STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056095	A. Building B. Wing	10/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1350 East Devonshire Avenue Hemet, CA 92544

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47832 Based on interview and record review, the facility failed to ensure list of home medications were obtained timely to ensure routine medications were made available and administered for one of the four sampled residents (Resident 2) on admission to the facility. This failure to make the medications readily available had the potential to cause an adverse effect on the health of the resident. Findings: On October 8, 2024, at 8:56 a.m., an unannounced visit was conducted at the facility to investigate a complaint on resident ' s rights and quality of care issue. A review of Resident 2 ' s admission record indicated Resident 2 was admitted to the facility on [DATE]. Resident 2 ' s diagnoses included sprain in the right knee (when ankle rolls or twists in an odd way), falls, difficulty walking, pain in the right knee and muscle weakness. A review of Resident 2 ' s progress notes dated September 23, 2024, by Registered Nurse (RN) 3 indicated, admitted .from (hospital 1) .under the care of (name of physician at skilled nursing facility). No medical history and no home medication on file . A review of Resident 2 ' s progress notes dated September 25, 2024, at 12:13 p.m., by RN 2 indicated, sent text message via facilities cell phone requesting for (name of physician at the skilled nursing facility) to contact this resident ' s PCP (primary care physician) (name of primary physician) to obtain a current/updated med (medication) list. Currently waiting for a response. A review of Resident 2 ' s progress notes dated September 25, 2024, at 5:14 p.m., by RN 2 indicated, called three times for medication list to be put on, no answer from the office. PCP (name of primary physician) . A review of Resident 2 ' s progress notes dated October 3, 2024, at 9:20 a.m., by the Social Services Director (SSD) indicated, . (name 3) requested resident ' s med list from PCP and (name of skilled nursing facility) cc (carbon copy) to ensure resident is taking heart medication. Information was sent to (name 3) via email with high importance. (continued on next page)

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On October 8, 2024, at 1:20 p.m., during an interview, RN 1 stated if a resident was admitted from the hospital, medications are reconciled by the doctor to continue or not to continue at the facility. RN1 stated if the doctor could not be reached, then next, had to call the medical director for orders. RN 1 stated the nurses do not have to wait overnight for the doctor to call back, they could reach out to the medical director. RN 1 also stated for Resident 2, staff failed to follow up with the primary care physician. RN 1 further stated that not administering the medications the resident used to take could put the resident at risk of having a change of condition which could also risk her life. On October 8, 2024, at 2:42 p.m., during an interview, RN 2 stated if the doctor could not be reached, the staff had to contact the medical director for orders. RN2 stated it was important to follow up on medications a resident was taking before coming to the facility. On October 8, 2024, at 3:00 p.m., during an interview, RN 3 stated Resident 2 was admitted from the emergency room and during report from the emergency room nurse she asked for the medication list but was told they did not administer any medications while the resident was in the emergency room and had no medication list. A review of the facility ' s policy and procedure titled, Reconciliation of Medications on Admission, revised July 2017 indicated, The purpose of this procedure is to ensure medication safety by accurately accounting for the resident ' s medications, routes and dosages upon admission or readmission to the facility . Preparation: 1. Gather the information needed to reconcile the medication list .All prescription and supplement information obtained from the resident/family during the medication history .medication reconciliation is the process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care .medication reconciliation .enhances resident safety by ensuring that the medications the resident needs and has been taking continue to be administered without interruption . Steps in the procedure. 1. If a medication history has not been obtained from the resident or family, complete this first. Information from the medication history should include: a. Prescription medications, including those taken only as needed .2. Ask the resident to list all physicians and pharmacies from which he or she has obtained medications .