

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 5RFS

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0031

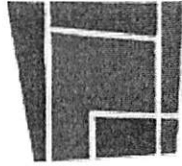
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 035145		3. NAME AND ADDRESS OF FACILITY (L3) DEVON GABLES REHABILITATION CENTER			4. TYPE OF ACTION: <u>2</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) 748491		(L4) 6150 EAST GRANT ROAD			1. Initial 2. Recertification	
		(L5) TUCSON, AZ (L6) 85712			3. Termination 4. CHOW	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9) 08/31/2012		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			5. Validation 6. Complaint	
6. DATE OF SURVEY 12/12/2019 (L34)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			7. On-Site Visit 9. Other	
8. ACCREDITATION STATUS: ___ (L10)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			8. Full Survey After Complaint	
0 Unaccredited 1 TJC 2 AOA 3 Other		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			FISCAL YEAR ENDING DATE: (L35)	
		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			12/31	
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:				
From (a): To (b):		<input checked="" type="checkbox"/> A. In Compliance With Program Requirements Compliance Based On: <input checked="" type="checkbox"/> 1. Acceptable POC B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: A1* (L12)				
12.Total Facility Beds 312 (L18)		And/Or Approved Waivers Of The Following Requirements:				
13.Total Certified Beds 312 (L17)		___ 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				
14. LTC CERTIFIED BED BREAKDOWN					15. FACILITY MEETS	
18 SNF	18/19 SNF	19 SNF	ICF	IID	1861 (e) (1) or 1861 (j) (1): (L15)	
(L37)	312 (L38)	(L39)	(L42)	(L43)		

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
 Devon Gables Rehabilitation Center was found to be out of compliance with federal regulations based on an annual survey conducted on 12/12/19.
 Devon Gables Rehabilitation Center is back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance, revisit survey completed on 02/07/2020 State Agency recommended recertification.

17. SURVEYOR SIGNATURE <i>for Dale Adams, Team Lead</i> Date: 02/07/2020 (L19)	18. STATE SURVEY AGENCY APPROVAL <i>Sandy Farmer</i> Date: 02/07/2020 (L20)
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PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY		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 : _____	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate <input type="checkbox"/> 2. Facility is not Eligible (L21)					
22. ORIGINAL DATE OF PARTICIPATION 11/08/1987 (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		26. TERMINATION ACTION: (L30)	
		24. LTC AGREEMENT ENDING DATE (L25)		VOLUNTARY <u>00</u> INVOLUNTARY	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		01-Merger, Closure 02-Dissatisfaction W/ Reimbursement 03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	
		A. Suspension of Admissions: (L44)		05-Fail to Meet Health/Safety 06-Fail to Meet Agreement	
		B. Rescind Suspension Date: (L45)		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

February 10, 2020

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 black ink that reads "Diane Eckles".

Diane Eckles
Bureau Chief

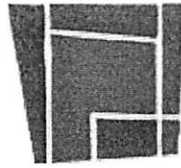
DE/sf

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

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ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 10, 2020

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On February 7, 2020, an offsite revisit 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 based on an allegation of compliance and acceptable plan of correction.

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 "Sandy Farmer".

Sandy Farmer
LTC Customer Service Representative IV

\sf

Enclosure

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: 02/07/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 02/07/2020
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 offsite follow up Federal Recertification and complaint investigation survey was conducted on 2/7/2020, no deficiencies were cited.	{F 000}			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 035145	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/7/2020	Y3
NAME OF FACILITY DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712		

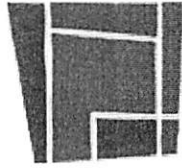
This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective 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 02/07/2020	ID Prefix F0623 Reg. # 483.15(c)(3)-(6)(8) LSC	Correction Completed 02/07/2020	ID Prefix F0625 Reg. # 483.15(d)(1)(2) LSC	Correction Completed 02/07/2020
ID Prefix F0689 Reg. # 483.25(d)(1)(2) LSC	Correction Completed 02/07/2020	ID Prefix F0732 Reg. # 483.35(g)(1)-(4) LSC	Correction Completed 02/07/2020	ID Prefix F0757 Reg. # 483.45(d)(1)-(6) LSC	Correction Completed 02/07/2020
ID Prefix F0761 Reg. # 483.45(g)(h)(1)(2) LSC	Correction Completed 02/07/2020	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) <i>DA</i>	DATE 2/7/2020	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 2/7/2020
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/12/2019

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? YES NO



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 10, 2020

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On February 10, 2020, an offsite **Life Safety Code** revisit was conducted at 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 based on an allegation of compliance and acceptable plan of correction.

Enclosed is the **Life Safety Code 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 black ink that reads "Sandy Farmer".

Sandy Farmer
LTC Customer Service Representative IV

\sf

Enclosure

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: 02/10/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED R 02/10/2020
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>All noted deficiencies on the survey dated December 13, 2019, have been corrected.</p> <p>This is a NO ON SITE follow-up based on an approved plan of correction with allegations of correction and supporting documentation.</p>	{K 000}			

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

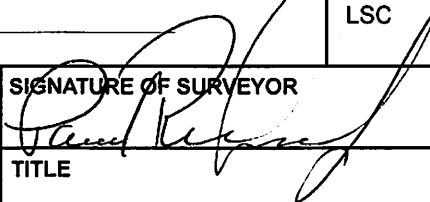
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

POST-CERTIFICATION REVISIT REPORT

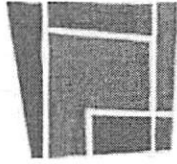
PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 035145	Y1	MULTIPLE CONSTRUCTION A. Building 01 - MAIN BUILDING 01 B. Wing	Y2	DATE OF REVISIT 2/10/2020	Y3
NAME OF FACILITY DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712		

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 _____ Reg. # NFPA 101 LSC K0353	Correction Completed 02/10/2020	ID Prefix _____ Reg. # NFPA 101 LSC K0363	Correction Completed 02/10/2020	ID Prefix _____ Reg. # NFPA 101 LSC K0511	Correction Completed 02/10/2020
ID Prefix _____ Reg. # NFPA 101 LSC K0920	Correction Completed 02/10/2020	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) <i>PK</i>	DATE 2/10/2020	SIGNATURE OF SURVEYOR 	DATE 2/10/2020
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/13/2019	<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
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ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

January 22, 2020

Receipt Of This Notice Is Presumed To Be -01/22/2020
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On **December 12, 2019**, 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 no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

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

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

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Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **February 3, 2020**. You must include all pages of the Statement of Deficiencies when submitting your PoC.

Failure to submit an acceptable PoC by **February 3, 2020** 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.
- Please provide all in-service records to include:
 - What was taught
 - When it was taught
 - Sign-in sheets of those who attended
 - Any copies of monitoring adults being done up to your Allegation of Compliance date

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 January 23, 2020.

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

Recommended Remedies

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

Recommending to CMS Civil Money, effective December 12, 2019
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on December 12, 2019. 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 June 8, 2020.

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 March 9, 2020. 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.

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

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Devon Gables Rehabilitation Center

January 22, 2020

Page Four

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 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**

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

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Health and Wellness for all Arizonans

Devon Gables Rehabilitation Center

January 22, 2020

Page Five

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

Informal Dispute Resolution

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

An informal dispute resolution process will not delay the effective date of any enforcement action. **Please note: 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 February 3, 2020, 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:dc

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

RECEIVED
FEB 03 2020
BY: [Signature]

PRINTED: 01/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/12/2019
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	F 000		
F 600 SS=D	<p>The annual recertification survey was conducted on December 9 through 12, 2019, in conjunction with the following Complaint investigations: #'s AZ160871, AZ160371, AZ160372, AZ160180, AZ160149, AZ160153 and AZ158386. The following deficiencies were cited.</p> <p>Free from Abuse and Neglect CFR(s): 483.12(a)(1)</p> <p>§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.</p> <p>§483.12(a) The facility must-</p> <p>§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, facility documentation, staff interviews, and policy review, the facility failed to ensure that one resident (#172) was free from abuse by another resident (#427). The deficient practice could result in the potential for further resident to resident abuse.</p> <p>Findings include: -Resident #172 was admitted to the facility on</p>	F 600	<p>Arizona Department of Health Division of Public Health Inspector Services</p> <p>FEB 3 2020</p> <p>RECEPTION DESK 150 N. 18th Ave #401 Phoenix AZ 85007</p> <p><u>F600</u></p> <p>Correct to individual: Resident #427 and #172 were immediately separated. Resident #427's scratch on his right temple was cleaned and there were no adverse outcomes from the scratch.</p> <p>Immediately following the incident on 10/25/2019, Resident #427 was placed on 1:1 monitoring and the Physician ordered to send resident to hospital for evaluation of agitation and behaviors. Resident #427 has been discharged from facility.</p> <p>Correct to all others: All residents have the potential to be affected. Direct care staff will receive re-education on abuse, including resident to resident altercations and early identification and de-escalation as means of prevention.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [Signature] TITLE: Administrator (X6) DATE: 2/3/2020

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>12/26/2018 with diagnoses that included dementia with behaviors, schizophrenia and anxiety disorder.</p> <p>Review of the care plan with a start date of 1/08/2019 revealed the resident had socially inappropriate and disruptive behaviors related to schizophrenia and dementia which included wandering into peers' rooms and physical aggression. Interventions included assessing whether the resident's behaviors endangered himself or others and intervening as needed, every 15 minute checks when indicated, maintaining a calm environment and approaching to de-escalate or prevent a situation.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 8/29/2019 revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident needed supervision for walking in the corridor and locomotion on the unit.</p> <p>Review of a nursing note dated 10/25/2019 revealed that at 6:20 AM resident #172 wandered into resident #427's room. Resident #427 became anxious, aggressive, and combative hitting resident #172 in the face with his foot. The residents were separated. Resident #172 continued to be mad stating "he wants to kill him" referring to resident #427. The note included the area to resident #172's right temple was cleaned and neuro checks were initiated.</p> <p>-Resident #427 was admitted to the facility on 6/3/2019 with diagnoses that included dementia with behaviors and mood disorder.</p>	F600	<p><u>System Correction:</u> Visual audits of resident interactions will be made weekly to help ensure that residents are safe.</p> <p><u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow up as needed.</p> <p><u>Correction Date:</u></p> <p><u>Responsible Person:</u> DON or Designee.</p>	2/1/2020

