State
Public Records Documents Only

Survey event #YZWT

Facility: DEVON GABLES REHABILITATION CENTER

Revised 7-2020

QUALITY RATING CERTIFICATE

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

ADHS

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 R9-10-427.

COMPONENTS	CRITERIA MET	
	Yes	No
I. Nursing Services	21	4
II. Resident Rights	25	0
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	96	4

QUALITY PERFORMANCE SCALE	
"A" Excellent	X
"B"	
"C"	
"D"	

"A" 90-100 Points
"B" 89-80 Points
"C" 70-79 Points
"D" 69 or fewer Points

License Effective

From: 04/29/2022

Issued: 05/13/2022

Number: NCI-2652

Recommended By: Diane Eckles

Issued By: Tom

Thomas Salow, Interim Assistant Director

TO BE FRAMED AND DISPLAYED IN A CONSPICUOUS PLACE

FIRE CODE PERMIT
CITY OF TUCSON

FIRE DEPARTMENT

Permit Activity Number: T21FO00539

Structure Address: 6150 E GRANT RD TUC

Project Description: 312 BEDS

Permit Type: State Llc Facls Annual Inspectio

Occupancy Group: I-4

Applicable Fire Code: 2018 IFC

Expiration Date: 11/30/2022 TDT ~~08/30/2022~~

- or - Until Revoked: N

Permit Conditions:

Fire Code Official / Fire Inspector

11/30/2021 TDT ~~08/30/2021~~

Issued Date

Fire is Everyone's Fight.

PIMA COUNTY
HEALTH DEPARTMENT

Pass

Food Establishment Inspection Report

Page 1 of 2

As Governed by Pima County Code 8.08
3950 S. Country Club Rd., Ste 2301
Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597

No. of Risk Factor/Intervention Violations: 0
No. of Repeat Risk Factor/Intervention Violations: 0
Rating: 0

Date: 1/22/18
Time In: 10:15
Time Out: 11:45

Establishment	Address	Permit #	Permit Holder	Purpose of Inspection	Est. Type	Risk Category
Dewn Cables Rehabilitation Center	6150 E. Grant Rd.	3120201		Reinspection	4000B	4

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

Circle designated compliance status (IN, OUT, N/O, N/A) for each numbered item
IN=in compliance OUT=not in compliance N/O=not observed N/A=not applicable
Mark "X" in appropriate box for COS and R
COS=corrected on-site during inspection R=repeat violation

	Compliance Status		COS	R
	Supervision			
1	IN OUT	Person in charge present, demonstrated knowledge, and performs duties.		
2	IN OUT N/A	Certified Food Protection Manager		
	Employee Health			
3	IN OUT	Management, food employee and conditional employee knowledge, reponsibilities and reporting		
4	IN OUT	Proper use of restriction and exclusion		
5	IN OUT	Procedures for responding to vomiting and diarrheal events		
	Good Hygienic Practices			
6	IN OUT N/O	Proper eating, tasting, drinking, or tobacco use		
7	IN OUT N/O	No discharge from eyes, nose, and mouth		
	Preventing Contamination by Hands			
8	IN OUT N/O	Hands clean and properly washed		
9	IN OUT N/A N/O	No bare hand contact with ready-to-eat foods or approved alternate method properly followed		
10	IN OUT	Adequate handwashing facilities supplied & accessible		
	Approved Source			
11	IN OUT	Food obtained from approved source		
12	IN OUT N/A N/O	Food received at proper temperature		
13	IN OUT	Food in good condition, safe, and unadulterated		
14	IN OUT N/A N/O	Required records available: shellstock tags, parasite destruction		
	Protection from Contamination			
15	IN OUT N/A	Food separated and protected		
16	IN OUT N/A	Food-contact surfaces: cleaned & sanitized		
17	IN OUT	Proper disposition of returned, previously served, reconditioned, and unsafe food		

	Compliance Status		COS	R
	Time/Temperature Control for Safety			
18	IN OUT N/A N/O	Proper cooking time and temperatures		
19	IN OUT N/A N/O	Proper reheating procedures for hot holding		
20	IN OUT N/A N/O	Proper cooling time and temperatures		
21	IN OUT N/A N/O	Proper hot holding temperatures		
22	IN OUT N/A	Proper cold holding temperatures		
23	IN OUT N/A N/O	Proper date marking and disposition		
24	IN OUT N/A N/O	Time as a public health control: procedures & records		
	Consumer Advisory			
25	IN OUT N/A	Consumer advisory provided for raw or undercooked foods		
	Highly Susceptible Populations			
26	IN OUT N/A	Pasteurized foods used; prohibited foods not offered		
	Food/Color Additives and Toxic Substances			
27	IN OUT N/A	Food additives: approved and properly used		
28	IN OUT	Toxic substances properly identified, stored, used		
	Conformance with Approved Procedures			
29	IN OUT N/A	Compliance with variance, specialized process, and HACCP plan		

Risk factors are food preparation practices and employees behaviors most commonly reported to the Centers for Disease Control and Prevention as contributing factors in foodborne illness outbreaks.
Public health interventions are control measures to prevent foodborne illness or injury.

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the introduction of pathogens, chemicals, and physical objects into foods.
Mark "X" in box if numbered item is **not** in compliance Mark "X" in appropriate box for COS and/or R COS=corrected on-site during inspection R=repeat violation

			COS	R
		Safe Food and Water		
30		Pasteurized eggs used where required		
31		Water and ice from approved source		
32		Variance obtained for specialized processing methods		
		Food Temperature Control		
33		Proper cooling methods used; adequate equipment for temperature control		
34		Plant food properly cooked for hot holding		
35		Approved thawing methods used		
36		Thermometers provided and accurate		
		Food Identification		
37		Food properly labeled; original container		
		Prevention of Food Contamination		
38		Insects, rodents, and animals not present		
39		Contamination prevented during food preparation, storage & display		
40		Personal cleanliness		
41		Wiping cloths: properly used and stored		
42		Washing fruits and vegetables		

			COS	R
		Proper Use of Utensils		
43		In-use utensils: properly stored		
44		Utensils, equipment and linens: properly stored, dried, handled		
45		Single-use/single-service articles: properly stored, used		
46		Gloves used properly		
		Utensils, Equipment and Vending		
47	TN	Food and nonfood-contact surfaces cleanable, properly designed, constructed, and used		
48		Warewashing facilities: installed, maintained, used; test strips		
49		Nonfood-contact surfaces clean		
		Physical Facilities		
50		Hot and cold water available; adequate pressure		
51		Plumbing installed; proper backflow devices		
52		Sewage and waste water properly disposed		
53		Toilet facilities: properly constructed, supplied, cleaned		
54		Garbage/refuse properly disposed; facilities maintained		
55		Physical facilities installed, maintained, and clean		
56		Adequate ventilation and lighting; designated areas use		
57	Yes No	Complies with Smoke Free Arizona 36-601.01		

