Medicare/Medicaid Public Records Documents Only

Survey event #YZWT

Facility: DEVON GABLES REHABILITATION CENTER

Revised 7-2020

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 31, 2022

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,

Diane Eckles

Diane Eckles
Bureau Chief

DE/MC:mm

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: YZWT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0031

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **035145**
2. STATE VENDOR OR MEDICAID NO.
(L2) **748491**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9) **08/31/2012**
6. DATE OF SURVEY **04/29/2022** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12. Total Facility Beds **312** (L18)
13. Total Certified Beds **312** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Devon Gables Rehabilitation Center Recertification survey #YZWT was conducted on 04/29/2022. There were deficiencies cited on the Federal and Life Safety Code. Based on the allegation of compliance and acceptable plan of correction with evidence of compliance, the revisit survey completed on 05/27/2022 (Health) and 05/25/22 (LSC), State Agency recommended recertification.

17. SURVEYOR SIGNATURE: Date: 05/27/2022 (L19)
Matt Connolly, HCM by M Sullivan

18. STATE SURVEY AGENCY APPROVAL Date: 05/27/2022 (L20)
M Sullivan

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03101
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 31, 2022

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On May 27, 2022, an offsite revisit, #YZWT12, 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,

Monica Miller
Program Project Specialist II

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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	R 05/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS An offsite follow-up survey was conducted on May 27, 2022. 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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035145 Y1	A. Building B. Wing Y2	5/27/2022 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0582	Correction	ID Prefix F0644	Correction	ID Prefix F0645	Correction
Reg. # 483.10(g)(17)(18)(i)-(v)	Completed	Reg. # 483.20(e)(1)(2)	Completed	Reg. # 483.20(k)(1)-(3)	Completed
LSC	06/06/2022	LSC	06/06/2022	LSC	06/06/2022
ID Prefix F0658	Correction	ID Prefix F0677	Correction	ID Prefix F0688	Correction
Reg. # 483.21(b)(3)(i)	Completed	Reg. # 483.24(a)(2)	Completed	Reg. # 483.25(c)(1)-(3)	Completed
LSC	06/06/2022	LSC	06/06/2022	LSC	06/06/2022
ID Prefix F0761	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.45(g)(h)(1)(2)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	06/06/2022	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	MC	5/27/2022	Matt Cruz	5/27/2022
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 4/29/2022

☐ 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

May 31, 2022

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On May 25, 2022, an offsite **Life Safety Code** revisit, #YZWT22, 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,

Monica Miller
Program Project Specialist II

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Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	R **05/25/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	INITIAL COMMENTS Based on an acceptable plan of correction submitted to the Arizona Department of Health Services on May 25, 2022, for standard level deficiencies cited during the Medicare and Medicaid (CMS) Life Safety Code survey, no on-site follow up survey will be conducted for Event # YZWT22.	{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.

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
035145 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	5/25/2022 Y3

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

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4		DATE Y5
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed
LSC	K0353	05/25/2022	LSC	K0363	05/25/2022	LSC	K0511	05/25/2022
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #	NFPA 101	Completed	Reg. #		Completed	Reg. #		Completed
LSC	K0921	05/25/2022	LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		
ID Prefix		Correction	ID Prefix		Correction	ID Prefix		Correction
Reg. #		Completed	Reg. #		Completed	Reg. #		Completed
LSC			LSC			LSC		

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	AV	05/25/2022	Anthony Valenti	05/25/2022
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
4/29/2022

☐ 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

May 13, 2022

Receipt of This Notice is Presumed To Be 05/13/2022
Important Notice - Please Read

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

Dear Ms. Friebus:

On **April 29, 2022**, a recertification survey #YZWT21 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 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,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bk

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	04/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments 42CFR 483.73, Long Term Care Facilities 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. No apparent deficiences noted at the time of the survey.	E 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.

POC F TAG

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 13, 2022

Receipt Of This Notice Is Presumed To Be -05/13/2022
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On **April 29, 2022**, a Medicare recertification survey #YZWT11 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).

[X] 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.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC.
Failure to submit an acceptable PoC by **May 23, 2022** may result in the imposition of remedies.

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

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

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 aduits 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 June 13, 2022.

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 April 29, 2022
Recommending to CMS Denial of Payment for New Admission

Mandatory Remedies

Your current period of noncompliance began on April 29, 2022. 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 **October 26, 2022**.

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 **July 28, 2022.** 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 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

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 **May 23, 2022**, licensure and/or recertification may be denied. If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING _____ B. WING _____	04/29/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
DEVON GABLES REHABILITATION CENTER	6160 EAST GRANT ROAD TUCSON, AZ 85712

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The Recertification survey was conducted on April 25, 2022 through April 29, 2022, in conjunction with the investigation of complaints #AZ00181961 and #AZ00163703. The census was 180. The following deficiencies were cited:	F 000	**F582** **Correct to the Individual:** Resident #108 was discharged from the facility.	
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible.	F 582	**Correct to all others:** All residents who have services that are no longer being covered under insurance could be affected. Admissions packet was updated to include advanced beneficiary notice that will be issued when a resident could have potential liability for payment. Social Services was educated on practice of issuing an ABN form when a resident could have potential liability for payment. **System Correction:** Audits will be done weekly to ensure when a resident could have potential liability for payment that an ABN was issued.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Heather Trubus	Administrator	5/23/2022

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 582	Continued From page 1 (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, policy review and the Form Instructions for the Facility Advanced Beneficiary Notice (SNFABN), the facility failed to provide evidence that the Skilled Nursing Advanced Beneficiary Notice (SNFABN) was issued to one (#108) of three sampled residents. The deficient practice could result in residents not being informed of their potential liability for payment. Findings include: Resident #108 was admitted March 7, 2022 with diagnoses that included atrial fibrillation, major depressive disorder, chronic obstructive pulmonary disease, altered mental status, anxiety	F 582	**Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** Administrator or Designee	06/06/2022

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F 582	Continued From page 2 disorder and type 2 diabetes mellitus. Review of the Admission Record face sheet revealed the resident was their own responsible party. The admission Minimum Data Set assessment dated March 14, 2022 revealed a score of 15 on the Brief Interview for Mental Status which indicated the resident had intact cognition. Review of the Notice of Medicare Non-Coverage (NOMNC) revealed the last day of coverage was on March 31, 2022. The notice also revealed an SNFABN form was provided to the resident. However, no evidence was revealed in the medical record that the SNFABN form informing the resident of care Medicare may not pay beginning on April 1, 2022 was issued to the resident. Further review of the clinical record revealed the resident continued to reside in the facility. An interview was conducted on April 26, 2022 at 2:23 PM with the Director of Social Services (staff #154). She stated that she does not complete the ABN form. She also stated that it should be completed with the Notice of Medicare Non-Coverage (NOMNC). She stated that she had reviewed the medical record and there were no signed, written ABN forms in the medical record. An interview was conducted on April 26, 2022 at 02:25 with the Admissions Coordinator (staff #228). He stated that they do not complete the ABN forms. He reviewed the Admissions packet	F 582		

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F 582	Continued From page 3	F 582		

given to residents on admission, and stated that the ABN is not included in the admission packet.

An interview was conducted on April 27, 2022 at 11:51 AM with the Administrator (staff #114), who stated that when the NOMNC is ready to be issued, social services discusses with the resident the last covered day and with that discussion they will cover discharge plans and covered benefits, private pay and Medicaid. The Administrator stated that at this time there is no form that the resident or family signs regarding education of Advanced Beneficiary Notice for resident #108.

