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	06/26/2025

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 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. (continued on next page)

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.

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

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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, review of clinical record, and review of facility policy and procedure, the facility failed to ensure three residents (#22, #26 and #27) were not abused by other residents (#125, #50 and#145). The deficient practice could lead to physical and psychosocial harm of residents.-Regarding Resident #22 (alleged victim):Resident #22 was re-admitted to the facility September 20, 2023, with diagnoses that included dysphagia, catatonic schizophrenia, cerebral infarction, hyperlipidemia, vascular dementia with behavioral disturbance, schizoaffective disorder, major depressive disorder with severe psychotic symptoms, and restlessness and agitation. A quarterly minimum data set (MDS) assessment dated [DATE], revealed Resident #22 had a Brief Interview for Mental Status (BIMS) score of 00, indicating severe cognitive impairment.A care plan dated November 8, 2017, revealed Resident #22 has socially inappropriate / disruptive behavioral symptoms as evidenced by making verbal unwanted statements and reaching out and grabbing staff and objects while being transported.A progress note dated April 6, 2023, revealed Resident #22 was involved in a physical altercation with his roommate. The roommate struck Resident #22 in the back. No injuries were noted. Both parties were separated and residing in private rooms at this time. -Regarding Resident #125 (alleged perpetrator):Resident #125 was re-admitted to the facility January 25, 2022, with diagnoses that included bipolar disorder, hemiplegia and hemiparesis affecting right dominant side, dysphagia, aphasia, catatonic disorder, ataxia, and unspecified mood disorder. An annual MDS assessment dated [DATE], revealed Resident #125 had a BIMS score of 00, indicating severe cognitive impairment.A care plan dated April 6, 2023, revealed Resident #125 is a threat to others due to physically assaulted another resident over a disagreement about the room temperature.A progress note dated April 5, 2023, revealed the behavioral health team was notified of a resident to resident altercation and requested Resident #125 have review and follow up by the behavioral health team. The resident struck his roommate with a closed fist on his back three times. No injuries were noted and the parties were separated for safety. Resident #125 admits he hit roommate because he doesn't listen to me. Both residents stating they were arguing over the temperature of the room. The Director of Nursing (DON) and social services were notified.A progress note dated April 7, 2023, revealed a certified nursing assistant (CNA) reports a second staff member required due to physical attempts of Resident #125 to grab at a female's groin and chest areas. The resident was very difficult to redirect from physical advances towards CNAs.A Witness Statement Form dated April 5, 2023, by a Licensed Practical Nurse (LPN / Staff #83), revealed the nurse was called to the room by a CNA. Resident #22 wheeled himself out of the room reporting that his roommate, Resident #125, hit him in the back four times with a closed fist. Resident #125 admitted to hitting Resident #22 because he doesn't listen to me. Both residents reported the incident occurred because of the heater being turned off and on. Resident #22 was removed from the room and the DON, social services, and the administrator were notified.A facility Reportable Event Record / Report submitted to the State Agency on April 8, 2023, revealed that on April 5, 2023, at approximately 12:20 PM, Resident #22 notified the nursing staff that his roommate, Resident #125, had struck him in the back four times. Resident #22 stated they had been arguing about the temperature of the room when the incident occurred. The nursing staff immediately separated the residents and notified the DON, social worker, and the Administrator of the incident. The DON spoke with both residents following the event. Resident #22 stated his roommate had struck him with a closed fist to the right shoulder/upper back area. He denied any pain or discomfort to the area and was able to move his right arm without difficulty. This writer assessed the area and noted no bruising, swelling or redness. The DON spoke with Resident #125 after the incident and asked if he had struck his roommate and he replied yes, I did but could not recall why he had done so. Per nursing staff, Resident #125 had stated that he had struck him because he doesn't listen to me. An interview was conducted with a CNA (Staff #101) on June 25, 2025, at approximately 10:45 AM. Staff #101 stated that she had heard about an altercation between those two residents, but did not see anything. Staff #101 stated that Resident #125 was getting very aggressive, and that Resident #22 was very sweet, but he did have a temper if anyone got in his way or said anything, then he could get violent. Staff #101 stated that the facility did investigate that incident, and both of those residents could not be in the dining room at the same time. An interview was conducted with the Social Services Director (Staff #148) on June 25, 2025, at 11:12 AM. Staff #148 stated that she was familiar with Resident #22, and that she believed he hit others when he was at the facility. Staff #148 stated she used to

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-Regarding Resident #26:Resident #26's record was admitted to the facility on [DATE] with diagnosis that included dementia with behavioral disturbances and repeated falls.The Minimum Data Set (MDS) dated [DATE], revealed the resident had a Brief Interview for Mental Status (BIMS) score of 99, indicating the resident was not able to complete the assessment.A Nursing Progress Note dated July 9, 2023, revealed a resident to resident altercation between resident #26 and resident #50. It explains that resident #26 went into a room and got into bed. Resident #50 and another resident, were in this room eating lunch together. Resident #50 attempted to get resident #26 out of bed and out of the room, and began yelling at resident #26. Resident #50 then attempted to pull resident #26 out of the bed. Resident #50 told staff when they entered that there had been a schoffel and that he did not remember what he did to resident #26 however, he did remember putting his hands on him.Resident #26 was noted to have a lump to the left eye and it was red in the sclera. -Regarding Resident #50: Resident #50's record was admitted to the facility on [DATE] with a diagnosis of dementia with behavioral disturbances, and repeated falls.The quarterly MDS dated [DATE] revealed the resident had a BIMS score of 13, indicating the resident was cognitively intact.The care plan dated March 29, 2023, revealed the resident was to be assessed for behavioral symptoms that present a danger to the resident and/or others. An update to the care plan, dated May 11, 2023, revealed the resident was noted to be intrusive with peers. The short term goal noted stated Resident will not invade residents personal space, hand and feet will remain to self.A Nursing Progress Note dated July 9, 2023 revealed the same resident to resident altercation. However, it also states thatresident #26 stated he hit me in the eye. The staff escorted resident #50 to the hallway where he stated I don't know what happened and where my room is. Staff escorted resident #50 back to this room where facility implemented a 1:1 sitter for monitoring of aggressive behaviors.On July 9, 2023 a Facility Reported Incident was submitted to the State Agency (SA) regarding the resident to resident altercation between both residents #26 and #50. On July 12, 2023 the Facility Investigation was submitted. The report reveals that the incident was unwitnessed by staff. However, the only resident witness to the event has advanced dementia and was unable to recall any details of the event. The Director of Nursing (DON) interviewed resident #26 after the incident, and he stated that resident #50 did not have a closed fist but he was struck by the back of his hand and that it was an accident. The DON also spoke with resident #50 and he stated he did not really remember. He explained I was trying to get him out of the room. I didn't mean to hit him and if I hurt him I'm truly sorry.A Nursing Progress Note dated July 10, 2023 reveals that resident #50 was noted to have edema to his right hand. Resident's provider applied a brace to the hand. A follow up X-ray revealed that the resident had sustained a right fifth metacarpal neck acute fracture. Resident was ordered a splint.A Nursing Progress Note dated July 10, 2023 reveals that resident #26 was sent to the hospital and did receive an X-ray to his left eye. No fractures were present. However, resident #26 would need follow up care with the Ophthalmologist.An interview was conducted on June 26, 2025 at 1:16 PM with the Administrator, staff #176, and the DON, staff #28. Staff #176 states yes, it happened and as soon as we found placement for resident #50. He was discharged . (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the facility policy titled Preventing, Reporting and Investigating Abuse, Revised July 2023, revealed residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. It is the responsibility of our employees, facility consultants, Attending Physicians, family members, visitors, etc., to promptly report any incident or suspected incident of neglect or resident abuse, including injuries of unknown source, and theft or misappropriation of resident property to facility management. All reports shall be promptly and thoroughly investigated by facility management. The facility is committed to protecting our residents from abuse by anyone. Abuse means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes the following types of abuse: verbal, sexual, physical, mental, exploitation, misappropriation of resident property, involuntary seclusion, and including abuse facilitated or enabled through the use of technology. Willful as used in this definition of abuse means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

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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. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on the clinical record, staff interviews, facility policy and facility records, the facility failed to ensure that 1 resident (#33) was safe. Failure to ensure the resident's safety could lead to resident harm. Findings include: Resident #33 was admitted on [DATE] with diagnoses of dementia, Major Depressive Disorder, and macular degeneration. A hospital history and physical dated October 7, 2023 included that this resident has chronic dementia and was unable to recall events of what happened. An admission assessment dated [DATE] included that this resident was attentive, disoriented, memory impaired, and had disorganized thinking. A care plan dated October 18, 2023 included that this resident is oriented to self and that this resident had Cognitive loss/dementia or alteration in thought processes related to diagnosis of dementia with behavioral disturbance as evidenced by impaired decision making, short and/or long term memory loss, and/or neurological symptoms. A treatment consent dated October 19, 2023 included that this resident's consents were signed by her Power of Attorney (POA). A care conference review report dated October 29, 2023 included that BIMS, she repeats three words, does not know year, month or day of week and can remember one of three words after five minutes, for a score of 05. A progress note dated November 5, 2023 included that this resident was observed exiting front courtyard with elder male and that the writer offered assistance with a leave of absence or an Against Medical Advice (AMA) form, and that the male reports I already did. This progress note included that the writer went to obtain Charge Nurse on duty as well as an AMA form, and a Certified Nursing Assistant (CNA) stopped the male's vehicle, prior to leaving premises. This progress note also included that the alleged perpetrator then signed AMA form and stated we might come back. However, review of both the medical and healthcare POA forms did not list alleged perpetrator as an agent. A progress note dated November 5, 2023 included the On Call Supervisor, DON, & Administrator were notified upon discovering the MPOA's were not the person who took the resident out of the facility. This note included that the MPOA advised writer to call the alleged perpetrator on cell phone and tell him to return this resident or police will be called. This note included that the writer called this person's primary number and left voice mail with clear instructions and called 911 and gave a description of event and description of the resident and her clothes, and a description of the alleged perpetrator, what he was wearing and what he was driving. A progress note dated November 5, 2023 included that an Officer with Tucson Police Department called to verify the resident was at her previous residence, safe and sound. A progress note dated November 5, 2023 included that per the resident's POA, this resident was safe at neighbor's home having coffee awaiting the co-POA and that an order of protection was to be filed against the alleged perpetrator, as family did not anticipate him taking this resident out of the facility. A progress note dated November 6, 2023 included that a POA contacted the facility to provide update on this resident's current situation and said that the family is obtaining a restraining order against the alleged perpetrator and was requesting that the alleged perpetrator be taken off the face sheet in case he returns to ask where the resident was being discharged to. This note included that the staff removed the alleged perpetrator from the face sheet. An interview conducted on June 26, 2025 at 1 P.M. with a Certified Nursing Assistant (CNA/staff #87) who said that she would report a resident going AMA to the nurse, and that the nurse is in charge and will get someone, and will notify the administrator. This CNA said that a resident leaving AMA was a risk for safety and environment. An interview conducted on June 26, 2025 at 1: 13 P.M. with a Registered Nurse (RN/staff #161) who said that if a resident wants to leave against medical advice, it would depend on if the resident is oriented. This nurse said that she would call the family members, and see if they could prevent the resident from leaving. This nurse also said that she would see if she could find the reason the resident wants to leave and see if she could help, then if the resident still wanted to leave, she would call the provider, educate the patient, and if the resident was oriented then the resident would sign the AMA sheet and they leave. This nurse said that if the person was not oriented that they would not be going home. This nurse reviewed the clinical record and said that she would call the POA, let her know what the alleged perpetrator is doing, let the physician know, find out why she wants to leave, but yeah she's not going to be going with the alleged perpetrator. She said that I would tell him She will not be leaving with you because that person is not the POA. This nurse said that this resident should not have left the building. This nurse said that this nurse should have talked to the medical POA prior to that. An interview was conducted on June 26, 2025 at 1:55 PM with a Licensed Practical Nurse (LPN/staff #240) who said that she remembered this resident and that she remembered the incident where