

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: ZTOG11

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: LTC0031

1. MEDICARE/MEDICAID PROVIDER NO. (L1) <b>035145</b>		3. NAME AND ADDRESS OF FACILITY (L3) <b>DEVON GABLES REHABILITATION CENTER</b>			4. TYPE OF ACTION: <u>6</u> (L8)	
2.STATE VENDOR OR MEDICAID NO. (L2) <b>748491</b>		(L4) <b>6150 EAST GRANT ROAD</b>			1. Initial	
		(L5) <b>TUCSON, AZ</b> (L6) <b>85712</b>			2. Recertification	
5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)		7. PROVIDER/SUPPLIER CATEGORY <u>02</u> (L7)			3. Termination	
6. DATE OF SURVEY (L34)		01 Hospital 05 HHA 09 ESRD 13 PTIP 22 CLIA			4. CHOW	
8. ACCREDITATION STATUS: (L10)		02 SNF/NF/Dual 06 PRTF 10 NF 14 CORF			5. Validation	
0 Unaccredited 1 TJC		03 SNF/NF/Distinct 07 X-Ray 11 ICF/IID 15 ASC			6. Complaint	
2 AOA 3 Other		04 SNF 08 OPT/SP 12 RHC 16 HOSPICE			7. On-Site Visit	
					8. Full Survey After Complaint	
11. LTC PERIOD OF CERTIFICATION		10. THE FACILITY IS CERTIFIED AS:			FISCAL YEAR ENDING DATE: (L35)	
From (a):		X A. In Compliance With			12/31	
To (b):		Program Requirements				
		Compliance Based On:				
12.Total Facility Beds <b>312</b> (L18)		___ 1. Acceptable POC			___ 2. Technical Personnel	
13.Total Certified Beds <b>312</b> (L17)		B. Not in Compliance with Program			___ 3. 24 Hour RN	
		Requirements and/or Applied Waivers:			___ 4. 7-Day RN (Rural SNF)	
		* Code: <b>A*</b> (L12)			___ 5. Life Safety Code	
14. LTC CERTIFIED BED BREAKDOWN		15. FACILITY MEETS			___ 6. Scope of Services Limit	
18 SNF 18/19 SNF 19 SNF ICF IID		1861 (c) (1) or 1861 (j) (1): <b>YES</b> (L15)			___ 7. Medical Director	
312					___ 8. Patient Room Size	
(L37) (L38) (L39) (L42) (L43)					___ 9. Beds/Room	

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

A complaint survey was conducted on 3/8/18 and no deficiencies were found.

17. SURVEYOR SIGNATURE		Date :	18. STATE SURVEY AGENCY APPROVAL		Date:
<i>for Chris Benson</i>		<i>3-13-18</i>	<i>Jandy Farmer</i>		<i>3-13-18</i>
		(L19)			(L20)

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

19. DETERMINATION OF ELIGIBILITY		20. COMPLIANCE WITH CIVIL RIGHTS ACT:		21. 1. Statement of Financial Solvency (HCFA-2572)	
<input checked="" type="checkbox"/> 1. Facility is Eligible to Participate				2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)	
<input type="checkbox"/> 2. Facility is not Eligible				3. Both of the Above :	
		(L21)			
22. ORIGINAL DATE OF PARTICIPATION (L24)		23. LTC AGREEMENT BEGINNING DATE (L41)		26. TERMINATION ACTION: (L30)	
				VOLUNTARY <u>00</u> INVOLUNTARY	
				01-Merger, Closure 05-Fail to Meet Health/Safety	
				02-Dissatisfaction W/ Reimbursement 06-Fail to Meet Agreement	
25. LTC EXTENSION DATE: (L27)		27. ALTERNATIVE SANCTIONS		03-Risk of Involuntary Termination OTHER	
		A. Suspension of Admissions: (L44)		04-Other Reason for Withdrawal 07-Provider Status Change	
		B. Rescind Suspension Date: (L45)		00-Active	
28. TERMINATION DATE: (L28)		29. INTERMEDIARY/CARRIER NO. <b>00000</b> (L31)		30. REMARKS	
31. RO RECEIPT OF CMS-1539 (L32)		32. DETERMINATION OF APPROVAL DATE <b>03/13/2018</b> (L33)		DETERMINATION APPROVAL	

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

PRINTED: 03/13/2018  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>035145</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>03/08/2018</b>
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NAME OF PROVIDER OR SUPPLIER  <b>DEVON GABLES REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6150 EAST GRANT ROAD TUCSON, AZ 85712</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A complaint (AZ146949, AZ145979, AZ145725, AZ145002) investigation was conducted on March 7 and 8, 2018. No deficiencies were cited.</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Heather Hughes*

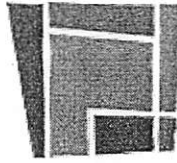
TITLE

*Administrator*

(X6) DATE

*3/21/18*

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



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

Receipt of Notice Presumed 03/13/2018 via email

March 13, 2018

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

Dear Ms. Friebus:

On **March 8, 2018**, a standard complaint survey was conducted at your facility by the Department of Health Services, Bureau of Long Term Care to determine if your facility was in compliance with Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs.

The enclosed Federal deficiency form which indicates that no deficiencies were found at the time of the complaint investigation #ZTOG11 inspection. This form will become a part of your public file; please sign and return the first page with original signatures and retain a copy for your files.

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

Sincerely,

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

Diane Eckles  
Bureau Chief

DE\sf

Attachments

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

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

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

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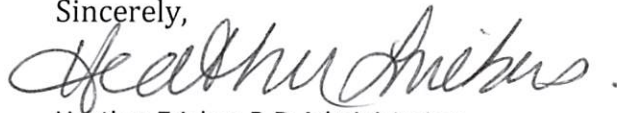
RECEIVED  
MAR 26 2018

BY 

Dear Diane Eckles,

Enclosed you will find our signed 2567's for the standard complaint survey conducted on March 8, 2018. Please let me know if you need anything further.

Sincerely,



Heather Friebus R.D Administrator  
Devon Gables Rehabilitation Center  
6150 E. Grant Rd.  
Tucson, Az 85712  
(520) 296-6181 X 5011  
(520) 298-0997 fax  
hfriebus@devongables.com





## Notice of Inspection Rights

Facility/Agency Name: Devon Gables Rehabilitation Center

Address: 6150 East Grant Road City: Tucson Zip: 85712

Facility I.D.#: LTC0031 License #: NCI-2652 Medicare #: 035145 Date of Inspection: March 7, 2018

Survey Event ID: ZTOG11

Inspector/Team Coordinator: Chris Benson

Accompanied By:

### BUREAU OF LONG TERM CARE LICENSING

This inspection is conducted under the authority of:

1. Arizona Revised Statutes (A.R.S.) Title 36, Chapters 1 and 4, and Arizona Administrative Code (A.A.C.), Title 9, Chapter 10. Some of the activities during the inspection may include, but are not limited to, a facility premise inspection, review and/or copying of records, including personnel records, interviews with residents/patients/clients, family and staff, and review of services offered.
2. The purpose of this inspection is to:
  - Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
  - Conduct a complaint investigation.
3. No fees are charged for this inspection.
4. An authorized representative of this facility may accompany the inspector(s) during the inspection conducted on these premises, except during any confidential interview.
5. You have the right to receive copies of any original documents taken by the inspector(s) during the inspection in those cases where the agency has authority to take original documents.
6. You and your staff have the opportunity to provide any information that would clarify an issue. Additionally, interviews with staff, family or residents/patients/clients may be conducted privately. Each person interviewed will be informed that statements made by the person may be included in the inspection report and each person whose conversations are tape or video recorded will be informed that the conversation is being tape or video recorded.
7. Upon completion of the inspection the inspector(s) will conduct an exit interview and informally disclose their findings. A Statement of Deficiencies (SOD) formally notifying you of the findings will be provided within 30 working days. You will be afforded an opportunity to submit a Plan of Correction (POC) unless the Department is considering enforcement against the license.
8. You have an opportunity to dispute any findings of non-compliance through an Informal Dispute Resolution (IDR). Details of the IDR process will be provided when the SOD is mailed to you.
9. If you have questions regarding this inspection, you may contact: Diane Eckles, Bureau Chief, at 150 N. 18th Ave., Suite 440, Phoenix, Arizona 85007-3242, Phone: (602) 364-2675, FAX: (602) 324-0993, E-Mail: Diane.Eckles@azdhs.gov. If you have an issue that you cannot resolve with the Bureau or the Division, you may contact the Office of Ombudsman-Citizens' Aide, 3737 N. 7th St., Suite 209, Phoenix, AZ 85014 (602) 277-7292.
10. Your administrative hearing rights are found at A.R.S. § 41-1092 et seq., and rights relating to appeal of a final agency decision can be found in A.R.S. §12-901 et seq.

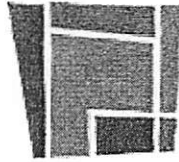
Upon entry to the premises for this inspection, the inspector(s) presented photo identification indicating that they are Arizona Department of Health Services (ADHS) employees and reviewed with me the above Notice of Inspection Rights. I have read the disclosures and am notified of my inspection and due process rights as listed. I understand that while I have the right to decline to sign this form, the ADHS representative(s) may proceed with the inspection.

Kendria Rogner Don 3/7/18  
 Administrator/Director/Agency Representative Signature Date:

- Administrator/Director/Agency Representative refused to sign this form.
- Administrator/Director/Agency Representative or authorized on-site representative is not present.

Chris Benson 3-7-18  
 Inspector/Team Coordinator Signature Date:

Copy left with Administrator/Director/Agency Representative



ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

March 13, 2018

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

**Re: Complaint Intake #AZ00146949  
Investigation # ZTOG11**

Dear Ms. Friebus:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

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

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

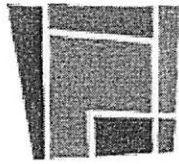
Douglas A. Ducey | Governor    Cara M. Christ MD, MS | Director

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ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

March 13, 2018

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

**Re: Complaint Intake #AZ00145002  
Investigation # ZTOG11**

Dear Ms. Friebus:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

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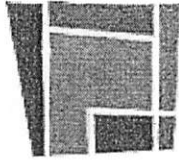
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OF HEALTH SERVICES

LICENSING

March 13, 2018

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

**Re: Complaint Intake #AZ00145725  
Investigation # ZTOG11**

Dear Ms. Friebus:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

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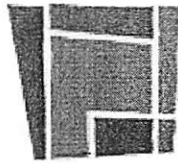
Shoalynn Gilliland-McCleery  
Program Project Specialist II  
Bureau of Long Term Care Licensing

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ARIZONA DEPARTMENT  
OF HEALTH SERVICES

LICENSING

March 13, 2018

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

**Re: Complaint Intake #AZ00145979  
Investigation # ZTOG11**

Dear Ms. Friebus:

Surveyors of the Arizona Department of Health Services (Long Term Care) have thoroughly investigated the above referenced complaint. Prior to being investigated, this complaint was broken down into allegations that correspond to the Department's rules for the facility.

The overall finding of this investigation is that the allegations were unable to be substantiated.

You are in receipt of a Statement of Deficiencies for this survey that confirms the complaint was unsubstantiated.

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

Sincerely,

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

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

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

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