #293 was observed to separate a dozen ready to eat rolls with his bare hands and then placed them in a basket on the steam table.

At this time, an interview was conducted with the assistant dietary manager (staff #109). She stated that the dinner rolls could not be served after having been touched by bare hands.

At 12:12 p.m. in the main dining room, there were two inverted glasses with liquid water droplets on the inside of the glasses. A dietary aid (staff #349) picked up the glasses and stacked them on a wet surface, on the beverage cart. She then separated the two glasses and poured juice into one glass and placed it in front of a resident. When the liquid droplets were pointed out to the

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<u>Correct to all others:</u>
Staff will receive re-education on procedure for passing hall trays and washing/sanitizing hands when assisting residents with meal service.
Dietary staff re-educated on storing, preparing, and serving food under sanitary conditions.

<u>System Correction:</u>
Audits will be completed on passing hall trays and washing/sanitizing hands when assisting residents with meal service 2 times weekly for 90 days and weekly thereafter.

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F 371	Continued From page 15 dietary staff member, she stated the water was on the outside of the glass. The second glass which had water droplets on the inside was then shown to the dietary staff member and she removed the glass and replaced it with a dry one. At 12:23 p.m. in the main dining room, a dietary staff member (staff #293) was observed washing his hands. From the time the water was turned on until the water was turned off, five seconds had elapsed. Following this observation, the dietary manager (staff #255) stated that staff were suppose to wash their hands for 20 seconds. At 12:50 p.m. in the main dining room, a dietary aid (staff #349) was observed washing her hands for 10 seconds. At 1:07 p.m. in the main dining room, a male dietary aid (staff #127) was observed serving beverages. At this time, staff #127 picked up a cup and touched the rim of the cup against his smock top. He then poured coffee in to the cup and served it to a resident. During an interview conducted at 1:08 p.m. on July 25, 2016, staff #127 stated he did not realize that he had touched the rim of the cup against his clothing, and stated it would be a problem. -During observations conducted in the kitchen at 11:26 a.m. on July 27, 2016, a dietary staff member (staff #352) was observed using a towel to dry multiple tongs and multiple scoops. The utensils were then placed in a steam table pan and covered in plastic wrap and were then placed on the main dining room cart.	F 371	Audits will be completed on air drying dish ware, serving ready to eat foods in a sanitary manner,ensuring food items are dated when opened and covering food when transporting 2 times weekly for 90 days and weekly thereafter. **Monitoring of System:** The analysis of the results of the audits will be taken to QAPI for review and follow-up as needed. Correction Date: Responsible Person: Administrator or Designee	9/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 16 At this time, staff #352 stated the utensils she had dried were to be used to serve lunch at the steam table in the main dining room. She stated that she dried the utensils with a towel because the utensils were wet, and they were now ready to use. During an interview conducted at 11:29 a.m. on July 27, 2016, the dietary consultant (#356) stated that all dishes must be air dried. Observations were conducted of tray line in the kitchen at 12:31 p.m. on July 27, 2016. A dietary staff member placed small plastic glasses with water droplets on the inside onto meal trays, and then placed the meal trays in the meal carts, ready to serve to residents. With a dietary consultant present at this same time, there was a plastic tub containing multiple stacks (approximately 8 glasses per stack and approximately 9 stacks) of small plastic glasses. More than 15 of the small plastic stacked glasses had water droplets on the inside surfaces of the glasses. At this time, staff #356 stated that the glasses were suppose to be air dried before being used. -An observation of the nourishment refrigerator on the West Central unit was conducted at 1:35 p.m. on July 27, 2016. Inside of the refrigerator was a quart of orange juice, with no date to indicate when it was opened. An observation of the nourishment refrigerator in the Annex nurses station was conducted at 1:40 p.m. on July 27, 2016. Inside was a loaf of bread	F 371		

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	035145	A. BUILDING _____ B. WING _____	07/29/2016

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

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F 371	Continued From page 17	F 371		

and an opened 20 ounce bottle of Pepsi which were not dated when opened. Also observed in a cupboard in this same area was a 5 pound container of peanut butter, which was not dated when opened.