Person in Charge (Signature) Donna R. Kemp Date: 1/22/18
Inspector (Print Name) Shelby Carrillo
Inspector (Signature)

Follow-up: YES (NO) (Circle one) Follow-up Date:

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Number of Priority/Priority Foundation Violations	0	Date 10/01/2021 Time in 10:55 AM
	Number of Core Violations	0	Time out 12:22 PM

Establishment	Address	Rating	
DEVON GABLES REHABILITATION CENTER	6150 E GRANT RD TUCSON AZ 85712	Educational	
Permit# 3120201	**Permit Holder** DEVON GABLES REHABILITATION CENTER LLC	**Purpose of Inspection**: Standard Frequency Inspection - Routine	**Est. Type and Risk Category**: Class 4 Institutional Food Operations 2500 to 7500sqft (4000B)

FOODBORNE ILLNESS RISK FACTORS AND PUBLIC HEALTH INTERVENTIONS

IN = in compliance **OUT** = not in compliance **N/O** = not observed **N/A** = not applicable **COS** = corrected on-site during inspection **R** = repeat violation

Risk factors are food preparation practices and employees behaviors most commonly reported to the Centers for Disease Control and Prevention as contributing factors in foodborne illness outbreaks.

Public health interventions are control measures to prevent foodborne illness or injury

Compliance Status		COS	R
Supervision			
01. In	PIC present, demonstrates knowledge, and performs duties	☐	☐
02. In	Certified Food Protection Manager	☐	☐
Employee Health			
03.	Management and food employee knowledge, and conditional employee; Knowledge, responsibility and reporting	☐	☐
04. In	Proper use of restrictions and exclusions	☐	☐
05. In	Clean-up of Vomiting and Diarrheal Events	☐	☐
Good Hygienic Practices			
06. In	Proper eating, tasting, drinking, or tobacco use	☐	☐
07. In	No discharge from eyes, nose, and mouth	☐	☐
Preventing Contamination by Hands			
08. In	Hands clean and properly washed	☐	☐
09. In	No bare hand contact with RTE foods or a pre-approved alternative procedure properly followed	☐	☐
10. In	Adequate handwashing sinks, properly supplied and accessible	☐	☐
Approved Source			
11. In	Food obtained from approved source	☐	☐
12. N/O	Food received at proper temperature	☐	☐
13. In	Food in good condition, safe, and unadulterated	☐	☐
14. N/A	Required records available: shellstock tags, parasite destruction	☐	☐
Protection from Contamination			
15. In	Food separated and protected	☐	☐
16. In	Food-contact surfaces: cleaned and sanitized	☐	☐
17. In	Proper disposition of returned, previously served, reconditioned, and unsafe food	☐	☐
Time Temperature Control for Safety Food (TCS Food)			
18. In	Proper cooking time and temperatures	☐	☐
19. N/O	Proper reheating procedures for hot holding	☐	☐
20. N/O	Proper cooling time and temperatures	☐	☐
21. In	Proper hot holding temperatures	☐	☐
22. In	Proper cold holding temperatures	☐	☐
23. In	Proper date marking and disposition	☐	☐
24. N/A	Time as a Public Health Control: procedures and records	☐	☐
Consumer Advisory			
25. N/A	Consumer advisory provided for raw or undercooked foods	☐	☐
Highly Susceptible Populations			
26. N/A	Pasteurized foods used; prohibited foods not offered	☐	☐
Food/Color Additives and Toxic Substances			
27. N/A	Food additives: approved and properly used	☐	☐
28. In	Toxic substances properly identified, stored, and used; held for retail sale, properly stored	☐	☐
Conformance with Approved Procedures			
29. N/A	Compliance with variance, specialized process, reduced oxygen packaging criteria or HACCP plan	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3120201	Date 10/01/2021

Establishment	Address
DEVON GABLES REHABILITATION CENTER	6150 E GRANT RDTUCSON AZ 85712

GOOD RETAIL PRACTICES

Good Retail Practices are preventative measures to control the introduction of pathogens, chemicals, and physical objects into foods.

IN = in compliance **OUT** = not in compliance **N/O** = not observed **N/A** = not applicable **COS** = corrected on-site during inspection **R** = repeat violation

Compliance Status		COS	R
Safe Food and Water			
30. N/O	Pasteurized eggs used where required	☐	☐
31. In	Water and ice from approved source	☐	☐
32. N/A	Variance obtained for specialized processing methods	☐	☐
Food Temperature Control			
33. In	Proper cooling methods used; adequate equipment for temperature control	☐	☐
34. In	Plant food properly cooked for hot holding	☐	☐
35. N/O	Approved thawing methods used	☐	☐
36. In	Thermometers provided and accurate	☐	☐
Food Identification			
37. In	Food properly labeled; original container	☐	☐
Prevention of Food Contamination			
38. In	Insects, rodents, and animals not present	☐	☐
39. In	Contamination prevented during food preparation, storage, and display	☐	☐
40. In	Personal cleanliness	☐	☐
41. In	Wiping cloths; properly used and stored	☐	☐
42. In	Washing fruits & vegetables	☐	☐
Proper Use of Utensils			
43. In	In-use utensils; properly stored	☐	☐
44. In	Utensils, equipment & linens; properly stored, dried, & handled	☐	☐
45. In	Single-use/single-service articles; properly stored, used	☐	☐
46. In	Gloves used properly	☐	☐
Utensils, Equipment and Vending			
47. In	Food and non-food-contact surfaces cleanable, properly designed, constructed and used	☐	☐
48. In	Warewashing facilities, installed, maintained, used, test strips	☐	☐
49. In	Non-food-contact surfaces clean	☐	☐
Physical Facilities			
50. In	Hot and cold water available; adequate pressure	☐	☐
51. In	Plumbing installed; proper backflow devices	☐	☐
52. In	Sewage and waste water properly disposed	☐	☐
53. In	Toilet facilities: properly constructed, supplied, clean	☐	☐
54. In	Garbage/refuse properly disposed; facilities maintained	☐	☐
55. In	Physical facilities installed, maintained, and clean	☐	☐
56. In	Adequate ventilation and lighting; designated areas used	☐	☐
Smoke Free			
57. In	Complies with Smoke Free Arizona 36-601.01	☐	☐
Pima County Code for Mobile Food Establishments ONLY			
58.	A1. Exterior	☐	☐
59.	A2. Interior	☐	☐
60.	B. Additional operating permit requirements	☐	☐
61.	C. Operations	☐	☐
62.	D. Commissary	☐	☐

PIMA COUNTY
HEALTH DEPARTMENT

FOOD SAFETY INSPECTION REPORT

As Governed by Pima County Code 8.08 3950 S. Country Club Rd, Ste 2301 Tucson AZ 85714 Phone 520-724-7908, Fax 520-724-9597	Permit# 3120201	Date 10/01/2021

