



QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES

NURSING CARE INSTITUTION



Issued To:

Devon Gables Rehabilitation Center, LLC
 Devon Gables Rehabilitation Center
 6150 East Grant Road
 Tucson, AZ 85712

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET		QUALITY PERFORMANCE SCALE	
	Yes	No		
I. Nursing Services	25	0	"A" Excellent	X
II. Resident Rights	25	0	"B"	
III. Administration	23	2	"C"	
IV. Environment and Infection Control	10	5	"D"	
V. Food Services	10	0		
TOTAL CRITERIA MET	93	7	"A" 90-100 Points "B" 89-80 Points "C" 70-79 Points "D" 69 or fewer Points	

License Effective

From: 12/12/2019

Issued: 1/21/2020

Number: NCI-2652

Recommended By: *Diane Eckles*

Issued By: *Cy3m*
 Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE



ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

February 10, 2020

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On February 7, 2020, an offsite revisit was conducted for your facility by the Arizona Department of Public Health, Licensing, and Certification Bureau, to determine if your facility was in compliance with the State participation requirements to operate a nursing home in the State of Arizona. Enclosed is the **State Revisit Report form**, which indicates the licensee to be in substantial compliance based on an allegation of compliance, and acceptable plan of correction. 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, appearing to read "Sandy Farmer".

Sandy Farmer
LTC Customer Service Representative IV

\sf

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

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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 02/07/2020
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NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712
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(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}	<p>Initial Comments</p> <p>The offsite follow up State Annual and complaint investigation survey was conducted on 2/7/2020, no deficiencies were cited.</p>	{Y 000}		

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER NCI-2652	Y1	MULTIPLE CONSTRUCTION A. Building B. Wing	Y2	DATE OF REVISIT 2/7/2020	Y3
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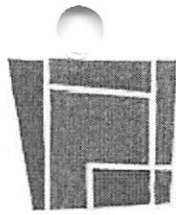
NAME OF FACILITY DEVON GABLES REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and 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 Y0337	Correction	ID Prefix Y1235	Correction	ID Prefix Y1477	Correction
Reg. # R9-10-403.C.2.a.	Completed	Reg. # R9-10-412.B.7.	Completed	Reg. # R9-10-414.B.3.b.	Completed
LSC	02/07/2020	LSC	02/07/2020	LSC	02/07/2020
ID Prefix Y2153	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # R9-10-421.D.1.	Completed	Reg. #	Completed	Reg. #	Completed
LSC	02/07/2020	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>AT</i>	DATE 2/7/2020	SIGNATURE OF SURVEYOR <i>Dale Adams</i>	DATE 2/7/2020
REVIEWED BY CMS RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 12/12/2019	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
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ARIZONA DEPARTMENT
OF HEALTH SERVICES

LICENSING

January 22, 2020

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

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

Dear Ms. Friebus:

Thank you for the courtesy and cooperation extended to our staff during the recent inspection of your facility.

Enclosed is a statement of STATE deficiencies noted during the inspection of your facility on December 12, 2019. 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 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.

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

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Health and Wellness for all Arizonans

Devon Gables Rehabilitation Center

January 22, 2020

Page Two

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:dc

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

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ADHS LICENSING SERVICES

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RECEIVED
FEB 03 2020
BY: *[Signature]*

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Y 000	Initial Comments The State compliance survey was conducted on December 9 through 12, 2019, in conjunction with the following Complaint investigations: #'s AZ160871, AZ160371, AZ160372, AZ160180, AZ160149, AZ160153 and AZ158386. The following deficiencies were cited.	Y 000		
Y 337	R9-10-403.C.2.a. Administration R9-10-403.C. An administrator shall ensure that: R9-10-403.C.2. Policies and procedures for physical health services and behavioral health services are established, documented, and implemented to protect the health and safety of a resident that: R9-10-403.C.2.a. Cover resident screening, admission, transport, transfer, discharge planning, and discharge; This RULE is not met as evidenced by: Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to implement their policy to ensure the Office of the State Long-Term Ombudsman was sent a copy of the hospital transfer notice for two residents (#185 and #229). Findings include: -Resident #185 was admitted to the facility on May 1, 2018, with diagnoses that included chronic kidney disease and depression. Review of a nursing note dated November 9,	Y 337	<p>Arizona Department of Health Services Division of Public Health Reception Desk 150 N. 18th Ave #40 Phoenix AZ 85007</p> <p>FEB 3 2020</p> <p><i>SN</i></p> <p><u>Y337</u></p> <p>Correct to individual: Resident #185 was told of Ombudsman's role if a transfer to a hospital occurs and verbalized understanding. Resident #229 was discharged from facility.</p> <p>Correct to all others: All residents that transfer or discharge from the facility have the potential for being affected. Staff will be re-educated on policy and procedure for notifying Long-Term Care Ombudsman upon a resident's discharge to the hospital.</p> <p>System Correction: Audits will be done weekly to ensure that the facility notifies the Ombudsman upon transfer to a hospital.</p>	