An observation of the nourishment refrigerator/freezer on the North Lodge unit was conducted at 1:50 p.m. on July 27, 2016. Inside of the freezer was a pint of ice cream which was not dated when opened.

A review of the Freezer, Refrigerated Storage and Dry Storage Quick Reference Guide revealed the time frames for how long foods which had been opened, could be stored and used. However, without dates on the containers to indicate when they were opened, it was not possible to determine if the undated foods were safe to eat/drink.

A review of the Handwashing and Glove Use policy and procedure revealed Hands must be washed following contact with any unsanitary surface. The policy included the following: Washing procedure...lather, vigorously rubbing hands together for 20 seconds. The policy further included that "Gloves must be worn when touching any ready-to-eat food."

A review of the Dry Storage-Dishes and Utensils policy revealed "Dishes must be stored to promote air drying..."

-An observation of the lunch room tray delivery was conducted on July 25, 2016, on the Lodge East nursing unit.

During this observation, uncovered dinner rolls

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	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

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F 371	Continued From page 18 were observed on the room trays on the food cart. At this time, the CNAs (Certified Nursing Assistant) were observed to take the room trays from on top of the food cart and walk down the hallway, beyond the four closest rooms. An interview was conducted on July 27, 2016 at 10:15 a.m. with a CNA, who had assisted with the lunch room trays on July 25. The CNA agreed that the dinner rolls were uncovered on the room trays and stated that all foods were suppose to be covered when being delivered to the resident's rooms. Another interview was conducted on July 27, 2016 at 10:55 a.m., with the CNA team lead. She stated that the dinner rolls should have been covered, if a room tray is being delivered more than one room away from the food cart. She stated that the CNA's were suppose to go directly into a resident's room and not walk down the hall, with uncovered foods. She stated that the procedure would allow for the delivery of the food tray one room away from the meal cart. A facility policy titled, Criteria for Completion of RDs (Registered Dietician) Quarterly Report Long Term Care included that all food on room trays must be covered.	F 371	F412 **Correct to the individual:** Resident #127 was seen by dentist on 8/5/16 and facility will continue to follow-up on recommendations made.	
F 412 SS=E	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in	F 412	**Correct to all others:** Staff will receive re-education on procedure for notifying the appropriate person when a resident refuses/misses an appointment.	

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

PRINTED: 08/09/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 19 making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on clinical record review, observations, and resident and staff interviews, the facility failed to ensure that a dental evaluation was obtained for one resident (#127). Findings include: Resident #127 was admitted on March 21, 2014, with diagnoses that included dementia, diabetes mellitus and gastro-esophageal reflux disease. A dental care plan was developed to address the potential for pain, health issues, and poor nutritional and weight loss, related to the resident having poor dentition. The care plan also included to obtain an order for a dental consultation if indicated. A review of the clinical record revealed a physician's order dated April 12, 2016, for a dental evaluation, due to difficulty chewing. However, the clinical record did not include any documented evidence that a dental consultation had been obtained. Review of the monthly summaries dated May 6, June 1 and July 6, 2016, revealed the resident had some/all natural teeth lost and that he does not have or does not use dentures or a partial plate.	F 412	**System Correction:** Audits will be completed to monitor that resident appointments are attended as scheduled and followed up on appropriately 2 times weekly for 90 days and then weekly thereafter. New policy was implemented regarding Dental Examination/Assessment. **Monitoring of System:** The analysis of the results of the audits will be taken to QAPI for review and follow-up as needed. **Correction Date:** **Responsible Person:** Director of Nursing or designee.	9/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 412	Continued From page 20	F 412		

Observations were conducted on July 26, 2016 at 9:05 a.m. and on July 27, 2016 at 1:10 p.m. During these observations, the resident was observed to have several missing teeth and poor dentition.