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F 600	<p>Continued From page 2</p> <p>Review of the care plan with a start date of 6/3/2019 revealed the resident was a threat to himself and others related to wandering in other residents' rooms and outside without purpose, and refusing to take medications. The goal was that the resident would have minimal harm to self and others. Interventions included assessing whether the behavior endangered the resident or others and intervening if necessary, maintaining a calm environment, and when the resident begins to become socially inappropriate and/or disruptive, provide comfort measures for his basic needs.</p> <p>A quarterly MDS assessment dated 9/5/2019 revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident could walk independently in the corridor and needed supervision for locomotion on the unit.</p> <p>A nursing note dated October 25, 2019 at 7:30 AM revealed a certified nursing assistant (CNA/staff #252) responded to noise on the hall and that resident #427 was observed holding resident #172 by the shirt dangling him off the floor before he dropped him on the floor and started stomping on resident #172 with his foot. The CNA separated the residents. Resident #427 was very upset and kept repeating "beat his ass". The note included one to one supervision was provided for resident #427.</p> <p>Review of the facility's investigation report dated 11/07/2019 revealed that on 10/25/2019 at approximately 6:20 AM a noise was heard in the hall. A CNA (staff #252) who was providing care to a resident went out into the hall and observed resident #172 on the floor in the doorway of</p>	F 600			

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F 600	<p>Continued From page 3</p> <p>resident #427's room with resident #427 over resident #172 holding resident #172 by the shirt. The CNA told resident #427 to let go of resident #172. Resident #427 let go of resident #172's shirt. Resident #427 then stepped over resident #172 striking him in the torso with his bare foot. Both residents were cursing and agitated at one another. The residents were separated and resident #427 was placed on 1:1 supervision. Resident #172 was observed to have a superficial abrasion on his cheek. No redness or bruising was noted on resident #172's torso. Resident #172 calmed down after a short period. Resident #427 continued to be agitated and focused on resident #172, stating that resident #172 had gone into his room. The report included resident #427 did not de-escalate from the incident and was ultimately sent to the hospital for evaluation of his agitation and behaviors at approximately 12:45 PM.</p> <p>An interview was conducted on 12/11/19 at 09:47 AM with the Director of Nursing (DON/staff #204). The DON stated that she was on duty when the incident happened. She stated the CNA (staff #252) did not see resident #172 being kicked in the face that the CNA only saw resident #172 being kicked in the torso. She stated that resident #172 was assessed to have no bruising, marks, or signs of pain to the chest but was observed to have a small scratch on his face that was assumed to have come from the altercation. The DON stated resident #172 was not observed hitting resident #427. The DON also stated that resident #427 was unable to calm down and was sent to the hospital.</p> <p>An interview was conducted on 12/11/19 at 3:17 PM with the CNA (staff #252) who witnessed the</p>	F 600		

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F 600	Continued From page 4 incident. Staff #252 stated that he heard resident #427 and resident #172 cursing and yelling. The CNA stated that he found resident #427 holding the shirt of resident #172 while resident #172 was on the ground, kicking resident #172 in the chest. He stated resident #427 stopped kicking resident #172 and continued to yell profanities at resident #172. Staff #252 stated the residents were separated and assessed for injury. Staff #252 also stated that resident #427 and resident #172 was placed on 1:1 supervision while the incident was being reported and investigated. During an interview conducted on 12/12/19 at 10:35 AM with the administrator (staff #85), the administrator stated that they are doing all they can to prevent incidents of abuse from occurring. Review of the facility's policy regarding preventing, reporting, and investigating abuse revised November 2017, revealed their residents have the right to be free from abuse and that they are committed to protecting their residents from abuse by anyone including other residents. The policy also revealed abuse means the willful infliction of injury with resulting physical harm, pain or mental anguish. The policy included willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy also included instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a	F 623		

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F 623	<p>Continued From page 5</p> <p>resident, the facility must-</p> <p>(i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.</p> <p>(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and</p> <p>(iii) Include in the notice the items described in paragraph (c)(5) of this section.</p> <p>§483.15(c)(4) Timing of the notice.</p> <p>(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.</p> <p>(ii) Notice must be made as soon as practicable before transfer or discharge when-</p> <p>(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;</p> <p>(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;</p> <p>(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;</p> <p>(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or</p> <p>(E) A resident has not resided in the facility for 30 days.</p>	F 623	<p><u>F623</u></p> <p><u>Correct to the individual:</u></p> <p>Resident #185 was told of Ombudsman's role if a transfer to a hospital occurs and verbalized understanding. Resident #229 was discharged from facility.</p> <p><u>Correct to all others:</u></p> <p>All residents that transfer or discharge from the facility have the potential for being affected.</p> <p>Staff will be re-educated on policy and procedure for notifying Long-Term Care Ombudsman upon a resident's discharge to the hospital.</p> <p><u>System Correction:</u></p> <p>Audits will be done weekly to ensure that the facility notifies the Ombudsman upon transfer to a hospital.</p>		

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F 623	Continued From page 6 §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon	F 623	<u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow up as needed. <u>Correction Date:</u> <u>Responsible Person:</u> Administrator or Designee	2/1/2020	

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F 623	<p>Continued From page 7 as practicable once the updated information becomes available.</p> <p>§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(i).</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure the Office of the State Long-Term Ombudsman was sent a copy of the hospital transfer notice for two of four sampled residents (#185 and #229). The deficient practice could result in the ombudsman not being notified of transfers/discharges.</p> <p>Findings include:</p> <p>-Resident #185 was admitted to the facility on May 1, 2018, with diagnoses that included chronic kidney disease and depression.</p> <p>Review of a nursing note dated November 9, 2019 at 12:14 a.m., revealed the resident was transferred to the hospital due to a change in condition.</p> <p>However, review of the clinical record revealed no evidence the Long-Term Care Ombudsman was sent a copy of the transfer/discharge notice.</p>	F 623			

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F 623	<p>Continued From page 8</p> <p>-Resident #229 was admitted to the facility on June 13, 2019 with diagnoses that included cerebrovascular disease, diabetes, hypertension, and acute kidney failure.</p> <p>Review of the nursing discharge summary progress note dated October 2, 2019 revealed the resident was sent to the hospital to be evaluated and treated for a change in condition.</p> <p>However, review of the clinical record revealed no evidence the Long-Term Care Ombudsman was sent a copy of the transfer notice.</p> <p>During an interview conducted with the social worker (staff #279) on December 10, 2019 at 2:25 p.m., staff #279 stated that they did not notify the ombudsman when residents were discharged to the hospital.</p> <p>An interview was conducted with the administrator (staff #85) on December 10, 2019 at 2:35 p.m. Staff #85 stated that they used to email the ombudsman when residents were discharged to the hospital and that she thought it was no longer a requirement to notify the ombudsman.</p> <p>Later at that day at 3:30 p.m., staff #85 stated that the ombudsman should have been notified when the residents were discharged to the hospital.</p> <p>Review of the facility's policy Transfer or Discharge Notice revised December 2012 revealed the state long-term care ombudsman will be sent a copy of the transfer or discharge notice when an immediate transfer or discharge</p>	F 623			

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F 623	Continued From page 9 is required by the resident's urgent medical needs.	F 623			
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on clinical record review, and resident and staff interviews, the facility failed to ensure one resident (#185) discharged to the hospital was	F 625	F625 <u>Correct to the individual:</u> Resident #185 was given bed hold policy and signed it on 1/27/2020. Resident #229 was discharged from facility. <u>Correct to all others:</u> All residents that are discharged to hospital or transferred on therapeutic leave have the potential for being affected. Admissions will be reviewing bed hold policy with all new residents and or responsible parties. Social Services will review bed hold policy with all current residents/responsible parties and have them sign. Staff will be re-educated on bed hold policy and procedure for notifying resident upon discharge to hospital or therapeutic leave. <u>System Correction:</u> Audits will be done weekly to ensure that bed hold policy is given to each resident upon discharge to hospital or therapeutic leave.		

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F 625	<p>Continued From page 10 informed in writing of the facility's bed hold policy. The deficient practice could result in residents that are transferred or discharged not being informed of the bed hold policy in writing.</p> <p>Findings include:</p> <p>Resident #185 was admitted to the facility on May 1, 2018, with diagnoses that included chronic kidney disease and depression.</p> <p>A quarterly Minimum Data Set assessment dated August 29, 2019 revealed a Brief Interview for Mental Status score of 12 which indicated the resident had moderate cognitive impairment.</p> <p>Review of a nursing note dated November 9, 2019 at 12:14 a.m., revealed the resident was transferred to the hospital due to a change in condition.</p> <p>A nursing progress note dated November 10, 2019 at 2:25 p.m. revealed the resident returned to the facility via stretcher.</p> <p>However, review of the clinical record revealed no evidence the resident was informed in writing of the bed hold policy.</p> <p>During an interview conducted with the resident on December 9, 2019 at 2:16 p.m., the resident stated he had to be hospitalized in November 2019 and that he was not told or informed in writing about the facility's bed hold policy.</p> <p>An interview was conducted with a Registered Nurse (RN/staff #309) on December 10, 2019 at 2:06 p.m. The RN stated residents are informed of the bed hold policy but did not think staff</p>	F 625	<p><u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow up as needed.</p> <p><u>Correction Date:</u></p> <p><u>Responsible Person:</u> Administrator or Designee</p>	2/1/2020

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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 12/12/2019
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 625	Continued From page 11 document that a resident has been informed of the bed hold policy.	F 625			
F 689 SS=D	<p>An interview was conducted with the administrator (staff #85) on December 11, 2019 at 8:18 a.m. She stated a resident has the right to know about the bed hold policy and need to be informed in writing about the bed hold policy. Staff #85 also stated they did not have a policy regarding notifying residents that are transferred or discharged in writing about their bed hold policy.</p> <p>Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2) Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure two residents (#225 and #477) were provided adequate supervision to prevent accidents. The deficient practice could result in residents being at risk for accidents and injury.</p> <p>Findings include: -Resident #225 was admitted to the facility on September 22, 2019, with diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and insomnia.</p>	F 689	<p><u>F689</u> <u>Correct to the individual:</u></p> <p>Resident #225 and #477 were immediately separated and 1:1 supervision was provided for resident #477. Resident #225 received basic first aid for his eye and had no adverse outcomes. Resident #477 had a Physician's order to be sent to Emergency Room for behaviors.</p> <p><u>Correct to all others:</u></p> <p>All residents have the potential to be affected.</p> <p>Staff was re-educated on providing a safe environment for residents through supervision, intervention and deescalation of behaviors.</p> <p><u>System Correction:</u></p> <p>Visual audits of staff to help ensure that adequate supervision of residents is provided to prevent accidents.</p>		

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F 689	Continued From page 12 The admission Minimum Data Set assessment dated September 29, 2019 revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident exhibited verbal and physical behavior symptoms directed toward others 1 to 3 days during the look-back period that put others at significant risk for physical injury. The assessment also included wandering behavior was not exhibited during the look-back period. Review of the care plan with a start date of October 4, 2019 revealed the resident had socially inappropriate and/or disruptive behaviors related to dementia that included agitation, yelling, exit seeking, and pacing in the hall and residents' rooms. The goal was that the resident would not harm himself or others. Interventions included assessing whether the behaviors would endanger himself or other and intervening as needed, limiting noise and distraction on the unit especially in the hallways after 9:00 PM, and maintaining a calm environment and approaching to help de-escalate a situation or prevent one. Review of a nursing progress note dated November 19, 2019, revealed the resident was wandering into other residents' rooms. The note included the resident appeared tired and was attempting to lie in an empty bed. The note also included the resident was re-directed to his room. A nursing progress note dated November 23, 2019 revealed that while walking down the hallway, resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye area. Resident	F 689	<u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow up as needed. <u>Correction Date:</u> <u>Responsible Party:</u> Director of Nursing or Designee.	2/1/2020