Review of the facility policy titled, Advance Beneficiary Notice of Non-Coverage (ABN) Policy, revealed that it is the policy to inform any Medicare beneficiary of the termination of their part A/Skilled stay via a NOMNC letter and follow up with notice of skilled nursing facility advance beneficiary notice of non-coverage (SNFABN) verbally with the resident and or representative when the NOMNC is delivered. This information is documented in the progress notes in the electronic medical record. The admission packet includes information on private pay rates and social services discusses private pay rates at the time the NOMNC is issued and documents the information provided

Review of the form instruction for the SNFABN revealed that Medicare requires skilled nursing facilities to issue the SNFABN to Medicare beneficiaries prior to providing care that Medicare usually covers but may not pay for when the care is not medically necessary. The SNFABN provides information to the beneficiary so that the resident can decide whether or not to get the care

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F 582	Continued From page 4 that may not be paid for by Medicare and assume financial responsibility.	F 582		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interview, and policy and procedure, the facility failed to ensure that one resident (#43) with a diagnosis of a serious mental illness was referred to the appropriate State-designated mental health or intellectual disability authority for review once the resident's stay exceeded 30 days. The sample size was 3. The deficient practice could result in necessary specialized services not being provided for residents that need it. Findings include:	F 644	**F644** **Correction to Individual:** Resident #43 had a Level I PASSR done on 05/03/2022 and the Arizona PASRR Coordinator did not feel a level II was appropriate. This information was placed in the Medical Record. **Correction to all others:** Residents with a mental disorder, intellectual disability or related condition have the potential to be affected. Social Services re-educated on the policy for coordination of PASRR and Assessments. An audit was completed of all residents with a mental health disorder, intellectual disability or a related condition to ensure they have a PASSR in place with appropriate referrals if needed. **System Correction:** Audits will be done weekly to ensure that residents who have a mental health disorder, intellectual disability, or a related condition have a PASRR in place with appropriate referrals if needed.	

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F 644	Continued From page 5 Resident #43 was admitted to the facility on November 28, 2020 with the following diagnoses: Unspecified dementia with behavioral disturbance; Bipolar disorder, current episode hypomanic; Other personality and behavioral disorders due to known physiological condition. Review of a Level I PASRR (Preadmission Screening and Resident Review) signed November 28, 2020 revealed the resident was for convalescent care and required 30 days or less nursing facility services. The section for "Identification of Potential Mental Illness" did not have anything circled. However, once the resident's stay exceeded 30 days, review of the clinical record revealed no evidence the Level I PASRR was updated. Review of a physician order dated August 3, 2021 revealed for Sertraline (antipsychotic medication) 175 milligrams by mouth once a day for Schizoaffective disorder, bipolar type. Review of the care plan dated September 6, 2021 revealed the resident used psychotropic drugs and is at risk for adverse consequence related to receiving antipsychotic (Risperidone) medication for treatment of schizoaffective bipolar type and antidepressant (Sertraline). Approaches included assessing if the resident's behavioral symptoms present a danger to the resident and/or others, intervene as needed. A physician order dated January 24, 2022 included Risperidone 3 milligrams orally at bedtime for bipolar disorder, current episode hypomanic.	F 644	**Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** Administrator or Designee	06/06/2022

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Review of the Medication Administration Record for April 2022 revealed the resident was administered Risperidone and Sertraline as ordered.

Further review of the clinical record revealed no evidence a PASRR Level I was updated/completed and that the resident was referred for a Level II PASRR.

During an interview conducted on April 28, 2022 at 12:53 PM with a Social Worker (staff #218), she stated that the resident was admitted with a PASRR which indicated that the resident did not have any mental illness, but listed dementia as one of the admitting diagnosis. She further stated that she or the other social worker were unaware of the subsequent diagnosis of bipolar disorder and because they were not informed of the later diagnoses no follow up PASRR documentation had occurred. She added after reviewing the resident's record, that the resident was receiving psychiatric services on an ongoing basis.

Review of the facility policy, Pre-admission Screening and Resident Review (PASRR), revealed that the PASRR helps to ensure individuals are not inappropriately placed in nursing homes for long term care. PASRR requires that 1) all applicants to a Medicaid certified nursing facility be evaluated for mental illness and/or intellectual disability; 2) be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting; and 3) receive the services they need in those settings including specialized services. The policy stated that for individuals requiring admission to a nursing facility for convalescent

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F 644	Continued From page 7 period or respite care (not to exceed 30 consecutive days), do not require a PASRR Level II evaluation. If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level 1 screening must be completed as soon as possible or within 40 calendar days of the admission date to the nursing facility. Additionally, it stated that a resident is to be referred for a PASRR if there has been a change in diagnosis/addition of a mental health diagnosis.	F 644		
F 645 SS=D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental	F 645	**F645** **Correct to Individual:** Resident #71 had a PASRR done on 07/26/2021 and when submitted to The Arizona State PASRR Coordinator on 04/27/2022 it was determined that a Level II PASRR was on file and that Resident #71 would not require any specialized services. This document was placed in the Medical Record. **Correct to all others:** Residents with a mental disorder, intellectual disability or related condition have the potential to be affected. Social Services re-educated on the policy for coordination of PASRR and Assessments. An audit was completed of all residents with a mental health disorder, intellectual disability or a related condition to ensure they have a PASSR in place with appropriate referrals if needed.	

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F 645	Continued From page 8 condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3)	F 645	**System Correction:** Audits will be done weekly to ensure that residents who have a mental health disorder, intellectual disability, or a related condition who have exceed a 30 day convalescent stay will have an appropriate PASRR sent to the Arizona State Coordinator. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Responsible Person:** Administrator or Designee	06/06/2022

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F 645	Continued From page 9 or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff interviews, and review of policy, the facility failed to ensure that one resident (#71) received a Level I Pre-admission Screening and Resident Review (PASRR) after remaining in the facility for longer than the predetermined 30-day convalescent stay. The deficient practice increases the risk that individuals identified with mental disorders may not be evaluated to receive care and services in the most integrated setting appropriate to their needs. Findings include: Resident #71 was admitted to the facility on 07/30/21 with diagnoses that included multiple fractures of the ribs left side, subsequent encounter for fracture with routine healing, nondisplaced intertrochanteric fracture of left femur, subsequent encounter for closed fracture with routine healing, and schizoaffective disorder, unspecified. A Level I PASRR screening document dated 07/30/21 revealed the physician had certified the resident required 30 days or less of convalescent care after receiving acute inpatient care from the hospital, and that the resident required nursing facility services for the same condition. The document indicated the resident did not have a primary diagnosis of a serious mental illness. Review of a History and Physical dated 08/02/21 revealed the history of the resident's present illness included alcohol abuse, bipolar disorder,	F 645		

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schizoaffective disorder. In addition, the documentation indicated that the resident had previously demonstrated agitation which had required restraints.

A physician's order dated 08/02/21 included an in-patient psychiatric consult for medication management. The associated diagnosis was stated as major depressive disorder, recurrent, severe with psychotic symptoms.

A nursing progress note dated 08/09/21 at 1:36 p.m. included that the resident had been yelling out that shift, more than twice per hour, "Help! Someone come help me!" The note indicated that the resident displayed obvious signs and symptoms of distress when staff entered the room as evidenced by crying, removing oxygen, pacing in the wheelchair, and restlessness. The resident demanded that the nurse "Hand me the tic tac toe off the wall so I can untangle all of this!" "Give me the cord of my phone so I can put it in the bottom of my dresser" "I need my bed done so I can start the finish!" The note included that despite redirection and reassurance the resident remained in a delusional state, and was inconsolable with interventions.

