| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **035145** | A. BUILDING _____ B. WING _____ | **12/12/2019** |

| NAME OF PROVIDER OF SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP |
|---|---|
| **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) |
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| F 0600<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ><br>Based on clinical record reviews, facility documentation, staff interviews, and policy review, the facility failed to ensure that one resident (#172) was free from abuse by another resident (#427). The deficient practice could result in the potential for further resident to resident abuse.<br>Findings include:<br>-Resident #172 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of the care plan with a start date of 1/08/2019 revealed the resident had socially inappropriate and disruptive behaviors related to [MEDICAL CONDITION] and dementia which included wandering into peers' rooms and physical aggression. Interventions included assessing whether the resident's behaviors endangered himself or others and intervening as needed, every 15 minute checks when indicated, maintaining a calm environment and approaching to de-escalate or prevent a situation.<br>A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident needed supervision for walking in the corridor and locomotion on the unit.<br>Review of a nursing note dated 10/25/2019 revealed that at 6:20 AM resident #172 wandered into resident #427's room. Resident #427 became anxious, aggressive, and combative hitting resident #172 in the face with his foot. The residents were separated. Resident #172 continued to be mad stating he wants to kill him referring to resident #427. The note included the area to resident #172's right temple was cleaned and neuro checks were initiated.<br>-Resident #427 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].<br>Review of the care plan with a start date of 6/3/2019 revealed the resident was a threat to himself and others related to wandering in other residents' rooms and outside without purpose, and refusing to take medications. The goal was that the resident would have minimal harm to self and others. Interventions included assessing whether the behavior endangered the resident or others and intervening if necessary, maintaining a calm environment, and when the resident begins to become socially inappropriate and/or disruptive, provide comfort measures for his basic needs.<br>A quarterly MDS assessment dated [DATE] revealed the resident's cognitive skills for daily decision making was moderately impaired. The assessment included the resident could walk independently in the corridor and needed supervision for locomotion on the unit.<br>A nursing note dated (MONTH) 25, 2019 at 7:30 AM revealed a certified nursing assistant (CNA/staff #252) responded to noise on the hall and that resident #427 was observed holding resident #172 by the shirt dangling him off the floor before he dropped him on the floor and started stomping on resident #172 with his foot. The CNA separated the residents. Resident #427 was very upset and kept repeating beat his ass. The note included one to one supervision was provided for resident #427.<br>Review of the facility's investigation report dated 11/07/2019 revealed that on 10/25/2019 at approximately 6:20 AM a noise was heard in the hall. A CNA (staff #252) who was providing care to a resident went out into the hall and observed resident #172 on the floor in the doorway of resident #427's room with resident #427 over resident #172 holding resident #172 by the shirt. The CNA told resident #427 to let go of resident #172. Resident #427 let go of resident #172's shirt. Resident #427 then stepped over resident #172 striking him in the torso with his bare foot. Both residents were cursing and agitated at one another. The residents were separated and resident #427 was placed on 1:1 supervision. Resident #172 was observed to have a superficial abrasion on his cheek. No redness or bruising was noted on resident #172's torso. Resident #172 calmed down after a short period. Resident #427 continued to be agitated and focused on resident #172, stating that resident #172 had gone into his room. The report included resident #427 did not de-escalate from the incident and was ultimately sent to the hospital for evaluation of his agitation and behaviors at approximately 12:45 PM.<br>An interview was conducted on 12/11/19 at 09:47 AM with the Director of Nursing (DON/staff #204). The DON stated that she was on duty when the incident happened. She stated the CNA (staff #252) did not see resident #172 being kicked in the face that the CNA only saw resident #172 being kicked in the torso. She stated that resident #172 was assessed to have no bruising, marks, or signs of pain to the chest but was observed to have a small scratch on his face that was assumed to have come from the altercation. The DON stated resident #172 was not observed hitting resident #427. The DON also stated that resident #427 was unable to calm down and was sent to the hospital.<br>An interview was conducted on 12/11/19 at 3:17 PM with the CNA (staff #252) who witnessed the incident. Staff #252 stated that he heard resident #427 and resident #172 cursing and yelling. The CNA stated that he found resident #427 holding the shirt of resident #172 while resident #172 was on the ground, kicking resident #172 in the chest. He stated resident #427 stopped kicking resident #172 and continued to yell profanities at resident #172. Staff #252 stated the residents were separated and assessed for injury. Staff #252 also stated that resident #427 and resident #172 was placed on 1:1 supervision while the incident was being reported and investigated.<br>During an interview conducted on 12/12/19 at 10:35 AM with the administrator (staff #85), the administrator stated that they are doing all they can to prevent incidents of abuse from occurring.<br>Review of the facility's policy regarding preventing, reporting, and investigating abuse revised (MONTH) (YEAR), revealed their residents have the right to be free from abuse and that they are committed to protecting their residents from abuse by anyone including other residents. The policy also revealed abuse means the willful infliction of injury with resulting physical harm, pain or mental anguish. The policy included willful means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. The policy also included instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. |
| F 0689<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | **Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ><br>Based on clinical record review, facility documentation, and staff interviews, the facility failed to ensure two residents (#225 and #477) were provided adequate supervision to prevent accidents. The deficient practice could result in residents being at risk for accidents and injury. |

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

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| F 0689<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | (continued... from page 1)<br>Findings include:<br>-Resident #225 was admitted to the facility on (MONTH) 22, 2019, with [DIAGNOSES REDACTED].<br>The admission Minimum Data Set assessment dated (MONTH) 29, 2019 revealed the resident's cognitive skills for daily decision making was severely impaired. The assessment included the resident exhibited verbal and physical behavior symptoms directed toward others 1 to 3 days during the look-back period that put others at significant risk for physical injury. The assessment also included wandering behavior was not exhibited during the look-back period.<br>Review of the care plan with a start date of (MONTH) 4, 2019 revealed the resident had socially inappropriate and/or disruptive behaviors related to dementia that included agitation, yelling, exit seeking, and pacing in the hall and residents' rooms. The goal was that the resident would not harm himself or others. Interventions included assessing whether the behaviors would endanger himself or other and intervening as needed, limiting noise and distraction on the unit especially in the hallways after 9:00 PM, and maintaining a calm environment and approaching to help de-escalate a situation or prevent one.<br>Review of a nursing progress note dated (MONTH) 19, 2019, revealed the resident was wandering into other residents' rooms. The note included the resident appeared tired and was attempting to lie in an empty bed. The note also included the resident was re-directed to his room.<br>A nursing progress note dated (MONTH) 23, 2019 revealed that while walking down the hallway, resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye area. Resident #477, while standing inside the doorway of his room, stated that he punched resident #225 in the face because resident #225 is always going into his room. Resident #225 was upset and yelling and crying out. The skin tear to resident #225's left eye was cleansed and already scabbing. The note included 1:1 supervision was placed with resident #477.<br>-Resident #477 was admitted to the facility on (MONTH) 8, (YEAR), with [DIAGNOSES REDACTED].<br>Review of the care plan with a start date of (MONTH) 21, (YEAR) revealed the resident had socially inappropriate and/or disruptive behavioral symptoms as evidenced by verbal and physical aggression. The goal was that the resident would not harm himself or others. Interventions included observing and reporting socially inappropriate and/or disruptive behaviors when around others and removing the resident from other residents' rooms and unsafe situations.<br>The quarterly MDS assessment dated (MONTH) 26, 2019 revealed a Brief Interview for Mental Status score of 6 which indicated the resident had severe cognitive impairment. The assessment included the resident exhibited verbal behavioral symptoms directed toward others 1 to 3 days during the look-back period. The assessment did not include whether the behavior had impact on others.<br>A nursing note dated (MONTH) 3, 2019 revealed that while staff were attempting to obtain the resident's vital signs and conduct a skin assessment, the resident became verbally aggressive, cursing at staff, and attempted to strike at the Certified Nursing Assistant (CNA).<br>Review of nursing progress notes dated (MONTH) 23, 2019 revealed that while walking down the hallway resident #225 yelled and walked out of resident #477's room. Resident #225 was observed with blood to the left eye. Resident #477 was standing inside the doorway and stated that he punched resident #225 because resident #225 is always going into his room. Resident #477 was upset and telling staff that he was leaving the facility tomorrow because he is tired of strangers coming into his room. 1:1 supervision was provided for resident #477 until the resident was sent to the emergency room for evaluation and treatment for [REDACTED].<br>Review of the facility's investigation report dated (MONTH) 2, 2019 revealed that on (MONTH) 23, 2019 at approximately 9:00 p.m., a Licensed [MEDICATION NAME] Nurse (LPN/Staff #165) heard resident #225 cry out and come walking out of resident #477's room. Staff #165 observed a scant amount of blood on resident #225's left orbital region. Resident #477, while standing in the doorway of his room, told staff #165 that he hit resident #225 because resident #225 came into his room. The residents were immediately separated. Resident #477 was placed with 1:1 supervision until he was sent to the emergency room for behavioral evaluation and management. Resident #225's abrasion by his left eye was treated. The report included resident #225 could not recall what happened or why he was in resident #477's room. The report also included resident #225 was transferred to the secured wandering unit on (MONTH) 25, 2019 secondary to not exhibiting behavior outside of pacing the halls and residents' rooms.<br>An interview was conducted on (MONTH) 11, 2019 at 9:30 a.m. with the Social Services Assistant (staff #184), who stated that on (MONTH) 26, 2019, resident #225 was moved to a secured behavior unit because of wandering and behavioral issues. She said that the resident was confused, combative, and exit seeking. She stated that it was her understanding that resident #225 was exit seeking, in and out of peers rooms, and that there would be staff on the behavior unit to redirect him. Staff #184 stated that there is an extra aid (hall monitor) on the behavioral unit to redirect the resident when he is wandering to keep him safe.<br>During the interview with staff #184, the Registered Nurse/In-service Director (RN/staff #18) joined the interview. She stated that there is an extra aid (hall monitor) on the unit every shift that monitors and/or supervises common areas where residents congregate. Staff #184 also stated that at night when the majority of residents are sleeping, the hall monitor would be in the hall to monitor, assist and redirect any residents getting up and coming out of their rooms as needed.<br>An interview was conducted on (MONTH) 11, 2019 at 10:35 a.m. with a CNA (staff #144), who stated that the residents on the secured behavioral unit exhibit sexually inappropriate, aggressive, and exit seeking behaviors. The staff member said that the residents on that unit are very territorial and it would not be appropriate for a resident, like resident #225, who wanders into other residents' personal space. The staff member also stated resident #225 was transferred to another secured unit for residents who are exit seeking.<br>An interview was conducted on (MONTH) 11, 2019 at 11:10 a.m. with the Director of Nursing (DON/staff #204), who stated that there are two CNAs scheduled for the secured units, one CNA to cover each hall and a third CNA who monitors both of the halls. The DON stated that the third CNA goes between the two halls to monitor, supervise and redirect residents as needed. |
| F 0757<br><br>**Level of harm** - Minimal harm or potential for actual harm<br><br>**Residents Affected** - Few | **Ensure each resident's drug regimen must be free from unnecessary drugs.**<br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** ><br>Based on clinical record review, staff interviews and policy review, the facility failed to ensure one resident's (#377) medication regimen was free from unnecessary medication, by administering insulin outside of the physician ordered parameters. The deficient practice could result in poor blood glucose control and residents receiving medications unnecessarily.<br>Findings include:<br>Resident #377 was admitted on (MONTH) 9, 2019 for a one week respite stay, with a [DIAGNOSES REDACTED].<br>A physician history and physical dated (MONTH) 9, 2019 included to monitor finger stick blood sugars and provide sliding scale insulin.<br>Review of the diabetes baseline care plan dated (MONTH) 9, 2019 revealed a goal that the resident's blood sugars would remain within the acceptable range. Interventions were to monitor blood sugars before meals and at bedtime.<br>Review of the (MONTH) 2019 physician orders [REDACTED]. Special Instructions: Hold for blood sugar less than 100.<br>Review of the (MONTH) 2019 Medication Administration Record [REDACTED].<br>Review of the nursing progress notes and (MONTH) 2019 MAR indicated [REDACTED].<br>During an interview conducted at 8:56 a.m. on (MONTH) 11, 2019 with a Registered Nurse (RN/staff #50), the nurse stated that before she begins to prepare medications for administration she checks to make sure that the resident's blood sugar results are within the parameters for administering.<br>In an interview with a Licensed Practical Nurse (LPN/staff #21) conducted on (MONTH) 12, 2019 at 9:51 a.m., staff #21 stated that before administering insulin she would check the resident's blood sugar. She said if the blood sugar was below the ordered parameter, she would hold the insulin and document that the medication was held and make a note explaining why the medication was held. She said if this happened a few times she would notify the physician and document the physician's response.<br>In an interview conducted with the Director of Nursing (DON/staff #205) on (MONTH) 12, 2019 at 9:56 a.m., the DON stated that she expects the nurse administering medications to review the blood sugars or obtain a blood sugar, and then administer the medication if the blood sugar is within the ordered parameters. She stated that the nurse may only administer the medication outside of the parameters, if the nurse contacts the physician and receives new direction from |

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| F 0757<br><br>**Level of harm -** Minimal harm or potential for actual harm<br><br>**Residents Affected -** Few | (continued... from page 2)<br>the physician. She also stated that if a nurse administered medication outside of ordered parameters, she would expect the nurse to notify the physician and document it. At this time, the DON reviewed the MAR for (MONTH) 10, 14, and 15 regarding the [MEDICATION NAME] and stated that the nurse did not administer the [MEDICATION NAME] in accordance with the physician's orders [REDACTED].<br>Review of a policy regarding Physician Medication Orders revealed that medications shall be administered only upon the written order of a person duly licensed and authorized to prescribe such medications.<br>A policy on nursing care of the resident with diabetes mellitus included the purpose of the guideline was to help the resident control his/her diabetes with diet, exercise, and insulin (as ordered) and to prevent [MEDICAL CONDITION]/[DIAGNOSES REDACTED]. |