

State
Public Records Documents
Only

Survey event #5416

Facility: DEVON GABLES REHAB
CTR

Revised 7-2020

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER NCI-2652	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/24/2021	Y3
NAME OF FACILITY DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712		

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 Y0342	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # R9-10-403.C.2.e.	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	02/24/2021	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 _____	_____
ID Prefix _____	Correction	ID Prefix _____	Correction	ID Prefix _____	Correction
Reg. # _____	Completed	Reg. # _____	Completed	Reg. # _____	Completed
LSC _____	_____	LSC _____	_____	LSC _____	_____

REVIEWED BY STATE AGENCY <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>mc</i>	DATE 2/23/21	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE 2/23/21
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 1/25/2021	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?	<input type="checkbox"/> YES	<input type="checkbox"/> NO
---	---	------------------------------	-----------------------------



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 24, 2021

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On February 24, 2021, an offsite revisit survey 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 the state requirements at the time of the focused infection control survey #541612.

Enclosed is the **State Revisit Report form**, which indicates the licensee to be **in substantial compliance**. A copy of this form will become a part of the facility's public file. Please keep this current inspection report in the facility and available for review.

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

Sincerely,

A handwritten signature in black ink that reads "Monica Miller".

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

\mm

Enclosure

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

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

W | azhealth.gov

Health and Wellness for all Arizonans

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 02/24/2021
--	---	---	---

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

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

{Y 000}	Initial Comments An offsite follow-up survey was conducted on February 23, 2021. No deficiencies were cited.	{Y 000}		
---------	---	---------	--	--

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



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 9, 2021

Receipt Of This Notice Is Presumed To Be 02/09/2021
Important Notice - Please Read Carefully

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

Dear Ms. Friebus:

Thank you for the courtesy and cooperation extended to our staff during the recent Infection Control Focus Survey of your facility.

Enclosed is a statement of **STATE** deficiencies noted during the inspection of your facility on January 25, 2021. A Plan of Correction (PoC) for the deficiencies must be submitted. This plan must be both specific to the problems noted and general to the overall process involved.

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 be advised that your plan of correction will be available as a public document for review by interested parties.

Please place your plan of correction in the space provided in the right column of the statement of deficiencies and return the original to this office no later than **February 19, 2021**. You must include all pages of the Statement of Deficiencies when submitting your PoC. Please ensure to retain a copy for your files. If the plan of correction is not received by this Office on or before this date, state enforcement action may be taken. The POC must be signed and dated by an official facility representative. Please send your POC by email to the following:

lrc.licensing@azdhs.gov

SUBJECT LINE: the name of your facility and POC

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

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

W | azhealth.gov

Health and Wellness for all Arizonans

Devon Gables Rehabilitation Center
February 9, 2021
Page 2

Informal Dispute Resolution - You have an opportunity to dispute any deficiencies or language listed on the SOD through an Informal Dispute Resolution (IDR). To dispute a deficiency or language listed on the SOD, send a written request on a separate document **due 10 days from receipt of this letter**. The written request must include documentation that shows the licensee was in compliance at the time of the inspection. The Department will review the written request and documentation provided to the Department and notify you of the Department's decision. If you have any questions, please call: Diane Eckles, Bureau Chief, Bureau of Long Term Care 150 North 18th Avenue, #440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,



Diane Eckles
Bureau Chief

DE:sf

Enclosure



DEVON GABLES
REHABILITATION CENTER

Dear AZDHS Licensing,

Attached you will find

- 2567 State SOD
- Staff #6 on SOD education sign in sheet and quiz
- COVID-19 Directed Plan of Correction Outline including System changes, Problem Statement, goal, Root cause analysis utilizing 5 why's, systemic changes and actions taken and monitoring signed by Administrator, Director of Nursing, both IP's and Medical Director
- COVID-19 Directed Plan of Correction for all staff including CDC video "Keeping COVID out", symptoms of COVID-19, Reporting Instruction etc Handout
- Sample Quiz given for all staff to show competency of education listed above.
- Sign in sheets for the directed plan of correction listed above
- Actual quizzes with staff signatures

- COVID-19 Directed Plan of Correction for all Screeners- "Screener Education Handouts"
- Sample Employee Screening Competency Quiz
- Sign in sheets for the directed plan of correction listed above
- Actual quizzes with staff signatures

- Audits performed for compliance with system correction

If you have any questions, please let me know.



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

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 01/25/2021
--	--	--	--

NAME OF PROVIDER OR SUPPLIER
DEVON GABLES REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
**6150 EAST GRANT ROAD
TUCSON, AZ 85712**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments An onsite focused infection control survey was conducted on January 25, 2021. The following deficiency was cited:	Y 000		
Y 342	R9-10-403.C.2.e. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.e. Cover infection control; This RULE is not met as evidenced by: Based on facility documentation, staff interviews, policy review, and the Centers for Disease Control (CDC), the facility failed to implement their policy to ensure the screening for COVID-19 was thorough for one staff (staff #6). Findings include: During the entrance conference conducted with the facility administrator (staff #28) and the Director of Nursing (DON/staff #56) on January 25, 2021 at 9:15 am, the administrator stated one staff member (staff #6) reported to the facility Infection Preventionist (IP/staff #32) on January 14, 2021 that she had been experiencing COVID-19 symptoms since January 7, 2021. The administrator stated the symptoms were not reported on the screening for COVID-19.	Y 342	<p>Y342</p> <p>Correct to all residents: All residents were tested for COVID-19 and placed in appropriate cohorts.</p> <p>Identification and correction for other residents potentially affected: Outbreak testing for all residents and staff continues until outbreak resolution. The facility continues to follow CMS requirement for testing based on county positivity rate and outbreak status.</p> <p>The Facility added additional screening question on 01/23/2021 to include inquiring regarding potential vaccination side effects.</p> <p>Staff were re-educated on policy and procedure for reporting COVID-19 like symptoms regardless of their belief of the cause.</p> <p>System Correction: Audits will be completed twice per week to ensure staff understands COVID-19 symptoms and reporting procedure.</p> <p>Audits of screening will be completed twice per week to ensure thorough screening was completed on staff and visitors for COVID-19 symptoms.</p> <p>Monitoring of System/Quality Assurance Program: The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed.</p> <p>Correction Date:</p> <p>Responsible Person: Infection Preventionist or Designee</p>	<p>ARIZONA DEPARTMENT OF HEALTH DIVISION OF PUBLIC HEALTH LICENSING</p> <p>FEB 23 2021</p> <p>LONG TERM CARE 150 N. 18TH AVE # 440 PHOENIX, AZ 85007</p> <p>2/24/2021</p>