A physician's order dated 08/19/21 revealed an open-ended in-house psychiatric consult. The associated diagnosis included bipolar, unspecified.

Another Level I PASRR screening document dated 08/30/21 revealed that the physician had certified that resident required 30 days or less of convalescent care after receiving acute inpatient care from the hospital, and that the resident required nursing facility services for the same

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condition. The document indicated that the resident did not have a primary diagnosis of a serious mental illness.

Review of a Social Services note dated 09/21/21 revealed that on that date the resident was to be transferred onto the long-term care unit. The note included that the resident and a family member were notified with no objections, and that social services would follow for the adjustment process as needed.

However, review of the clinical record did not indicate a Level I PASRR was completed/updated and/or that the resident had been referred to the state authority for Level II PASRR screening.

The quarterly Minimum Data Set assessment dated 12/08/21 revealed the resident scored 6 on the Brief Interview for Mental Status, indicating severely impaired cognition. The assessment revealed the resident had no mood issues or behaviors, including hallucinations or delusions. The resident required 2-person extensive assistance for most activities of daily living, active diagnoses included depression, bipolar disease, and schizophrenia. The resident received antipsychotic and antidepressant medications for 7 out of 7 days in the look-back period, and according to the assessment, had not received psychological therapy.

On 04/27/22 at 2:04 p.m., an interview was conducted with the Director of Social Services (staff #154). She stated that there were 3 social workers in the facility who divided the residents between them. She stated that her expectation was that residents who are admitted for a 30-day convalescent stay, but remain in the facility

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longer, would receive additional PASRR screening. She stated that she would consider schizoaffective disorder to be a serious mental illness. She stated that she thought the screening was probably overlooked.

An interview was conducted on 04/29/22 at 9:42 a.m. with the Director of Nursing (DON/staff #188). She stated that social services are responsible for management and review of the PASRRs. She stated that if a resident was enrolled into long-term care, a new screening evaluation will be completed. She stated that the lack of further screening did not meet her expectations.

The facility's policy titled Pre-Admission Screening and Resident Review (PASRR) included that PASRR screening is guided by federal regulations that require all individuals being considered for admission to a Medicare-certified nursing facility (NF) be screened prior to admission to determine if the person has, or is suspected of having, a mental illness, intellectual disability, or related condition. PASRR helps to ensure that individuals are not inappropriately placed in nursing homes for long-term care, that they are offered the most appropriate setting for their needs, and that they receive the services that they need in those settings including specialized services. For individuals requiring admission to a nursing facility for a convalescent period or respite care (not to exceed 30 consecutive days), they do not require a PASRR Level II Evaluation. If it is later determined that the admission will last longer than 30 consecutive days, a new PASRR Level I screening must be completed as soon as possible or within 40 calendar days of the

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F 645	Continued From page 13 admission date to the nursing facility.	F 645		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, and review of policy, the facility failed to ensure medications were not left in the room of one resident (#95). The deficient practice could negatively impact residents' care, and could result in residents not receiving medications as ordered by the physician. Findings include: Resident #95 was admitted to the facility on November 6, 2015 with diagnoses that included vascular dementia without behavioral disturbance and major depressive disorder. Review of the clinical record revealed a Self-Administration of Medication Observation dated completed on December 22, 2021. The document stated the resident did not want to self-administer medications and that it was not appropriate for the resident to self-administer any medications. Review of the annual Minimum Data Set assessment dated March 8, 2022 revealed a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition.	F 658	**F658** **Correct to Individual:** Resident #95 took his medications with supervision of nurse. Resident #95 was interviewed and would like to continue to exercise his right to have Nursing administer his medications. **Correct to all others:** All residents who receive medications have the potential to be affected. All Licensed Nurses were re-educated regarding the Facility policy on safe medication administration and the process for self administration of medications, should a resident want to exercise their right to do so. All Licensed Nurses completed a medication safety and storage quiz to ensure their competency. **System Correction:** Audits will be done weekly to ensure that Nurses are practicing safe medication administration and medications are not left in resident rooms if resident is not assessed to self administer their medications.	

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F 658	Continued From page 14 During an observation conducted on April 25, 2022 between 10:21 AM, a white paper medication cup was observed on resident #95's bedside table. The cup contained approximately 11 medications. The bedside table was across the room, out of reach of the resident who was lying in bed sleeping. Another observation was conducted on April 25, 2022 at 10:39 AM, in which the medication cup containing medications was still on the bedside table away from the resident. The resident was sleeping in the bed. At that time, a CNA (Certified Nursing Assistant) entered the room and then exited. During a resident interview and observation conducted on April 25, 2022 at 11:04 AM, the medication cup containing pills was still on the bedside table. The resident was lying in bed awake. The resident stated that the pills were left on the bedside table, because he went to sleep before they gave them to him. He also stated that the nurses leave the pills at his bedside a couple of times a week. The resident further stated that they trust him to take the medications because he knows they are important. He also stated that the morning medications had been left on his bedside table this morning. An observation was conducted on April 25, 2022 at 11:45 AM. The medication cup containing medications was still on the bedside table, away from the resident's reach. An interview was conducted on April 25, 2022 at 11:50 AM with a Licensed Practical Nurse (LPN/staff #231), who stated that when	F 658	**Monitoring of System:** The analysis of the audits will be taken to QAPI for review and follow-up as needed. **Date of Correction:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

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F 658	Continued From page 15	F 658		

administering medications, she stays in the resident's room until the resident has taken all of the medications and that this is the facility's policy. The nurse then entered resident #95's room and observed the medication cup containing medications on the bedside table. She stated that she did pass medications this morning between 8:00 thorough 10:00 AM, and that these medications had been left on the bedside table, and had not been taken. She stated that this did not follow the facility policy and the risk is that the resident's roommate may have taken them, and that the resident is not receiving the medications he needs, or as ordered.

An interview was conducted on April 27, 2022 at 8:51 AM with a Certified Nursing Assistant (CNA/staff #15), who stated that if a resident was assessed for self-administration of medications, it would be on the care plan, and that it would not be for prescription medications.

An interview was conducted on April 27, 2022 at 9:04 AM with the Minimum Data Set (MDS) Director (staff #53), who stated that there should be a physician's order for a resident to self-administer medications, and it would be documented on the care plan. She further stated that medications should not be left at the bedside for residents to take later.

An interview was conducted on April 27, 2022 at 11:07 AM with the Director of Nursing (DON/staff #188), who stated that the facility process for medication administration includes checking for the right drug, patient, time, and route, then the medication would be administered to the resident. She also stated the nurse should stay at the bedside while the patient is taking the medication.