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F 689	<p>Continued From page 13</p> <p>#477, while standing inside the doorway of his room, stated that he punched resident #225 in the face because resident #225 is always going into his room. Resident #225 was upset and yelling and crying out. The skin tear to resident #225's left eye was cleansed and already scabbing. The note included 1:1 supervision was placed with resident #477.</p> <p>-Resident #477 was admitted to the facility on September 8, 2017, with diagnoses that included violent behavior, Schizophrenia, and anxiety disorder.</p> <p>Review of the care plan with a start date of September 21, 2017 revealed the resident had socially inappropriate and/or disruptive behavioral symptoms as evidenced by verbal and physical aggression. The goal was that the resident would not harm himself or others. Interventions included observing and reporting socially inappropriate and/or disruptive behaviors when around others and removing the resident from other residents' rooms and unsafe situations.</p> <p>The quarterly MDS assessment dated September 26, 2019 revealed a Brief Interview for Mental Status score of 6 which indicated the resident had severe cognitive impairment. The assessment included the resident exhibited verbal behavioral symptoms directed toward others 1 to 3 days during the look-back period. The assessment did not include whether the behavior had impact on others.</p> <p>A nursing note dated November 3, 2019 revealed that while staff were attempting to obtain the resident's vital signs and conduct a skin assessment, the resident became verbally</p>	F 689		

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F 689	<p>Continued From page 14</p> <p>aggressive, cursing at staff, and attempted to strike at the Certified Nursing Assistant (CNA).</p> <p>Review of nursing progress notes dated November 23, 2019 revealed that while walking down the hallway resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye. Resident #477 was standing inside the doorway and stated that he punched resident #225 because resident #225 is always going into his room. Resident #477 was upset and telling staff that he was leaving the facility tomorrow because he is tired of strangers coming into his room. 1:1 supervision was provided for resident #477 until the resident was sent to the emergency room for evaluation and treatment for violent behaviors.</p> <p>Review of the facility's investigation report dated December 2, 2019 revealed that on November 23, 2019 at approximately 9:00 p.m., a Licensed Practicing Nurse (LPN/Staff #165) heard resident #225 cry out and come walking out of resident #477's room. Staff #165 observed a scant amount of blood on resident #225's left orbital region. Resident #477, while standing in the doorway of his room, told staff #165 that he hit resident #225 because resident #225 came into his room. The residents were immediately separated. Resident #477 was placed with 1:1 supervision until he was sent to the emergency room for behavioral evaluation and management. Resident #225's abrasion by his left eye was treated. The report included resident #225 could not recall what happened or why he was in resident #477's room. The report also included resident #225 was transferred to the secured wandering unit on November 25, 2019 secondary to not exhibiting behavior outside of pacing the</p>	F 689			

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F 689	<p>Continued From page 15 halls and residents' rooms.</p> <p>An interview was conducted on December 11, 2019 at 9:30 a.m. with the Social Services Assistant (staff #184), who stated that on September 26, 2019, resident #225 was moved to a secured behavior unit because of wandering and behavioral issues. She said that the resident was confused, combative, and exit seeking. She stated that it was her understanding that resident #225 was exit seeking, in and out of peers rooms, and that there would be staff on the behavior unit to redirect him. Staff #184 stated that there is an extra aid (hall monitor) on the behavioral unit to redirect the resident when he is wandering to keep him safe.</p> <p>During the interview with staff #184, the Registered Nurse/In-service Director (RN/staff #18) joined the interview. She stated that there is an extra aid (hall monitor) on the unit every shift that monitors and/or supervises common areas where residents congregate. Staff #184 also stated that at night when the majority of residents are sleeping, the hall monitor would be in the hall to monitor, assist and redirect any residents getting up and coming out of their rooms as needed.</p> <p>An interview was conducted on December 11, 2019 at 10:35 a.m. with a CNA (staff #144), who stated that the residents on the secured behavioral unit exhibit sexually inappropriate, aggressive, and exit seeking behaviors. The staff member said that the residents on that unit are very territorial and it would not be appropriate for a resident, like resident #225, who wanders into other residents' personal space. The staff member also stated resident #225 was</p>	F 689			

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F 689	Continued From page 16 transferred to another secured unit for residents who are exit seeking. An interview was conducted on December 11, 2019 at 11:10 a.m. with the Director of Nursing (DON/staff #204), who stated that there are two CNAs scheduled for the secured units, one CNA to cover each hall and a third CNA who monitors both of the halls. The DON stated that the third CNA goes between the two halls to monitor, supervise and redirect residents as needed.	F 689			
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.	F 732	Re-education of staff responsible for posting nurse staffing data was completed in order to ensure that residents and visitors were informed of the Nurse staff data. <u>System Correction:</u> Audits will be done weekly to ensure that nurse staffing data is posted daily. <u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. <u>Correction Date:</u> <u>Responsible Person:</u> Administrator or Designee.	2/1/2020	

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F 732	<p>Continued From page 17</p> <p>§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of policies and procedures, the facility failed to post the actual hours worked by licensed and unlicensed nursing staff on a daily basis. The deficient practice could result in residents and visitors not being aware of the nurse staffing data information.</p> <p>Findings include:</p> <p>A review of the facility's daily nurse staffing information for the previous three months revealed that the actual hours worked by licensed and unlicensed nursing staff were only posted on the following days: November 8, 9, 27, 28, 29 and 30, 2019 and December 4, 6 and 7, 2019.</p> <p>An interview was conducted with the staffing coordinator (staff #6) on December 11, 2019 at 1:00 p.m. Staff #6 stated that she was unaware that it was a requirement to post the actual hours worked on a daily basis.</p> <p>An interview was conducted with the Administrator (staff #85) on December 11, 2019</p>	F 732		

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F 732	Continued From page 18 at 1:15 p.m. Staff #85 stated she noticed that the actual hours worked by licensed and unlicensed nursing staff was not posted. Staff #85 stated that the actual hours worked was posted on the nursing schedule, but it was not posted in a public location.	F 732			
F 757 SS=D	Review of the facility's policy titled, Posting Direct Care Daily Staffing Numbers revealed "Our facility will post on a daily basis for each shift, the number of nursing personnel responsible for providing direct care to residents... The information recorded on the form shall include: The actual time worked during that shift for each category and type of nursing staff..." Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons	F 757	<u>F757</u> Correct to the individual: Resident #377 was discharged from facility. Correct to all others: All residents that have medications may be affected. Re-education of staff regarding following Provider orders with parameters/special instructions to avoid administering unnecessary medications was completed. System Correction: Audits will be done weekly to help ensure that Provider Orders with parameters/special instructions are followed. Monitoring of System: The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed.		

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F 757	<p>Continued From page 19 stated in paragraphs (d)(1) through (5) of this section.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on clinical record review, staff interviews and policy review, the facility failed to ensure one resident's (#377) medication regimen was free from unnecessary medication, by administering insulin outside of the physician ordered parameters. The deficient practice could result in poor blood glucose control and residents receiving medications unnecessarily.</p> <p>Findings include:</p> <p>Resident #377 was admitted on October 9, 2019 for a one week respite stay, with a diagnosis of type 1 diabetes mellitus.</p> <p>A physician history and physical dated October 9, 2019 included to monitor finger stick blood sugars and provide sliding scale insulin.</p> <p>Review of the diabetes baseline care plan dated October 9, 2019 revealed a goal that the resident's blood sugars would remain within the acceptable range. Interventions were to monitor blood sugars before meals and at bedtime.</p> <p>Review of the October 2019 physician orders revealed orders for sliding scale insulin and orders for Lantus Insulin solution 100 unit/milliliter, give 16 units subcutaneous once a day. Special Instructions: Hold for blood sugar less than 100.</p> <p>Review of the October 2019 Medication Administration Record (MAR) revealed that Lantus insulin was administered when the</p>	F 757	<p><u>Correction Date:</u></p> <p><u>Person Responsible:</u> Director of Nursing or Designee</p>	2/1/2020	

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F 757	<p>Continued From page 20</p> <p>resident's BS was less than 100 on the following days: on October 10 at 9:00 a.m. for a recorded blood sugar of 85; on October 14 at 9:00 a.m. for a recorded BS of 86; and on October 15 at 9:00 a.m. for a recorded BS of 71.</p> <p>Review of the nursing progress notes and October 2019 MAR revealed there was no documentation as to why the Lantus insulin was administered outside of the physician ordered parameters on October 10, 14 and 15.</p> <p>During an interview conducted at 8:56 a.m. on December 11, 2019 with a Registered Nurse (RN/staff #50), the nurse stated that before she begins to prepare medications for administration she checks to make sure that the resident's blood sugar results are within the parameters for administering.</p> <p>In an interview with a Licensed Practical Nurse (LPN/staff #21) conducted on December 12, 2019 at 9:51 a.m., staff #21 stated that before administering insulin she would check the resident's blood sugar. She said if the blood sugar was below the ordered parameter, she would hold the insulin and document that the medication was held and make a note explaining why the medication was held. She said if this happened a few times she would notify the physician and document the physician's response.</p> <p>In an interview conducted with the Director of Nursing (DON/staff #205) on December 12, 2019 at 9:56 a.m., the DON stated that she expects the nurse administering medications to review the blood sugars or obtain a blood sugar, and then administer the medication if the blood sugar is</p>	F 757			

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F 757	Continued From page 21 within the ordered parameters. She stated that the nurse may only administer the medication outside of the parameters, if the nurse contacts the physician and receives new direction from the physician. She also stated that if a nurse administered medication outside of ordered parameters, she would expect the nurse to notify the physician and document it. At this time, the DON reviewed the MAR for October 10, 14, and 15 regarding the Lantus insulin and stated that the nurse did not administer the Lantus insulin in accordance with the physician's order. She said the nurse should have called the physician for clarification of the order, since Lantus is a long acting insulin and ordinarily does not have parameters for blood sugars. Review of a policy regarding Physician Medication Orders revealed that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications. A policy on nursing care of the resident with diabetes mellitus included the purpose of the guideline was to help the resident control his/her diabetes with diet, exercise, and insulin (as ordered) and to prevent hyperglycemia/hypoglycemia.	F 757			
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761			