Establishment	Address
DEVON GABLES REHABILITATION CENTER	6150 E GRANT RDTUCSON AZ 85712

TEMPERATURE OBSERVATIONS

Item/Location	Temperature in Fahrenheit	Item/Location	Temperature in Fahrenheit
hot dogs / dining	178	yogurt / reachin	39
milk / walkin	41	cream cheese / walkin	40
hot dogs / hot holding	197	ground hot dog / hot holding	178
gravy / hot holding	178	corned beef / reachin	38
cooked beef patty	39	mashed pot / hot holding	160
cream of celery / dining	179		

OBSERVATIONS AND CORRECTIVE ACTIONS

PIC = Person in charge RTE = Ready to eat TCS = Time/temperature control for safety

Item P /Pf/ C — Violations cited in this report must be corrected in the frames below as indicated. — Correction Date

PREVIOUS OBSERVATIONS

PIC = Person in charge RTE = Ready to eat TCS = Time/temperature control for safety

Item P /Pf/ C — Violations cited below were observed during a previous inspection. A pattern of non-compliance may result in Probationary status per PCC 8.08.060B

No previously cited observations

ACTIONS TAKEN

CLOSING COMMENTS

rating would be: Excellent

Person in Charge (Print Name): Genny Williams

Person in Charge (Signature):  **Date** 10/01/2021

Inspector (Print Name): Larry Geringer, Environmental Health Specialist I

Inspector (Signature):  **Date** 10/01/2021

INSPECTION ADDITIONAL DETAILS

Notice of Inspection Rights Provided?	Yes
Does this Inspection Require a Foodborne Illness Investigation Response?	No

Consumer Health and Food Safety
3950 S. Country Club Rd., Ste 2301
Tucson, AZ 85714
Phone 520-724-7908 • Fax 520-724-9597

PIMA COUNTY
HEALTH DEPARTMENT

NOTIFICATION OF INSPECTION RIGHTS

REGULATED PERSON INFORMATION

Regulated Person/Facility DEVON GABLES Permit#(s) 3120201

Site Location 6150 e Grant

Site Contact Genny Williams Phone 296-6181

Email Address gwilliams@devongables.com

DEPARTMENT INFORMATION

Inspector Name larry geringer Inspection Date 10-1-2021 Time 11:00am

Notice of Inspection Rights Under A.R.S.§ 11-1603

Upon entering the premises, the Pima County Health Department inspectors met with the regulated person or the regulated person's on-site representative, presented photo identification showing that they are Pima County employees and explained:

- The purpose of the inspection is to determine compliance with Pima County Code, Title 8, Health and Safety and for Public School Physical Plants, also A.A.C. Title 9, Chapter 8, Article 7. The legal authority for the inspection is: ■ Food Establishments: P.C.C. 8.04.110(G)(1); ☐ Public and Semi-Public Aquatic Facilities: P.C.C. 8.04.110(G)(3); ☐ Motels, Hotels, Resorts, and Tourist Courts: P.C.C. 8.04.110(G)(4); ☐ Mobile Home and Travel Trailer Parks: 8.04.110(G)(5); ☐ Public School Physical Plants: 8.04.110(G)(7); ☐ Camp Grounds and Children's Camps: 8.04.110(G)(8); ☐ Ice Manufacturing and Beverage Plants: 8.04.110(G)(2)
- The fee for this inspection is: $0.
- With the exception of inspections of food establishments or swimming pools and spas, the regulated person or representative may accompany the Department inspectors on the premises, except during confidential interviews.
- The regulated person has the right to: copies of any original documents taken by the Department during the inspection; a split or duplicate of any samples taken during the inspection if the split or duplicate would not prohibit an analysis from being conducted or render an analysis inconclusive; copies of any performed on samples taken during the inspection.
- Each person whose conversation is tape-recorded will be informed that the conversation is being tape-recorded.
- Each person interviewed during the inspection will be informed that statements made by the person may be included in the inspection report.
- Right of Appeal: A person who has been adversely affected by an action of the health officer may appeal that action by filing with the Pima County Health Director a written request for appeal within ten days of the time the person notified of the action. See P.C.C. 8.04.130(A). Written requests must be sent to the Pima County Health Director at 3950 S. Country Club Rd. Ste. 100, Tucson, AZ 85714.
- The following person may be contacted about the final decision based on the results of the inspection: **Loni Anderson, Division Manager,** (520) 724-7908. I have read this notification and discussed any questions or concerns with the Department inspectors.

X G. Williams Date:

☐ Declined to sign the notification ☐ No authorized on-site representative is present at the facility

Copies of the inspection report and this notification are available at Pima County Health Department, 3950 S. Country Club Rd. Tucson AZ 85714

****Note: Department inspectors may still proceed with the inspection even if the regulated party declines to sign this form****

Consumer Health and Food Safety
3950 S. Country Club Rd., Ste 2301
Tucson, AZ 85714
Teléfono 520-724-7908 • Fax 520-724-9597

PIMA COUNTY
HEALTH DEPARTMENT

AVISO DE DERECHOS DE INSPECCIÓN

INFORMACIÓN SOBRE LA PERSONA ENCARGADA

Nombre de la persona/ Instalación_____Número de permiso(s) _____

Ubicación de la instalación _____

Persona de contacto en la instalación _____Número de teléfono_____

Dirección de envío _____

INFORMACIÓN DEL DEPARTAMENTO

Nombre de inspector_____Fecha de inspección_____ Hora _____

Aviso de Derechos de Inspección Bajo A.R.S. § 11-1603

Al entrar a la instalación, los inspectores del Departamento de Salud del Condado Pima se comunicaron con la persona encargada o un representante de la persona encargada, presentaron identificación con foto que muestra que son empleados del Condado Pima y explicaron:

- El propósito de esta inspección es verificar si el establecimiento cumple con el Código del Condado Pima, Título 8, La Salubridad y Seguridad y para Instalaciones Físicas de Escuelas Públicas, también A.A.C. Título 9, Capítulo 8, Artículo 7. La autoridad legal para esta inspección es: ☐ Establecimientos de Alimentos P.C.C. 8.04.110(G)(1); ☐ Instalaciones Acuáticas Públicas y Semipúblicas: P.C.C. 8.04.110(G)(3); ☐Moteles, Hoteles, y Sitios Turísticos: P.C.C. 8.04.110(G)(4); Casas Móviles y Lugares para Casas con Remolque: 8.04.110(G)(5); ☐ Instalaciones Físicas de Escuelas Públicas: 8.04.110(G)(7); ☐ Sitios de Campaña y Campamentos para Niños: 8.04.110(G)(8); ☐ Plantas de Bebidas y Fábricas de Hielo: 8.04.110(G)(2)
- La tarifa para esta inspección es: $_____.
- Con la excepción de las inspecciones de establecimientos de alimentos o acuáticas, la persona encargada o su representante puede acompañar al inspector del departamento durante la inspección, excepto durante entrevistas confidenciales.
- La persona encargada tiene derecho de recibir: copias de los documentos originales producidos por el departamento durante la inspección; parte de o un duplicado de cualquier muestra obtenida durante la inspección mientras la porción o el duplicado no prohibirá que se haga un análisis o que un análisis resulte inconcluso; copias de cualquier análisis realizado con las muestras de la inspección.
- Cada persona cuya conversación es grabada será informada de que la conversación está siendo grabada.
- Cada persona entrevistada durante la inspección será informada que sus declaraciones pueden ser incluidas en el reporte de inspección.
- Derecho de apelación: Una persona que ha sido afectada negativamente por una acción del oficial de salud puede apelar esa acción mediante una solicitud de apelación enviada por escrito al director del departamento dentro de los diez días de la fecha en que la persona fue notificada de la acción. Vea P.C.C. 8.04.130 (A). Enviado por escrito a 3950 S. Country Club Rd. Ste. 100, Tucson, AZ 85714
- Puede comunicarse con la siguiente persona acerca de la decisión final que se tomó a base de los resultados de la inspección: **Loni Anderson, Gerente de División,** (520) 724-7908.

He leído este aviso y discutido cualquier pregunta o duda con los inspectores del Departamento.

X_____Fecha:_____

☐ Se negó a firmar el aviso ☐ No había un representante autorizado presente en el establecimiento

Copias del reporte de inspección y este aviso están disponibles en el departamento de Salud del Condado Pima, 3950 S. Country Club Rd. Tucson AZ 85714

****Nota: Los inspectores del Departamento pueden proceder con la inspección aún si la persona encargada se negó a firmar este aviso****

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 31, 2022

IMPORTANT NOTICE- PLEASE READ CAREFULLY

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

Dear Ms. Friebus:

On May 27, 2022, an offsite revisit, #YZWT12, was conducted for your facility by the Arizona Department of Public Health, Licensing and Certification Bureau, to determine if your facility was in compliance with 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,

Monica Miller
Program Project Specialist II

\mm

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 05/27/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{Y 000}	Initial Comments An offsite follow-up survey was conducted on May 27, 2022. 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	5/27/2022 Y3

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

This report is completed by a 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 Y0341	Correction	ID Prefix Y0630	Correction	ID Prefix Y1077	Correction
Reg. # R9-10-403.C.2.d.	Completed	Reg. # R9-10-406.E.2.	Completed	Reg. # R9-10-410.C.2.	Completed
LSC	06/06/2022	LSC	06/06/2022	LSC	06/06/2022
ID Prefix Y1477	Correction	ID Prefix Y2159	Correction	ID Prefix	Correction
Reg. # R9-10-414.B.3.b.	Completed	Reg. # R9-10-421.D.3.a.	Completed	Reg. #	Completed
LSC	06/06/2022	LSC	06/06/2022	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

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

FOLLOWUP TO SURVEY COMPLETED ON 4/29/2022

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

ARIZONA DEPARTMENT OF HEALTH SERVICES

LICENSING

May 13, 2022

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

Heather Friebus, Administrator
Devon Gables Rehabilitation Center
6150 East Grant Road
Tucson, 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 April 29, 2022. 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 **May 23, 2022**. 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:

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

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, Suite 440, Phoenix, Arizona 85007 at (602) 364-2690.

Sincerely,

Diane Eckles

Diane Eckles
Bureau Chief

DE:bk

Attachments

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 _____	04/29/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The State compliance survey was conducted on April 25, 2022 through April 29, 2022, in conjunction with the investigation of complaints #AZ00181962 and #AZ00163702. The census was 180. The following deficiencies were cited:	Y 000		
Y 341	R9-10-403.C.2.d. 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.d. Cover storing, dispensing, administering, and disposing of medication; This RULE is not met as evidenced by: Based on observation, staff interviews, and review of policy, the facility failed to implement their policy to ensure medications were not left in the room of one resident (#95). Findings include: Resident #95 was admitted to the facility on November 6, 2015 with diagnoses that included vascular dementia without behavioral disturbance and major depressive disorder. Review of the clinical record revealed a Self-Administration of Medication Observation dated completed on December 22, 2021. The document stated the resident did not want to	Y 341	**Y341** Resident #95 took his medications with supervision of nurse. Resident #95 was interviewed and would like to continue to exercise his right to have Nursing administer his medications. **Correct to all others:** All residents who receive medications have the potential to be affected. All Licensed Nurses were re-educated regarding the facility policy on safe medication administration and the process for self administration of medications should a resident want to exercise their right to do so. All Licensed Nurses completed a medication safety and storage quiz to ensure their competency. **System Correction:** Audits will be done weekly to ensure that Nurses are practicing safe medication administration and medications are not left in resident rooms if resident is not assessed to self administer their medications.	

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

ADHS LICENSING SERVICES

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Y 341	Continued From page 1 self-administer medications and that it was not appropriate for the resident to self-administer any medications. Review of the annual Minimum Data Set assessment dated March 8, 2022 revealed a Brief Interview for Mental Status score of 14 which indicated the resident had intact cognition. During an observation conducted on April 25, 2022 between 10:21 AM, a white paper medication cup was observed on resident #95's bedside table. The cup contained approximately 11 medications. The bedside table was across the room, out of reach of the resident who was lying in bed sleeping. Another observation was conducted on April 25, 2022 at 10:39 AM, in which the medication cup containing medications was still on the bedside table away from the resident. The resident was sleeping in the bed. At that time, a CNA (Certified Nursing Assistant) entered the room and then exited. During a resident interview and observation conducted on April 25, 2022 at 11:04 AM, the medication cup containing pills was still on the bedside table. The resident was lying in bed awake. The resident stated that the pills were left on the bedside table, because he went to sleep before they gave them to him. He also stated that the nurses leave the pills at his bedside a couple of times a week. The resident further stated that they trust him to take the medications because he knows they are important. He also stated that the morning medications had been left on his bedside table this morning. An observation was conducted on April 25, 2022	Y 341	**Monitoring of System:** The analysis of the audits will be taken to QAPI for review and follow-up as needed. **Date of Correction:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