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F 658	Continued From page 16 The DON stated that it is not following the facility process for the nurse to leave medications at the bedside. She reviewed the resident's medical record, and stated that there is not a care plan or order for self-administration of medication. She also stated the risk of leaving medication at the bedside unattended could result in a medication error, especially with psychiatric medications not taken on time, and risk that another resident could take them. She further stated that this does not meet the facility policy and she has already educated the nurse. Review of the facility policy titled, Medication Administration/Oral revealed only licensed nurses may administer medications. The policy also revealed to document administration of medications immediately, discard used containers, and move onto the next resident. Review of the facility policy titled, Self-Administration of Medications, revealed that all administration of medications will be under the supervision of a licensed nurse and documented by the licensed nurse. If a resident wishes to self-administer their medication, and the interdisciplinary care team decides the resident is capable, the medication will be given to the resident by a licensed nurse at the appropriate time and allow self-administration. The medication will be stored in the medication cart, not in the resident's room. If the medical provider orders that a medication(s) is to be kept at the bedside, the facility will supply a locked cabinet to be used to store the medications to prevent the medications from falling into the wrong hands.	F 658		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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F 677	Continued From page 17 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews, clinical record review, and review of policy and procedure, the facility failed to provide one sampled resident (#335) the necessary services to maintain good grooming and personal hygiene. The deficient practice could result in the resident's hygiene needs not being met. Findings include: Resident #335 was admitted to the facility on 04/11/22 with diagnoses that included pneumonitis due to inhalation of food and vomit, chronic obstructive pulmonary disease, unspecified, and pain, unspecified. The 5-day admission Minimum Data Set assessment dated 04/18/22 included that the resident scored 15 on the Brief Interview for Mental Status, indicating intact cognition. The resident displayed no behaviors including rejection of care, and required extensive to total 1-2 person physical assistance for most activities of daily living (ADL). An ADL Functional/Rehabilitation Potential care plan dated 04/20/22 related to debility post infection and hospitalization had a goal for ADL needs to be met daily. Interventions included assisting the resident with bathing body parts that the resident could not do.	F 677	**F677** **Correct to Individual:** Resident #335 was interviewed for showering preferences and he states that he was refusing his showers and that he would be better about taking showers twice weekly as scheduled. His target behaviors and care plan were updated. **Correct to all others:** All residents have the potential to be affected. Staff will be re-educated on policy for documentation of activities of daily living to ensure hygiene needs are met and refusals of care are properly documented. **System Correction:** Audits will be done weekly to ensure residents hygiene needs are being met and documented appropriately. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

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F 677	Continued From page 18 On 04/25/22 at 11:10 a.m., an interview was conducted with resident #335 who stated since arriving at the facility, he had only received one shower. The resident also stated that staff have not offered him opportunities to shower and that he would like to have showers more often. An interview was conducted on 04/28/22 at 2:29 p.m. with the Director of Nursing (DON/staff #238). She stated that all of the shower documentation could be found in the Certified Nursing Assistants' (CNA) documentation in the clinical record. However, review of the CNA documentation revealed that the resident had received only one shower on 04/18/22. Review of the nursing progress notes did not include documentation which indicated that the resident had refused showers. On 04/28/22 at 2:32 p.m., an interview was conducted with a CNA (staff #33). She stated that when she gives a resident a shower she will document it in the CNA point of care notes in the resident's clinical record. She stated that residents receive 2 showers per week. She said that if residents refuse their shower, she will return later and ask again. She stated that if the resident continues to refuse she will tell the nurse. She stated that she will document the refusal in her point of care notes. The CNA stated that she remembered assisting the resident with at least one shower. The CNA pulled up the resident's shower documentation and indicated that she had documented the shower on 04/18/22. However, she reviewed the documentation and stated that the CNA record	F 677		

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did not indicate that the resident had received additional showering/bathing opportunities. She stated that if the resident had refused, it would specifically state that in the record. Staff #33 then pulled up the refusal area in the documentation program and stated that if the resident had refused it would be included as such in the documentation. She stated that the code "did not occur" meant that the resident did not receive a shower.

An interview was conducted on 04/29/22 at 7:45 a.m. with a Licensed Practical Nurse (LPN/staff #50). She stated that she speaks with the CNAs daily and asks them to notify her if a resident is refusing showers. She stated that she was not made aware that resident #335 had refused showers. The LPN stated that 3 attempts should be made to shower the resident, after which the nurse will document the refusal in the clinical record. The LPN stated that it would not meet her expectation for a resident not to receive 2 showers per week.

On 04/29/22 at 9:49 a.m., an interview was conducted with the Director of Nursing (DON/staff #238). She stated that residents are offered 2 showers per week and that staff try to accommodate additional showers if requested. She stated that if the resident refuses, the CNAs are instructed to tell the nurse. The DON said that additional refusals would warrant a call to the provider and family. The DON stated that she thought that if a resident refused, it would be documented as "did not occur" in the resident's record. She stated that her expectation was for CNAs to offer showers to the residents 2 times each week and to accommodate their preferences accordingly.

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F 677	Continued From page 20 The facility's policy titled Bath/Shower included that the facility has a schedule for each unit to include bathing at least twice weekly.	F 677		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to ensure that three residents (#88, #109, and #108) received ROM (Range of Motion) as ordered. The deficient practice could result in residents experiencing a decrease in ROM. Findings include: -Resident #88 was admitted to the facility on June 21, 2016 with the following diagnoses: Type 2	F 688	**F688** **Correct to Individual:** Resident #88 and #109 will receive restorative services per orders. Resident #108 was discharged from the facility. **Correct to all others:** Residents with orders for ROM have the potential to be affected. All residents with orders for ROM will be evaluated by therapy quarterly. Staff responsible for restorative services will be educated on restorative plan, charting, and meetings to ensure that resident's receive the necessary restorative services to prevent an avoidable decrease in ROM/Mobility and provide clinical documentation if decrease is unavoidable.	

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F 688	Continued From page 21 diabetes mellitus with diabetic nephropathy; Type 2 diabetes mellitus with hyperglycemia; Pressure ulcer of sacral region, stage 4; Pressure ulcer of right heel, unstageable; Pressure ulcer of left buttock, unspecified stage. Review of the clinical record revealed a physician order dated January 27, 2022 for PROM (Passive Range of Motion) to the bilateral lower extremities and upper extremities as tolerated 3 to 5 times a week, once a day. Review of the progress note dated February 1, 2022 revealed the resident had decreased functional mobility and strength. The 5-day Minimum Data Set assessment dated April 4, 2022 revealed a Brief Interview for Mental Status score of 8 which indicated the resident had moderate impaired cognition. The assessment included the resident is totally dependent on the staff for activities of daily living. A review of the care plan last reviewed April 25, 2022 revealed the resident receives restorative nursing services to maintain/improve functional mobility. The goal was that the resident will maintain joint function. Intervention included AROM (Active Range of Motion) 3-5 times a week by restorative nursing, and monitoring and recording any increased stiffness in joints and reporting it to the resident's nurse. Review of facility documentation revealed that for April 2022 the resident received PROM two times the first week of April, one time the second week, and two times the third week. During the month of March 2022, the resident was out at the hospital for 6 days in the beginning of the month, then on	F 688	**System Correction:** Audits will be done weekly to ensure that residents are receiving restorative services as ordered. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

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F 688	Continued From page 22 week 3 the resident received 3 sessions, and week 4 the resident received two sessions. During an interview conducted with the resident on April 26, 2022 at 11:17 AM, the resident stated that he has been getting weaker and weaker and now they do not get him out of bed anymore. The resident further stated that he would like to work on getting some of his strength back so that he could get up more. The resident added that he used to have exercises in bed but has not lately received any exercises. During an interview conducted on April 29, 2022 at 8:19 AM with the Rehabilitation Director (staff #106), she stated that the resident is a Long-Term Care patient and is not currently scheduled for any Physical Therapy or Occupational Therapy. Staff #106 further stated that the resident is to receive restorative nursing assistance on the unit and that it is run by the nursing department. During an interview conducted on April 29, 2022 at 8:45 AM with a Certified Nursing Assistant (CNA/staff #165), she stated that she is also the Restorative Nursing Assistant (RNA) who is assigned to the unit. She added that the resident is to receive RNA services for PROM, three to five times a week. She further added that she documents the services on paper in a book at the nursing station and not in the electronic medical record. She stated that the amount of restorative nursing assistance provided depends on the unit staffing whether or not she is assigned to the RNA work. The CNA stated that due to the lack of staff, she is working less than 50% of her time and that she has only had 10 days in the last month to perform the restorative services. She	F 688		

