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	06/10/2025

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 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	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** Based on clinical record review, staff interviews and review of facility protocol and policies the facility failed to ensure one resident (#5) was free from accidents during a hoyer transfer. The deficient practice could lead to major injury. Findings include: Resident #5 was admitted originally on October 5, 2020 and readmitted on [DATE] with diagnosis that included epilepsy, transient cerebral ischemic attach, other mechanical complication of internal fixation device of right femur, bipolar disorder, acute respiratory failure, non-ST elevation myocardial infraction. A significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed a Brief Interview for Mental Status (BIMS) summary score of 02. indicating severe cognitive impairment. Further review of the MDS assessment revealed the resident was dependent and needed the assistance of 2 or more helpers to complete any activities dealing with transfers. A care plan created May 26, 2025 revealed an approach that the resident is a hoyer lift with 3 staff persons present due to his utilization of a geriatric chair. A facility investigation dated June 6, 2025 revealed that the hoyer sling had impaired integrity and deemed that the root cause of the sling breaking and causing the resident to fall and suffer a hip fracture. A progress note dated June 5, 2025 at 9:45 a.m. revealed that staff reported that the resident's hoyer sling tore during a transfer. The note further reveals that the resident slid out of the sling and onto the floor and was complaining of right hip pain. The note details that 911 was called and the fire department transferred the resident to the local emergency room. The note concludes that notifications were made to the provider, hospice, case manager and responsible party. An Interdisciplinary Team (IDT) note dated June 6, 2025 at 10:23 a.m. revealed that the resident suffered a fall and that the root cause analysis showed that the resident's hoyer sling broke during the transfer. The note states that staff will use a bariatric sling for all transfers upon the residents return from the hospital. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A progress note dated June 10, 2025 at 18:05 p.m. revealed that the resident returned to the facility with a right intertrochanteric fracture of his right hip as a result of his fall. Review of the clinical record did not reveal any orders or assessments done in regards to the accident during the hoyer transfer. An interview was conducted with a Certified Nursing Assistant (CNA/staff #29) on June 10, 2025 at 8:38 a.m. The CNA stated that the facilities' process is to always have 2 CNAs during a hoyer transfer but there could be a resident that requires 3. Staff #29 stated that there are in-services yearly where staff will be guided into a room and shown again how to properly operate the other lift. The CNA stated that she is also taught how to check and see if there is anything wrong with the function of the machine. The CNA stated that the night shift staff are responsible for setting up a resident in a hoyer sling prior to transfers. However she stated that she is still able to place a resident in a hoyer sling as needed. Staff #29 stated that she had entered the residents room and the resident already had the hoyer sling under him so she was unsure of the status of the slings integrity. She stated that there were 3 CNAs in the room as it was protocol for Resident #5's transfers. The CNA further stated that the resident was transferred from his bed to his geri chair for breakfast with no issues. She followed up by saying when the staff went to transfer the resident from his geri chair back to bed was when the sling ripped and the resident fell. An interview was conducted with a CNA (staff #34) on June 10, 2025 at 8:56 a.m. The CNA stated that the facility's process regarding hoyer transfers is to ensure that the right size of sling is being used and making sure its integrity is intact. She further stated that during a 3-person hoyer transfer one CNA would guide the resident's feet, one would guide the resident's body and one would operate the hoyer machine. The CNA stated that the resident was being transferred via hoyer back to his bed from his geri chair, and that during the transfer when the resident was lifted, the sling snapped and he fell to the ground. An interview was conducted with a CNA (Staff #98) on June 10, 2025 at 9:06 a.m. The CNA stated that the facility's process is to place the hoyer sling under the resident to ensure that the highest part reaches the resident's shoulder height. The CNA stated next they ensure that the right anchor points are being used and attached to the hoyer machine. Staff #98 stated that if a resident is heavier, they will most likely be a 3-person assist with hoyer transfers. The CNA said that when the resident was being transferred back to bed via hoyer the sling ripped towards the bottom right where the fabric strap attaches. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	An interview was conducted with a CNA (Staff #48) on June 10, 2025at 10:13 a.m. who stated that the facility's process is to find out what kind of sling the resident needs regarding their height and weight. The CNA followed up stating that he will glance over to ensure the slings are intact with no tears or withering away at the corners or the back part of the sling. He stated that he will roll the resident to the side and place the sling at the residents shoulders and ensure it is laid out appropriately. Staff #48 then stated that he would roll the resident to the other side and lay out the sling and help the resident lay back flat and ensure they are appropriately seated in the sling. The CNA stated that when operating he would also listen for any audible concerns and if he notes any he would let a nurse know. The CNA stated he checks a hoyer sling's integrity by stretching it out to make sure it is not over used or withered, as well as pulling on each corner and anchor point to make sure that there are no weak points or visible signs of fraying. The CNA stated that he had some concerns regarding Resident #5's hoyer sling due to some noises that were made during a transfer the day prior, and some fraying that he spotted during that transfer as well. Staff #48 stated that he let a team lead know regarding his concerns. An interview was conducted with a Licensed Practical Nurse (LPN/staff #56) on June 10, 2025 at 10:40 a.m. The LPN stated he was caring for the resident during the time of his incident and responded when he heard the CNAs calling for help. Staff #56 stated that the CNAs are usually responsible for hoyer transfers but a nurse can step in and aid if it is needed. The LPN stated that if there is a concern with a hoyer sling's integrity he would dispose of it and get a new sling. The LPN stated that when checking a hoyer sling's integrity he is looking at the stitching to ensure it is intact and that there aren't any visible signs of fraying. Staff #56 stated that he was not in the resident's room at the time of the hoyer incident, but after he responded he assessed the resident who ended up transferring to the local emergency room via 911. An interview was conducted with the Director of Nursing (DON/Staff # 27) on June 10, 2025 at 10:51 a.m. The DON stated that her expectations regarding hoyer transfers would initially start by checking the integrity of the hoyer sling that is going to be used, as well as proper placement of the hoyer sling on the resident. The DON continued by stating that she expects staff to use proper safety and placement with the anchor point of the sling, and that the chair or surface they are transferring, is placed appropriately to avoid any unsafe situations. She concluded by stating that she expects staff to verbalize what is being done during the transfer to the resident. The DON stated that she expects staff to check the the hoyer sling thoroughly by checking the integrity of the cloth as well as the seamlines. The DON further stated that if there are any concerns regarding the sling integrity, or a sling looks too worn, then the faulty sling should be placed in a bag and given to the lead CNA to be replaced. The DON stated that Resident #5 was a 3-person assist hoyer transfer and that it was reported to her that the staff transferring the resident had no issues initially, and at the time of the second transfer back to the resident's bed the sling ripped. The DON stated that there was impaired integrity to Resident #5's hoyer sling and that it was brought to her attention during her investigation after two CNAs identified issues with the sling's integrity prior to the incident. Staff #27 stated that the sling should have been pulled out of service, and she deemed this to be an area of improvement. The DON stated that the risk of using a hoyer sling with impaired integrity could result in the sling breaking and causing harm to a resident. A follow-up interview was conducted with CNA (staff #34) on June 10, 2025 at 11:06 a.m. who stated that nothing was reported to her the day previously regarding the sling's integrity. The CNA confirmed that the anchor point (strap) was still attached to the machine and the sling ripped at the seam where the anchor point was attached. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	A facility policy dated 2001 and revised February of 2014, titled, Lifting Machine, Using a Portable, revealed that staff are to document per facility protocol to report other information in accordance with facility policy and professional standards of practice.