At the time of the above observations, the resident stated that he had a dental appointment scheduled, but he didn't go because he was not allowed enough time to get ready. The resident also stated that sometimes he has difficulty chewing his food and that he would like to see a dentist, because something needed to be done about his teeth.

An interview was conducted on July 27, 2016 at 2:15 p.m., with the Registered Nurse/Unit Manger (staff #28), who confirmed that a dental consultation had been scheduled in April 2016, for the resident.

An interview was conducted on July 29, 2016 at 8:15 a.m., with the Director of Nursing (staff #276), who confirmed that the resident had not received the dental consultation in April 2016. She also stated that another dental consultation has now been scheduled for August. Staff #276 further stated that it was the responsibility of the licensed staff to complete the appointment/transportation request slip, so that the scheduler could make those arrangements.

On July 29, 2016 at 8:50 a.m., an interview was conducted with the appointment/transportation scheduler (staff #105). She provided a copy of the April 29, 2016, dental appointment/transportation request that had been completed. Per staff #105, if the appointment was

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

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F 412	Continued From page 21 canceled and needed to be re-scheduled, licensed staff should have completed another appointment/transportation request form. However, staff #105 stated that she had never been informed by licensed staff to re-schedule the dental consultation and arrange transportation. According to administrative staff (staff #98), the facility did not have a written policy regarding dental consultations.	F 412		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	F441 **Correct to the Individual:** Staff will wash hands when assisting residents with meal service. **Correct to all others:** Staff will receive re-education on hand washing with meal service. **System Correction:** Audits of hand washing during meal service will be completed 2 times per week for 90 days and weekly thereafter.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ______ B. WING ______	07/29/2016

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

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F 441	Continued From page 22 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and policy review, the facility failed to ensure that two staff members used proper hand washing technique. Findings include: On July 25, 2016, a meal observation was conducted on the Lodge East assisted dining room. During this observation, a CNA (Certified Nursing Assistant) was observed to enter the dining room and wash her hands at the kitchen sink. The CNA turned the water faucet on, lathered her hands, rinsed her hands, then dried her hands with a paper towel. The CNA then turned off the water faucet with the same paper towel and then redried her hands with the same paper towel. During this observation, a unit assistant was also observed to wash her hands. The unit assistant was observed to turn the water faucet on, lather her hands, rinse her hands, and then turned the	F 441	**Monitoring of System:** The analysis of the results of the audits will be taken to QAPI for review and follow-up as needed. **Correction Date:** **Responsible Person:** Director of Nursing or Designee.	9/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING ____ B. WING ____	07/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 23 water faucet off with a paper towel and then dried her hands with the same paper towel. An interview was conducted on July 25, 2016, with the CNA. She stated that normally she would wash her hands, turn off the faucet with a paper towel, then dry her hands with the same paper towel. A facility policy titled Washing/Hand Hygiene included, "The facility considers hand hygiene the primary means to prevent the spread of infections." The policy also included the following: 4. Dry hands thoroughly with a paper towel and then turn off faucets with a clean, dry paper towel.	F 441		

ARIZONA DEPARTMENT OF HEALTH SERVICES
LICENSING

Public Health Licensing Services
Bureau of Long Term Care Licensing
150 North 18th Avenue, Suite 440
Phoenix, Arizona 85007-3242
(602) 364-2690 Office
(602) 324-0993 Fax

DOUGLAS A. DUCEY, GOVERNOR
CARA M. CHRIST, MD, DIRECTOR

August 10, 2016

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

Dear Ms Friebus:

Enclosed is the Life Saftey Code deficiency form which indicates that no deficiencies were found at the time of the recertification inspection. These forms will become a part of our public file; please sign then send back the first page with orginal signatures and retain a copy for your files.