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F 688	Continued From page 23 added that if the resident refuses the service she reports it to the nurse. During an interview conducted on April 29, 2022 at 8:53 AM with a Licensed Practical Nurse (staff #138), she stated that if the resident refuses to get up, then she would note that in her progress notes. She added that the resident is not receiving physical therapy, only Restorative Nursing Assistance, and that the rest of the staff will encourage the resident to assist with turning in bed, and that the resident tends to not want to get up. She added that the resident has some behavior issues. She also added that the unit is short staffed about 30% of the time. During an interview conducted on April 29, 2022 at 8:47 AM with the Director of Nursing (DON/staff #188), she stated that the Restorative Nursing Assistance program is per the physician order and if the aide assigned is not able to complete the service they are to advise her. She added that the staff from the RNA program are often pulled to do weights or other Certified Nursing Assistant duties. She further stated that this has been a concern as the residents should be getting services as ordered and that they are starting to look at a process improvement project. -Resident #109 was admitted August 30, 2018 with diagnoses that included a tear of the medial meniscus, age related physical debility, hemiplegia and hemiparesis of the left side. Review of the clinical record revealed an order dated January 7, 2019 for restorative nursing (RNA) 3 to 5 times per week to prevent a decrease in range of motion.	F 688		

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A care plan dated March 12, 2019 revealed that the resident is receiving restorative nursing services to maintain functional ability. The goal is that the resident will maintain joint function. Approaches including AROM (Active Range of Motion) to the lower extremity as tolerated 3- 5 times per week.

Review of the care plan dated July 17, 2020 revealed the resident is at high risk for falls related to limited function. Approaches included implementing an exercise program that targeted strength, gait and balance.

The significant change in status minimum data set (MDS) assessment dated March 14, 2022 revealed a score of 15 on the brief interview for mental status (BIMS) indicating the resident was cognitively intact. The assessment also revealed the resident required extensive assistance for bed mobility, toilet use, personal hygiene, and dressing with one-person assistance, and was totally dependent for transfer with two+ persons. The MDS assessment further revealed the resident received AROM 5 times during the 7-day lookback period and that the training and skill practice was in bed mobility.

Review of the restorative flowsheet from November 2021 through April 2022 revealed the resident was not seen consistently 3 to 5 times per week despite notes that the resident was cooperative. One resident refusal was documented on March 3, 2022 and some difficulty in resident abilities were also noted in March 2022.

On April 29, 2022 at 7:43 AM, an interview with

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25	F 688		

Restorative (staff #225) was conducted. She stated that resident #109 was not being seen as ordered because of staffing shortages with RNA staff. She said that CNAs were doing weights and other CNA duties and had little time for their RNA duties. She said that the facility is aware that there were not enough staff to see all the restorative residents. She stated that they are very short staffed and management is very aware. She stated that the documentation does not reflect why the residents were not being seen as ordered. She stated that this had been ongoing since COVID and has been a facility wide problem. She said that it was a concern to her that the residents were not seen as ordered as they may lose their abilities.

-Resident #108 was admitted March 7, 2022 with diagnoses that included paroxysmal atrial fibrillation, pacemaker, weakness, pain and diabetes mellitus type 2.

The care plan dated March 8, 2022 revealed the resident is at high risk for falls related to general weakness.

The admission MDS assessment dated March 14, 2022 revealed a score of 15 on the BIMS indicating that the resident was cognitively intact. The MDS assessment also revealed the resident needed limited assistance with bed mobility with two+ person assistance, toilet use and personal hygiene with one-person assistance; and extensive assistance to transfer with two+ person assistance. The assessment further revealed the resident did not receive RNA.

Review of the clinical record revealed a physical therapy (PT) discharge summary dated March 31,

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	035145	A. BUILDING _____ B. WING _____	04/29/2022

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F 688	Continued From page 26	F 688		

2022 that the restorative program (RNA) was established. The discharge was per physician/case manager recommendation.

A review of the clinical record revealed a referral to restorative nursing dated April 6, 2022 from PT for 3 to 5 times per week to maintain mobility and range of motion.

Review of the RNA flowsheet for April 2022 revealed the resident was seen by RNA 8 times from April 6 - 28, 2022. The first visit was April 14, 2022. The included notes did not reveal any refusals or any explanation as to the delay of onset of services.

An interview with the director of PT (staff #106) was conducted on April 7, 2022 at 2:02 p.m. She stated that resident #108 was receiving PT and occupational therapy (OT), was discharged, and currently receives RNA with staff #16. Staff #106 stated that the resident was referred to RNA services after the discharge from PT on March 31, 2022.

On April 28, 2022 at 8:46 AM, an interview was conducted with the RNA (staff #16). She stated that she receives a paper "order" referral from PT and she then follows up with the resident. She said the order for resident #108 was put in on April 6, 2022. She said the purpose of restorative therapy is to maintain the progress a resident made during PT and OT. She further stated that a resident can be on RNA for weeks or years. Staff #16 stated she tracks the progress of the resident and documents on a paper chart not in the electronic health record. Staff #16 stated that this resident was not seen until April 14, 2022 because the resident was assigned to her when

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F 688	Continued From page 27	F 688		

she was out sick. She said no other RNA picked up the resident in her absence and she is not sure why the resident was not seen by someone else while she was sick. Staff #16 said that the resident has been seen about 3 times per week since then, but that the resident is the same as when the resident started, no improvement, no decline.

An additional interview was conducted with staff #106 on April 28, 2022 at 9:01 AM. She stated that as the director of therapy, she writes the order for a resident to receive RNA services. She stated she puts a copy in the box for staff #225, who is the coordinator for the RNA program and handles all the RNA scheduling.

An interview with the DON (staff #188) was conducted on April 28, 2022 at 10:44 AM. She stated that for the RNA program, therapy makes a referral and the provider writes an order which is put into the electronic health record. The DON stated the order specifies the frequency per week which is usually 3 to 5 times a week. She said that staff #225 is in charge of assigning an RNA to all residents that receive RNA services and that this process usually takes 1-3 days to get the resident on the RNA schedule. The DON said her expectation is that if an RNA is sick or on vacation, a different RNA should be assigned to work with the resident, as waiting more than 3 or 4 days does not meet her expectation. The DON stated if a resident has to wait more than 3 to 4 days, the resident could regress and lose the progress made with PT.

On April 29, 2022 at 7:43 AM, an interview with Restorative (staff #225) was conducted. She stated that she was the RNA team leader and

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F 688	Continued From page 28	F 688		

handled RNA scheduling. She stated that in addition to doing RNA assignments, she had additional duties as a CNA and is in charge of weights for the facility. She said that RNA duties were divided by unit and there are 2 full time and 2 part time RNA staff members. She said that if a staff member is out, one of the other RNAs will pick up and fill in. Staff #225 stated there is a retired staff member that used to work RNA and often steps in to help. Staff #225 stated that she reviews the resident documentation to ensure that the documentation is complete at the end of month. She said if there are any issues, such as a resident refusal, the RNA staff should inform the charge nurse and the information should be documented on the flowsheet. She stated that resident #108 was not seen from April 7-13, 2022 because the RNA assigned to the resident was not in the building and there was no staff to pick up the resident visits.

An additional interview was conducted with the DON (staff #188) on April 29, 2022 at 8:47 AM. She stated that the RNA program is per order and if the staff are not able to see the residents as ordered they are expected to advise her of the problem. She stated that the staff from Restorative are pulled often to do weights or other CNA duties. The DON stated that this is a concern, as the residents should be receiving services as ordered. She said they are starting to look at process improvement in this area.

Review of the facility's policy Restorative Nursing Carry Over Following Physical, Occupational and/or Speech Therapy (5/2010) revealed that, nursing picks up restorative services as directed by therapies to reduce the risk of functional decline in the resident. Restorative nursing is

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F 688	Continued From page 29 overseen by the Director of Nursing or designee and is to reinforce and extend progress made in therapy. The policy further revealed that the restorative aide will follow the treatment plan and frequency written in the order and will document resident treatments on the restorative flow sheet.	F 688		
F 761 SS=E	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 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and review of the policy and procedures, the facility	F 761	**F761** **Correct to Individual:** No individual residents were affected **Correct to all others:** Has the potential to affect all residents receiving medications. Licensed Nurses were re-educated on the policy for storage and labeling of medications and the proper disposal of discontinued or expired medications. All Licensed Nurses completed a medication safety and storage quiz to ensure their competency. **System Correction:** Audits of medication storage areas will be completed weekly to ensure that medications are stored and labeled according to policy. **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 761	Continued From page 30 failed to ensure that medications were dated according to the standard of practice, and failed to ensure that expired medications were not available for administration. The deficient practice could result in expired medications being administered to residents. Findings include: -An observation was conducted on April 28, 2022 at 1:30 p.m. of the medication cart on hall 209-228, sub-acute unit. An insulin box with a pharmacy label Aspart Insulin contained two opened vials of insulin inside. The first vial with a maroon top was labeled Insulin Lispro, and the second vial with a silver top was labeled insulin Aspart. The insulin vials had no resident's name, or open dates. An interview was conducted on April 28, 2022 at 1:33 p.m. with an RN (Registered Nurse/staff #204). Staff #204 stated each insulin is usually in an individual box with the resident's name and opened date. Staff #204 looked at the insulin vials and stated the maroon top is insulin Lispro, and the silver top is insulin Aspart. The RN stated it was not a normal procedure for a box to have two different insulin vials, and no resident's name. -An observation was conducted on April 28, 2022 at 1:49 p.m. of the South medication room and medication refrigerator. Inside the medication refrigerator was a bottle of Vancomycin solution with an expiration date of April 11, 2022, and an opened vial of regular insulin without an open date. An immediate follow up interview was conducted with staff #204, who stated the vial of insulin was	F 761	**Date of Correction:** **Responsible Person:** Director of Nursing or Designee	06/06/2022

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F 761	Continued From page 31 opened because the vial was no longer sealed. Staff #204 stated she did not know how long the insulin had been opened because it did not have an open date on it. Staff #204 stated the expiration date on the Vancomycin solution was April 11, 2022 and that the medication has expired. An interview was conducted on April 28, 2022 at 2:31 p.m. with the Director of Nursing (DON/staff #188). Staff #188 stated opened insulin vials are good for 28 days and should be dated. The DON stated expired medications should be discarded promptly. A facility's policy, Storage of Medications, stated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy included drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. The policy also included that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, and all such drugs shall be returned to the dispensing pharmacy or destroyed.	F 761		

POC K TAG

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 13, 2022

Receipt Of This Notice Is Presumed To Be -05/13/2022
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

On April 29, 2022, a **Life Safety Code** survey #YZWT21 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.

[X] 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.

Plan of Correction

A Plan of Correction (PoC) for the deficiencies must be submitted by **May 23, 2022**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Failure to submit an acceptable PoC by **May 23, 2022**, 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.

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

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

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 **06/13/2022.**

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 April 29, 2022

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 April 29, 2022. 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 10/26/2022.

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 **May 23, 2022**, recertification may be denied. If you have any questions concerning the instructions contained in this letter, please contact the Bureau of Long Term Care at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE\bk

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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K 000	INITIAL COMMENTS 42 CFR 482.41 Nursing Home The facility must meet the applicable provisions of the 2012 Edition of the Life Safety Code of the National Fire Protection Association This is a recertification survey for Medicare under LSC 2012, Chapter 19, Existing. The entire facility, was surveyed on April 26, 2022. The facility meets the standards, based on acceptance of a plan of correction.	K 000		
K 353 SS=D	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to	K 353	**K353** The Sprinkler heads with dust/lint covering them were cleaned on 05/02/2022. The 2 Corroded sprinkler heads in the dish washing area of the kitchen were replaced on 05/02/2022 Sprinkler heads will be maintained according to code and will be monitored monthly by the Director of Maintenance as part of the ongoing preventative maintenance quality assurance programs. The Director of Maintenance or designee will present the information from the audits to the QAPI committee that meets routinely. Director of Maintenance will be responsible.	05/02/2022 05/20/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 5/23/2022

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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K 353	Continued From page 1 maintain the sprinkler heads in laundry room of the facility. Two (2) sprinkler heads in the kitchen were corroded. Failing to maintain sprinkler heads could cause harm to residents and/or staff by allowing a fire to spread before the temperature is reached to set of the sprinkler head. NFPA 101 Life Safety Code, 2012 edition, Chapter 19, Section 19.3.5.1 "Buildings containing nursing homes shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7." Chapter 9, Section 9.7.1 "Each automatic sprinkler system required by another section of this Code shall be in accordance with on of the following." " NFPA 13, Standard for the Installation of Sprinkler Systems." Chapter 26, Section 26.1 "General." "A sprinkler system installed in accordance with standard shall be properly inspected, tested, and maintained by the property owner or their authorized representative in accordance with NFPA 25. NFPA 25, Section 5.2.1 "Sprinklers, Section 5.2.1.1.1 "Sprinklers shall not show signs of leakage, shall be free of corrosion, foreign materials, paint and physical damage." Findings include: Observations made while on tour on April 26, 2022, revealed six (6) out of seven (7) sprinkler heads with dust/lint covering them in the laundry area. There were two (2) corroded sprinkler heads in dishwashing area of the kitchen. During the exit conference on April 26, 2022, the above findings were again acknowledged by the management team.	K 353		

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K 363 SS=D	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors 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.	K 363	**K363** Resident rooms 26, 27, and 210 with excessive gap between the door and upper frame were repaired on 05/20/2022. Resident rooms 28, 30, 35, and 54 with delaminating doors were relaminated on 05/20/2022. Resident room 34 with excessive gap between the door and the lower frame was repaired on 05/20/2022. Resident room 21 with 1 inch under cut was repaired on 05/20/2022. Doors will be maintained according to code and will be monitored monthly by the Director of Maintenance as part of the ongoing preventative maintenance program. The Director of Maintenance or Designee will present the information to the QAPI committee that meets routinely. Director of Maintenance or designee will be responsible.	05/20/2022 05/20/2022 05/20/2022 05/20/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 363	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to ensure rated corridor doors to be properly maintained. The door would not resist the passage of smoke. Several of the doors were delaminating. Failing to protect resident sleeping rooms from heat or smoke will cause harm to the resident and/or staff. NFPA 101, Life Safety Code, 2012 edition, Chapter 19, Section 19.3.6.3.5. "Doors shall be provided with a means for keeping the door closed that is acceptable to the authority having jurisdiction." Findings Include: Observations made while on tour on April 26, 2022, revealed the following door issues; 1) Resident room 26 excessive gap between the door and upper frame 2) Resident room 28 door was delaminating 3) Resident room 27 excessive gap between the door and upper frame 4) Resident room 30 door was delaminating 5) Resident room 34 excessive gap between the door and lower frame 6) Resident room 35 door was delaminating, had duct tape on the lower portion of the door 7) Resident room 54 door was delaminating 8) Resident room 21 had a 1 inch under cut 9) Resident room 210 excessive gap between the door and upper frame During the exit conference on April 26, 2022, the above findings were again acknowledged by the management team.	K 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 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 the facility failed to ensure a protected covering over exposed wires. Failure to have the appropriate protection around exposed wires could cause harm to residents and/or staff. NFPA 101, 2012 Edition Chapter 19. "19.5.1 Utilities. 19.5.1.1 Utilities shall comply with the provisions of Section 9.1" " 9.1 Utilities. 9.1.2 Electrical Systems. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless such installations are approved existing installations, which shall be permitted to be continued in service. NFPA 70, 2011 Edition Chapter 1 General "110.27(A) Live Parts Guarded Against Accidental Contact. Except as elsewhere required or permitted by this Code, live parts of electrical equipment operating at 50 volts or more shall be guarded against accidental contact by approved enclosures or by any of the following means: (1) By location in a room, vault, or similar enclosure	K 511	**K511** The electrical cord for the S well cart was replaced on 05/02/2022 Electrical cords on appliances will be maintained according to code and will be monitored monthly by the Director of Maintenance as part of the on going preventative maintenance program. 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.	05/02/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 511	Continued From page 5 that is accessible only to qualified persons. (2) By suitable permanent, substantial partitions or screens arranged so that only qualified persons have access to the space within reach of the live parts. Any openings in such partitions or screens shall be sized and located so that persons are not likely to come into accidental contact with the live parts or to bring conducting objects into contact with them. (3) By location on a suitable balcony, gallery, or platform elevated and arranged so as to exclude unqualified persons. (4) By elevation of 2.5 m (8 ft) or more above the floor or other working surface." Findings include: Observations made while on tour on April 26, 2022, revealed the facility failed to ensure a 220 volt electrical cord on a 5 well cart was damaged. The cord jacket was split exposing the internal wire. During the exit conference on February 2, 2022, the above findings were again acknowledged by the management staff. .	K 511		
K 921 SS=D	Electrical Equipment - Testing and Maintenanc CFR(s): NFPA 101 Electrical Equipment - Testing and Maintenance Requirements The physical integrity, resistance, leakage current, and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair	K 921	**K921** An agreement was executed with Arizona Biomedical Services to conduct testing and maintenance for the physical integrity, resistance, leakage current and touch current tests for fixed and portable patient-care related electrical equipment (PCREE) An audit of all fixed and portable patient-care related electrical equipment was made and will be tested by Arizona Biomedical Services on 05/27/2022.	05/16/2022 05/27/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 6 or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training. 10.3, 10.5.2.1, 10.5.2.1.2, 10.5.2.5, 10.5.3, 10.5.6, 10.5.8 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to provide a record of electrical equipment tests, repairs, and modifications. Failing to conduct maintenance on patient care appliances could cause harm to the resident if the appliance malfunctions. NFPA 101 Life Safety Code, 2012, Chapter 19, Section 19.3.2.4 "Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities." NFPA 99 2012 Edition Chapter 10, Section 10.5.6 Record Keeping-Patient Appliances Electrical Equipment - Testing and Maintenance Requirements "The physical integrity, resistance, leakage current, and touch current tests for fixed and	K 921	Arizona Biomedical will present a full report of all testing of fixed and portable patient-care related electrical equipment to ensure equipment is maintained according to facility policy. Electrical Equipment and testing will be in compliance with code and monitored monthly by the Director of Maintenance or Designee as part of the on going preventative maintenance program. The Director of Maintenance or Designee will present the information of the auditing to the QAPI committee that meets routinely. Director of Maintenance or designee will be responsible.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 7 portable patient-care related electrical equipment (PCREE) is performed as required in 10.3. Testing intervals are established with policies and protocols. All PCREE used in patient care rooms is tested in accordance with 10.3.5.4 or 10.3.6 before being put into service and after any repair or modification. Any system consisting of several electrical appliances demonstrates compliance with NFPA 99 as a complete system. Service manuals, instructions, and procedures provided by the manufacturer include information as required by 10.5.3.1.1 and are considered in the development of a program for electrical equipment maintenance. Electrical equipment instructions and maintenance manuals are readily available, and safety labels and condensed operating instructions on the appliance are legible. A record of electrical equipment tests, repairs, and modifications is maintained for a period of time to demonstrate compliance in accordance with the facility's policy. Personnel responsible for the testing, maintenance and use of electrical appliances receive continuous training." Findings include: Observation, record review and staff interview on April 26, 2022, revealed the facility was unable to produce policies or protocols or documentation to identify electrical equipment tests, repairs, and modifications. The facility provided documentation of a visual inspection of patient care related electrical equipment, such as the cords but were unable to provide documentation for leakage current. During the exit conference on April 26, 2022, the above findings were again acknowledged by the	K 921		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/29/2022**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 921	Continued From page 8 management staff.	K 921		

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

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey: From: F1 (mm/dd/yyyy)	To: F2 (mm/dd/yyyy)	Extended Survey: From: F3 (mm/dd/yyyy)	To: F4 (mm/dd/yyyy)
04/25/2022	04/29/2022		

Name of Facility	Provider Number	Fiscal Year Ending: F5 (mm/dd/yyyy)
Devon Gables Rehabilitation Center	035145	12/31/2021

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

Is this facility hospital based? F10 ..... ○ Yes ● No
If yes, indicate Hospital Provider Number: F11

Ownership: F12: 13

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

Owned or leased by Multi-Facility Organization: F13 ..... ○ Yes ● No

Name of Multi-Facility Organization: F14

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

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
0	24	0
F18 Disabled Children/Young Adults	**F19 Head Trauma**	**F20 Hospice**
0	0	12
F21 Huntington's Disease	**F22 Ventilator/Respiratory Care**	**F23 Other Specialized Rehabilitation**
1	0	32

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	09:45
Signature: Heather Friebus	Date: 04/27/2022

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

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No.	Medicare	Medicaid	Other	Total Residents
035145	15 F75	129 F76	36 F77	180 F78

		Independent		Assist of One or Two Staff		Dependent
Bathing	F79	10	F80	104	F81	66
Dressing	F82	18	F83	139	F84	23
Transferring	F85	28	F86	94	F87	58
Toilet Use	F88	26	F89	116	F90	38
Eating	F91	133	F92	41	F93	6

A. Bowel/Bladder Status

F94 20 With indwelling or external catheter

F95 Of the total number of residents with catheters, how many were present on admission 20

F96 120 Occasionally or frequently incontinent of bladder

F97 101 Occasionally or frequently incontinent of bowel

F98 129 On urinary toileting program

F99 116 On bowel toileting program

B. Mobility

F100 2 Bedfast all or most of time

F101 136 In a chair all or most of time

F102 6 Independently ambulatory

F103 70 Ambulation with assistance or assistive device

F104 0 Physically restrained

F105 Of the total number of residents with restraints, how many were admitted or readmitted with orders for restraints 0 ?

F106 74 With contractures

F107 Of the total number of residents with contractures, how many had a contracture(s) on admission 65 ?