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

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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 761	<p>Continued From page 23</p> <p>Review of the admission Minimum Data Set (MDS) assessment dated November 28, 2019 revealed a Brief Interview Mental Status score of 15, indicating the resident was cognitively intact.</p> <p>A physician's order dated November 21, 2019 included for Silver Sulfadiazine cream 1% (topical antimicrobial drug) one application each dose topically for second degree burn of the left foot twice a day. This order was discontinued on November 22, 2019.</p> <p>Review of a physician's order dated November 21, 2019, revealed for Santyl ointment 250 unit/gram (removes dead tissue from wounds) one dose topically, apply to left ankle burns once a day. This order was discontinued on November 22, 2019.</p> <p>An observation was conducted on December 12, 2019 at 10:05 a.m. of the resident in her room. On a table closest to the door, there was one box with an opened tube of Santyl ointment 250 unit/gm with instructions on the label to apply as directed topically to left ankle burns daily. The prescription label included it was filled on November 21, 2019. Also on the table was one box with an opened tube of Silver Sulfadiazine Cream 1% with directions on the label to apply as directed topically to affected area(s) twice daily. This medication was filled on 11/21/19. During the observation, the resident stated that the Santyl was for her burns and was previously applied by the nurse, but she was no longer using it. She said the Silver Sulfa has been on the table since she arrived. She said it was applied, but was not sure if it is still being used, and did not know why it was prescribed. She said the medications have been on the table for a long time. In addition,</p>	F 761			

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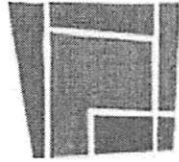
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F 761	<p>Continued From page 24</p> <p>there was a white plastic bottle of Toinaftate Antifungal Powder 1% net weight 45 grams on the mobile bedside table. The resident stated that she did not know if the powder was being applied.</p> <p>Further review of the current physician orders for this resident revealed there was no order for Toinaftate Antifungal Powder 1%.</p> <p>An interview was conducted on December 12, 2019 at 10:20 a.m. with a Registered Nurse (RN/staff #50), who stated that a resident is allowed to keep medications in their room, if there is a form signed by the resident and the physician, which states that it is okay. However, she said that resident #62 is not allowed to keep medications in her room. At this time, staff #50 observed that the Santyl ointment and the Silver Suifadiazine cream were on the table which was closest to the door and that the antifungal powder was on the mobile bedside table. Staff #50 stated that she did not know why the medications were left in the room and that the medications were not supposed to be left in the room. Staff #50 removed the medications from the room.</p> <p>An interview was conducted on December 12, 2019 at 11:32 a.m. with the Director of Nursing (DON/staff #204), who said that all medications are to be locked up when they are not being used. She said even if a resident is able to self-administer medications, including treatment medications, such as ointments, creams and powders, all medications would be kept on the cart and secured when not being used. The DON said the nurse would give the medications to the resident when the medications were to be administered. She stated if the resident wanted to keep the medications in his or her room, the</p>	F 761		
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F 761	Continued From page 25 resident would be given a box where the medications could be locked up. Review of the Storage of Medications policy revised April 2007, revealed that the facility shall store all drugs and biologicals in a safe and secure manner. The policy included that nursing staff shall be responsible for maintaining medication storage. Drugs shall be stored in cabinets, drawers, carts or automatic dispensing systems. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use.	F 761			



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

January 22, 2020

Receipt Of This Notice Is Presumed To Be -01/22/2020
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On December 13, 2019, a Life Safety Code survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiency(ies) in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (D).

This survey found the most serious deficiency(ies) in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (E).

This survey found the most serious deficiency(ies) in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached form 2567 whereby corrections are required (F).

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).

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 form 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 form 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.

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

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **February 3, 2020**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **February 3, 2020**, may result in the imposition of remedies.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice, on both a temporary and permanent basis, including the date the correction will be accomplished;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur; and,
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and the title, or position, of the person responsible for implementing/monitoring the corrective action.
- The signature and date you approve the Plan of Correction on the first page.

Allegation of Compliance

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

To ensure that this office has time to confirm compliance before mandatory remedies are imposed, the Bureau of Long Term Care recommends that an allegation of compliance date be within one week of **January 24, 2020**.

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

Recommended Remedies

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

Recommending to CMS Civil Money, per day, per tag, effective December 13, 2019

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Devon Gables Rehabilitation Center

January 22, 2020

Page Three

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

Mandatory Remedies

Your current period of noncompliance began on December 13, 2019. 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 June 8, 2020.

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.

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 February 3, 2020, 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\dc

Attachments

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

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K 353	Continued From page 1 were provided sprinkler system coverage. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.5.1, "Buildings containing health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." " Chapter 9, Section 9.7.1.1, " Each automatic sprinkler system required by another section of this Code shall be installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems." NFPA 13, Chapter 8, Section 8.5.6 Clearance to Storage. Section 8.5.6.1 Unless the requirements of 8.5.6.2, 8.5.6.3, 8.5.6.4. or 8.5.6.5 are met a clearance between the deflector and the storage shall be 18 inches. (457mm) or greater. Findings include: On December 12, 2019, the surveyor, accompanied by the Director of Maintenance observed the Annex linen closet had pillows stacked within a couple of inches of the sprinkler deflector. During the exit conference on December 12, 2019, the above findings were again acknowledged by the Administrator and Director of Maintenance. Failing to provide sprinkler coverage in storage areas by blocking the sprinkler heads could result in harm to the patients in time of a fire.	K 353		
K 363 SS=E	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors	K 363		

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K 363	Continued From page 2 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation it was determined that the	K 363	<u>K363</u> Bids were obtained and a deposit made to replace the pair of fire doors and frames missing UL listed labels at the service hall going to the kitchen and to replace the one fire door and frame missing UL listed labels at the break room. Doors and frames to be replaced Paint was removed from the UL listed labels on the fire doors and frames at the Lodge South ramp and at West 2 Dining Room on 12/13/2019. Doors will be maintained according to code and will be monitored by the Director of Maintenance as part of the on going preventative maintenance and quality assurance programs. The Director of Maintenance or Designee will present the information to the QAPI committee that meets routinely. The Director of Maintenance or Designee will be responsible.	1/23/2020 4/1/2020 12/14/2019

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K 363	<p>Continued From page 3</p> <p>facility failed to ensure that the U.L. listed labels on the fire smoke doors in several smoke barrier doors were obscured by paint.</p> <p>NFPA 101 Life Safety Code, 2012, Chapter 7, Section 7.2.1.15.2 Fire rated door assemblies shall be inspected and tested in accordance with NFPA 80, Standard for Fire Doors and Other Opening Protectives. Smoke door assemblies shall be inspected and tested in accordance with NFPA 105, Standard for Smoke Door Assemblies and Other Opening Protectives. NFPA 105 Standard for Smoke Door Assemblies and Other Opening Protectives, 2016, Chapter 5, Section 5.2.4.4.2 As a minimum, the following items shall be verified: (1) Labels on fire rated smoke door assemblies are clearly visible and legible and bear the "S" label marking. NFPA 101 Life Safety Code 2012 Section 8.3.3 Fire Doors and Windows Section 8.3.3.2.3 Labels on fire door assemblies shall be maintained in legible condition.</p> <p>Findings include:</p> <p>On December 12, 2019 the surveyor, accompanied by the Director of Maintenance observed several smoke barrier doors throughout the facility had the U.L listed labels on the doors and frames. Door labels were missing or obscured by paint.</p> <p>During the exit conference on December 12, 2019 the above findings were again acknowledged by the Administrator and Director of Maintenance.</p> <p>Failing to properly display the door rating information could allow a non rated door to be</p>	K 363			

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K 363	Continued From page 4 used which will allow smoke and heat to penetrate into other wings or possibly the whole facility which could cause harm to the residents in time of fire.	K 363			
K 511 SS=D	Utilities - Gas and Electric CFR(s): NFPA 101 Utilities - Gas and Electric Equipment using gas or related gas piping complies with NFPA 54, National Fuel Gas Code, electrical wiring and equipment complies with NFPA 70, National Electric Code. Existing installations can continue in service provided no hazard to life. 18.5.1.1, 19.5.1.1, 9.1.1, 9.1.2 This REQUIREMENT is not met as evidenced by: Based on observation it was determined the facility failed to provide protection from electrical shock. NFPA 101 Life Safety Code, 2012, Chapter 18, Section 18.5.1.1 or Chapter 19, Section 19.5.1.1 "Utilities shall comply with the provisions of Section 9.1. Section 9.1.2, "Electrical wiring and equipment installed shall be in accordance with NFPA 70 "National Electrical Code. NEC, 1999, 2011 Edition, Article 110 Requirements for Electrical Installations, "110.12(B) Integrity of Electrical Equipment and Connections. Internal parts of electrical equipment, including busbars, wiring terminals, insulators, and other surfaces, shall not be damaged or contaminated by foreign materials such as paint, plaster, cleaners,	K 511	<u>K511</u> The two broken outlets in the Human Resources Office and the two broken outlets in the Central Dining Room were replaced on 12/13/2020. All outlets will be checked to assure that all outlets are in safe operating condition. This will be monitored by the Director of Maintenance as part of the Ongoing Preventative Maintenance and Quality Assurance Programs. The Director of Maintenance or Designee will present the information to the QAPI committee that meets routinely. Director of Maintenance or Desingee will be responsible.	12/14/2019 12/14/2019	

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K 511	Continued From page 5 abrasives, or corrosive residues. There shall be no damaged parts that may adversely affect safe operation or mechanical strength of the equipment such as parts that are broken; bent; cut; or deteriorated by corrosion, chemical action, or overheating." Findings Include: On December 12, 2019, the surveyor accompanied by the Director of Maintenance observed the following areas with broken electrical receptacles. 1. Two broken outlets in the Human Resources office. 2. Two broken outlets in the Central Dining room. During the exit interview on December 12, 2019, the above finding was again acknowledged by the Administrator and the Director of Maintenance. Failing to protect energized electrical equipment or wiring can cause a shock or fire. A fire could cause harm to the patient.	K 511		
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assemblies that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident	K 920		

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

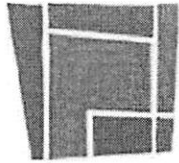
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NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712	
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K 920	Continued From page 6 rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on Observation it was determined the facility allowed the use of power strips and did not use the wall outlet receptacles for appliances. NFPA 101, Life Safety Code, 2012. Chapter 2, Section 2.1 The following documents or portions thereof are referenced within this Code as mandatory requirements and shall be considered part of the requirements of this Code. Chapter 2 "Mandatory References" NFPA 99 "Standard for Health Care Facilities, " 2012 Edition. NFPA 99, Chapter 6, Section 6.3.2.2.6.2 , "All Patient Care Areas," Sections 6.3.2.2..6.2 (A) through 6.3.2.2.6.2 (E) Receptacles (2)" Minimum Number of Receptacles." "The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters. Findings include:	K 920	<u>K920</u> The refrigerator plugged into a power strip in the Physical Therapy Department was removed and plugged directly into an outlet on 12/13/2019. The multiple power strips plugged into a UPC (Power strip with a battery) in the server room were removed from the UPC. The Facility will check to assure that appliances are plugged directly into outlets not power strips. The Facility will check to assure that power strips are plugged directly into outlets not UPC. The Facility will check that power strips are not plugged into other power strips. Staff were re-educated on the requirement that appliances should be plugged directly into outlets not power strips. This will be monitored by the Director of Maintenance as part of the ongoing preventative maintenance and quality assurance programs.	12/14/2019 2/3/2020 1/31/2020