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

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bh

Attachments

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

PRINTED: 07/29/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING 01 - MAIN BUILDING 01 B. WING ______	07/28/2016

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS 42CFR 483.70(a) Nursing Homes The facility must meet the applicable provisions of the 2000 Edition of the Life Safety Code of the National Fire Protection Association. This is a Recertification survey for Medicare under LSC 2000, Chapter 19 Existing of a Skilled Nursing Facility under Health Care. The facility was surveyed using the C.M.S. 2786S (02/2013) Short Form. The facility meets the standards, based upon compliance with all provisions of the standards.	K 000	AUG 24 2016	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Mulkins
TITLE: Administrator
(X6) DATE: 8/24/16.

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

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

LONG TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey
From: F1 07 25 16 To: F2 07 29 16
MM DD YY MM DD YY

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

Name of Facility		Provider Number	Fiscal Year Ending: F5
Devon Gables Rehabilitation Center		035145	12 31 16 (MM DD YY)

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

Telephone Number: F6	State/County Code: F7	State/Region Code: F8
520-296-6181	090	A2

A. F9 03

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

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

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

Ownership: F12 ☐☐

For Profit	NonProfit	Government	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 Yes ☑ No ☐

Name of Multi-Facility Organization: F14
Altitude Health Services

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

F15 ☐☐☐ AIDS
F16 ☐24 Alzheimer's Disease
F17 ☐☐☐ Dialysis
F18 ☐☐☐ Disabled Children/Young Adults
F19 ☐☐☐ Head Trauma
F20 ☐☐☐ Hospice
F21 ☐☐☐ Huntington's Disease
F22 ☐☐☐ Ventilator/Respiratory Care
F23 ☐32 Other Specialized Rehabilitation

Does the facility currently have an organized residents group?	F24	Yes ☑	No ☐
Does the facility currently have an organized group of family members of residents?	F25	Yes ☐	No ☑
Does the facility conduct experimental research?	F26	Yes ☐	No ☑
Is the facility part of a continuing care retirement community (CCRC)?	F27	Yes ☐	No ☑

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement. Date: F28 ☐☐ ☐☐ ☐☐ Hours waived per week: F29________
Waiver of 24 hr licensed nursing requirement. Date: F30 ☐☐ ☐☐ ☐☐ Hours waived per week: F31________
MM DD YY

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

FACILITY STAFFING

	Tag Number	A Services Provided 1	A Services Provided 2	A Services Provided 3	B Full-Time Staff (hours)	C Part-Time Staff (hours)	D Contract (hours)
Administration	F33				1283	Ø	Ø
Physician Services	F34	Y	N	Y			
Medical Director	F35				Ø	Ø	2Ø
Other Physician	F36				Ø	Ø	14
Physician Extender	F37	N	N	N	Ø	Ø	Ø
Nursing Services	F38	Y	N	N			
RN Director of Nurses	F39				8Ø	Ø	Ø
Nurses with Admin. Duties	F40				824	Ø	Ø
Registered Nurses	F41				838	292	Ø
Licensed Practical/ Licensed Vocational Nurses	F42				1928 / Ø	633 / Ø	Ø / Ø
Certified Nurse Aides	F43				6213	17Ø6	Ø
Nurse Aides in Training	F44				Ø	Ø	Ø
Medication Aides/Technicians	F45				Ø	Ø	Ø
Pharmacists	F46	Y	N	Y	Ø	Ø	3Ø
Dietary Services	F47	Y	N	N			
Dietitian	F48				8Ø	Ø	35
Food Service Workers	F49				1485	382	Ø
Therapeutic Services	F50						
Occupational Therapists	F51	Y	N	N	143	33	Ø
Occupational Therapy Assistants	F52				7Ø	Ø	Ø
Occupational Therapy Aides	F53				Ø	Ø	Ø
Physical Therapists	F54	Y	N	N	22Ø	15	8Ø
Physical Therapists Assistants	F55				81	15	Ø
Physical Therapy Aides	F56				82	Ø	Ø
Speech/Language Pathologist	F57	Y	N	N	74	Ø	Ø
Therapeutic Recreation Specialist	F58	Y	N	N	Ø	Ø	Ø
Qualified Activities Professional	F59	Y	N	N	8Ø	Ø	Ø
Other Activities Staff	F60	Y	N	N	1Ø95	626	Ø
Qualified Social Workers	F61	Y	N	N	16Ø	Ø	Ø
Other Social Services	F62	Y	N	N	64	Ø	Ø
Dentists	F63	N	N	N	Ø	Ø	Ø
Podiatrists	F64	Y	N	Y	Ø	Ø	4
Mental Health Services	F65	Y	N	Y	Ø	Ø	3Ø
Vocational Services	F66	N	N	N			
Clinical Laboratory Services	F67	N	N	N			
Diagnostic X-ray Services	F68	N	N	N			
Administration & Storage of Blood	F69	N	N	N			
Housekeeping Services	F70	Y	N	N	2133	Ø	Ø
Other	F71				529	83	16

