

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 035145	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/26/2026
NAME OF PROVIDER OR SUPPLIER Devon Gables Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and review of facility policy, the facility failed to ensure that appropriate infection prevention and control practices were followed regarding catheter bag placement, dining services and meal tray delivery services for 5 residents (#9, #117, #110, #52 and #145) The deficient practice could result in the spread of infection. Findings include:-Regarding Resident #9 Resident #9 was admitted on [DATE] with diagnosis including hemiplegia and hemiparesis following a cerebral infarction affecting the left non-dominant side, major depressive disorder-recurrent, other cerebrovascular disease, vascular dementia-unspecified severity without behavior disturbance, psychotic disturbance, mood disturbance, schizoaffective disorder-bipolar type, essential hypertension, other urogenital candidiasis, unspecified urinary incontinence, elevated white blood cell count-unspecified and atherosclerotic heart disease. A review of the care plan revealed that the resident may use a condom catheter as needed and that the noted interventions included to not allow the tubing or any part of the drainage system to touch the floor and to position the bag below the level of the bladder with a start date of August 6, 2024. The care plan further revealed that when a catheter is used to keep the catheter system closed as much as possible. A review of the quarterly MDS (minimum data set) dated June 2, 2026 revealed that the resident had a BIMS (brief interview of mental status) score of 14, indicating that the resident was cognitively intact. The MDS further revealed that the resident had upper extremity impairment, had an external catheter and was on a urinary toileting program. A review of the physician orders revealed an order dated January 29, 2026 noting that the condom catheter is to be changed twice weekly on shower days and may be changed as needed if rolled or leakage is seen. An observation was conducted on June 23, 2026 at 9:08 AM on the facility's central hallway. Resident #9 was observed to be maneuvering his wheelchair with his feet past the main entrance of the building toward the hall on the right where the social service office was located. It was further observed that the resident's catheter bag was dragging on the floor underneath the resident's wheelchair. An interview was conducted on June 23, 2023 at 9:12 AM with the Director of Nursing (DON/ Staff #122) who was observed in the same central hallway. When the DON was asked about the resident's catheter bag, she stated that she observed the catheter positioned under the resident's wheelchair to be touching the floor. She stated that the catheter bag should always have a privacy bag on it and should not be touching the floor. She stated that the risk to the resident could include infection. An interview was conducted on June 26, 2026 at 8:46 AM with certified nursing assistant (CNA/ staff #34). Staff #34 stated that a catheter site should always be kept clean and monitored for any site of infection. She stated that if she observed anything of concern regarding a resident's catheter she would notify the nurse right away. She further stated that the catheter bag should be lower than the bladder but should never touch the floor. Staff #34 stated that if she observed a resident in a wheelchair with a bag touching the floor, she would conduct hand (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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: 035145	Facility ID: 035145 If continuation sheet Page 1 of 5

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff and residents interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure medications were administered and stored according to policy for one out of 34 sampled resident (#13). The universe was 171. The deficient practice could result in overdose, negative medication interactions and other residents having unrestricted access to medications. Findings include: Resident #13 was admitted on [DATE] and readmitted on [DATE] with diagnosis including degenerative disease of the nervous system, cellulitis of right lower limb, bacteremia, methicillin resistant staphylococcus aureus infection, dementia, anxiety, obstructive sleep apnea, thrombosis of unspecified deep veins of unspecified lower extremity, spinal stenosis-lumbar region, obesity-class 3, partial loss of teeth, indwelling urethral catheter, and other psychoactive substance dependence. A review of the care plan revealed that the resident was at risk for skin impairment due to incontinence of bowel and bladder and the use of clothing, briefs and delaying care with a start date of August 27, 2025. The care plan further revealed that the resident had chronic pain and was at risk for alteration in comfort that could limit participation in ADL's (activities of daily living), tasks, therapy, socialization, sleep patterns, appetite and contribute to behavioral symptoms with a noted start date of February 5, 2025. The annual MDS (minimum data set) dated June 2, 2026 revealed that the resident had BIMS (brief interview of mental status) score of 14, indicating that the resident was cognitively intact. The physician orders revealed that the resident had an order for Muscle Rub (methyl salicylate-menthol) OTC (over the counter) cream 15-10%, noting to apply a liberal amount topically every shift; however, there was no evidence of an order for self-administration of the muscle rub. The physician's orders further revealed an order for Hibacleanse to be applied to the legs with showers once a day on Wednesday and Saturday; however, there was no evidence of an order to self-administer the Hibacleanse. A review of the physician's orders also revealed an order for Miconazole Nitrate [OTC] powder 2%, noting to apply a moderate amount topically to the abdominal pannus (apron belly) and then to cover with Interdry (a special fabric designed to manage moisture, friction and odor); however, there was no evidence of an order for self-administration of the Miconazole Nitrate powder. Further, there was no order in the electronic health record for Halls Cough Drops. A further review of the electronic health record revealed no evidence of an assessment or care planning of self-administration of medications. An observation was conducted June 22, 2026 at 11:40 AM in the room of Resident #13. A 3 ounce Thera Antifungal Powder (containing Miconazole Nitrate) container was observed on the resident's night table along with Hibacleanse antiseptic skin cleanser and Muscle Rub. Further observation revealed a bag of cherry flavored Halls Cough Drops on the bedside table. All items were observed to be in plain site on top of the table and nightstand. An interview was conducted with resident #13 on June 22, 2026 at 11:42 AM. The resident stated that the Cough Drops on the bedside table were brought in by his brother 2 days ago, as he could not obtain them through the facility. The resident further stated that staff was aware of the cough drops, and other medications on the table and stand and that he did not consider these to be medications. An interview was conducted on June 22, 2026 at 11:55 AM with licensed practical nurse (LPN/ staff #201), who stated that a medication is anything ordered by a provider that could include tablets, liquids, oxygen, topicals and even OTC medications. The LPN further stated that cough drops are also consider to be medications, as well as antifungal powders, antiseptic cleansers (continued on next page)		

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