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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QQR411

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: 9 (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)

6. DATE OF SURVEY (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)

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

12. Total Facility Beds (L18)

13. Total Certified Beds (L17)

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

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

* Code: A* (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE
for Samantha Potter, Surveyor
Date: 07/09/2020 (L19)

18. STATE SURVEY AGENCY APPROVAL
Daniel Coleman
Date: 07/09/2020 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION (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.
00000
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: QQR411

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: LTC0031

C&T REMARKS - CMS 1539 FORM — STATE AGENCY REMARKS

Devon Gables Rehabilitation Center was found to be out of compliance with federal regulations based on an infection control survey conducted on 5/27/2020.

On 7/7/2020, an offsite revisit survey was conducted. Devon Gables Rehabilitation Center has been placed back in compliance with federal regulations based on an allegation of compliance and acceptable plan of correction with evidence of compliance. The State Agency is recommending recertification at this time.

ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

July 8, 2020

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On July 7, 2020, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with the state requirements at the time of the focused infection control survey #QQR412.

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,

Daniel Coleman
LTC Customer Service Representative IV

\dc

Enclosure

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2652	A. BUILDING: _____ B. WING _____	R 07/07/2020

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) COMPLETE DATE
{Y 000}	Initial Comments An offsite follow-up survey was conducted on July 7, 2020. No deficiencies were cited.	{Y 000}		

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
NCI-2652 Y1	A. Building B. Wing Y2	7/7/2020 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 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 Reg. # R9-10-403.C.2.e. LSC	Correction Completed 07/02/2020	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	ne	7/7/2020	Matt Cruz	7/7/2020
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**
FOLLOWUP TO SURVEY COMPLETED ON 5/27/2020	☐ 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

June 23, 2020

Receipt Of This Notice Is Presumed To Be 06/23/2020
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 **May 27, 2020**. 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 **July 3, 2020**. You must include all pages of the Statement of Deficiencies when submitting your PoC. **Plans of correction sent via fax will not be accepted.** 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.

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

Diane Eckles
Bureau Chief

DE:dc

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2652	A. BUILDING: _____ B. WING _____	05/27/2020

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

RECEIVED JUL 07 2020

(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 May 27, 2020. The following deficiency was cited:	Y 000	Y342 **Correct to all residents:** All residents that dine have the potential for being affected.	
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 observations, staff interviews, review of the Center for Disease Control (CDC) recommendations and policies and procedures, the facility failed to implement their policy to ensure infection control standards were followed. Findings include: On May 27, 2020 at approximately 1:15 p.m. an observation of the Central Unit was conducted with the Director of Nursing (DON/staff #41). Staff #41 stated that the Central Unit was a secured dementia unit that housed both male and female residents. She stated there were currently 20 residents that resided there. Upon entry to the unit, a communal dining room was observed on the left side of the main hallway.	Y 342	Staff re-educated on policy and procedure for COVID-19 Dining Protocol which includes social distancing for dining and Staff members who are providing assistance for more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents. **System Correction:** Audits will be done weekly to ensure that residents remain 6 feet apart during dining. Audits will be done weekly to ensure that staff are completing hand hygiene between assisting residents when assisting with their meals. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow up as needed.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Heather Ruckus. TITLE: Administratn (X6) DATE: 7/2/2020.

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2652	A. BUILDING: _____ B. WING _____	05/27/2020

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

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Y 342	Continued From page 1 17 residents were observed in the dining room eating their meals. 13 of the residents were eating independently. Five square tables in the room were observed to accommodate 2 residents each. Three over-the-bed tables had one resident seated at each table. Two horseshoe shaped tables were observed along the left wall of the room. Each horseshoe shaped table accommodated two residents and a Certified Nursing Assistant (CNA). The CNA assisted both residents at their table with their meals. Each resident in the room was observed to be within one arm's length of one or more other residents. 6 feet social distancing was not observed. During the observation, one of the residents seated at the square table in the middle of the room was observed to reach across the table and take the other resident's roll off her plate and begin eating it. The DON quickly walked into the dining room and asked the resident for the roll. The resident gave the DON the roll. The DON requested another roll for the resident whose roll was taken. Directly behind each CNA seated at the horseshow shaped tables, a hand sanitizer dispenser was observed mounted on the wall. The CNAs were assisting the residents with eating and drinking. They alternated their assistance between each resident seated at their tables. However, neither of the CNAs was observed to utilize hand sanitizer between residents. An interview was conducted with the DON on May 27, 2020 at 1:25 p.m. She stated that the residents dine communally due to their risks for choking and aspiration and that some of the residents required cueing.	Y 342	**Correction Date:** **Responsible Person:** Infection Preventionist Nurse or designee	7/02/2020

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NCI-2652	A. BUILDING: _____ B. WING _____	05/27/2020

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

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Y 342	Continued From page 2 On May 27, 2020 at 2:10 p.m., an interview was conducted with a member of the maintenance staff (staff #33) regarding the size of the tables in the dining room. Staff #33 measured the tables and stated that the two horseshoe tables measured 6 feet long by 4 feet wide, the five square tables measured 42 inches by 42 inches, and the over-the-bed tables measured 30 inches long by 15 inches wide. 6 feet is 72 inches. An interview was conducted on May 27, 2020 at 3:08 p.m. with a CNA (staff #64). She stated that it was facility policy to sanitize your hands between residents when assisting residents with their meals. She further stated that day; she had forgotten to sanitize her hands between residents. The facility's policy titled COVID-19 Resident Dining Protocol revised March 16, 2020 revealed a key reason for cancelling communal dining is linked to the concept of social distancing (e.g., limiting people being in close proximity to each other for periods of time; ideally people should keep about 6 feet apart). Social distancing is recommended by CMS for facilities regarding resident interactions. Communal dining is a common group activity that places residents in close proximity to each other. This can spread respiratory viruses. The policy included the facility will follow the CMS guidance with the following protocol: Implement social distancing in dining practices. Recommended approaches included: 1. Provide in-room meal service for those that are assessed to be capable of feeding themselves without supervision or assistance. 2. Identify high-risk choking residents and those at risk for aspiration who may cough, creating	Y 342	**System Correction:** Audits will be done weekly to ensure that residents remain 6 feet apart during dining. Audits will be done weekly to ensure that staff are completing hand hygiene between assisting residents when assisting with their meals. **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:** Infection Preventionist Nurse or designee	7/02/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 3 droplets. Meals for these residents should ideally be provided in their rooms; or the resident should remain at least 6 feet or more from others if in a common area for meals, and with as few other residents in the common areas as feasible during their mealtime ... 3. If residents need to be brought to the common area for dining, do this in intervals to maintain social distancing ... 4. Residents who need assistance with feeding should be spaced apart as much as possible, ideally 6 feet or more or no more than one person per table (assuming a standard 4 person table)... The policy also revealed staff member who are providing assistance for more than one resident simultaneously must perform hand hygiene with at least hand sanitizer each time when switching assistance between residents. The CDC guidance titled Preparing for COVID-19 in Nursing Homes stated that given the congregate nature and resident population served, nursing home populations are at high risk of being affected by respiratory pathogens like COVID-19. The guidance stated that implementation of social distancing measures should include aggressive social distancing measures (remaining at least 6 feet apart from others), and cancelling communal dining and group activities. The CDC guidelines titled Considerations for Memory Care Units in Long-term Care Facilities included limiting the number of residents or space residents at least 6 feet apart as much as feasible when in a common area. The CDC guidelines titled Hand Hygiene in Healthcare Settings stated multiple opportunities	Y 342		

ADHS LICENSING SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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Y 342	Continued From page 4 for hand hygiene may occur during a single care episode. The clinical indications for hand hygiene include immediately before touching a resident and after touching a resident or a resident's immediate environment.	Y 342		

ADHS
LICENSING

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: May 27, 2020

Survey Event ID: QQR411

Inspector/Team Coordinator: P. Samantha Potter

Accompanied By: Lisa Andrin-Mazur

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.

Heather Drehis — 5/27/2020

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.

P. Samantha Potter — 5/25/2020

Inspector/Team Coordinator Signature: — Date:

☒ Copy left with Administrator/Director/Agency Representative