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

PRINTED: 01/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 12/13/2019
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	
K 920	<p>Continued From page 7</p> <p>On December 12, 2019 the surveyor, accompanied by the Director of Maintenance, observed the following power strips in the facility and appliances not directly plugged in to the receptacle wall outlets.</p> <ol style="list-style-type: none"> 1. A refrigerator plugged into a power strip in the Physical Therapy Department. 2. Multiple power strips plugged into a UPC (power strip with a battery) in the server room. <p>During the exit conference on December 12, 2019, the above findings were again acknowledged by the Administrator and the Director of Maintenance.</p> <p>The use of multiple outlet adapters could create an overload of the electrical system and could cause a fire or an electrical hazard. A fire could cause harm to the patients.</p>	K 920	<p>The Director of Maintenance or Designee will present the information to the QAPI committee that meets routinely.</p> <p>Director of Maintenance or Designee will be responsible.</p>		



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

January 22, 2020

Receipt of This Notice is Presumed To Be 01/22/2020
Important Notice - Please Read

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

Dear Ms. Friebus:

On **December 13, 2019**, 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\dc

Attachments

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

PRINTED: 01/21/2020
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/13/2019
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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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</p> <p>FEB 3 2020</p> <p>50 N. 18th Ave #40 Tucson AZ 85707</p> <p>RECEIVED FEB 03 2020 BY: <i>[Signature]</i></p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Heather Anubus* TITLE *Administrator* (X6) DATE *2/3/2020*

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:		Extended Survey:	
From: F1 (mm/dd/yyyy)	To: F2 (mm/dd/yyyy)	From: F3 (mm/dd/yyyy)	To: F4 (mm/dd/yyyy)
12/9/19		12/12/19	
Name of Facility		Provider Number	Fiscal Year Ending: F5 (mm/dd/yyyy)
Devon Gables Rehabilitation Center		035145	12/31/2019
Street Address			
6150 E. Grant Rd.			
City	County	State	Zip Code
Tucson	Pima	AZ	85712
Telephone Number: F6	State/County Code: F7		State/Region Code: F8
520-296-6181			

F9 <table style="width: 100%;"> <tr> <td style="border: 1px solid black; width: 30px; text-align: center;">0</td> <td style="border: 1px solid black; width: 30px; text-align: center;">3</td> <td style="padding-left: 10px;">01 Skilled Nursing Facility (SNF) - Medicare Participation</td> </tr> <tr> <td></td> <td></td> <td>02 Nursing Facility (NF) - Medicaid Participation</td> </tr> <tr> <td></td> <td></td> <td>03 SNF/NF - Medicare/Medicaid</td> </tr> </table>	0	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 <table style="width: 100%; border: 1px solid black;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>						
	0	3	01 Skilled Nursing Facility (SNF) - Medicare Participation													
		02 Nursing Facility (NF) - Medicaid Participation														
		03 SNF/NF - Medicare/Medicaid														

Ownership: F12	For-Profit	Non-Profit	Government
13	01 Individual 02 Partnership 03 Corporation 13 Limited Liability Corporation	04 Church Related 05 Nonprofit Corporation 06 Other Nonprofit	07 State 08 County 09 City 10 City/County 11 Hospital District 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 <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0			F16 Alzheimer's Disease <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">2</td><td style="width: 30px; height: 20px; text-align: center;">4</td><td style="width: 30px; height: 20px;"></td></tr></table>	2	4		F17 Dialysis <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0		
0											
2	4										
0											
F18 Disabled Children/Young Adults <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0			F19 Head Trauma <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0			F20 Hospice <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0		
0											
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0											
F21 Huntington's Disease <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0			F22 Ventilator/Respiratory Care <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr></table>	0			F23 Other Specialized Rehabilitation <table style="width: 100%; border: 1px solid black;"><tr><td style="width: 30px; height: 20px; text-align: center;">4</td><td style="width: 30px; height: 20px; text-align: center;">0</td><td style="width: 30px; height: 20px;"></td></tr></table>	4	0	
0											
0											
4	0										

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:		Waiver of 24 hr licensed nursing requirement:	
Date: F28 (mm/dd/yyyy)	Hours waived per week: F29	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	Time
Heather Friebus Administrator	8:45am
Signature	Date
Heather Friebus	12/10/19

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035145	4	190	43	237
	F75	F75	F77	F78
ADL	Independent	Assist of One or Two Staff	Dependent	
Bathing	F79 8	F80 119	F81 110	
Dressing	F82 18	F83 203	F84 16	
Transferring	F85 33	F86 127	F87 77	
Toilet Use	F88 26	F89 173	F90 38	
Eating	F91 130	F92 94	F93 11	

A. Bowel/Bladder Status

- F94 22 With indwelling or external catheter
- F95 Of total number of residents with catheters, 19 were present on admission.
- F96 171 Occasionally or frequently incontinent of bladder
- F97 141 Occasionally or frequently incontinent of bowel
- F98 173 On individually written bladder training program
- F99 146 On individually written bowel training program

B. Mobility

- F100 4 Bedfast all or most of time
- F101 207 In chair all or most of time
- F102 14 Independently ambulatory
- F103 85 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 130 With contractures
- F107 Of total number of residents with contractures, 88 had contractures on admission.

C. Mental Status

- F108 2 With mental retardation
- F109 10 With documented signs and symptoms of depression
- F110 125 With documented psychiatric diagnosis (exclude dementias and depression)
- F111 125 Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type
- F112 78 With behavioral symptoms
- F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program 78.
- F114 0 Receiving health rehabilitative services for MI/MR

D. Skin Integrity

- F115 12 With pressure sores (exclude Stage I)
- F116 Of the total number of residents with pressure sores excluding Stage I, how many residents had pressure sores on admission? 8.
- F117 171 Receiving preventive skin care
- F118 7 With rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

<p>E. Special Care</p> <p>F119 <u>19</u> Receiving hospice care benefit</p> <p>F120 <input type="checkbox"/> Receiving radiation therapy</p> <p>F121 <input type="checkbox"/> Receiving chemotherapy</p> <p>F122 <u>7</u> Receiving dialysis</p> <p>F123 <u>4</u> Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion</p> <p>F124 <u>75</u> Receiving respiratory treatment</p> <p>F125 <input type="checkbox"/> Receiving tracheostomy care</p> <p>F126 <u>5</u> Receiving ostomy care</p>	<p>F127 <input type="checkbox"/> Receiving suctioning</p> <p>F128 <u>52</u> Receiving injections (exclude vitamin B12 injections)</p> <p>F129 <u>1</u> Receiving tube feedings</p> <p>F130 <u>74</u> Receiving mechanically altered diets including pureed and all chopped food (not only meat)</p> <p>F131 <u>39</u> Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)</p> <p>F132 <u>29</u> Assistive devices while eating</p>
<p>F. Medications</p> <p>F133 <u>75</u> Receiving any psychoactive medication</p> <p>F134 <u>75</u> Receiving antipsychotic medications</p> <p>F135 <u>50</u> Receiving antianxiety medications</p> <p>F136 <u>143</u> Receiving antidepressant medications</p> <p>F137 <u>9</u> Receiving hypnotic medications</p> <p>F138 <u>9</u> Receiving antibiotics</p> <p>F139 <u>106</u> On pain management program</p>	<p>G. Other</p> <p>F140 <u>4</u> With unplanned significant weight loss/gain</p> <p>F141 <u>10</u> Who do not communicate in the dominant language of the facility (include those who use sign language)</p> <p>F142 <input type="checkbox"/> Who use non-oral communication devices</p> <p>F143 <u>237</u> With advance directives</p> <p>F144 <u>18</u> Received influenza immunization</p> <p>F145 <u>147</u> Received pneumococcal vaccine</p>

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

Signature of Person Completing the Form 	Title DON	Date 12/09/2019
---	--------------	--------------------

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 12/05/2015 thru 12/05/2019
Arizona

Run Date: 12/05/2019
 Job # 87366409
 Last Update: 12/04/2019
 Page 1 of 5

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 Provider Category: SNF/NF (DUAL)
 Total: 312
 Certified: 312 Type Action: RECERTIFICATION
 Type Ownership: FOR PROFIT - LIMITED

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

Program Requirements

Current Survey/Revisit Dates - 02/13/2019

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
04/2015		07/2016		08/2017		11/01/2018			
-	-	-	-	-	-	-	-	-	REQ F0154-INFORMED OF HEALTH STATUS, CARE, & TREATMENTS
-	-	-	-	-	-	-	-	-	REQ F0156-NOTICE OF RIGHTS, RULES, SERVICES, CHARGES
-	-	-	-	-	-	-	-	-	REQ F0160-CONVEYANCE OF PERSONAL FUNDS UPON DEATH
-	-	-	-	-	-	-	-	-	REQ F0221-RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS
X	D	-	-	-	-	-	-	-	REQ F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
-	-	-	-	X	D	-	-	-	REQ F0224-PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN
X	D	-	-	-	-	-	-	-	REQ F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
X	D	-	-	-	-	-	-	-	REQ F0226-DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES
-	-	X	E	-	-	-	-	-	REQ F0241-DIGNITY AND RESPECT OF INDIVIDUALITY
-	-	-	-	-	-	-	-	-	REQ F0246-REASONABLE ACCOMMODATION OF
-	-	-	-	-	-	-	-	-	REQ F0278-ASSESSMENT ACCURACY/COORDINATION/CERTIFIED
-	-	-	-	-	-	-	-	-	REQ F0279-DEVELOP COMPREHENSIVE CARE PLANS
X	D	X	D	-	-	-	-	-	REQ F0281-SERVICES PROVIDED MEET PROFESSIONAL
X	E	-	-	-	-	-	-	-	REQ F0309-PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING
-	-	-	-	-	-	-	-	-	REQ F0314-TREATMENT/SVCS TO PREVENT/HEAL PRESSURE
-	-	X	G	-	-	-	-	-	REQ F0323-FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES
-	-	-	-	-	-	-	-	-	REQ F0356-POSTED NURSE STAFFING INFORMATION
-	-	-	-	-	-	-	-	-	REQ F0365-FOOD IN FORM TO MEET INDIVIDUAL NEEDS
-	-	X	D	-	-	-	-	-	REQ F0366-SUBSTITUTES OF SIMILAR NUTRITIVE VALUE
-	-	X	E	-	-	-	-	-	REQ F0371-FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY
-	-	-	-	-	-	-	-	-	REQ F0411-ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS
-	-	X	E	-	-	-	-	-	REQ F0412-ROUTINE/EMERGENCY DENTAL SERVICES IN NFS
-	-	-	-	-	-	-	-	-	REQ F0431-DRUG RECORDS, LABEL/STORE DRUGS &
-	-	X	D	-	-	-	-	-	REQ F0441-INFECTION CONTROL, PREVENT SPREAD, LINENS
-	-	-	-	-	-	-	-	-	REQ F0463-RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH
-	-	-	-	X	E	-	-	-	REQ 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 12/05/2015 thru 12/05/2019**

