STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035145	A. Building B. Wing	10/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devon Gables Rehabilitation Center	6150 East Grant Road Tucson, AZ 85712

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on staff interviews, clinical record review, facility documents and facility policy, the facility failed to ensure that three residents (#33, #24, #11) were not abused. This deficient practice could result in further incidents of abuse. Findings include: Regarding resident #33 and resident #24 A facility reported incident was made on May 14, 2024. This report included Staff responded to visitor calling for help, stating those two men are fighting. She states that she heard raised voices coming from the room across the hallway. She looked across the hallway and observed (residents #24 and #33) in the bathroom doorway and appeared to be fighting. A 5 day report dated May 17, 2024 included Per staff report (resident #24) had been having increased behavioral episodes the prior day and night. He was seen packing his belongings, pushing at doors and very difficult for the staff to re-direct. Per night staff he had slept very little the previous night. (resident #33 can be very territorial about his room and belongings. This document also included (resident #24 and (resident #33) have different rooms but share a bathroom between them; it is thought that (resident #33) left the bathroom through the door to (resident #24)'s room by mistake,which created the verbal altercation in the bathroom area. -Resident #24 was admitted on [DATE] with diagnoses of Alzheimer's disease, Mood disorder due to known physiological condition with depressive features and Vascular dementia A Quarterly Minimum Data Set (MDS) dated [DATE] included that this resident was moderately cognitively impaired and that the resident was able to independently walk in the corridor and around the room. A care plan dated December 19, 2022 included Cognitive loss/dementia or alteration in thought processes related to diagnosis as evidenced by impaired decision making, short and/or long term memory loss, and neurological symptoms and included interventions to redirect resident when entering unsafe areas. (continued on next page)

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

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Resident #33 was admitted on [DATE] with diagnoses of Schizoaffective disorder, unspecified dementia with other behavioral disturbance, and mild intellectual disabilities. A care plan dated May 14, 2023 included this resident has physical behavioral symptoms toward another resident (e.g. hitting, pushing) with a long term goal that this resident will not harm others secondary to physically abusive behavior. A progress note dated May 14, 2023 included that resident #33 was in bed and a 2 nurse body check was completed. This note included a hematoma forming to the right wrist area 2cm discoloration, with approximated skin tear measuring 0.75 cm and that the resident reports falling. This note stated that it was unclear why resident #33 was in sitting position in rm 117 between conjoined restroom and peers brown recliner with bedside table between both residents. An interview was conducted on October 22, 2024 at 3:11 P.M. with a Certified Nursing Assistant (CNA/staff #87) who said that this is a secured behavioral unit and that they attempt to prevent incidents by giving residents attention, reminding them and making sure they have what they need. This CNA said that resident #24 had a lot of behaviors which included being very forgetful and that he gets aggressive. This CNA said that this resident wanders into people's rooms. An interview was conducted on October 25, 2024 at 1:52 P.M. with a CNA (staff #43) who said that she remembered that she was in the dining room and heard bang like a bedside table, and she ran to the first room, and resident #33 was with the bedside table on top of resident #24. She said that she did not think it was an altercation, she thinks that the resident went into the wrong room. An interview was conducted October 25, 2024 at 2:23 P.M. with a family member who said that her husband is in the room across the hall, and that she heard something so she stood up and looked over there. She said that she saw the resident who belonged in the room and a resident who did not. She said that she saw 1 of them striking the other. She said that she then called out for help, and when people started running she sat down. She said that she told facility staff what she saw, and that she heard the yelling, because she was seated beside her husband's bed. Regarding resident #24 and resident #11 A facility reported incident was made on June 11, 2023. This report included that on June 11, 2023 Staff observed (resident #24) stroking (resident #11)'s penis. (resident #11) was laying in (resident #24)'s bed. Both residents have advanced Dementia and reside on a locked Dementia unit at the facility. Staff immediately separated the Residents. Implemented 1:1 staffing and 15 minute checks -Resident #11 was admitted [DATE] with diagnoses of unspecified dementia, and altered mental status. A care plan dated June 11, 2023 included that this resident was showing disinhibited behaviors in public and towards others with interventions to re-direct resident to his room when displaying inappropriate behavior and staff to encourage and attempt 6foot rule between him and peers until evaluated and treated by psych. However, this resident had no prior care plan for public disinhibition or public masturbation. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A progress note dated May 3, 2023 included that this resident is being monitored for public masturbation. Progress notes dated May 11, 2023 and June 9, 2023 included that this resident had an instance of public masturbation. A progress note dated June 11, 2023 included upon staff assisting another resident down hall way, staff reports that they observed (resident #11) laying in male peers' bed next to male peer and was observed to have pants pulled down and peer was stroking (resident #11) erected penis. Staff intervened and assisted peer away from (resident #11). (resident #11) pulled pants up over penis and was observed to stand up and adjust self. staff assisted (resident #11) out of peers room and directed him to his room. 1:1 provided to (resident #11) at this time . An interview was conducted on October 25, 2024 at 10:54 A.M. with a CNA (staff #104) who said that resident #24 had dementia and that he was sometimes aggressive but that he was always confused. He said that heard of the incident between residents #11 and #24 and that the residents were separated from then on. An interview was conducted on October 25, 2024 at 1:52 with a CNA (staff #43) who said that resident #24 had started masturbating in the dining room though he had not previously been directly sexual with staff or residents. She said that the staff were start starting rounds in which they would check on the residents and change briefs if needed. She said that she turned around because resident #24 had left after the meal and she saw resident #11 on edge of bed kind of laying back and that resident #24 was massaging his private and that she said oh, in shock, and that resident #11 pulled his pants on really quick. She said that another CNA was with her and that she went and got a nurse. She said she told them what she had seen and started 1 on 1 supervision with resident #11. She said that resident #24 is really confused and that resident #11 was on 1 on 1 supervision until he left. An interview was conducted on October 25, 2024 at 10:45 A.M. with a Licensed Practical Nurse (LPN/staff #65) who stated that she remembered hearing about it and that in this situation residents should be separated and the management notified. She said that these residents would not have been capable of consent. An interview conducted on October 25, 2024 at 2:39 P.M. with a LPN (staff #56) who said that the MDS coordinator does care planning, the floor nurses do not. She said that if the nurses feel that the care plan needs a change, they notify the MDS and that staff will make changes. This nurse said that she makes sure that her residents are capable of consent if there is a possibility of a sexual relationship. This nurse said that abuse includes mental, physical, verbal, involuntary seclusion as well as other types and that being yelled at is verbal abuse. She said that a lot of their residents have dementia so consent is always a concern. An interview conducted on October 25, 2024 at 3:38 P.M. with the Director of Nursing (DON/staff #58) said that resident #24 is not capable of consent. She said that he is on the dementia unit and that his wife is was power of attorney and made his decisions. She said that resident #11 was moved out because of his constant behaviors and also would not have been able to consent. This DON said that we need to be advocates and protectors of the vulnerable population. This DON said that the onset of public masturbation should have been updated in the care plan. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Regarding the altercation between resident #24 and #33, the DON said that it does not meet her expectations that residents were yelling and punching at each other. An interview was conducted with the administrator (staff #95) on October 25, 2024 immediately following this interview included that being assessed for the ability to consent is not obtained prior to residents attempting personal contact, so that an assessment was not warranted prior to the act. This administrator said that these two residents did not have prior contact. However, as these residents were not assessed as able to make decisions regarding their daily lives, an assessment of consent should have been conducted for sexual interactions to be considered consensual. A policy titled Preventing, Reporting and Investigating Abuse revised July 2023 included our residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. This document included our facility is committed to protecting our residents from abuse by anyone including, but not necessarily limited to other residents. A policy titled Care Plans, Comprehensive Person-Centered revised March, 2022 revealed that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42319 Based on clinical record review, staff and resident interviews, facility records and facility policy the facility failed to ensure that one resident (#24) is free from preventable falls. This deficient practice could result in increased morbidity and mortality. Findings include: Resident #24 was admitted on [DATE] with diagnoses of Alzheimer's disease, Mood disorder due to known physiological condition with depressive features and Vascular dementia A 5-day Minimum Data Set (MDS) dated [DATE] included that this resident was unable to answer questions for cognition and that the resident had a fall prior to entry. A care plan dated December 19, 2022 included this resident is at risk for falls related to diagnosis and history of falls. A progress note dated July 27, 2023 included Upon entering pts room he was noted laying on back in front of closet. pt stated I fell . Body check done, no new injuries. Denies hitting head, no red, raised or open areas. Neuro check done due to unwitness fall. Passive ROM to upper and lower extremitys. Pt s/sx pain dont touch that refering to left leg 2-person assist to bed. Gripper socks applied A care plan intervention dated July 27, 2023 was added of Give resident verbal reminders not to ambulate/transfer without assistance. However, this intervention was cancelled the same day and no new interventions were put into place. A progress note dated August 5, 2023 included Resident found on floor in dining room with head and shoulders resting on wall. Resident stated he was attempting to stand when lost balance. No new injury noted at this time. Assisted back into chair and educated of safety awareness and mechanical lift order, resident smiled. VSS, noreports of new pained areas, skin intact. Neuros initiated and continuing, New order for Xray of left hipto compare from previous fall per provider, order input in matric and rapid ray. Spoke to [NAME] from rapidray order placed STAT. A progress note dated August 5, 2023 included Xray of left hip results as follows: left superior and inferior pubic rami fracture results related to on call provider, new telephone order to send resident toTMC ER for evaluation via transport, if exceeding 3hr wait please call for emergent transport. MOD and wife . made aware. Denies pain when asked, smiles and attempts to stand up. 1:1 supervision placed for safety. Call placed to the transport company, result is wait time up to 3 hours. A care plan intervention dated August 8, 2023 was added of Floor mat at bedside and bed in knee bend height position for safe entry and exit However, this intervention was cancelled the same day and no new interventions were put into place. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on October 22, 2024 at 3:11 P.M. with a Certified Nursing Assistant (CNA/staff #87) who said that this is a secured behavioral unit and that this staff's goal was to make sure everyone had a good day and had no accidents. This staff said they attempt to prevent incidents by giving residents attention, reminding them and making sure they have what they need with pads beside beds and call lights within reach. This CNA said that resident #24 had a lot of behaviors which included being very forgetful and that he had a bad hip. This CNA said that this resident had a pad for beside his bed. An interview was conducted on October 23, 2024 at 3:10 P.M. with a Licenced Practical Nurse (LPN/staff #89) who said that when a resident falls, the staff report it to her and she does an assessment. She said that if the resident is safe to transfer to bed, they will do so and begin the neurological assessments. She said that they will review the care plan and then the Registered Nurse will update the care plan. This nurse said that resident #24 sundowns and wants to get up in the evenings. She said that the interventions to prevent falls were to position bed to lowest, place a fall mat, and that if the resident was restless we will do a one on one, or the CNA's will put him at the desk. An interview was conducted on October 25, 2024 at 3:38 P.M. with the Director of Nursing (DON/staff #58) who said falls should be care planned. She said that with resident #24, she would have to find out why they removed the interventions immediately and that for him they use a lot of diversional opportunities. She said that since the left superior and inferior pubic rami fracture that this resident was not as mobile anymore, and that now he requires the assistance of a hoyer for transfer as he is not able to move on his own at all. She said that if there is not an added intervention for each fall then it would not meet her expectation. She said that placing an intervention and cancelling it within a day does not meet the requirement. A policy titled Care Plans, Comprehensive Person-Centered revised March 2022 revealed that assessments of residents are ongoing and care plans are revised as information about the residents and the residents' conditions change.