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Y 341	Continued From page 2 at 11:45 AM. The medication cup containing medications was still on the bedside table, away from the resident's reach. An interview was conducted on April 25, 2022 at 11:50 AM with a Licensed Practical Nurse (LPN/staff #231), who stated that when administering medications, she stays in the resident's room until the resident has taken all of the medications and that this is the facility's policy. The nurse then entered resident #95's room and observed the medication cup containing medications on the bedside table. She stated that she did pass medications this morning between 8:00 thorough 10:00 AM, and that these medications had been left on the bedside table, and had not been taken. She stated that this did not follow the facility policy and the risk is that the resident's roommate may have taken them, and that the resident is not receiving the medications he needs, or as ordered. An interview was conducted on April 27, 2022 at 8:51 AM with a Certified Nursing Assistant (CNA/staff #15), who stated that if a resident was assessed for self-administration of medications, it would be on the care plan, and that it would not be for prescription medications. An interview was conducted on April 27, 2022 at 9:04 AM with the Minimum Data Set (MDS) Director (staff #53), who stated that there should be a physician's order for a resident to self-administer medications, and it would be documented on the care plan. She further stated that medications should not be left at the bedside for residents to take later. An interview was conducted on April 27, 2022 at 11:07 AM with the Director of Nursing (DON/staff	Y 341		

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Y 341	Continued From page 3 #188), who stated that the facility process for medication administration includes checking for the right drug, patient, time, and route, then the medication would be administered to the resident. She also stated the nurse should stay at the bedside while the patient is taking the medication. The DON stated that it is not following the facility process for the nurse to leave medications at the bedside. She reviewed the resident's medical record, and stated that there is not a care plan or order for self-administration of medication. She also stated the risk of leaving medication at the bedside unattended could result in a medication error, especially with psychiatric medications not taken on time, and risk that another resident could take them. She further stated that this does not meet the facility policy and she has already educated the nurse. Review of the facility policy titled, Medication Administration/Oral revealed only licensed nurses may administer medications. The policy also revealed to document administration of medications immediately, discard used containers, and move onto the next resident. Review of the facility policy titled, Self-Administration of Medications, revealed that all administration of medications will be under the supervision of a licensed nurse and documented by the licensed nurse. If a resident wishes to self-administer their medication, and the interdisciplinary care team decides the resident is capable, the medication will be given to the resident by a licensed nurse at the appropriate time and allow self-administration. The medication will be stored in the medication cart, not in the resident's room. If the medical provider orders that a medication(s) is to be kept at the bedside, the facility will supply a locked cabinet to	Y 341		

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Y 341	Continued From page 4 be used to store the medications to prevent the medications from falling into the wrong hands.	Y 341		
Y 630	R9-10-406.E.2. Personnel R9-10-406.E. An administrator shall ensure that a personnel member or an employee or volunteer who has or is expected to have direct interaction with a resident for more than eight hours a week provides evidence of freedom from infectious tuberculosis: R9-10-406.E.2. As specified in R9-10-113. This RULE is not met as evidenced by: Based on personnel record review, facility document, staff interview, and policy review, the facility failed to ensure a Licensed Practical Nurse (LPN/staff #60) had evidence of freedom from infectious Tuberculosis (TB) on an annual basis. Findings include: Review of the personal record for an LPN (staff #60) revealed a hire date of September 7, 2021. The record included a tuberculosis (TB) test that was conducted on November 19, 2020. Further review of the record revealed no evidence of freedom from TB after November 19, 2020. In a written statement provided by the facility dated April 28, 2022, it was revealed that the documentation of the staff #60's TB test was misread and the solution lot expiration date was read as the test validity date. The document stated that the facility failed to schedule a new TB test as of November 19, 2021. The statement further revealed that the employee was taken off	Y 630	**Y630** **Correct to Individual:** No individual residents were affected. **Correct to all others:** All residents have the potential to be affected Staff #60 had a TB test completed on 05/13/2022 and is free from active tuberculosis. An audit was completed of all active employees or volunteers to ensure that all employees or volunteers with direct interaction with a resident for more than eight hours a week have evidence of freedom from infectious tuberculosis. **System Correction:** Audits will be done monthly to ensure that all active employees or volunteers with direct interaction with a resident for more than eight hours a week have evidence of freedom from infectious tuberculosis. **Monitoring of System:** The analysis of the audits will be taken to QAPI for review and follow-up as needed. **Date of Correction:**	06/06/2022

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Y 630	Continued From page 5 the schedule and will not be put on the schedule until the facility has a valid TB clearance. An interview with the director of nursing (DON/staff #188) was conducted on April 28, 2022 at 10:52 AM. She stated that all hiring and employee processes and testing are to be done in a timely manner. She said that her expectation is that an employee that does not have a current TB clearance is to be off the schedule until a current TB is on file. The DON stated that a staff member that is not cleared of TB is a potential danger to other staff, residents, and others because TB can be spread easily. Review of the facility policy Tuberculosis Clearance-Staff and Volunteers (2018) revealed that all employees are to remain free of tuberculosis and submit evidence of freedom from infectious pulmonary tuberculosis (TB) by submitting documentation of a negative TB test or a physician statement dated within the 6 months before the start date and chest x-ray within the past 5 years. Employees will have their current TB status updated annually either by additional testing, chest x- ray or additional letter written by a provider.	Y 630	**Person Responsible:** Administrator or Designee	
Y1077	R9-10-410.C.2. Resident Rights R9-10-410.C. A resident has the following rights: R9-10-410.C.2. To receive treatment that supports and respects the resident's individuality, choices, strengths, and abilities;	Y1077		

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Y1077	Continued From page 6 This RULE is not met as evidenced by: Based on resident and staff interviews, clinical record review, and review of policy and procedure, the facility failed to ensure one resident (#335) received treatment that supported and respected the resident's choices and abilities, by failing to provide the necessary services to maintain good grooming and personal hygiene. Findings include: Resident #335 was admitted to the facility on 04/11/22 with diagnoses that included pneumonitis due to inhalation of food and vomit, chronic obstructive pulmonary disease, unspecified, and pain, unspecified. The 5-day admission Minimum Data Set assessment dated 04/18/22 included that the resident scored 15 on the Brief Interview for Mental Status, indicating intact cognition. The resident displayed no behaviors including rejection of care, and required extensive to total 1-2 person physical assistance for most activities of daily living (ADL). An ADL Functional/Rehabilitation Potential care plan dated 04/20/22 related to debility post infection and hospitalization had a goal for ADL needs to be met daily. Interventions included assisting the resident with bathing body parts that the resident could not do. On 04/25/22 at 11:10 a.m., an interview was conducted with resident #335 who stated since arriving at the facility, he had only received one shower. The resident also stated that staff have not offered him opportunities to shower and that he would like to have showers more often.	Y1077	**Y1077** **Correct to Individual:** Resident #335 was interviewed for showering preferences and he states that he was refusing his showers and that he would be better about taking showers twice weekly as scheduled. His target behaviors and care plan were updated. **Correct to all others:** All residents have the potential to be affected. Staff will be re-educated on policy for documentation of activities of daily living to ensure hygiene needs are met and refusals of care are properly documented. **System Correction:** Audits will be done weekly to ensure resident's hygiene needs are being met and documented appropriately. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

ADHS LICENSING SERVICES

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Y1077	Continued From page 7 An interview was conducted on 04/28/22 at 2:29 p.m. with the Director of Nursing (DON/staff #238). She stated that all of the shower documentation could be found in the Certified Nursing Assistants' (CNA) documentation in the clinical record. However, review of the CNA documentation revealed that the resident had received only one shower on 04/18/22. Review of the nursing progress notes did not include documentation which indicated that the resident had refused showers. On 04/28/22 at 2:32 p.m., an interview was conducted with a CNA (staff #33). She stated that when she gives a resident a shower she will document it in the CNA point of care notes in the resident's clinical record. She stated that residents receive 2 showers per week. She said that if residents refuse their shower, she will return later and ask again. She stated that if the resident continues to refuse she will tell the nurse. She stated that she will document the refusal in her point of care notes. The CNA stated that she remembered assisting the resident with at least one shower. The CNA pulled up the resident's shower documentation and indicated that she had documented the shower on 04/18/22. However, she reviewed the documentation and stated that the CNA record did not indicate that the resident had received additional showering/bathing opportunities. She stated that if the resident had refused, it would specifically state that in the record. Staff #33 then pulled up the refusal area in the documentation program and stated that if the resident had refused it would be included as such in the documentation. She stated that the code "did not	Y1077		

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Y1077	Continued From page 8 occur" meant that the resident did not receive a shower. An interview was conducted on 04/29/22 at 7:45 a.m. with a Licensed Practical Nurse (LPN/staff #50). She stated that she speaks with the CNAs daily and asks them to notify her if a resident is refusing showers. She stated that she was not made aware that resident #335 had refused showers. The LPN stated that 3 attempts should be made to shower the resident, after which the nurse will document the refusal in the clinical record. The LPN stated that it would not meet her expectation for a resident not to receive 2 showers per week. On 04/29/22 at 9:49 a.m., an interview was conducted with the Director of Nursing (DON/staff #238). She stated that residents are offered 2 showers per week and that staff try to accommodate additional showers if requested. She stated that if the resident refuses, the CNAs are instructed to tell the nurse. The DON said that additional refusals would warrant a call to the provider and family. The DON stated that she thought that if a resident refused, it would be documented as "did not occur" in the resident's record. She stated that her expectation was for CNAs to offer showers to the residents 2 times each week and to accommodate their preferences accordingly. The facility's policy titled Bath/Shower included that the facility has a schedule for each unit to include bathing at least twice weekly.	Y1077		
Y1477	R9-10-414.B.3.b. Comprehensive Assessment; Care Plan	Y1477		

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Y1477	Continued From page 9 R9-10-414.B. An administrator shall ensure that a care plan for a resident: R9-10-414.B.3. Ensures that a resident is provided nursing care institution services that: 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. This RULE is not met as evidenced by: Based on clinical record reviews, resident and staff interviews, and policy review, the facility failed to assist three residents (#88, #109, and #108) in maintaining their highest practicable well-being by failing to ensure the residents received ROM (Range of Motion) as ordered. Findings include: -Resident #88 was admitted to the facility on June 21, 2016 with the following diagnoses: Type 2 diabetes mellitus with diabetic nephropathy; Type 2 diabetes mellitus with hyperglycemia; Pressure ulcer of sacral region, stage 4; Pressure ulcer of right heel, unstageable; Pressure ulcer of left buttock, unspecified stage. Review of the clinical record revealed a physician order dated January 27, 2022 for PROM (Passive Range of Motion) to the bilateral lower extremities and upper extremities as tolerated 3 to 5 times a week, once a day. Review of the progress note dated February 1,	Y1477	**Y1477** **Correct to Individual:** Resident #88 and #109 will receive restorative services per orders. Resident #108 was discharged from the facility. **Correct to all others:** Residents with orders for ROM have the potential to be affected. All residents with orders for ROM will be evaluated by therapy quarterly. Staff responsible for restorative services will be educated on restorative plan, charting, and meetings to ensure that residents receive the necessary restorative services to prevent an avoidable decrease in ROM/Mobility and provide clinical documentation if decrease is unavoidable. **System Correction:** Audits will be done weekly to ensure that residents are receiving restorative services as ordered. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow-up as needed. **Correction Date:** **Person Responsible:** Director of Nursing or Designee	06/06/2022

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Y1477	Continued From page 10 2022 revealed the resident had decreased functional mobility and strength. The 5-day Minimum Data Set assessment dated April 4, 2022 revealed a Brief Interview for Mental Status score of 8 which indicated the resident had moderate impaired cognition. The assessment included the resident is totally dependent on the staff for activities of daily living. A review of the care plan last reviewed April 25, 2022 revealed the resident receives restorative nursing services to maintain/improve functional mobility. The goal was that the resident will maintain joint function. Intervention included AROM (Active Range of Motion) 3-5 times a week by restorative nursing, and monitoring and recording any increased stiffness in joints and reporting it to the resident's nurse. Review of facility documentation revealed that for April 2022 the resident received PROM two times the first week of April, one time the second week, and two times the third week. During the month of March 2022, the resident was out at the hospital for 6 days in the beginning of the month, then on week 3 the resident received 3 sessions, and week 4 the resident received two sessions. During an interview conducted with the resident on April 26, 2022 at 11:17 AM, the resident stated that he has been getting weaker and weaker and now they do not get him out of bed anymore. The resident further stated that he would like to work on getting some of his strength back so that he could get up more. The resident added that he used to have exercises in bed but has not lately received any exercises. During an interview conducted on April 29, 2022	Y1477		

ADHS LICENSING SERVICES

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	NCI-2652	A. BUILDING: _____ B. WING _____	04/29/2022

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

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Y1477	Continued From page 11 at 8:19 AM with the Rehabilitation Director (staff #106), she stated that the resident is a Long-Term Care patient and is not currently scheduled for any Physical Therapy or Occupational Therapy. Staff #106 further stated that the resident is to receive restorative nursing assistance on the unit and that it is run by the nursing department. During an interview conducted on April 29, 2022 at 8:45 AM with a Certified Nursing Assistant (CNA/staff #165), she stated that she is also the Restorative Nursing Assistant (RNA) who is assigned to the unit. She added that the resident is to receive RNA services for PROM, three to five times a week. She further added that she documents the services on paper in a book at the nursing station and not in the electronic medical record. She stated that the amount of restorative nursing assistance provided depends on the unit staffing whether or not she is assigned to the RNA work. The CNA stated that due to the lack of staff, she is working less than 50% of her time and that she has only had 10 days in the last month to perform the restorative services. She added that if the resident refuses the service she reports it to the nurse. During an interview conducted on April 29, 2022 at 8:53 AM with a Licensed Practical Nurse (staff #138), she stated that if the resident refuses to get up, then she would note that in her progress notes. She added that the resident is not receiving physical therapy, only Restorative Nursing Assistance, and that the rest of the staff will encourage the resident to assist with turning in bed, and that the resident tends to not want to get up. She added that the resident has some behavior issues. She also added that the unit is short staffed about 30% of the time.	Y1477		