Run Date: 12/05/2019
 Job # 87366409
 Last Update: 12/04/2019
 Page 2 of 5

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
04/2015		07/2016		08/2017		11/01/2018			
-	-	-	-	-	-	-	-	-	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-COMPLETE/ACCURATE/ACCESSIBLE
-	-	-	-	-	-	-	-	-	REQ F0520-QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS
-	-	-	-	-	-	X C	D	01/23/2019	REQ F0600-Free from Abuse and Neglect
-	-	-	-	-	-	X !	G	02/22/2018	REQ F0658-Services Provided Meet Professional Standards
-	-	-	-	-	-	X C	D	01/23/2019	REQ F0686-Treatment/Svcs to Prevent/Heal Pressure Ulcer
-	-	-	-	-	-	X !	G	-	REQ F0760-Residents are Free of Significant Med Errors
-	-	-	-	-	-	X C	D	01/23/2019	REQ F0773-Lab Srvcs Physician Order/Notify of Results

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
04/2015		07/2016		08/2017		11/01/2018			
X	D	-	-	-	-	-	-	-	STD K0232-Aisle, Corridor, or Ramp Width
-	-	-	-	-	-	-	-	-	STD K0271-Discharge from Exits
-	-	-	-	-	-	-	-	-	STD K0281-Illumination of Means of Egress
-	-	-	-	-	-	-	-	-	STD K0291-Emergency Lighting
-	-	-	-	-	-	-	-	-	STD K0293-Exit Signage
X	D	-	-	-	-	-	-	-	STD K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	-	-	-	STD K0324-Cooking Facilities
-	-	-	-	X	D	-	-	-	STD K0351-Sprinkler System - Installation
-	-	-	-	X	E	-	-	-	STD K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	-	-	-	STD K0363-Corridor - Doors
-	-	-	-	-	-	-	-	-	STD K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	-	-	-	STD K0511-Utilities - Gas and Electric
-	-	-	-	-	-	-	-	-	STD K0753-Combustible Decorations

I = Past Non-compliance C = Date of Correction N = No Date Given P = Plan of Correction R = Refused to Correct W = Waived F = FSSES 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 12/05/2015 thru 12/05/2019**

Run Date: 12/05/2019
 Job # 87366409
 Last Update: 12/04/2019
 Page 3 of 5

DEVON GABLES REHABILITATION CENTER

CCN: 035145

Edition of LSC Applied

2012 HC Prior 3 Survey 04/2015	S/S Code	2012 HC Prior 2 Survey 07/2016	S/S Code	2012 HC Prior 1 Survey 08/2017	S/S Code	2012 HC Current Survey 11/01/2018	S/S Code	Plan/Date of Correction	LSC Deficiencies - Bldg # 01
-	-	-	-	X	E	-	-	-	STD K0920-Electrical Equipment - Power Cords and Extens
-	-	-	-	X	D	-	-	-	STD K0923-Gas Equipment - Cylinder and Container Storag

! = 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 12/05/2015 thru 12/05/2019**

Run Date: 12/05/2019
 Job # 87366409
 Last Update: 12/04/2019
 Page 4 of 5

DEVON GABLES REHABILITATION CENTER

CCN: 035145

Deficiency Summary

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

Complaint Survey Information

Survey Date	Status
05/16/2019	Unsubstantiated
11/01/2018	Substantiated
03/08/2018	Unsubstantiated
08/10/2017	Substantiated



CASPER Report 0003D
Provider History Profile
Based on Current Surveys from 12/05/2015 thru 12/05/2019

Run Date: 12/05/2019
Job # 87366409
Last Update: 12/04/2019
Page 5 of 5

DEVON GABLES REHABILITATION CENTER

CCN: 035145

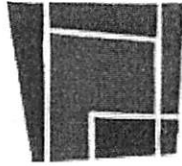
LTC Resident Census

Resident Census on 11/01/2018

Total: 226
Medicare: 7
Medicaid: 178
Other: 41

Total Certified Beds: 312

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



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

January 22, 2020

Important Notice - Please Read Carefully

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

Re: **Complaint Intake #AZ00160153/AZ00160149**
Investigation # 5RFS11

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, appearing to read 'Daniel Coleman'.

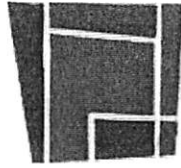
Daniel Coleman
LTC Customer Service Representative IV
Bureau of Long Term Care Licensing

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

January 22, 2020

Important Notice - Please Read Carefully

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

Re: **Complaint Intake #AZ00160371/AZ00160372**
Investigation # 5RFS11

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, appearing to read 'Daniel Coleman'.

Daniel Coleman
LTC Customer Service Representative IV
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
Division of Public Health
Hazardous Services

FEB 3 2020

reception desk
50 N. 18th Ave #401
Phoenix AZ 85007

February 3, 2020

Dear Diane Eckles,

Please see my enclosed plan of correction for Federal Survey completed 12/12/2019. I have attached:

- F600 Syllabus for education provided to staff on abuse, and neglect and early intervention and de-escalation as a means of prevention, corresponding sign in sheets and audits.
- F623 Education done on requirements, corresponding sign in sheet, audits and examples of faxed copy to Ombudsman, and note for Resident #185.
- F625 Education done on requirements, corresponding sign in sheet, bed hold policy, bed hold admission acknowledgement, bed hold policy fax sheet for ER, examples of faxed copies to ER, and acknowledgement by all current residents.
- F689 Education done on safety, transporting and hall safety, corresponding sign in sheets, and audits
- F732 Education on requirements, sign in sheet, new form for posting actual hours worked, examples of posted forms, and audits.
- F757 Education on Drug Regimen is free from Unnecessary Drugs with corresponding test, sign in sheets, and audits.
- F761 Education on medication storage and safety, sign in sheet, and audits

I am also attaching the plan of correction for State Survey completed 12/12/20.

- Y337- Please utilize F623 attachments
- Y1235- Please utilize F757 attachments
- Y1477- Please utilize F600 and F689 attachments
- Y2153- Please utilize F761 attachments.

If you have any questions or concerns. Please feel free to contact me.

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
Division of Public Health
Mesa, Arizona

FEB 3 2020

Reception Desk
50 N. 18th Ave #40
Phoenix, AZ 85007
February 3, 2020

Dear Diane Eckles,

Please see my enclosed plan of correction for Life Safety Survey completed 12/13/2019. I have attached the receipt indicating we paid deposit for doors, and will be installing as soon as they arrive from manufacture. I have also included a syllabus for education provided, corresponding sign in sheets for education provided to staff, and audits. Please let me know if you have any questions or concerns

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



Supplemental POC Documents

Syllabus for Devon Gables Annual Mandatory Inservice for all staff: 2019/2020

1. New Regulations reviewed:
 - a. Competency based on Facility Assessment.
 - b. Trauma Informed Care
 - c. Infection Preventionist
 - d. Ethics
2. QAPI Defined
3. PIP defined
4. Infection Prevention and Control
 - a. Antibiotic Stewardship
 - b. Accountability and surveillance
 - c. Hand Hygiene opportunities
 - d. ABR and Hand Washing
 - e. PPE to include Splash Precautions
 - f. Precaution types reviewed (Standard, Contact, Droplet, and Enhanced Barrier)
 - g. Colonization
 - h. Environmental and terminal cleaning procedures
 - i. Food Handling
5. Communication
 - a. customer service
 - b. communicating with dementia residents
 - c. avoiding argumentative conversations
 - d. a smile says welcome
6. Cultural competency
7. Person Centered care and Preferences and choices
8. Care starts at admission and role of baseline careplan and how C.N.A's can access the careplan.
9. Dignity, privacy, terms of endearment.
10. Disaster preparedness
 - a. Drills reviewed (fire, evacuation, disaster)
 - b. R.A.C.E. reviewed
 - c. P.A.S.S. reviewed
 - d. Aisle clearance and access.
 - e. Emergency codes
 - f. E.O.P.
 - g. H.V.A. reviewed
 - h. Emergency generators
11. Abuse
 - a. E.J.A. reviewed
 - b. Abuse Defined
 - c. 2 hour requirement and procedures for notification of abuse officers.
 - d. Resident to Resident Altercations as form of abuse and reviewed early intervention and de-escalation as means of prevention.
 - e. Abuse vs Grievance reviewed and Grievance procedures discussed.
12. Safety
 - a. Body Mechanics
 - b. Transporting and hall safety
 - c. Slipping hazards
 - d. Medication storage and safety.
 - e. Oxygen storage and safety
 - f. 18 inch clearance for storage in fire sprinkler areas
 - g. Never plug appliances into power strips. Always plug appliances directly into outlet.
 - h. Smoking/Vaping policy and safety
 - i. Ethics and Compliance
13. HIPAA
14. Resident rights

F600
Attachments

In-Service 01/24/2020

F623 Requirements Before Transfer/Discharge

Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)

483.15(c){3} Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State

Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when-

A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(8) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(1).

Y337 R9-10-403.C.2.a Administration

R9-10-403.C. An Administrator shall ensure that:

R9-10-403.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:

R9-10-403.C.2.a. Cover resident screening, admission, transport, discharge planning, and discharge.

Please ensure that Pima Council on Aging (PCOA) is notified of all discharges as outlined above by faxing census to PCOA office daily or within 72 hours.

F625 Notice of bed Hold Policy Before/Upon Transfer

Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

- (i)The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;
- (ii)The reserve bed payment policy in the state plan, under§ 447.40 of this chapter, if any;
- (iii)The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and
- (iv)The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

Please see attached copy of Bed Hold Policy and Procedures.

All residents will be given bed hold policy upon admission and when transfer to Hospital occurs.

Social Services will be giving all current residents/resident representatives the bed hold policy.

TITLE/AREA TO MONITOR: F 623 Audit Tool Date: 1/13/2020.

Statement of standard or indicator(s):

Instructions: Frequency – See POC_ Sample selection: See POC

Responsible See POC_____

QA & A Audit Form

ITEM OR INDICATOR	Yes <u>DL</u>	No	Yes <u>✓</u>	No <u>R.R</u>	Yes	No	Yes	No
	Date <u>1/9/2020</u>		Date <u>1/12/2020</u>		Date _____		Date _____	
Was the Ombudsman Office notified of any transfers to the hospital?	✓		✓					

Comments:

Summary of findings:

Completed by _____

CONFIDENTIAL: This document has been prepared for review and evaluation by the Quality Assessment and Assurance Committee and is entitled to the protection of the peer review, medical review, quality assurance, or other similar privileges provided for by state and federal law. It is not to be copied or distributed without the express, written consent of the legal department.

In-Service 01/24/2020

F623 Requirements Before Transfer/Discharge

Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8)

483.15(c){3} Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State

Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and

(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.

(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

(ii) Notice must be made as soon as practicable before transfer or discharge when-

A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;

(8) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;

(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;

(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or

(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:

(i) The reason for transfer or discharge;

(ii) The effective date of transfer or discharge;

(iii) The location to which the resident is transferred or discharged;

(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;

(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;

(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and

(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.