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

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Y 337	<p>Continued From page 1</p> <p>2019 at 12:14 a.m., revealed the resident was transferred to the hospital due to a change in condition.</p> <p>However, review of the clinical record revealed no evidence the Long-Term Care Ombudsman was sent a copy of the transfer/discharge notice.</p> <p>-Resident #229 was admitted to the facility on June 13, 2019 with diagnoses that included cerebrovascular disease, diabetes, hypertension, and acute kidney failure.</p> <p>Review of the nursing discharge summary progress note dated October 2, 2019 revealed the resident was sent to the hospital to be evaluated and treated for a change in condition.</p> <p>However, review of the clinical record revealed no evidence the Long-Term Care Ombudsman was sent a copy of the transfer notice.</p> <p>During an interview conducted with the social worker (staff #279) on December 10, 2019 at 2:25 p.m., staff #279 stated that they did not notify the ombudsman when residents were discharged to the hospital.</p> <p>An interview was conducted with the administrator (staff #85) on December 10, 2019 at 2:35 p.m. Staff #85 stated that they used to email the ombudsman when residents were discharged to the hospital and that she thought it was no longer a requirement to notify the ombudsman.</p> <p>Later at that day at 3:30 p.m., staff #85 stated that the ombudsman should have been notified when the residents were discharged to the hospital.</p>	Y 337	<p><u>Monitoring of System:</u> The analysis of the audits will be taken to QAPI meeting for review and follow up as needed.</p> <p><u>Correction Date:</u></p> <p><u>Responsible Person:</u> Administrator or Designee</p>	2/1/2020
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Y 337	Continued From page 2 Review of the facility's policy Transfer or Discharge Notice revised December 2012 revealed the state long-term care ombudsman will be sent a copy of the transfer or discharge notice when an immediate transfer or discharge is required by the resident's urgent medical needs.	Y 337		
Y1235	R9-10-412.B.7. Nursing Services R9-10-412.B. A director of nursing shall ensure that: R9-10-412.B.7. An unnecessary drug is not administered to a resident. This RULE is not met as evidenced by: Based on clinical record review, staff interviews and policy review, the facility failed to ensure one resident's (#377) medication regimen was free from unnecessary medication, by administering insulin outside of the physician ordered parameters. Findings include: Resident #377 was admitted on October 9, 2019 for a one week respite stay, with a diagnosis of type 1 diabetes mellitus. A physician history and physical dated October 9, 2019 included to monitor finger stick blood sugars and provide sliding scale insulin. Review of the diabetes baseline care plan dated October 9, 2019 revealed a goal that the	Y1235	<u>Y1235</u> Correct to the individual: Resident #377 was discharged from facility. Correct to all others: All residents that have medications may be affected. Re-education of staff regarding following Provider orders with parameters/special instructions to avoid administering unnecessary medications was completed. System Correction: Audits will be done weekly to help ensure that Provider Orders with parameters/special instructions are followed. Monitoring of System: The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed.	