C. Mental Status

F108-114 – indicate the number of residents with:

F108 3 Intellectual and/or developmental disability

F109 56 Documented signs and symptoms of depression

F110 92 Documented psychiatric diagnosis (exclude dementias and depression)

F111 102 Dementia: (e.g., Lewy-Body, vascular or Multi-infarct, mixed, frontotemporal such as Pick's disease; and dementia related to Parkinson's or Creutzfeldt-Jakob diseases), or Alzheimer's Disease

F112 64 Behavioral healthcare needs

F113 Of the total number of residents with behavioral healthcare needs, how many have an individualized care plan to support them 64 ?

F114 0 Receiving health rehabilitative services for MI and/or ID/DD

D. Skin Integrity

F115-118 – indicate the number of residents with:

F115 16 Pressure ulcers (exclude Stage 1)

F116 Of the total number of residents with pressure ulcers excluding Stage 1, how many residents had pressure ulcers on admission 7 ?

F117 178 Receiving preventive skin care

F118 4 Rashes

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

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

Number of residents receiving:

F119 12 Hospice care

F120 0 Radiation therapy

F121 3 Chemotherapy

F122 6 Dialysis

F123 4 Intravenous therapy, IV nutrition, and/or blood transfusion

F124 41 Respiratory treatment

F125 0 Tracheostomy care

F126 7 Ostomy care

F127 1 Suctioning

F128 38 Injections (exclude vitamin B12 injections)

F129 3 Tube feedings

F130 50 Mechanically altered diets including pureed and all chopped food (not only meat)

F131 39 Rehabilitative services (Physical therapy, speech-language therapy, occupational therapy, etc.) Exclude health rehabilitation for MI and/or ID/DD

F132 1 Assistive devices with eating

F. Medications

F133-139 – indicate the number of residents receiving:

F133 140 Any psychoactive medication

F134 57 Antipsychotic medications

F135 40 Antianxiety medications

F136 24 Antidepressant medications

F137 9 Hypnotic medications

F138 14 Antibiotics

F139 149 On pain management program

G. Other

F140 21 With unplanned significant weight loss/gain

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

F142 0 Who use non-oral communication devices

F143 180 With advance directives

F144 110 Received influenza immunization

F145 134 Received pneumococcal vaccine

Signature of Person Completing the Form	Title	Date
Kendra Rogney	RN - DON	4/25/2022

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 %

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

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

Provider Beds
Total: 312
Certified: 312

Provider Category: SNF/NF (DUAL)

Type Action: RECERTIFICATION
Type Ownership: FOR PROFIT - LIMITED

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

Program Requirements

Current Survey/Revisit Dates - 02/07/2020

Prior 3 Survey 07/2016	S/S Code	Prior 2 Survey 08/2017	S/S Code	Prior 1 Survey 11/2018	S/S Code	Current Survey 12/12/2019	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	REQ	F0223-FREE FROM ABUSE/INVOLUNTARY SECLUSION
-	-	X	D	-	-	- -	-	-	REQ	F0224-PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN
-	-	-	-	-	-	- -	-	-	REQ	F0225-INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS
-	-	-	-	-	-	- -	-	-	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	-	-	-	-	- -	-	-	REQ	F0281-SERVICES PROVIDED MEET PROFESSIONAL
-	-	-	-	-	-	- -	-	-	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

DEVON GABLES REHABILITATION CENTER CCN: 035145

Prior 3 Survey 07/2016	S/S Code	Prior 2 Survey 08/2017	S/S Code	Prior 1 Survey 11/2018	S/S Code	Current Survey 12/12/2019	S/S Code	Plan/Date of Correction		Requirement
-	-	-	-	-	-	- -	-	-	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	D	X C	D	02/07/2020	REQ	F0600-Free from Abuse and Neglect
-	-	-	-	-	-	X C	D	02/07/2020	REQ	F0623-Notice Requirements Before Transfer/Discharge
-	-	-	-	-	-	X C	D	02/07/2020	REQ	F0625-Notice of Bed Hold Policy Before/Upon Trnsfr
-	-	-	-	X	G	- -	-	-	REQ	F0658-Services Provided Meet Professional Standards
-	-	-	-	X	D	- -	-	-	REQ	F0686-Treatment/Svcs to Prevent/Heal Pressure Ulcer
-	-	-	-	-	-	X C	D	02/07/2020	REQ	F0689-Free of Accident Hazards/Supervision/Devices
-	-	-	-	-	-	X C	B	02/07/2020	REQ	F0732-Posted Nurse Staffing Information
-	-	-	-	-	-	X C	D	02/07/2020	REQ	F0757-Drug Regimen is Free from Unnecessary Drugs
-	-	-	-	X	G	- -	-	-	REQ	F0760-Residents are Free of Significant Med Errors
-	-	-	-	-	-	X C	D	02/07/2020	REQ	F0761-Label/Store Drugs and Biologicals
-	-	-	-	X	D	- -	-	-	REQ	F0773-Lab Srvcs Physician Order/Notify of Results

LSC Deficiencies

Edition of LSC Applied

2012 HC Prior 3 Survey 07/2016	S/S Code	2012 HC Prior 2 Survey 08/2017	S/S Code	2012 HC Prior 1 Survey 11/2018	S/S Code	2012 HC Current Survey 12/12/2019	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	-	-	-	-	- -	-	-	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
-	-	-	-	-	-	- -	-	-	STD	K0321-Hazardous Areas - Enclosure
-	-	-	-	-	-	- -	-	-	STD	K0324-Cooking Facilities

DEVON GABLES REHABILITATION CENTER CCN: 035145

Edition of LSC Applied

2012 HC Prior 3 Survey 07/2016	S/S Code	2012 HC Prior 2 Survey 08/2017	S/S Code	2012 HC Prior 1 Survey 11/2018	S/S Code	2012 HC Current Survey 12/12/2019	S/S Code	Plan/Date of Correction		LSC Deficiencies - Bldg # 01
-	-	X	D	-	-	- -	-	-	STD	K0351-Sprinkler System - Installation
-	-	X	E	-	-	X C	D	02/10/2020	STD	K0353-Sprinkler System - Maintenance and Testing
-	-	-	-	-	-	X C	E	02/10/2020	STD	K0363-Corridor - Doors
-	-	-	-	-	-	- -	-	-	STD	K0374-Subdivision of Building Spaces - Smoke Barrie
-	-	-	-	-	-	X C	D	02/10/2020	STD	K0511-Utilities - Gas and Electric
-	-	-	-	-	-	- -	-	-	STD	K0753-Combustible Decorations
-	-	X	E	-	-	X C	D	02/10/2020	STD	K0920-Electrical Equipment - Power Cords and Extens
-	-	X	D	-	-	- -	-	-	STD	K0923-Gas Equipment - Cylinder and Container Storag

DEVON GABLES REHABILITATION CENTER **CCN:** 035145

Deficiency Summary

Type of Deficiency	Current Survey	Prior 1 Survey	Prior 2 Survey	Prior 3 Survey
Requirement	7	3	2	7
Health Total	7	3	2	7
Life Safety Code	4	0	4	0
Life Safety Code + Health	11	3	6	7

Complaint Survey Information

Survey Date	Status
01/25/2021	Substantiated
12/12/2019	Substantiated
05/16/2019	Unsubstantiated
11/01/2018	Substantiated

DEVON GABLES REHABILITATION CENTER **CCN:** 035145

LTC Resident Census

Resident Census on 12/12/2019
Total: 237
Medicare: 4
Medicaid: 190
Other: 43

Total Certified Beds: 312

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

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 31, 2022

Important Notice - Please Read Carefully

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

Re: Complaint Intake #AZ00181961, #AZ00181962, #AZ00163702, #AZ00163703
Investigation # YZWT11

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,

Diane Eckles

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