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Y1477	Continued From page 12 During an interview conducted on April 29, 2022 at 8:47 AM with the Director of Nursing (DON/staff #188), she stated that the Restorative Nursing Assistance program is per the physician order and if the aide assigned is not able to complete the service they are to advise her. She added that the staff from the RNA program are often pulled to do weights or other Certified Nursing Assistant duties. She further stated that this has been a concern as the residents should be getting services as ordered and that they are starting to look at a process improvement project. -Resident #109 was admitted August 30, 2018 with diagnoses that included a tear of the medial meniscus, age related physical debility, hemiplegia and hemiparesis of the left side. Review of the clinical record revealed an order dated January 7, 2019 for restorative nursing (RNA) 3 to 5 times per week to prevent a decrease in range of motion. A care plan dated March 12, 2019 revealed that the resident is receiving restorative nursing services to maintain functional ability. The goal is that the resident will maintain joint function. Approaches including AROM (Active Range of Motion) to the lower extremity as tolerated 3- 5 times per week. Review of the care plan dated July 17, 2020 revealed the resident is at high risk for falls related to limited function. Approaches included implementing an exercise program that targeted strength, gait and balance. The significant change in status minimum data	Y1477		

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Y1477	Continued From page 13 set (MDS) assessment dated March 14, 2022 revealed a score of 15 on the brief interview for mental status (BIMS) indicating the resident was cognitively intact. The assessment also revealed the resident required extensive assistance for bed mobility, toilet use, personal hygiene, and dressing with one-person assistance, and was totally dependent for transfer with two+ persons. The MDS assessment further revealed the resident received AROM 5 times during the 7-day lookback period and that the training and skill practice was in bed mobility. Review of the restorative flowsheet from November 2021 through April 2022 revealed the resident was not seen consistently 3 to 5 times per week despite notes that the resident was cooperative. One resident refusal was documented on March 3, 2022 and some difficulty in resident abilities were also noted in March 2022. On April 29, 2022 at 7:43 AM, an interview with Restorative (staff #225) was conducted. She stated that resident #109 was not being seen as ordered because of staffing shortages with RNA staff. She said that CNAs were doing weights and other CNA duties and had little time for their RNA duties. She said that the facility is aware that there were not enough staff to see all the restorative residents. She stated that they are very short staffed and management is very aware. She stated that the documentation does not reflect why the residents were not being seen as ordered. She stated that this had been ongoing since COVID and has been a facility wide problem. She said that it was a concern to her that the residents were not seen as ordered as they may lose their abilities.	Y1477		

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Y1477	Continued From page 14 -Resident #108 was admitted March 7, 2022 with diagnoses that included paroxysmal atrial fibrillation, pacemaker, weakness, pain and diabetes mellitus type 2. The care plan dated March 8, 2022 revealed the resident is at high risk for falls related to general weakness. The admission MDS assessment dated March 14, 2022 revealed a score of 15 on the BIMS indicating that the resident was cognitively intact. The MDS assessment also revealed the resident needed limited assistance with bed mobility with two+ person assistance, toilet use and personal hygiene with one-person assistance; and extensive assistance to transfer with two+ person assistance. The assessment further revealed the resident did not receive RNA. Review of the clinical record revealed a physical therapy (PT) discharge summary dated March 31, 2022 that the restorative program (RNA) was established. The discharge was per physician/case manager recommendation. A review of the clinical record revealed a referral to restorative nursing dated April 6, 2022 from PT for 3 to 5 times per week to maintain mobility and range of motion. Review of the RNA flowsheet for April 2022 revealed the resident was seen by RNA 8 times from April 6 - 28, 2022. The first visit was April 14, 2022. The included notes did not reveal any refusals or any explanation as to the delay of onset of services. An interview with the director of PT (staff #106) was conducted on April 7, 2022 at 2:02 p.m. She	Y1477		

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Y1477	Continued From page 15	Y1477		

stated that resident #108 was receiving PT and occupational therapy (OT), was discharged, and currently receives RNA with staff #16. Staff #106 stated that the resident was referred to RNA services after the discharge from PT on March 31, 2022.

On April 28, 2022 at 8:46 AM, an interview was conducted with the RNA (staff #16). She stated that she receives a paper "order" referral from PT and she then follows up with the resident. She said the order for resident #108 was put in on April 6, 2022. She said the purpose of restorative therapy is to maintain the progress a resident made during PT and OT. She further stated that a resident can be on RNA for weeks or years. Staff #16 stated she tracks the progress of the resident and documents on a paper chart not in the electronic health record. Staff #16 stated that this resident was not seen until April 14, 2022 because the resident was assigned to her when she was out sick. She said no other RNA picked up the resident in her absence and she is not sure why the resident was not seen by someone else while she was sick. Staff #16 said that the resident has been seen about 3 times per week since then, but that the resident is the same as when the resident started, no improvement, no decline.

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

An interview with the DON (staff #188) was conducted on April 28, 2022 at 10:44 AM. She

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Y1477	Continued From page 16 stated that for the RNA program, therapy makes a referral and the provider writes an order which is put into the electronic health record. The DON stated the order specifies the frequency per week which is usually 3 to 5 times a week. She said that staff #225 is in charge of assigning an RNA to all residents that receive RNA services and that this process usually takes 1-3 days to get the resident on the RNA schedule. The DON said her expectation is that if an RNA is sick or on vacation, a different RNA should be assigned to work with the resident, as waiting more than 3 or 4 days does not meet her expectation. The DON stated if a resident has to wait more than 3 to 4 days, the resident could regress and lose the progress made with PT. On April 29, 2022 at 7:43 AM, an interview with Restorative (staff #225) was conducted. She stated that she was the RNA team leader and handled RNA scheduling. She stated that in addition to doing RNA assignments, she had additional duties as a CNA and is in charge of weights for the facility. She said that RNA duties were divided by unit and there are 2 full time and 2 part time RNA staff members. She said that if a staff member is out, one of the other RNAs will pick up and fill in. Staff #225 stated there is a retired staff member that used to work RNA and often steps in to help. Staff #225 stated that she reviews the resident documentation to ensure that the documentation is complete at the end of month. She said if there are any issues, such as a resident refusal, the RNA staff should inform the charge nurse and the information should be documented on the flowsheet. She stated that resident #108 was not seen from April 7-13, 2022 because the RNA assigned to the resident was not in the building and there was no staff to pick up the resident visits.	Y1477		