ADHS LICENSING SERVICES

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Y1235	<p>Continued From page 3</p> <p>resident's blood sugars would remain within the acceptable range. Interventions were to monitor blood sugars before meals and at bedtime.</p> <p>Review of the October 2019 physician orders revealed orders for sliding scale insulin and orders for Lantus Insulin solution 100 unit/milliliter, give 16 units subcutaneous once a day. Special Instructions: Hold for blood sugar less than 100.</p> <p>Review of the October 2019 Medication Administration Record (MAR) revealed that Lantus insulin was administered when the resident's BS was less than 100 on the following days: on October 10 at 9:00 a.m. for a recorded blood sugar of 85; on October 14 at 9:00 a.m. for a recorded BS of 86; and on October 15 at 9:00 a.m. for a recorded BS of 71.</p> <p>Review of the nursing progress notes and October 2019 MAR revealed there was no documentation as to why the Lantus insulin was administered outside of the physician ordered parameters on October 10, 14 and 15.</p> <p>During an interview conducted at 8:56 a.m. on December 11, 2019 with a Registered Nurse (RN/staff #50), the nurse stated that before she begins to prepare medications for administration she checks to make sure that the resident's blood sugar results are within the parameters for administering.</p> <p>In an interview with a Licensed Practical Nurse (LPN/staff #21) conducted on December 12, 2019 at 9:51 a.m., staff #21 stated that before administering insulin she would check the resident's blood sugar. She said if the blood sugar was below the ordered parameter, she</p>	Y1235	<p><u>Correction Date:</u></p> <p><u>Responsible Person:</u> Administrator or Designee</p>	2/1/2020

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Y1235	<p>Continued From page 4</p> <p>would hold the insulin and document that the medication was held and make a note explaining why the medication was held. She said if this happened a few times she would notify the physician and document the physician's response.</p> <p>In an interview conducted with the Director of Nursing (DON/staff #205) on December 12, 2019 at 9:56 a.m., the DON stated that she expects the nurse administering medications to review the blood sugars or obtain a blood sugar, and then administer the medication if the blood sugar is within the ordered parameters. She stated that the nurse may only administer the medication outside of the parameters, if the nurse contacts the physician and receives new direction from the physician. She also stated that if a nurse administered medication outside of ordered parameters, she would expect the nurse to notify the physician and document it. At this time, the DON reviewed the MAR for October 10, 14, and 15 regarding the Lantus insulin and stated that the nurse did not administer the Lantus insulin in accordance with the physician's order. She said the nurse should have called the physician for clarification of the order, since Lantus is a long acting insulin and ordinarily does not have parameters for blood sugars.</p> <p>Review of a policy regarding Physician Medication Orders revealed that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.</p> <p>A policy on nursing care of the resident with diabetes mellitus included the purpose of the guideline was to help the resident control his/her diabetes with diet, exercise, and insulin (as</p>	Y1235		

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Y1235	Continued From page 5 ordered) and to prevent hyperglycemia/hypoglycemia.	Y1235		
Y1477	<p>R9-10-414.B.3.b. Comprehensive Assessment; Care Plan</p> <p>R9-10-414.B. An administrator shall ensure that a care plan for a resident:</p> <p>R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that:</p> <p>R9-10-414.B.3.b. Assist the resident in maintaining the resident's highest practicable well-being according to the resident's comprehensive assessment.</p> <p>This RULE is not met as evidenced by: Based on clinical record reviews, facility documentation and staff interviews, the facility failed to assist residents in maintaining their highest practicable well-being, by failing to provide adequate supervision to prevent altercations between resident (#225 and #477) and between resident (#172 and #427).</p> <p>Findings include:</p> <p>-Resident #172 was admitted to the facility on 12/26/2018 with diagnoses that included dementia with behaviors, schizophrenia and anxiety disorder.</p> <p>Review of the care plan with a start date of 1/08/2019 revealed the resident had socially inappropriate and disruptive behaviors related to</p>	Y1477	<p><u>Y1477</u></p> <p>Correct to individual: Resident #427 and #172 were immediately separated. Resident#427's scratch on his right temple was cleaned and there were no adverse outcomes from the scratch. Immediately following the incident on 10/25/2019, Resident #427 was placed on 1: 1 monitoring and the Physician ordered to send resident to hospital for evaluation of agitation and behaviors. Resident #427 has been discharged from facility.</p> <p>Resident #225 and #477 were immediately separated and 1:1 supervision was provided for resident #477. Resident #225 received basic first aid for his eye and had no adverse outcomes. Resident #477 had a Physician's order to be sent to Emergency Room for behaviors.</p> <p>Correct to all others: All residents have the potential to be affected. Direct care staff will receive re-education on abuse, including resident to resident altercations and early identification and de-escalation as means of prevention.</p>	

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Y1477	<p>Continued From page 6</p> <p>schizophrenia and dementia which included wandering into peers' rooms and physical aggression. Interventions included assessing whether the resident's behaviors endangered himself or others and intervening as needed, every 15 minute checks when indicated, maintaining a calm environment and approaching to de-escalate or prevent a situation.</p> <p>A quarterly Minimum Data Set (MDS) assessment dated 8/29/2019 revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident needed supervision for walking in the corridor and locomotion on the unit.</p> <p>Review of a nursing note dated 10/25/2019 revealed that at 6:20 AM resident #172 wandered into resident #427's room. Resident #427 became anxious, aggressive, and combative hitting resident #172 in the face with his foot. The residents were separated. Resident #172 continued to be mad stating "he wants to kill him" referring to resident #427. The note included the area to resident #172's right temple was cleaned and neuro checks were initiated.</p> <p>-Resident #427 was admitted to the facility on 6/3/2019 with diagnoses that included dementia with behaviors and mood disorder.</p> <p>Review of the care plan with a start date of 6/3/2019 revealed the resident was a threat to himself and others related to wandering in other residents' rooms and outside without purpose, and refusing to take medications. The goal was that the resident would have minimal harm to self and others. Interventions included assessing whether the behavior endangered the resident or</p>	Y1477	<p>Staff was re-educated on providing a safe environment for residents through supervision, intervention and deescalation of behaviors.</p> <p>System Correction: Visual audits of staff to help ensure that adequate supervision of residents is provided to prevent accidents.</p> <p>Visual audits of resident interactions will be made weekly to help ensure that residents are safe.</p> <p>Monitoring of System: 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: DON or Designee</p>	2/1/2020

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Y1477	<p>Continued From page 7</p> <p>others and intervening if necessary, maintaining a calm environment, and when the resident begins to become socially inappropriate and/or disruptive, provide comfort measures for his basic needs.</p> <p>A quarterly MDS assessment dated 9/5/2019 revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident could walk independently in the corridor and needed supervision for locomotion on the unit.</p> <p>A nursing note dated October 25, 2019 at 7:30 AM revealed a certified nursing assistant (CNA/staff #252) responded to noise on the hall and that resident #427 was observed holding resident #172 by the shirt dangling him off the floor before he dropped him on the floor and started stomping on resident #172 with his foot. The CNA separated the residents. Resident #427 was very upset and kept repeating "beat his ass." The note included one to one supervision was provided for resident #427.</p> <p>Review of the facility's investigation report dated 11/07/2019 revealed that on 10/25/2019 at approximately 6:20 AM a noise was heard in the hall. A CNA (staff #252) who was providing care to a resident went out into the hall and observed resident #172 on the floor in the doorway of resident #427's room with resident #427 over resident #172 holding resident #172 by the shirt. The CNA told resident #427 to let go of resident #172. Resident #427 let go of resident #172's shirt. Resident #427 then stepped over resident #172 striking him in the torso with his bare foot. Both residents were cursing and agitated at one another. The residents were separated and resident #427 was placed on 1:1 supervision.</p>	Y1477		

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 12/12/2019
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NAME OF PROVIDER OR SUPPLIER DEVON GABLES REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6150 EAST GRANT ROAD TUCSON, AZ 85712
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Y1477	<p>Continued From page 8</p> <p>Resident #172 was observed to have a superficial abrasion on his cheek. No redness or bruising was noted on resident #172's torso. Resident #172 calmed down after a short period. Resident #427 continued to be agitated and focused on resident #172, stating that resident #172 had gone into his room. The report included resident #427 did not de-escalate from the incident and was ultimately sent to the hospital for evaluation of his agitation and behaviors at approximately 12:45 PM.</p> <p>An interview was conducted on 12/11/19 at 09:47 AM with the Director of Nursing (DON/staff #204). The DON stated that she was on duty when the incident happened. She stated the CNA (staff #252) did not see resident #172 being kicked in the face that the CNA only saw resident #172 being kicked in the torso. She stated that resident #172 was assessed to have no bruising, marks, or signs of pain to the chest but was observed to have a small scratch on his face that was assumed to have come from the altercation. The DON stated resident #172 was not observed hitting resident #427. The DON also stated that resident #427 was unable to calm down and was sent to the hospital.</p> <p>An interview was conducted on 12/11/19 at 3:17 PM with the CNA (staff #252) who witnessed the incident. Staff #252 stated that he heard resident #427 and resident #172 cursing and yelling. The CNA stated that he found resident #427 holding the shirt of resident #172 while resident #172 was on the ground, kicking resident #172 in the chest. He stated resident #427 stopped kicking resident #172 and continued to yell profanities at resident #172. Staff #252 stated the residents were separated and assessed for injury. Staff #252 also stated that resident #427 and resident #172</p>	Y1477		

ADHS LICENSING SERVICES

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Y1477	<p>Continued From page 9</p> <p>was placed on 1:1 supervision while the incident was being reported and investigated.</p> <p>During an interview conducted on 12/12/19 at 10:35 AM with the administrator (staff #85), the administrator stated that they are doing all they can to prevent incidents from occurring.</p> <p>-Resident #225 was admitted to the facility on September 22, 2019, with diagnoses that included dementia with behavioral disturbance, Alzheimer's disease, and insomnia.</p> <p>The admission Minimum Data Set assessment dated September 29, 2019 revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident exhibited verbal and physical behavior symptoms directed toward others 1 to 3 days during the look-back period that put others at significant risk for physical injury. The assessment also included wandering behavior was not exhibited during the look-back period.</p> <p>Review of the care plan with a start date of October 4, 2019 revealed the resident had socially inappropriate and/or disruptive behaviors related to dementia that included agitation, yelling, exit seeking, and pacing in the hall and residents' rooms. The goal was that the resident would not harm himself or others. Interventions included assessing whether the behaviors would endanger himself or other and intervening as needed, limiting noise and distraction on the unit especially in the hallways after 9:00 PM, and maintaining a calm environment and approaching to help de-escalate a situation or prevent one.</p> <p>Review of a nursing progress note dated</p>	Y1477		

ADHS LICENSING SERVICES

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Y1477	<p>Continued From page 10</p> <p>November 19, 2019, revealed the resident was wandering into other residents' rooms. The note included the resident appeared tired and was attempting to lie in an empty bed. The note also included the resident was re-directed to his room.</p> <p>A nursing progress note dated November 23, 2019 revealed that while walking down the hallway, resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye area. Resident #477, while standing inside the doorway of his room, stated that he punched resident #225 in the face because resident #225 is always going into his room. Resident #225 was upset and yelling and crying out. The skin tear to resident #225's left eye was cleansed and already scabbing. The note included 1:1 supervision was placed with resident #477.</p> <p>-Resident #477 was admitted to the facility on September 8, 2017, with diagnoses that included violent behavior, Schizophrenia, and anxiety disorder.</p> <p>Review of the care plan with a start date of September 21, 2017 revealed the resident had socially inappropriate and/or disruptive behavioral symptoms as evidenced by verbal and physical aggression. The goal was that the resident would not harm himself or others. Interventions included observing and reporting socially inappropriate and/or disruptive behaviors when around others and removing the resident from other residents' rooms and unsafe situations.</p> <p>The quarterly MDS assessment dated September 26, 2019 revealed a Brief Interview for Mental Status score of 6 which indicated the resident had severe cognitive impairment. The assessment</p>	Y1477		
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Y1477	<p>Continued From page 11</p> <p>included the resident exhibited verbal behavioral symptoms directed toward others 1 to 3 days during the look-back period. The assessment did not include whether the behavior had impact on others.</p> <p>A nursing note dated November 3, 2019 revealed that while staff were attempting to obtain the resident's vital signs and conduct a skin assessment, the resident became verbally aggressive, cursing at staff, and attempted to strike at the Certified Nursing Assistant (CNA).</p> <p>Review of nursing progress notes dated November 23, 2019 revealed that while walking down the hallway resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye. Resident #477 was standing inside the doorway and stated that he punched resident #225 because resident #225 is always going into his room. Resident #477 was upset and telling staff that he was leaving the facility tomorrow because he is tired of strangers coming into his room. 1:1 supervision was provided for resident #477 until the resident was sent to the emergency room for evaluation and treatment for violent behaviors.</p> <p>Review of the facility's investigation report dated December 2, 2019 revealed that on November 23, 2019 at approximately 9:00 p.m., a Licensed Practicing Nurse (LPN/Staff #165) heard resident #225 cry out and come walking out of resident #477's room. Staff #165 observed a scant amount of blood on resident #225's left orbital region. Resident #477, while standing in the doorway of his room, told staff #165 that he hit resident #225 because resident #225 came into his room. The residents were immediately separated. Resident #477 was placed with 1:1</p>	Y1477		

ADHS LICENSING SERVICES

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Y1477	<p>Continued From page 12</p> <p>supervision until he was sent to the emergency room for behavioral evaluation and management. Resident #225's abrasion by his left eye was treated. The report included resident #225 could not recall what happened or why he was in resident #477's room. The report also included resident #225 was transferred to the secured wandering unit on November 25, 2019 secondary to not exhibiting behavior outside of pacing the halls and residents' rooms.</p> <p>An interview was conducted on December 11, 2019 at 9:30 a.m. with the Social Services Assistant (staff #184), who stated that on September 26, 2019, resident #225 was moved to a secured behavior unit because of wandering and behavioral issues. She said that the resident was confused, combative, and exit seeking. She stated that it was her understanding that resident #225 was exit seeking, in and out of peers rooms, and that there would be staff on the behavior unit to redirect him. Staff #184 stated that there is an extra aid (hall monitor) on the behavioral unit to redirect the resident when he is wandering to keep him safe.</p> <p>During the interview with staff #184, the Registered Nurse/In-service Director (RN/staff #18) joined the interview. She stated that there is an extra aid (hall monitor) on the unit every shift that monitors and/or supervises common areas where residents congregate. Staff #184 also stated that at night when the majority of residents are sleeping, the hall monitor would be in the hall to monitor, assist and redirect any residents getting up and coming out of their rooms as needed.</p> <p>An interview was conducted on December 11, 2019 at 10:35 a.m. with a CNA (staff #144), who</p>	Y1477		

ADHS LICENSING SERVICES

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Y1477	<p>Continued From page 13</p> <p>stated that the residents on the secured behavioral unit exhibit sexually inappropriate, aggressive, and exit seeking behaviors. The staff member said that the residents on that unit are very territorial and it would not be appropriate for a resident, like resident #225, who wanders into other residents' personal space. The staff member also stated resident #225 was transferred to another secured unit for residents who are exit seeking.</p> <p>An interview was conducted on December 11, 2019 at 11:10 a.m. with the Director of Nursing (DON/staff #204), who stated that there are two CNAs scheduled for the secured units, one CNA to cover each hall and a third CNA who monitors both of the halls. The DON stated that the third CNA goes between the two halls to monitor, supervise and redirect residents as needed.</p>	Y1477		
Y2153	<p>R9-10-421.D.1. Medication Services</p> <p>R9-10-421.D. When medication is stored at a nursing care institution, an administrator shall ensure that:</p> <p>R9-10-421.D.1. Medication is stored in a separate locked room, closet, or self-contained unit used only for medication storage;</p> <p>This RULE is not met as evidenced by: Based on observation, interviews and policy and procedures, the facility failed to ensure that medications were secured for one (#62) out of 34 residents.</p> <p>Findings include:</p>	Y2153		

ADHS LICENSING SERVICES

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Y2153	Continued From page 14 Resident #62 was admitted on July 12, 2019 and readmitted on November 21, 2019, with diagnoses that included dermatitis, rash and other unspecified skin eruption. A care plan dated July 22, 2019, revealed the resident had burns to her leg and foot, upon admission to the facility. Review of the admission Minimum Data Set (MDS) assessment dated November 28, 2019 revealed a Brief Interview Mental Status score of 15, indicating the resident was cognitively intact. A physician's order dated November 21, 2019 included for Silver Sulfadiazine cream 1% (topical antimicrobial drug) one application each dose topically for second degree burn of the left foot twice a day. This order was discontinued on November 22, 2019. Review of a physician's order dated November 21, 2019, revealed for Santyl ointment 250 unit/gram (removes dead tissue from wounds) one dose topically, apply to left ankle burns once a day. This order was discontinued on November 22, 2019. An observation was conducted on December 12, 2019 at 10:05 a.m. of the resident in her room. On a table closest to the door, there was one box with an opened tube of Santyl ointment 250 unit/gm with instructions on the label to apply as directed topically to left ankle burns daily. The prescription label included it was filled on November 21, 2019. Also on the table was one box with an opened tube of Silver Sulfadiazine Cream 1% with directions on the label to apply as directed topically to affected area(s) twice daily.	Y2153	<u>Y2153</u> Correct to individual: With Resident #62's permission, the prescription treatment supplies were removed from her room on 12/12/19. Correct to all others: All residents could be affected. Re-education of staff on storage of drugs and biologicals was completed. System Correction: Audits will be done weekly to help ensure that rooms are free from unsecured biologicals. 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: Director of Nursing or Designee.	2/1/2020

ADHS LICENSING SERVICES

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Y2153	<p>Continued From page 15</p> <p>This medication was filled on 11/21/19. During the observation, the resident stated that the Santyl was for her burns and was previously applied by the nurse, but she was no longer using it. She said the Silver Sulfa has been on the table since she arrived. She said it was applied, but was not sure if it is still being used, and did not know why it was prescribed. She said the medications have been on the table for a long time. In addition, there was a white plastic bottle of Tolnaftate Antifungal Powder 1% net weight 45 grams on the mobile bedside table. The resident stated that she did not know if the powder was being applied.</p> <p>Further review of the current physician orders for this resident revealed there was no order for Tolnaftate Antifungal Powder 1%.</p> <p>An interview was conducted on December 12, 2019 at 10:20 a.m. with a Registered Nurse (RN/staff #50), who stated that a resident is allowed to keep medications in their room, if there is a form signed by the resident and the physician, which states that it is okay. However, she said that resident #62 is not allowed to keep medications in her room. At this time, staff #50 observed that the Santyl ointment and the Silver Sulfadiazine cream were on the table which was closest to the door and that the antifungal powder was on the mobile bedside table. Staff #50 stated that she did not know why the medications were left in the room and that the medications were not supposed to be left in the room. Staff #50 removed the medications from the room.</p> <p>An interview was conducted on December 12, 2019 at 11:32 a.m. with the Director of Nursing (DON/staff #204), who said that all medications are to be locked up when they are not being used. She said even if a resident is able to</p>	Y2153		
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Y2153	<p>Continued From page 16</p> <p>self-administer medications, including treatment medications, such as ointments, creams and powders, all medications would be kept on the cart and secured when not being used. The DON said the nurse would give the medications to the resident when the medications were to be administered. She stated if the resident wanted to keep the medications in his or her room, the resident would be given a box where the medications could be locked up.</p> <p>Review of the Storage of Medications policy revised April 2007, revealed that the facility shall store all drugs and biologicals in a safe and secure manner. The policy included that nursing staff shall be responsible for maintaining medication storage. Drugs shall be stored in cabinets, drawers, carts or automatic dispensing systems. Compartments (including but not limited to, drawers, cabinets, rooms, refrigerators, carts and boxes) containing drugs and biologicals shall be locked when not in use.</p>	Y2153		



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: December 9, 2019

Survey Event ID: 5RFS11

Inspector/Team Coordinator: Chris Benson

Accompanied By: Ernie Cull, Lisa Thomas, Jean Lapour, Carey Sexton, Teresa Gallego

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:
 - x Determine compliance with health care institution requirements pursuant to the above A.R.S. and A.A.C.
 - x 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.

Diane Eckles
Administrator/Director/Agency Representative Signature

12/9/19
Date:

Administrator/Director/Agency Representative refused to sign this form.

Administrator/Director/Agency Representative or authorized on-site representative is not present.

Chris Benson
Inspector/Team Coordinator Signature:

12/9/19
Date:

Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE



ARIZONA DEPARTMENT OF HEALTH SERVICES NURSING CARE INSTITUTION

Issued To: *Devon Gables*

The above named facility has met licensure requirements, has been licensed for one year or more and, therefore, has received the following quality rating as required by R9-10-919.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	25	
II. Resident Rights	25	
III. Administration	23	2
IV. Environment and Infection Control	10	5
V. Food Services	10	
TOTAL CRITERIA MET	93	7

QUALITY PERFORMANCE SCALE	
"A"	✓
"B"	
"C"	
"D"	
"A": 90 to 100 points "B": 80 to 89 points "C": 70 to 79 points "D": 69 or fewer points	

License Effective:

From: _____ To: _____

Issued: _____

Number: NCI- _____

Recommended By _____

Issued By _____ Assistant Director

Quality Rating Evaluation

Facility: _____

Phone: _____

Address: _____

Survey Date: _____

Contact Person: _____

Nursing Services:

Criteria: _____

Criteria Met?
Pts. YES NO

The nursing care institution is implementing a system that ensures residents are provided nursing services to maintain the resident's highest practicable physical, mental, and psychosocial well-being according to the resident's comprehensive assessment and care plan.	15	/	
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	/	
The nursing care institution ensures the resident's representative is notified and the resident's attending physician is consulted if a resident has a significant change in condition or if the resident is in an incident that requires medical services.	5	/	

Points Yes 25

Points No _____

Comments:

Resident Rights:

Criteria: Criteria Met?
Pts. YES NO

The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	/	
The nursing care institution ensures that a resident is free from physical and chemical restraints for purposes other than to treat the resident's medical condition.	10	/	
The nursing care institution ensures that a resident or the resident's representative is allowed to participate in the planning of, or decisions concerning treatment including the right to refuse treatment and to formulate a health care directive.	5	/	

Points Yes 25

Points No _____

Comments:

Administration:

Criteria: Criteria Met?
Pts. YES NO

The nursing care institution has no repeat deficiencies that resulted in actual harm or immediate jeopardy to residents that were cited during the last survey or other survey or complaint investigation conducted between the last survey and the current survey.	10	/	
The nursing care institution is implementing a system to prevent abuse of a resident and misappropriation of resident property, investigate each allegation of abuse of a resident and misappropriation of resident's property, and report each allegation of abuse of a resident and misappropriation of resident's property to the Office of Long Term Care Licensure and as required by A.R.S. § 46-454.	5	/	
The nursing care institution is implementing a quality management program that addresses nursing care institution services provided to residents, resident complaints, and resident concerns, and documents actions taken for response, resolution, or correction of issues about nursing care institution services provided to residents, resident complaints, and resident concerns.	5	/	
The nursing care institution is implementing a system to provide social services and a program of ongoing recreational activities to meet the resident's needs based on the resident's comprehensive assessment.	1	/	
The nursing care institution is implementing a system to ensure that records documenting freedom from infectious pulmonary tuberculosis are maintained for each personnel member, volunteer, and resident.	1	/	
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2		/
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	/	

Points Yes 23

Points No 2

Comments:

Environment and Infection Control:

Criteria: Criteria Met?
Pts. YES NO

The nursing care institution environment is free from a condition or situation within the nursing care institution's control that may cause a resident injury.	5		/
The nursing care institution establishes and maintains a pest control program.	1	/	
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	/	
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	/	
The nursing care institution maintains a clean and sanitary environment.	1	/	
The nursing care institution is implementing a system to prevent and control infection.	5	/	
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	/	

Points Yes 10

Points No 5

Comments:

Food Services:

Criteria: Criteria Met?
Pts. YES NO

The nursing care institution complies with 9 A.A.C. 8, Article 1, for food preparation, storage and handling as evidenced by a current food establishment license	1	/	
The nursing care institution provides each resident with food that meets the resident's needs as specified in the resident's comprehensive assessment and care plan.	3	/	
The nursing care institution obtains input from each resident or the resident's representative and implements recommendations for meal planning and food choices consistent with the resident's dietary needs	2	/	
The nursing care institution provides assistance to a resident who needs help in eating so that the individual's nutritional, physical, and social needs are met.	2	/	
The nursing care institution prepares menus at least one week in advance, conspicuously posts each menu, and adheres to each planned menu unless an uncontrollable situation such as food spoilage or non-delivery of a specified food requires substitution.	1	/	
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	/	

Points Yes 10

Points No _____

Comments: