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	05/19/2026

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 - Few	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** Based on clinical record review, staff interviews, facility documentation, and review of facility policies and procedures, the facility failed to protect the rights of one three resident's (#20) to be free from abuse by another resident. The deficient practice had the potential to result in further abuse of residents.-Regarding Resident # 35:Resident #35 (alleged perpetrator) was admitted to the facility on [DATE], with diagnoses including unspecified dementia, altered mental status, and brief psychotic disorder.A quarterly Minimum Data Set (MDS) assessment, dated February 11, 2026, revealed Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition, no behaviors of wandering were exhibited during the assessment period.A psychosocial well-being care plan, initiated on November 18, 2025, revealed the following problem area: Adjustment to living in a secure environment related to dementia, memory impairment and history of attempts to elope and wandering. The goal was for the resident to show acceptance living in a secure unit environment as evidenced by social interactions with staff and peers with a target date of July 29, 2026. Interventions included to assess characteristics that may impede ability to interact with others, determine/support the resident's ability and desire to relate to others,A nursing progress note dated April 10, 2026 reported that another resident (#20) wandered into Resident #35's room. The note revealed that staff heard yelling from the room and removed Resident #20 from the room, and Resident #35 remarked of attempts of thievery to his personal belongings. The note revealed that Resident #35 was moved to another room to avoid future incidents.An Event Report dated April 10, 2026, revealed that the resident exhibited paranoid behavior, and had no injuries related to the incident.A care plan revealed a focus initiated on April 11, 2026, for cognitive impairment related to dementia with increased confusion, paranoia, and self-directed speech. Interventions included staff education on resident behaviors, reassurance and calm redirection during paranoia, maintaining clear boundaries with belongings, and Behavioral Health Team follow-up as needed.An interview was conducted with Resident #35 on May 19,2026 at 1:18 p.m., who stated that he recalled Resident #20 as a former roommate and confirmed they previously shared the same room. Resident #35 reported that he struck Resident #20 in self-defense after being hit multiple times on the right shoulder and right thigh, stating the incident occurred prior to a room change. He also reported that staff assessed his skin for bruising following the incident.-Regarding Resident #20:Resident #20 (alleged victim) was re-admitted to the facility on [DATE], with diagnoses including vascular dementia, unspecified psychosis, anxiety disorders, depression, other specified mental disorders due to known physiological condition, chronic obstructive pulmonary disease, and hypertension.Review of the clinical records between November 18, 2025 and April 10, 2026 revealed no evidence of wandering behaviors or resident altercations.A care plan, initiated April 2, 2026, revealed a focus addressing the risk for adverse consequences related to antimanic medication use for treatment of vascular dementia, with interventions including monitoring behavioral and mood symptoms for potential risk to self or others and implementing interventions as needed.A behavior monitoring progress note dated April 9, 2026 revealed that the resident exhibited intrusive behavior twice, was redirected and interventions of 1 to 1, reassurance (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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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and food/fluids were effective.A nursing progress note dated April 10, 2026 revealed that the resident had been using the restroom and exhibited disorientation and confusion which lead to the resident entering a shared room. The note relayed that during the disorientation the resident approached another resident and that yelling was heard coming from the resident's room. The note indicated that staff responded immediately and reoriented Resident #20 to his room. The note revealed that discoloration to the left outer eye, the left shin and right knee were noted with discoloration and abrasions. The note revealed that the resident denied pain or discomfort, and stated he felt safe, neuro checks and 1:1 staff were initiated.A skin assessment completed for Resident #20 on April 10, 2026, documented bruising and abrasions to the left outer eye, bilateral upper extremities, left shin, and right knee. An Event Report dated April 10, 2026, revealed that the resident exhibited wandering behavior, and obtained bruising to the left eye, left shin and right knee during the episode. The report relayed that the resident was redirected, moved to a quiet area with 1:1 staff.Review of the updated care plan after the incident revealed a focus initiated on April 10, 2026, addressing cognitive impairment related to dementia with wandering, impaired room recognition, misdirected toileting, and occasional resistance to care. The care plan indicated that due to disorientation, the resident was at times unable to identify his room and entered other residents' rooms or handled their belongings, placing him at risk for safety concerns. Interventions included close staff proximity, redirection, and providing a structured, secure environment to support safe wandering on the behavioral dementia unit.A 5-day investigation report and Incident report revealed that the incident was related to injury of unknown origin and was a significant event. The report revealed that staff entered Resident #35's room due to yelling from the room, and observed Resident #20 in Resident #35's room. The report included that a Licensed Practical Nurse (LPN) separated the residents and noted bruising to the left eye and left shin of Resident #20. The report relayed that Resident #20 stated that the other guy hit me, but I'm ok. The report indicated that the facility determined that Resident #35's action was not willful intent to cause injury, but instead was protecting his belongings. The report revealed that Resident #35 was acting as any reasonable person would if someone was breaking into their property. The report included a type written statement from Registered Nurse (RN, Staff #120), who relayed that on April 10, 2026, Resident #20 reported that Resident #35 hit him. The statement also included that Resident #35 reported that Resident #20 was trying to steal his stuff, and that Resident #20 was hitting him in the shoulders and knees. The RN reported that Resident #35 further stated that he hit Resident #20 because Resident #20 was trying to steal his stuff.A telephonic interview was conducted with Certified Nursing Assistant (CNA/Staff #200) on May 19, 2026 at 2:01 PM, who stated that she heard yelling from resident #35's room, and along with Licensed Practical Nurse (LPN/Staff #300) entered the room. The CNA further stated that she observed Resident #20 inside Resident #35's room attempting to open a cabinet. The CNA reported that staff observed bruising to Resident #20's left eye, right shin, and right knee, which was not present prior to the incident. The CNA also stated that Resident #35 stated Resident #20 hit him first and attempted to take his belongings. The CNA stated that unwanted physical contact such as hitting or slapping a resident would be considered abuse.An interview was conducted with Licensed Practical Nurse (LPN/Staff #100) on May 19, 2026 at 2:07 PM, who stated that she was not present during the incident but was informed that an altercation occurred between Residents #20 and #35. The LPN stated that Resident #35 was relocated to a different room following the incident. The LPN further stated that staff reported bruising on Resident #20's left eye that was not present prior to the incident and were unaware of any prior altercations between the residents.An interview was conducted with the Director of Nursing (DON, Staff #400) on May 19, 2026 at 2:29 PM, who stated that she was not present during the incident but was informed that staff heard yelling, entered the room, and separated the residents. The DON also stated that Resident #20 was noted to have discoloration to the left eye and abrasions to the shin and right knee, with no prior documentation of these injuries before the incident. The DON reported no known history of abuse or issues between Residents #20 and #35.An interview was (continued on next page)

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