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

Heather Grebus

TITLE

Administrator

(X6) DATE

2/19/2021

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2021
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 342	<p>Continued From page 1</p> <p>The Start of Shift Employee Screening logs for the month of January 2021 revealed staff #6 was screened and that no COVID-19 symptoms were documented on January 1, 4, 5, 7, 8, 9, 10, 12, 13, and 14, 2021.</p> <p>The facility's employee routine testing records for the month of January 2021 revealed staff #6 was tested for COVID-19 using the facility's rapid antigen test on January 5, 8, 12, and 14, 2021, all with negative results.</p> <p>Review of the facility's line list tracking for COVID-19 revealed staff #6 received a COVID-19 polymerase chain reaction (PCR) test on January 14, 2021 and the positive result was reported on January 15, 2021.</p> <p>In the interview conducted with the administrator and the DON on January 25, 2021 at 9:15 a.m., the administrator stated that education was provided to staff regarding reporting symptoms and that a question was added to the screening for COVID-19.</p> <p>On January 25, 2021 at 2:40 pm, an attempt was made to interview staff #6 via phone, a voicemail was left.</p> <p>An interview was conducted with the IP (staff #32) via facetime on January 25, 2021 at 3:50 pm. Staff #32 stated staff #6 reported to her on January 14, 2021 that she had been experiencing fatigue and muscle aches since January 7, 2021 and had developed a cough on January 14, 2021. The IP stated that staff #6 said that she thought her symptoms were side effects from the COVID-19 vaccine she had received at the facility on January 5, 2021. Staff #32 stated staff #6 was</p>	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2662	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/25/2021
NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Y 342	<p>Continued From page 2</p> <p>tested at the facility at that time (January 14, 2021) using the facility's rapid antigen test and that the test was negative. The IP stated staff #6 was sent home and a sample was sent for PCR testing. The IP stated the PCR test result was positive for COVID-19.</p> <p>Review of the facility's document titled Education 1/20/2021 revealed to "always report symptoms no matter if you think they are side effects from the vaccine etc."</p> <p>The facility's policy COVID-19 Clinical Protocol for Visitor and Employee Screening included that as part of routine practice, health care personnel (HCP) will be asked to regularly monitor themselves for fever, respiratory symptoms and COVID-19 like symptoms. It also included that HCP should be reminded to stay home when they are ill, and if HCP develop COVID-19 like symptoms while at work, they should immediately put on a facemask (if not already wearing), inform their supervisor, and leave the workplace. The policy was revised January 25, 2021, for screening to include questioning all HCP if they have symptoms related to COVID-19 vaccine.</p> <p>The CDC guidance Preparing for COVID-19 in Nursing Homes Updated Nov. 20, 2020 stated to screen all HCP at the beginning of their shift for fever and symptoms of COVID-19. Actively take their temperature and document absence of symptoms consistent with COVID-19. If they are ill, have them keep their cloth face covering or facemask on and leave the workplace. Facilities should reinforce sick leave policies, and remind HCP not to report to work when ill.</p> <p>The CDC Post Vaccine Considerations for Healthcare Personnel updated December 13,</p>	Y 342			

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NCI-2652	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2021
--	--	---	--

NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 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) COMPLETE DATE
Y 342	<p>Continued From page 3</p> <p>2020, revealed strategies are needed for healthcare facilities to appropriately evaluate and manage post-vaccination signs and symptoms among healthcare personnel (HCP). Systemic signs and symptoms, such as fever, fatigue, headache, chills, myalgia, and arthralgia, can occur following COVID-19 vaccination. Preliminary data from mRNA COVID-19 vaccine trials indicate that most systemic post-vaccination signs and symptoms are mild to moderate in severity, occur within the first three days of vaccination, resolve within 1-2 days of onset, and are more frequent and severe following the second dose and among younger persons compare to those who are older (>55 years). Inform HCP about the potential for short-term systemic signs and symptoms post-vaccination. Develop a strategy to provide timely assessment of HCP with systemic signs and symptoms post-vaccination. Evaluate the HCP with signs and symptoms that may be from either the COVID-19 vaccination, SARS-CoV-2 infection, or another infection. Offer nonpunitive sick leave options (e.g., paid sick leave) for HCP with systemic signs and symptoms post-vaccination to remove barriers to reporting these symptoms.</p>	Y 342		



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: January 25, 2021

Survey Event ID: 541611

Inspector/Team Coordinator: Rebecca Jacobson

Accompanied By: Carey Sexton, Sallie Martinez

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, 7878 N. 16th St., Suite 235 Phoenix AZ 85020 (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.

Signature of Administrator/Director/Agency Representative: [Handwritten Signature] Date: 1/25/21

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

Inspector/Team Coordinator Signature: [Handwritten Signature] Date: 1/25/21

Copy left with Administrator/Director/Agency Representative