If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(1).

Y337 R9-10-403.C.2.a Administration

R9-10-403.C. An Administrator shall ensure that:

R9-10-403.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:

R9-10-403.C.2.a. Cover resident screening, admission, transport, discharge planning, and discharge.

Please ensure that Pima Council on Aging (PCOA) is notified of all discharges as outlined above by faxing census to PCOA office daily or within 72 hours.

F625 Notice of bed Hold Policy Before/Upon Transfer

Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

§483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies-

(i)The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility;

(ii)The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any;

(iii)The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and

(iv)The information specified in paragraph (e)(1) of this section.

§483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section.

Please see attached copy of Bed Hold Policy and Procedures.

All residents will be given bed hold policy upon admission and when transfer to Hospital occurs.

Social Services will be giving all current residents/resident representatives the bed hold policy.

BED HOLD POLICY

POLICY: It is the policy of Devon Gables Rehabilitation Center to request a bed hold fee from residents who are transferred to a hospital or who are on therapeutic leave if it is the expectation of the resident to return to this facility and is not covered by another payor. This will enable the resident to be assigned to the same bed upon return to the facility. The bed cannot be assigned to another resident as long as it is on hold.

1. The fee shall be collected in advance for a five-day bed hold. Any unused portion of the bed hold fee shall be credited to the resident's account. If you wish to initiate a bed hold, please contact the Business Office at 520-296-6181 Ext. 5025 to make arrangements for the payment of this fee.
2. ALTCS residents are allowed therapeutic leave days and bed hold days per their plan contract per year. When a resident is transferred to the hospital or goes out on a therapeutic leave, the facility will hold his/her bed according to the following provisions:
 - a) The facility shall first contact ALTCS to determine if they will pay for a bed hold. If the resident's plan authorizes a bed hold, the resident will be informed of the duration of the bed hold. If ALTCS does not pay for a bed hold, the resident may elect to pay for a bed hold.
 - b) The resident may also pay for bed hold days in excess of what ALTCS covers.
 - c) If a bed hold is not paid, a resident shall have the right to return to the facility upon the first available semi-private bed appropriate to the resident's needs.
3. Medicare does not pay for a bed hold. Medicare beneficiaries, when temporarily leaving the Skilled Nursing Facility (SNF), may request, and pay for, a bed hold. In order to ensure that upon return to the facility, the resident will be able to resume residency in the same room and bed that the resident has temporarily vacated, the resident will be charged privately at the current daily room rate.
4. Private Pay residents, upon being transferred to the hospital or temporarily leaving the facility, may request a bed hold. The resident will be charged privately at the current daily room rate.
5. Residents and their resident representative will be provided a copy of the facility's Bed Hold Policy upon admission and at the time of transfer of a resident for hospitalization or therapeutic leave.
6. In cases of emergency transfer, notice "at time of transfer" means that the resident or resident representative are provided with written notification within 24 hours of the transfer. A copy of the notice may be sent with other papers accompanying the resident to the hospital.

F625, F626

Bed Hold Policy (Rev. 1/2020)



DEVON GABLES
REHABILITATION CENTER

BED HOLD POLICY

It is the policy of Devon Gables Rehabilitation Center to request a bed hold fee from residents who are transferred to a hospital or who are on therapeutic leave if it is the expectation of the resident to return to this facility. This will enable the resident to be assigned to the same bed upon return to the facility. The bed cannot be assigned to another resident as long as it is on hold.

Private Pay residents, upon being transferred to the hospital or temporarily leaving the facility, may request a bed hold. The resident will be charged privately at the current daily room rate.

The fee shall be collected in advance for a five-day bed hold. Any unused portion of the bed hold fee shall be credited to the resident's account. If you wish to initiate a bed hold, please contact the Business Office at 520-296-6181 Ext. 5025 to make arrangements for the payment of this fee.

ALTCS residents are allowed therapeutic leave days and bed hold days per their plan contract per year. When a resident is transferred to the hospital or goes out on a therapeutic leave, the facility will hold his/her bed according to the following provisions:

- A. Devon Gables Rehabilitation Center shall first contact ALTCS to determine if they will pay for a bed hold. If ALTCS does not pay for a bed hold, the resident may elect to pay for a bed hold.
- B. The resident may also pay for bed hold days in excess of what ALTCS covers.
- C. If a bed hold is not paid, a resident shall have the right to return to the facility upon the first available semi-private bed appropriate to the resident's needs.

Medicare does not pay for a bed hold. Medicare beneficiaries, when temporarily leaving the Skilled Nursing Facility (SNF), may request, and pay for, a bed hold. In order to ensure that upon return to the facility, the resident will be able to resume residency in the same room and bed that the resident has temporarily vacated, the resident will be charged privately at the current daily room rate.

Residents covered by any alternate payor source will be allowed therapeutic leave days and bed hold days per their individual plan's contract.

Resident or Resident Representative

Date

1/9 -
1/10/2020

TITLE/AREA TO MONITOR: F 625 Audit Tool Date: 1/10/2020

Statement of standard or indicator(s):

Instructions: Frequency - See POC_ Sample selection: See POC

Responsible See POC _____

QA & A Audit Form

ITEM OR INDICATOR	<u>Resident</u>		<u>Resident</u>		<u>Resident</u>		<u>Resident</u>	
	Yes	No	Yes	No	Yes	No	Yes	No
Was bed hold policy given to resident upon discharge to hospital or therapeutic leave?								

Comments:

Summary of findings:
 0 transfers to hospital

Completed by Kendria Kozney

TITLE/AREA TO MONITOR: F 625 Audit Tool Date: 1/13 - 1/17/2020

Statement of standard or indicator(s):

Instructions: Frequency - See POC_ Sample selection: See POC

Responsible See POC_____

QA & A Audit Form

ITEM OR INDICATOR	Resident		Resident		Resident		Resident	
	Yes	No	Yes	No	Yes	No	Yes	No
Was bed hold policy given to resident upon discharge to hospital or therapeutic leave?								

Comments:

Summary of findings: Ø transfers to hospital

Completed by Kendia Keyser

1. New Regulations reviewed:
 - a. Competency based on Facility Assessment.
 - b. Trauma Informed Care
 - c. Infection Preventionist
 - d. Ethics
2. QAPI Defined
3. PIP defined
4. Infection Prevention and Control
 - a. Antibiotic Stewardship
 - b. Accountability and surveillance
 - c. Hand Hygiene opportunities
 - d. ABR and Hand Washing
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5. Communication
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 - e. Emergency codes
 - f. E.O.P.
 - g. H.V.A. reviewed
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 - b. Abuse Defined
 - c. 2 hour requirement and procedures for notification of abuse officers.
 - d. Resident to Resident Altercations as form of abuse and reviewed early intervention and de-escalation as means of prevention.
 - e. Abuse vs Grievance reviewed and Grievance procedures discussed.
12. Safety
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 - c. Slipping hazards
 - d. Medication storage and safety.
 - e. Oxygen storage and safety
 - f. 18 inch clearance for storage in fire sprinkler areas
 - g. Never plug appliances into power strips. Always plug appliances directly into outlet.
 - h. Smoking/Vaping policy and safety
 - i. Ethics and Compliance
13. HIPAA
14. Resident rights

In-Service 01/24/2020

F732 Posted Nurse Staffing Information

F 732 Posted Nurse Staffing Information SS=B CFR(s): 483.35(9)(1)-(4)

§483.35(9) Nurse Staffing Information.

§483.35(9)(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

iv) Resident census.

§483.35(9)(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

§483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

§483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

Please ensure that nursing hours are posted and retained as stated above in the regulation. See new attached form for reporting hours.

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: _____

Resident Census: _____

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____
3pm-11pm	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____
11pm-7am	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-30-2020
Resident Census: 234

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>640</u>	RN: <u>625</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>86.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>189.75</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>16.25</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>81.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>185.0</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>17.5</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>40.0</u>
	CNA	CNA: <u>13</u>	CNA: <u>104.0</u>	CNA: <u>103.0</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-29-2020
Resident Census: 232

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64</u>	RN: <u>66.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88</u>	LPN: <u>88.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180</u>	CNA: <u>204.75</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>240</u>	RN: <u>160</u>
	LPN	LPN: <u>9</u>	LPN: <u>72</u>	LPN: <u>77.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>172.5</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>160</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>39.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>107.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-28-2020
Resident Census: 234

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>640</u>	RN: <u>637.5</u>
	LPN	LPN: <u>11</u>	LPN: <u>880</u>	LPN: <u>847.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>1800</u>	CNA: <u>2037.5</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>240</u>	RN: <u>217.5</u>
	LPN	LPN: <u>9</u>	LPN: <u>720</u>	LPN: <u>695</u>
	CNA	CNA: <u>24</u>	CNA: <u>1800</u>	CNA: <u>1865</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>82.5</u>
	LPN	LPN: <u>5</u>	LPN: <u>400</u>	LPN: <u>480</u>
	CNA	CNA: <u>15</u>	CNA: <u>1200</u>	CNA: <u>1112.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-27-2020
Resident Census: 232

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>640</u>	RN: <u>65.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>80.25</u>
	CNA	CNA: <u>25</u>	CNA: <u>1875</u>	CNA: <u>206.0</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>14.75</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>77.0</u>
	CNA	CNA: <u>25</u>	CNA: <u>1875</u>	CNA: <u>185.50</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>17.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>39.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>101.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-26-2020
Resident Census: 232

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>2375</u>
	LPN	LPN: <u>10</u>	LPN: <u>80.0</u>	LPN: <u>84.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>165.75</u>
3pm-11pm	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>19.5</u>
	LPN	LPN: <u>10</u>	LPN: <u>80</u>	LPN: <u>61.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180</u>	CNA: <u>157.0</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>16.0</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>40.25</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>103.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-25-2020
Resident Census: 227

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>4</u>	RN: <u>320</u>	RN: <u>290</u>
	LPN	LPN: <u>9</u>	LPN: <u>720</u>	LPN: <u>727.5</u>
	CNA	CNA: <u>25</u>	CNA: <u>1875</u>	CNA: <u>1852.5</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>240</u>	RN: <u>25.5</u>
	LPN	LPN: <u>9</u>	LPN: <u>720</u>	LPN: <u>630</u>
	CNA	CNA: <u>24</u>	CNA: <u>1860</u>	CNA: <u>1530</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>25.5</u>
	LPN	LPN: <u>4</u>	LPN: <u>320</u>	LPN: <u>31.5</u>
	CNA	CNA: <u>15</u>	CNA: <u>1200</u>	CNA: <u>99.75</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-24-2020
Resident Census: 227

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>64.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>80.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>188.25</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>16.0</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>65.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>171.0</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>24.5</u>
	LPN	LPN: <u>5</u>	LPN: <u>40</u>	LPN: <u>33.0</u>
	CNA	CNA: <u>15</u>	CNA: <u>120</u>	CNA: <u>110.0</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-23-2020
Resident Census: 229

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>62.75</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>89.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>196.25</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>23.0</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>64.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>185.75</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>15.75</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>39.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>96.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-22-2020
Resident Census: 225

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>63.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>79.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>197.25</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>24.25</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>53.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>191.25</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>16.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>40.0</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>100.0</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-21-2020
Resident Census: 226

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>67.0</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>89.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>176.75</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>16.25</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>69.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>173.25</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.75</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>40.5</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>104.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-20-2020
Resident Census: 228

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>60.5</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>81.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>192.25</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>22.75</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>64.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>165.25</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>16.0</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>46.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>97.0</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1/19/2020
Resident Census: 225

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>5.75</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>88.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>162.0</u>
3pm-11pm	RN	RN: <u>1</u>	RN: <u>8.0</u>	RN: <u>16.5</u>
	LPN	LPN: <u>10</u>	LPN: <u>80.0</u>	LPN: <u>70.75</u>
	CNA	CNA: <u>24.5</u>	CNA: <u>180.5</u>	CNA: <u>161.5</u>
11pm-7am	RN	RN: <u>1</u>	RN: <u>8.0</u>	RN: <u>15.25</u>
	LPN	LPN: <u>6</u>	LPN: <u>48.0</u>	LPN: <u>32.75</u>
	CNA	CNA: <u>13.5</u>	CNA: <u>108.0</u>	CNA: <u>102.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-18-2020
Resident Census: 225

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>15.25</u>
	LPN	LPN: <u>10</u>	LPN: <u>80.0</u>	LPN: <u>80</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>171.5</u>
3pm-11pm	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>13.25</u>
	LPN	LPN: <u>10</u>	LPN: <u>80.0</u>	LPN: <u>72.25</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>161.25</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>14.75</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>39.75</u>
	CNA	CNA: <u>12</u>	CNA: <u>96.0</u>	CNA: <u>94.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-17-2020
Resident Census: 226

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>68.5</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>81.50</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>198.0</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>32.0</u>	RN: <u>24.25</u>
	LPN	LPN: <u>8</u>	LPN: <u>64.0</u>	LPN: <u>61.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>171.5</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>24.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>32.5</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>111</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-16-2020
Resident Census: 226

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>58.0</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>87.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>179.5</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>32.0</u>	RN: <u>15.5</u>
	LPN	LPN: <u>8</u>	LPN: <u>64.0</u>	LPN: <u>73.25</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>185.75</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.75</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>42.0</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>104.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-15-2020
Resident Census: 726

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>52.0</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>87.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>200</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>32.0</u>	RN: <u>26.75</u>
	LPN	LPN: <u>8</u>	LPN: <u>64.0</u>	LPN: <u>55.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>173.5</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>40.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>108.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-14-2020
Resident Census: 229

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>640</u>	RN: <u>657.5</u>
	LPN	LPN: <u>11</u>	LPN: <u>880</u>	LPN: <u>892.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>207.5</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>320</u>	RN: <u>312.5</u>
	LPN	LPN: <u>8</u>	LPN: <u>640</u>	LPN: <u>547.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>175.0</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>160</u>	RN: <u>77.5</u>
	LPN	LPN: <u>5</u>	LPN: <u>400</u>	LPN: <u>402.5</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>102.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-13-2020
Resident Census: 223

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>9</u>	RN: <u>720</u>	RN: <u>70.5</u>
	LPN	LPN: <u>10</u>	LPN: <u>80.0</u>	LPN: <u>74.5</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>183.25</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>320</u>	RN: <u>290</u>
	LPN	LPN: <u>8</u>	LPN: <u>64.0</u>	LPN: <u>63.25</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>175.75</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.0</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>47.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>95.25</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-12-20
Resident Census: 225

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>16.0</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>80.0</u>
	CNA	CNA: <u>25</u>	CNA: <u>187.5</u>	CNA: <u>188.0</u>
3pm-11pm	RN	RN: <u>1</u>	RN: <u>8.0</u>	RN: <u>8.0</u>
	LPN	LPN: <u>13</u>	LPN: <u>97.5</u>	LPN: <u>80.75</u>
	CNA	CNA: <u>30</u>	CNA: <u>240.0</u>	CNA: <u>181.75</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>39.25</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>110.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1/11/20

Resident Census: 225

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN ^{x8}	RN: <u>2</u>	RN: <u>16</u>	RN: <u>9.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>85.75</u>
	CNA ^{x25}	CNA: <u>27</u>	CNA: <u>202.5</u>	CNA: <u>201.75</u>
3pm-11pm	RN ^{x4}	RN: <u>2</u>	RN: <u>4</u>	RN: <u>11.5</u>
	LPN	LPN: <u>12</u>	LPN: <u>96</u>	LPN: <u>71.75</u>
	CNA ^{x25}	CNA: <u>26</u>	CNA: <u>195</u>	CNA: <u>178.25</u>
11pm-7am	RN ^{x8}	RN: <u>2</u>	RN: <u>16</u>	RN: <u>16.75</u>
	LPN ^{x6}	LPN: <u>4</u>	LPN: <u>32</u>	LPN: <u>31.5</u>
	CNA ^{x8}	CNA: <u>14</u>	CNA: <u>112</u>	CNA: <u>112</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-10-2020

Resident Census: 231

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>54.25</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>77.25</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>185.0</u>
3pm-11pm	RN	RN: <u>3</u>	RN: <u>24.0</u>	RN: <u>16.5</u>
	LPN	LPN: <u>9</u>	LPN: <u>72.0</u>	LPN: <u>71.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>182.0</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>18.0</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>32.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>105.0</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: 1-9-2020
Resident Census: 228

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: <u>8</u>	RN: <u>64.0</u>	RN: <u>58.5</u>
	LPN	LPN: <u>11</u>	LPN: <u>88.0</u>	LPN: <u>91.0</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>189.25</u>
3pm-11pm	RN	RN: <u>4</u>	RN: <u>32.0</u>	RN: <u>32.5</u>
	LPN	LPN: <u>8</u>	LPN: <u>64.0</u>	LPN: <u>55.75</u>
	CNA	CNA: <u>24</u>	CNA: <u>180.0</u>	CNA: <u>181.25</u>
11pm-7am	RN	RN: <u>2</u>	RN: <u>16.0</u>	RN: <u>8.25</u>
	LPN	LPN: <u>5</u>	LPN: <u>40.0</u>	LPN: <u>41.75</u>
	CNA	CNA: <u>15</u>	CNA: <u>120.0</u>	CNA: <u>115.5</u>

Devon Gables Rehabilitation Center
Report of Nursing Staff
Directly Responsible for Resident Care

Date: _____
Resident Census: _____

Shift	Category of Staff	Scheduled Number of Staff	Scheduled hours of Staff to work	Actual Staffing hours worked
7am-3pm	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____
3pm-11pm	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____
11pm-7am	RN	RN: _____	RN: _____	RN: _____
	LPN	LPN: _____	LPN: _____	LPN: _____
	CNA	CNA: _____	CNA: _____	CNA: _____

Medication Administration:

Following Provider orders not to administer unnecessary medications.

Many order such as cardiac medications, diabetic medications, and pain medications have parameters for administration identified by the Provider.

Always see special instructions on orders and follow any parameters set for administration to avoid an unnecessary medication being given when indicated to hold.

If your nursing judgement identifies a need for the Resident to have the medication the Provider should be notified, order clarified and the rationale documented in the EMR.

When medications are given outside the parameter set by a Provider a medication error has occurred and needs to be documented.

Below are some examples of orders that identify parameters for administration:

Order Description:	metformin tablet; 500 mg; amt: 500 mg; oral
Disciplines:	
Frequency:	Once A Day 1: 09:00
Special Instructions:	HOLD for FSBS <100
Diagnosis:	E11.65:Type 2 diabetes mellitus with hyperglycemia
Related Event:	
Task(s) to Record:	Blood Sugar
Order Class:	Physician Order (PO)

Order Description:	metoprolol tartrate tablet; 25 mg; amt: 25 mg; oral
Disciplines:	
Frequency:	Every 12 Hours 1: 09:00 2: 21:00
Special Instructions:	HOLD FOR SBP<100, HR<55
Diagnosis:	I15.9:Secondary hypertension, unspecified
Related Event:	
Task(s) to Record:	Pulse; Blood Pressure
Order Class:	Physician Order (PO)

QAPI Audit Form

F757 Medication Administration per Provider order

Person Completing: _____ Date: _____

ITEM OR INDICATOR	Resident:		Resident:		Resident:		Resident:		Resident:	
	Med:	Med:	Med:	Med:	Med:	Med:	Med:	Med:	Med:	Med:
1) Medication with parameters given/held as ordered by Provider. (Run report in Matrix under Emar compliance)	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
XXXXXXXXXXXXXXXXXX	XXXX	XXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX	XXXX

*To be done weekly

System change and/or education provided or disciplinary action taken for noted discrepancies: _____

Syllabus for Devon Gables Annual Mandatory Inservice for all staff: 2019/2020

1. New Regulations reviewed:
 - a. Competency based on Facility Assessment.
 - b. Trauma Informed Care
 - c. Infection Preventionist
 - d. Ethics
2. QAPI Defined
3. PIP defined
4. Infection Prevention and Control
 - a. Antibiotic Stewardship
 - b. Accountability and surveillance
 - c. Hand Hygiene opportunities
 - d. ABR and Hand Washing
 - e. PPE to include Splash Precautions
 - f. Precaution types reviewed (Standard, Contact, Droplet, and Enhanced Barrier)
 - g. Colonization
 - h. Environmental and terminal cleaning procedures
 - i. Food Handling
5. Communication
 - a. customer service
 - b. communicating with dementia residents
 - c. avoiding argumentative conversations
 - d. a smile says welcome
6. Cultural competency
7. Person Centered care and Preferences and choices
8. Care starts at admission and role of baseline careplan and how C.N.A's can access the careplan.
9. Dignity, privacy, terms of endearment.
10. Disaster preparedness
 - a. Drills reviewed (fire, evacuation, disaster)
 - b. R.A.C.E. reviewed
 - c. P.A.S.S. reviewed
 - d. Aisle clearance and access.
 - e. Emergency codes
 - f. E.O.P.
 - g. H.V.A. reviewed
 - h. Emergency generators
11. Abuse
 - a. E.J.A. reviewed
 - b. Abuse Defined
 - c. 2 hour requirement and procedures for notification of abuse officers.
 - d. Resident to Resident Altercations as form of abuse and reviewed early intervention and de-escalation as means of prevention.
 - e. Abuse vs Grievance reviewed and Grievance procedures discussed.
12. Safety
 - a. Body Mechanics
 - b. Transporting and hall safety
 - c. Slipping hazards
 - d. Medication storage and safety.
 - e. Oxygen storage and safety
 - f. 18 inch clearance for storage in fire sprinkler areas
 - g. Never plug appliances into power strips. Always plug appliances directly into outlet.
 - h. Smoking/Vaping policy and safety
 - i. Ethics and Compliance
13. HIPAA
14. Resident rights