Name of Person Completing Form	Heather Friebus	Time	1:45pm
Signature	[signature]	Date	7/26/16

Form CMS-671 (12/02)

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035145	6 F75	183 F76	44 F77	233 F78

ADL	Independent	Assist of One or Two Staff	Dependent
Bathing	F79 5	F80 153	F81 75
Dressing	F82 29	F83 158	F84 46
Transferring	F85 51	F86 120	F87 62
Toilet Use	F88 32	F89 136	F90 65
Eating	F91 122	F92 93	F93 18

A. Bowel/Bladder Status

F94 13 With indwelling or external catheter

F95 Of total number of residents with catheters, 12 were present on admission.

F96 161 Occasionally or frequently incontinent of bladder

F97 130 Occasionally or frequently incontinent of bowel

F98 215 On individually written bladder training program

F99 141 On individually written bowel training program

B. Mobility

F100 7 Bedfast all or most of time

F101 189 In chair all or most of time

F102 18 Independently ambulatory

F103 73 Ambulation with assistance or assistive device

F104 2 Physically restrained

F105 Of total number of residents restrained, 1 were admitted with orders for restraints.

F106 16 With contractures

F107 Of total number of residents with contractures, 11 had contractures on admission.

C. Mental Status

F108 3 With mental retardation

F109 87 With documented signs and symptoms of depression

F110 147 With documented psychiatric diagnosis (exclude dementias and depression)

F111 146 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type

F112 88 With behavioral symptoms

F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 88.

F114 Ø 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? 5.

F117 84 Receiving preventive skin care

F118 13 With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

E. Special Care

F119 22 Receiving hospice care benefit

F120 Ø Receiving radiation therapy

F121 Ø Receiving chemotherapy

F122 7 Receiving dialysis

F123 4 Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion

F124 49 Receiving respiratory treatment

F125 Ø Receiving tracheostomy care

F126 4 Receiving ostomy care

F127 0 Receiving suctioning

F128 64 Receiving injections (exclude vitamin B12 injections)

F129 5 Receiving tube feedings

F130 82 Receiving mechanically altered diets including pureed and all chopped food (not only meat)

F131 34 Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)

F132 33 Assistive devices while eating

F. Medications

F133 178 Receiving any psychoactive medication

F134 93 Receiving antipsychotic medications

F135 78 Receiving antianxiety medications

F136 149 Receiving antidepressant medications

F137 10 Receiving hypnotic medications

F138 14 Receiving antibiotics

F139 170 On pain management program

G. Other

F140 55 With unplanned significant weight loss/gain

F141 8 Who do not communicate in the dominant language of the facility (include those who use sign language)

F142 Ø Who use non-oral communication devices

F143 233 With advance directives

F144 134 Received influenza immunization

F145 173 Received pneumococcal vaccine

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

Signature of Person Completing the Form	Title	Date
Kendra Rogney	RN - DON	7/25/16

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 Ø %

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/19/2012 thru 07/19/2016
Arizona

DEVON GABLES REHABILITATION CENTER
6150 EAST GRANT ROAD
TUCSON, AZ 85712
State's Region Code: TUC
Compliance Status: Provider meets requirements based on an acceptable plan of correction

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

Provider Beds
Total: 312
Certified: 312

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

Program Requirements

Current Survey/Revisit Dates - 06/12/2015

Prior 3 Survey 09/2011	S/S Code	Prior 2 Survey 12/2012	S/S Code	Prior 1 Survey 02/2014	S/S Code	Current Survey 04/30/2015	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
									REQ	F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
X	B								REQ	F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
		X	E						REQ	F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
						X C	D	06/12/2015	REQ	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
X	D	X	D			X C	D	06/12/2015	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
		X	D			X C	D	06/12/2015	REQ	F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
		X	E						REQ	F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
									REQ	F0246-REASONABLE ACCOMMODATION OF
		X	D						REQ	F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
									REQ	F0279-DEVELOP COMPREHENSIVE CARE PLANS
						X C	D	06/12/2015	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
						X C	E	06/12/2015	REQ	F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
									REQ	F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
				X	G				REQ	F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
									REQ	F0356-POSTED NURSE STAFFING INFORMATION
									REQ	F0365-FOOD IN FORM TO MEET INDIVIDUAL NEEDS
		X	E						REQ	F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
X	D								REQ	F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
		X	D	X	E				REQ	F0431-DRUG RECORDS, LABEL/STORE DRUGS &
									REQ	F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
									REQ	F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
									REQ	F0502-ADMINISTRATION
									REQ	F0504-LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN
									REQ	F0505-PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS

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

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/19/2012 thru 07/19/2016

DEVON GABLES REHABILITATION CENTER CCN: 035145

Prior 3 Survey 09/2011	S/S Code	Prior 2 Survey 12/2012	S/S Code	Prior 1 Survey 02/2014	S/S Code	Current Survey 04/30/2015	S/S Code	Plan/Date of Correction		Requirement
									REQ	F0507-LAB REPORTS IN RECORD - LAB NAME/ADDRESS
		X	D						REQ	F0514-RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE
		X	E						REQ	F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS

LSC Deficiencies

Edition of LSC Applied

2000 HC Prior 3 Survey 09/2011	S/S Code	2000 HC Prior 2 Survey 12/2012	S/S Code	2000 HC Prior 1 Survey 02/2014	S/S Code	2000 HC Current Survey 04/30/2015	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
									STD	K0018-LIFE SAFETY CODE STANDARD
				X	E				STD	K0027-LIFE SAFETY CODE STANDARD
X	E	X	D			X C	D	06/05/2015	STD	K0029-LIFE SAFETY CODE STANDARD
									STD	K0038-LIFE SAFETY CODE STANDARD
						X C	D	06/05/2015	STD	K0039-LIFE SAFETY CODE STANDARD
									STD	K0045-LIFE SAFETY CODE STANDARD
									STD	K0046-LIFE SAFETY CODE STANDARD
									STD	K0047-LIFE SAFETY CODE STANDARD
		X	D						STD	K0062-LIFE SAFETY CODE STANDARD
		X	E						STD	K0069-LIFE SAFETY CODE STANDARD
									STD	K0073-LIFE SAFETY CODE STANDARD
				X	D				STD	K0076-LIFE SAFETY CODE STANDARD
X	E								STD	K0147-LIFE SAFETY CODE STANDARD

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CASPER Report 0003D
Provider History Profile
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DEVON GABLES REHABILITATION CENTER   **CCN:** 035145

Deficiency Summary

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

Complaint Survey Information

Survey Date	Status
04/30/2015	Unsubstantiated
06/18/2014	Unsubstantiated
02/27/2014	Substantiated
07/02/2013	Substantiated

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* = Regional Office Flag (Includes COPs)   ELE = Element   STD = Standard   COP = Condition   REQ = Requirement

CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 07/19/2012 thru 07/19/2016

DEVON GABLES REHABILITATION CENTER **CCN:** 035145

LTC Resident Census

Resident Census on 04/30/2015
Total: 243
Medicare: 5
Medicaid: 171
Other: 67

Total Certified Beds: 312

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