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Y1477	Continued From page 17 An additional interview was conducted with the DON (staff #188) on April 29, 2022 at 8:47 AM. She stated that the RNA program is per order and if the staff are not able to see the residents as ordered they are expected to advise her of the problem. She stated that the staff from Restorative are pulled often to do weights or other CNA duties. The DON stated that this is a concern, as the residents should be receiving services as ordered. She said they are starting to look at process improvement in this area. Review of the facility's policy Restorative Nursing Carry Over Following Physical, Occupational and/or Speech Therapy (5/2010) revealed that, nursing picks up restorative services as directed by therapies to reduce the risk of functional decline in the resident. Restorative nursing is overseen by the Director of Nursing or designee and is to reinforce and extend progress made in therapy. The policy further revealed that the restorative aide will follow the treatment plan and frequency written in the order and will document resident treatments on the restorative flow sheet.	Y1477		
Y2159	R9-10-421.D.3.a. Medication Services R9-10-421.D. When medication is stored at a nursing care institution, an administrator shall ensure that: R9-10-421.D.3. Policies and procedures are established, documented, and implemented to protect the health and safety of a resident for: R9-10-421.D.3.a. Receiving, storing, inventorying, tracking, dispensing, and discarding medication including expired medication;	Y2159	**Y2159** **Correct to Individual:** No individual residents were affected. **Correct to all others:** Has the potential to affect all residents receiving medications. Licensed Nurses were re-educated on the policy for storage and labeling of medications and the proper disposal of discontinued or expired medications. All Licensed Nurses completed a medication safety and storage quiz to ensure their competency.	

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Y2159	Continued From page 18 This RULE is not met as evidenced by: Based on observations, staff interviews, and review of the policy and procedures, the facility failed to implement their policy to ensure that medications were dated according to the standard of practice, and failed to ensure that expired medications were not available for administration. Findings include: -An observation was conducted on April 28, 2022 at 1:30 p.m. of the medication cart on hall 209-228, sub-acute unit. An insulin box with a pharmacy label Aspart Insulin contained two opened vials of insulin inside. The first vial with a maroon top was labeled Insulin Lispro, and the second vial with a silver top was labeled insulin Aspart. The insulin vials had no resident's name, or open dates. An interview was conducted on April 28, 2022 at 1:33 p.m. with an RN (Registered Nurse/staff #204). Staff #204 stated each insulin is usually in an individual box with the resident's name and opened date. Staff #204 looked at the insulin vials and stated the maroon top is insulin Lispro, and the silver top is insulin Aspart. The RN stated it was not a normal procedure for a box to have two different insulin vials, and no resident's name. -An observation was conducted on April 28, 2022 at 1:49 p.m. of the South medication room and medication refrigerator. Inside the medication refrigerator was a bottle of Vancomycin solution with an expiration date of April 11, 2022, and an	Y2159	**System Correction:** Audits of medication storage areas will be completed weekly to ensure that medications are stored and labeled according to policy. **Monitoring of System:** The analysis of the audits will be taken to QAPI meeting for review and follow up as needed. **Date of Correction:** 06/06/2022 **Responsible Person:** Director of Nursing or Designee	

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Y2159	Continued From page 19 opened vial of regular insulin without an open date. An immediate follow up interview was conducted with staff #204, who stated the vial of insulin was opened because the vial was no longer sealed. Staff #204 stated she did not know how long the insulin had been opened because it did not have an open date on it. Staff #204 stated the expiration date on the Vancomycin solution was April 11, 2022 and that the medication has expired. An interview was conducted on April 28, 2022 at 2:31 p.m. with the Director of Nursing (DON/staff #188). Staff #188 stated opened insulin vials are good for 28 days and should be dated. The DON stated expired medications should be discarded promptly. A facility's policy, Storage of Medications, stated the facility shall store all drugs and biologicals in a safe, secure, and orderly manner. The policy included drugs and biologicals shall be stored in the packaging, containers or other dispensing systems in which they are received. The policy also included that the facility shall not use discontinued, outdated, or deteriorated drugs or biologicals, and all such drugs shall be returned to the dispensing pharmacy or destroyed.	Y2159		

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: April 25, 2022

Survey Event ID: YZWT11

Inspector/Team Coordinator: P. Samantha Potter

Accompanied By: Lisa Andrin-Mazur, Lisa Bashford, Paul Rehman, Melinda Spiwak, Erlinda Tucker,

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.

Rebecca Johnson — 04/25/22

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 — 4/25/22

Inspector/Team Coordinator Signature: — Date:

☒ Copy left with Administrator/Director/Agency Representative

QUALITY RATING CERTIFICATE

Arizona Department of Health Services

ARIZONA DEPARTMENT OF HEALTH SERVICES
NURSING CARE INSTITUTION

Issued To: Devon Gables Rehabilitation Center

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	21	4
II. Resident Rights	25	0
III. Administration	25	0
IV. Environment and Infection Control	15	0
V. Food Services	10	0
TOTAL CRITERIA MET	96	4

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:	Pts.	Criteria Met? 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	11	4
The nursing care institution ensures that each resident is free from medication errors that resulted in actual harm.	5	5	0
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	5	0

Points Yes 21

Points No 4

Comments:

Resident Rights:

Criteria:	Pts.	Criteria Met? YES	NO
The nursing care institution is implementing a system that ensures a resident's privacy needs are met.	10	10	0
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	10	0
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	5	0

Points Yes 25

Points No 0

Comments:

Administration:

Criteria:	Pts.	Criteria Met? 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	10	0
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	5	0
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	5	0
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	1	0
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	1	0
The nursing care institution is implementing a system to ensure that a resident is free from unnecessary drugs.	2	2	0
The nursing care institution is implementing a system to ensure a personnel member attends in-service education according to policies and procedures.	1	1	0

Points Yes 25

Points No 0

Comments:

Environment and Infection Control:

Criteria:	Pts.	Criteria Met? 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	5	0
The nursing care institution establishes and maintains a pest control program.	1	1	0
The nursing care institution develops a written disaster plan that includes procedures for protecting the health and safety of residents.	1	1	0
The nursing care institution ensures orientation to the disaster plan for each staff member is completed within the first scheduled week of employment.	1	1	0
The nursing care institution maintains a clean and sanitary environment.	1	1	0
The nursing care institution is implementing a system to prevent and control infection.	5	5	0
An employee washes hands after each direct resident contact or where hand washing is indicated to prevent the spread of infection.	1	1	0

Points Yes 15

Points No 0

Comments:

Food Services:

Criteria:	Pts.	Criteria Met? 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	1	0
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	3	0
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	2	0
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	2	0
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	1	0
The nursing care institution provides food substitution of similar nutritive value for residents who refuse the food served or who request a substitution.	1	1	0

Points Yes 10

Points No 0

Comments: