STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40000

Based on interview and record review, the facility failed to ensure an allegation of physical abuse involving Resident 1 was reported to the California Department of Public Health (CDPH - a state agency), Omdubsman, and law enforcement immediately, or not later than two hours after the allegation was made according to the facility's policy and procedure, for one of three residents (Resident 1).

This failure had the potential to place Resident 1 at risk for harm from further abuse.

Findings:

On January 16, 2025, at 3:51 p.m., CDPH received a facsimile (fax - telephonic transmission) report of a complaint from Adult Protective Services Department (APS) indicating an allegation of abuse involving Resident 1. The report indicated the reporting individual to APS alleged Resident 1 was assaulted by another resident at the facility, but the incident was not reported by the facility.

On January 30, 2025, at 10:13 a.m., an unannounced visit was conducted at the facility for complaint investigations.

On February 3, 2025, Resident 1 ' s record was reviewed. Resident 1 ' s record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included traumatic subdural hemorrhage (bleeding between the skull and brain caused by trauma), multiple sclerosis (a long lasting disease of the central nervous system disorder) and cerebral palsy (temporary paralysis or weakness of the facial muscles on one side of the face).

A review of Resident 1 ' s History and Physical Examination, dated July 5, 2024, indicated Resident 1 had the capacity to understand and make decisions.

A review of Resident 1's Minimum Data Set (MDS- a clinical assessment tool), dated December 20, 2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a screening tool used to assess a resident ' s cognitive status) score of 15 (cognitively intact).

A review of Resident 1 ' s SBAR (Situation, Background, Appearance, Recommendation- a clinical assessment and communication tool), created on December 20, 2024, at 4 p.m., indicated .WOKE UP 12/19/24 (December 19, 2024) SAID SOMEONE WAS PULLING HER HAIR .

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025

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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident 1 ' s record indicated there was no documented evidence Resident 1 was monitored following the allegation of abuse on December 20, 2024, nor was there documented evidence an investigation was conducted by the Interdisciplinary Team (IDT) regarding the incident. On February 4, 2025, at 2:30 p.m., a concurrent interview was conducted with the DON and Nurse Consultant (NC).The DON stated he was aware of the SBAR created on December 20, 2024, and remembered he talked to the resident about the abuse allegation. The DON stated the details of the story always changed, and since the allegation was not substantiated, the allegation was not reported to the CDPH, the Ombudsman or the police. The DON further stated the incident was not reported since there was no proof Resident 1 was abused. The DON explained the facility ' s abuse protocol indicated the allegation reported by Resident 1 was an allegation of abuse and should have been reported to the CDPH, the Ombudsman and the law enforcement agency. In a concurrent interview, the NC stated the incident involving Resident 1 was an allegation of abuse and should have been reported to the state agencies and the local law enforcement agency. A review of the facility ' s policy and procedure titled, Abuse Investigation and Reporting, revised July 2017, indicated, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management .Reporting . All alleged violations involving abuse .will be reported by the facility Administrator, or his/her designee, to the following persons or agencies: .The State licensing/certification agency responsible for surveying/licensing the facility .The local/State Ombudsman .The Resident ' s Representative .Adult Protective Services .Law enforcement officials .The resident ' s Attending Physician; and .The facility Medical Director .An alleged violation of abuse .will be reported immediately, but not later than: .Two (2) hours if the alleged violation involves abuse OR has resulted in serious bodily injury; or .Twenty-four (24) hours if the alleged violation does not involve abuse AND has not resulted in serious bodily injury .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to conduct a thorough investigation of an allegation of abuse, for one of three residents (Resident 1), when Resident 1 reported to the facility staff on December 20, 2024, that someone pulled her hair. This failure resulted in Resident 1 to not be provided sufficient protection, and potentially exposed the resident to further abuse. Findings: On January 16, 2025, at 3:51 p.m., the California Department of Public Health (CDPH - state agency) received a facsimile (fax - telephonic transmission) report of a complaint from the Adult Protective Services Department (APS) containing an allegation of abuse involving Resident 1. The report indicated the reporting individual to APS alleged Resident 1 was assaulted by a fell ow resident at the facility, but the incident was not reported by the facility. On January 30, 2025, at 10:13 a.m., an unannounced visit was conducted at the facility for complaint investigations. On February 3, 2025, Resident 1 ' s record was reviewed. A review of Resident 1 ' s record indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included traumatic subdural hemorrhage (bleeding between the skull and brain caused by trauma), multiple sclerosis (a long lasting disease of the central nervous system disorder) and cerebral palsy (temporary paralysis or weakness of the facial muscles on one side of the face). A review of Resident 1 ' s History and Physical Examination, dated July 5, 2024, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's Minimum Data Set (MDS- a clinical assessment tool), dated December 20, 2024, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- a screening tool used to assess a resident ' s cognitive status) score of 15 (cognitively intact). A review of Resident 1 ' s SBAR (Situation, Background, Appearance, Recommendation- a clinical assessment and communication tool), created on December 20, 2024, at 4 p.m., indicated .WOKE UP 12/19/24 (December 19, 2024) SAID SOMEONE WAS PULLING HER HAIR . Further review of Resident 1 ' s record indicated there was no documented evidence Resident 1 was monitored following the allegation of abuse on December 20, 2024, nor was there documented evidence a thorough investigation was conducted by the Interdisciplinary Team (IDT - a group of healthcare professionals) regarding the allegation of abuse by Resident 1. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 4, 2025, at 2:30 p.m., a concurrent interview was conducted with the DON and the Nurse Consultant (NC). The DON stated he was aware of the SBAR created on December 20, 2024, and remembered he talked to Resident 1 about the abuse allegation. The DON stated the details of the story always changed and concluded the abuse allegation was not substantiated. The DON stated no further investigation was conducted (e.g. interview with other residents and staff). The DON explained the facility ' s abuse protocol and stated the incident involving Resident 1 was an allegation of abuse and should have been investigated further. In a concurrent interview, the NC stated the incident involving Resident 1 was an allegation of abuse. The NC further stated the incident should have been investigated following the facility ' s policy and procedure on abuse prevention. A review of the facility ' s policy and procedure titled, Abuse Investigation and Reporting, revised July 2017, indicated, .All reports of resident abuse, neglect, exploitation, misappropriation of resident property, mistreatment and/or injuries of unknown source (abuse) shall be promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management . Implementation .Role of the Administrator: .If an incident or suspected incident of resident abuse .is reported, the Administrator will assign the investigation to an appropriate individual .The Administrator will provide any supporting documents relative to the alleged incident to the person in charge of the investigation .The Administrator will keep the resident and his/her representative (sponsor) informed of the progress of the investigation .The Administrator will ensure that any further potential abuse .is prevented .The Administrator will inform the resident and his/her representative of the status of the investigation and measures taken to protect the safety and privacy of the resident .The Role of the Investigator .Review the completed documentation forms .Review the resident ' s medical record to determine events leading up to the incident . Interview the person(s) reporting the incident .Interview the resident (as medically appropriate) .Interview the resident ' s Attending Physician as needed to determine the resident ' s current level of cognitive function and medical condition .Interview staff members (on all shifts) who have had contact with the resident during the period of the alleged incident .Interview the resident ' s roommate, family members, and visitors .Review all events leading up to the alleged incident .Witness reports will be obtained in writing. Either the witness will write his/her statement and sign and date it, or the investigator may obtain a statement, read it back to the member and have him/her sign and date it .The investigator will notify the ombudsman that an abuse investigation is being conducted .The investigator will consult daily with the Administrator concerning the progress/findings of the investigation .Upon conclusion of the investigation, the investigator will record the results of the investigation on approved documentation forms and provide the completed documentation to the Administrator .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER: Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1350 East Devonshire Avenue Hemet, CA 92544	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on observation, interview, and record review, the facility failed to follow the physician ' s treatment orders for skin conditions, for two of three residents (Residents 3 and 4). This failure had the potential to result in the worsening of Resident 3 and 4 ' s skin conditions. Findings: On February 3, 2025, at 10 a.m., an unannounced visit was conducted at the facility to investigate complaint intakes. 1. On February 3, 2025, at 11:22 a.m., Resident 3 was observed lying in bed. On February 3, 2025, a review of Resident 3 ' s record indicated the resident was admitted to the facility on [DATE], with diagnoses which included gastrostomy status (presence of a surgical opening in the stomach) and ileostomy status (a piece of the upper small intestines is diverted to an artificial opening in the abdominal wall, allowing waste to leave the body). A review of Resident 3 ' s History and Physical Examination, dated January 9, 2025, indicated Resident 3 had the capacity to understand and make decisions. A review of Resident 3 ' s Minimum Data Set (MDS- a clinical assessment tool), dated January 13, 2025, indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a screening tool used to assess a resident ' s cognitive status) score of 13 (cognitively intact). A review of Resident 3 ' s Body Check, dated July 8, 2024, indicated Resident 3 had a right lower abdomen ileostomy. A review of Resident 3 ' s Treatment Administration Record (TAR), for January 2025, included the following treatment orders: - Right lower abdomen ileostomy care daily and as needed every day shift; date ordered January 10, 2025; - Right lower abdomen ileostomy, cleanse with normal saline pat, dry change ileostomy bag every 3 days and as needed; date ordered January 10, 2025; and - Right lower abdomen redness, wash with soap and water, rinse, pat dry, apply nystatin powder (antifungal powder), and leave open to air daily and as needed every day shift for 21 days; date ordered January 10, 2025. A review of Resident 3 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the right lower abdomen ileostomy care daily on the following dates: - January 11 to 13, 2025 (three days); (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- January 18 to 27, 2025 (10 days); and - January 29 to 30 (two days); total of 15 days for January 2025. A review of Resident 3 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment order to change the ilestomy bag every three days on January 13, 22, and 25, 2025. A review of Resident 3 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment order for the right lower abdomen redness on the following dates: - January 11 to 13, 2025 (three days); - January 18 to 27, 2025 (10 days); and - January 29 to 30 (two days); total of 15 days for January 2025. On February 4, 2025, at 11:15 a.m., a concurrent interview and record review was conducted with Treatment Nurse (TN) 1. TN 1 stated there were 2 TNs for the facility, she worked Tuesday to Friday from 8:30 a.m. to 5 p.m, and TN 2 worked Saturday to Tuesday from 8:30 a.m. to 5 p.m. TN 1 stated there was only one TN daily, and the only day of the week when there were 2 TNs working in the facility was on Tuesdays. TN 1 stated both TNs were out sick from January 19 to 27, 2025, so a licensed nurse was assigned to do the treatments. TN 1 stated TN2 had an emergency on January 18, 2025, and had to leave work early, which may be the reason why the TAR was not signed that day. TN 1 stated she was not able to sign Resident 3 ' s TAR on January 29 and 30, 2025, because the caseload was heavy and she had to focus on doing the actual care for the residents and did not have time to document the treatment orders for Resident 3 were provided. TN 1 stated she should have signed the TAR, since if it was not documented, then the care was not done. On February 4, 2025, at 1:15 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated during the week of January 18 to 27, 2025, they had designated Licensed Vocational Nurse (LVN) 1 to do the treatments, because both TNs were out sick. The DON stated he was not sure why LVN 1 did not document on Resident 3 ' s TAR. The DON stated LVN 1 he should have documented on the TAR. The DON further stated the nurses should have initialed on the TAR to indicate the care had been provided to the residents. 2. On February 3, 2025, at 11:16 a.m., Resident 4 was observed lying in bed. On February 3, 2025, a review of Resident 4 ' s record indicated the resident was admitted to the facility on [DATE], with diagnoses which included nontraumatic intracerebral hemorrhage (bleeding inside the brain not caused by trauma), hemiplegia (paralysis on one side of the body), high blood pressure, and aphasia (language disorder, inability to communicate effectively). A review of Resident 4 ' s History and Physical Examination, dated December 7, 2024, indicated Resident 4 did not have the capacity to understand and make decisions. A review of Resident 4 ' s MDS, dated [DATE], indicated Resident 4 had a BIMS score of five (severe cognitive impairment), and an MASD (Moisture-associated skin damage- skin inflammation that occurs when the skin is exposed to moisture for a long time). (continued on next page)

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

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4 ' s Body Check, dated December 6, 2024, indicated .PERINEAL (area of skin and muscle located between the anus and the external genitalia) TO PERIANAL (around the anus) EXTENDING TO THE BILATERAL (both) BUTTOCKS MASD . A review of Resident 4 ' s Treatment Administration Record (TAR), for January 2025 included the following treatment orders; - Perineal to perianal extending to the bilateral buttocks MASD, wash with soap and water, rinse, pat dry, apply zinc oxide ointment (used to treat skin irritations including diaper rash and eczema), then apply nystatin powder and leave open to air daily and as needed for 30 days; date ordered January 5, 2025; A review of Resident 4 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the MASD on both buttocks on January 13, 19, 25, 26, 2025 (four days). On February 4, 2025, at 2:30 p.m., the Director of Nursing (DON) and Nurse Consultant (NC) were concurrently interviewed. The DON stated during the week of January 18 to 27, 2025, they had designated Licensed Vocational Nurse (LVN) 1 to do treatments, because both TNs were out sick. The DON stated they reviewed the TAR for Resident 4 and found that LVN1 also did not sign on the dates specified above. The DON stated LVN 1 should have documented on Resident 4 ' s TAR. The DON further stated the nurses should have initialed on the TAR to indicate the treatments had been provided to the residents. In a concurrent interview, the NC stated the licensed and treatment nurses were expected to document right away after each medication was administered, and after each treatment had been completed. Before they leave at the end of their shift, they need to make sure that they have documented all the care they have rendered to the residents. A review of the facility ' s policy and procedure titled, Nursing Documentation, effective June 27, 2022, indicated, .PURPOSE .To communicate patient ' s status and provide complete, comprehensive, and accessible accounting of care and monitoring provided .Nursing documentation will follow (name of company) policy and procedure and federal and state guidelines .Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures .

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F 0686

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Provide appropriate pressure ulcer care and prevent new ulcers from developing.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 40000

Based on observation, interview, and record review, the facility failed ensure the physician ' s orders for treatment of pressure injuries (a localized area of skin and/or underlying tissue damage caused by prolonged pressure, shear, and/or friction) was conducted, for two of three residents reviewed (Residents 3 and 4).

This failure had the potential to result in the worsening of Resident 3 and 4 ' s pressure injuries.

Findings:

On February 3, 2025, at 10 a.m., an unannounced visit was conducted at the facility to investigate complaint intakes.

1.On February 3, 2025, at 11:22 a.m., Resident 3 was observed lying in bed. In a concurrent interview, Resident 3 stated she had a pressure wound to her bottom.

On February 3, 2025, Resident 3 ' s record was reviewed. A review of Resident 3 ' s record indicated Resident 3 was admitted to the facility on [DATE], with diagnoses which included anemia (when the blood produces a lower-than-normal amount of healthy red blood cells) in chronic (occurs over time) kidney disease, acute and chronic respiratory failure with hypoxia (low oxygen), and cardiomyopathy (disease that affects the heart muscle).

A review of Resident 3 ' s History and Physical Examination, dated January 9, 2025, indicated Resident 3 had the capacity to understand and make decisions.

A review of Resident 3 ' s Minimum Data Set (MDS- a clinical assessment tool), dated January 13, 2025, indicated Resident 3 had a Brief Interview for Mental Status (BIMS- a

screening tool used to assess a resident ' s cognitive status) score of 13 (cognitively intact).

A review of Resident 3 ' s Body Check, dated July 8, 2024, indicated Resident 3 had an unstageable wound to the sacrococcyx (tailbone area).

A review of Resident 3 ' s Care Plan indicated a care plan initiated November 12, 2024 with a focus on the sacrocccyx pressure ulcer/SDTI with interventions which included, .TREATMENT AS ORDERED .CLEANSE WITH NORMAL SALINE PAT DRY APPLY VENELEX OINTMENT AND LEAVE OPEN TO AIR Q(every)DAILY AND PRN (as needed) x 30 DAYS .

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s Treatment Administration Record (TAR) for January 2025, included a treatment order, dated January 10, 2025, which indicated, .Sacrococcyx pressure ulcer injury/SDTI (suspected deep tissue injury- the underlying soft tissue is damaged due to pressure or shear): Cleanse with normal saline, pat dry, apply Venelex ([NAME]/castor oil - an ointment used on the skin to cover wounds, also helps get rid of smells and might relieve pain from the wound) and cover with border foam dressing (type of dressing made of highly absorbent foam) daily and as needed, every day shift for 30 days . A review of Resident 3 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the pressure injury on the sacroccyx on the following dates: - January 11 to 13, 2025 (three days); - January 18 to 27, 2025 (10 days); and - January 29 to 30, 2025 (two days); total of 14 days. On February 4, 2025, at 11:15 a.m., a concurrent interview and record review was conducted with Treatment Nurse (TN) 1. TN 1 stated there were two TNs for the facility, she worked Tuesday to Friday from 8:30 a.m. to 5 p.m., and TN 2 worked Saturday to Tuesday from 8:30 a.m. to 5 p.m. TN 1 stated there was only one TN daily, and the only day of the week when there were 2 TNs working in the facility was on Tuesdays. TN 1 stated the week of January 19 to 27, 2025, both TNs were out sick, so a licensed nurse was assigned to do the treatments. TN 1 stated TN2 had an emergency on January 18, 2025, and had to leave work early, which may be the reason why the TAR was not signed that day. TN 1 stated she returned to work on January 28, 2025. TN 1 stated she was not able to sign Resident 3 ' s TAR on January 29 and 30, 2025, because the case load was heavy and she had to focus on doing the actual care for the residents and did not have time to document the treatment rendered. TN 1 stated she should have signed the TAR, since if it was not documented, then the care was not done. On February 4, 2025, at 1:15 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated during the week of January 18 to 27, 2025, they had designated Licensed Vocational Nurse (LVN) 1 to do the treatments, because both TNs were out sick. The DON stated he was not sure why LVN 1 did not document on Resident 3 ' s TAR, and he should have done so. The DON further stated the nurses should have initialed on the TAR to indicate the treatments had been provided to the residents. 2. On February 3, 2025, at 11:16 a.m., Resident 4 was observed lying in bed. In a concurrent interview, Resident 4 stated she had sores on her feet. On February 3, 2205, a review of Resident 4 ' s record indicated the resident was admitted to the facility on [DATE], with diagnoses which included nontraumatic intracerebral hemorrhage (bleeding inside the brain not caused by trauma), hemiplegia (paralysis on one side of the body), high blood pressure, and aphasia (language disorder, inability to communicate effectively). A review of Resident 4 ' s History and Physical Examination, dated December 7, 2024, indicated Resident 4 did not have the capacity to understand and make decisions. (continued on next page)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 4 ' s MDS, dated [DATE], indicated Resident 4 had a BIMS score of five (severe cognitive impairment) and an unstageable deep tissue injury. A review of Resident 4 ' s Body Check, dated December 6, 2024, indicated, .SACROCOCCYX PRESSURE ULCER INJURY SDTI WOUND BED IS 100% NECROTIC BOGGY MUSHY PURPLE DISCOLORATION (4CM [centimeter- unit of measurement] X 4CM X UTD [unable to determine]) NO DRAINAGE NOTED AT THIS TIME . A review of Resident 4 ' s Treatment Administration Record (TAR), for January 2025 included the following treatment orders: - Right lateral malleolus (knobby bone on the outside of the right ankle) pressure ulcer injury: Cleanse with normal saline, pat dry, apply medihoney (wound treatment gel containing manuka honey and helps wound heal by reducing bacteria, reducing inflammation, and promoting a moist wound environment), cover with foam dressing daily and as needed every day shift x 30 days; date ordered January 5, 2025; - Left lateral malleolus (knobby bone on the outside of the left ankle) unstageable wound: Cleanse with normal saline, pat dry, apply medihoney, cover with dry dressing daily and as needed, every day shift for 30 days; date ordered January 28, 2025; - Sacrococcyx pressure ulcer injury/SDTI: Cleanse with normal saline pat dry cover with dry dressing daily and as needed, every day shift for 30 days; date ordered January 5, 2025; and - Venelex External ointment (Balsam Peru Castor Oil) Apply to sacrococcyx topically every day shift for pressure ulcer injury/SDTI for 30 days; date ordered January 5, 2025 A review of Resident 4 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the pressure injury on the right lateral malleolus on January 13, 19, 25, 26, and 31, 2025 (five days); A review of Resident 4 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the pressure injury on the left lateral malleolus on January 31, 2025. A review of Resident 4 ' s TAR, for January 2025, indicated there was no licensed nurse signature on the treatment orders for the pressure injury on the sacrococcyx SDTI on January 11, 13, 19, 25, and 26, 2025 (five days). On February 4, 2025, at 2:30 p.m., the Director of Nursing (DON) and Nurse Consultant (NC) were concurrently interviewed. The DON stated during the week of January 18 to 27, 2025, they had designated Licensed Vocational Nurse (LVN) 1 to the treatments, because both TNs were out sick. The DON stated LVN 1 should have documented on the TAR. The DON further stated the licensed nurses should have initialed on the TAR to indicate the care had been provided to the residents. In a concurrent interview, the NC stated the licensed and treatment nurses were expected to document right away after each medication was administered, and after each treatment has been completed. Before they leave at the end of their shift, they need to make sure that they have documented all the care they have rendered to the residents. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056095	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/04/2025
NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 East Devonshire Avenue Hemet, CA 92544	

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility ' s pressure ulcer list indicated 13 residents with pressure injuries, ranging from one to five pressure injury sites per resident, and with varying degrees of pressure injuries ranging from SDTIs to Stage 4 (the most severe stage where the skin damage extends fully through all tissue layers, exposing underlying muscle, tendon, or bone, often with visible dead tissue [slough or eschar] and a high risk of infection), as well as unstageable (a full-thickness wound where the base of the injury is obscured by slough or eschar) pressure injuries. A review of the facility ' s policy and procedure titled, Nursing Documentation, effective June 27, 2022, indicated, .PURPOSE .To communicate patient ' s status and provide complete, comprehensive, and accessible accounting of care and monitoring provided .Nursing documentation will follow (name of company) policy and procedure and federal and state guidelines .Timely entry of documentation must occur as soon as possible after the provision of care and in conformance with time frames for completion as outlined by other policies and procedures .

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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 40000

Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented according to the facility policies and procedures and Centers for Disease and Prevention Control (CDC) guidelines, when the facility had COVID -19 (respiratory infection caused by the SARS-CoV virus) outbreak with 33 residents and 12 staff tested positive for COVID-19, when:

1.The Director of Nursing (DON) was observed wearing an N95 respirator mask (a type of respiratory protective device or personal protective equipment [PPE] designed to achieve a very close facial fit and very efficient filtration of airborne [suspended in air] particles) which was not fit-tested (a procedure that verifies that a respirator fits a person's face and provides the expected level of protection). In addition, the DON had a beard while wearing an N95 mask;

2. 46 out of 70 current direct care staff (Registered Nurses [RN] 1, 2, 3, 4, Licensed

Vocational Nurses [LVN] 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, Restorative Nursing Assistant [RNA] 1, Certified Nursing Assistants [CNA] 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, Physical Therapy Assistant [PTA] 1, Housekeepers [HSKP] 1, 2, ,3, 4, 5, 6) were not fit-tested for N95 respirator masks;

3. Eight of 18 rooms on SPECIAL DROPLET CONTACT PRECAUTIONS (used to prevent the spread of diseases that can be transmitted by touching a patient or their belongings, or by breathing in droplets from a cough or sneeze) for residents with positive COVID-19 were not kept close; and

4. The facility ' s COVID-19 outbreak was not reported to the California Department of Public Health (CDPH-state agency) upon identification of a COVID-19 outbreak which started on January 20, 2025.

These failures had the potential to result in further spread of COVID-19 infection among healthcare personnel and residents, during an existing COVID-19 outbreak in the facility.

Findings:

On January 30, 2025, at 10:13 a.m., an unannounced visit was conducted at the facility for complaint investigations. Upon reaching the lobby, a notice to the public, printed on red colored paper, indicated the facility had a COVID-19 outbreak since January 20, 2025, and use of an N95 respirator mask was being implemented.

1. On January 30, 2025, at around 10:20 a.m., the DON was observed wearing a white Honeywell (brand of N95 mask) N95 mask, which was not fitted securely to the bridge of the nose. The DON was also observed to have a beard which interfered with the fit of the N95 mask.

On January 30, 2025, beginning at 10:20 a.m., the Infection Preventionist (IP) was interviewed. The IP stated the DON was fit-tested with the BYD (another brand of N95 mask). In a concurrent record review of the DON ' s Qualitative Respirator Fit Test Record, dated December 16, 2024, indicated the fit-testing was conducted by the IP on the DON for the BYD half-face one size N95 respirator.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The IP confirmed the DON was currently wearing the white Honeywell N95 respirator mask. The IP stated the DON should be wearing the BYD N95 respirator mask since that was what he was fit-tested for. The IP stated the DON did not have any facial hair when he was fit-tested , but now he had a beard. The IP further stated the DON should not have facial hair when wearing the N95 respirator mask, since proper seal on the face could not be maintained. On January 30, 2025, at 10:45 a.m., during an interview conducted with the DON, he stated he was fit-tested for the use of BYD N95 mask, and was not sure if he was fit-tested for the use of the Honeywell N95 mask. In a concurrent record review of the fit-testing, the DON stated he was fit-tested with the use of the BYD mask. The DON stated he should be using the BYD N95 mask and he should not have facial hair when wearing an N95 mask. A review of the facility ' s undated policy and procedure titled, COVID-19 Management, indicated, .To provide a safe environment and to prevent the development and tramission (sic) of COVID-19 .When Covid-19 hospitalization s are high or when in an outbreak, all staff should wear a surgical/procedure mask or higher (N95 respirator) for source control when providing resident care, working with a resident in-person, or in resident care areas in the facility . A review of the facility ' s policy and procedure titled, N95 Fit Testing, effective January 1, 2021, indicated, . The person wearing an N95 respirator should not have a beard or excessive facial hair that will interfere with providing a good fit . 2. On January 30, 2025, at 11:30 a.m., a concurrent interview and record review was conducted with the IP. A review of the facility document titled, All Staff Vaccines 2024-2025 included a list for N95 Fit Test, which indicated 61 out of 87 direct care staff on the list did not have dates when their N95 respirator mask fit-testing was completed. The IP acknowledged that 50-60% of staff have not been fit-tested , and the current list was not updated to exclude staff who no longer worked in the facility. A review of the facility document COVID-19 line list, indicated a total of 12 staff and 33 residents were tested COVID-19 positive starting January 20, 2025. On January 30, 2025, at 2:31 p.m., Certified Nursing Assistant (CNA) 1 was observed wearing a white Honeywell N95 mask. In a concurrent interview, CNA 1 stated she was not fit-tested for the use of the N95 mask. On January 30, 2025, at 2:40 p.m., Licensed Vocational Nurse (LVN) 1 was observed wearing white Honeywell N95 mask. In a concurrent interview, LVN 1 stated he was not fit-tested for the use of the N95 mask since he was hired in August 2024. On January 30, 2025, at 2:55 p.m., Licensed Vocational Nurse (LVN) 2 was observed wearing a white Honeywell N95 mask. In a concurrent interview, LVN 2 stated he was not fit-tested for this N95 mask since he was hired in September 2024. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On January 30, 2025, at 3 p.m., a concurrent interview and record review was conducted with the IP. The IP stated she did not conduct an N95 fit-test for CNA 1, and was not sure if the Director of Staff Development (DSD) did one with CNA 1. The IP stated she had deferred conducting an N95 fit-test on LVN 1 upon hire due to presence of beard, and to figure out what type of respirator would then be appropriate for him to test. The IP stated she was not able to do the follow up and LVN 1 was never fit-tested . The IP stated she did not conduct any N95 fit-test on LVN 2 since he was hired in September 2024. The IP stated the expectation was for all staff to be fit-tested for the use of N95 upon hire and annually thereafter, and also when there are changes to their facial structures that would affect the fit of the mask. On January 30, 2025, at 8:44 p.m., the final list of completed N95 fit tests for facility staff was submitted by the ADM, the DON and the IP. The list was reviewed and indicated there were 46 out of the 70 currently employed direct care staff who did not have any N95 respirator fit test done prior to January 30, 2025. The document also indicated 17 direct care staff were fit-tested on [DATE]. A review of the facility ' s undated policy and procedure titled, COVID-19 Management, indicated, .To provide a safe environment and to prevent the development and tramission (sic) of COVID-19 .Transmission Based Precautions and Personal Protective Equipment (PPE) .Covid-19 transmission based precautions will use the following PPE .N95 respirator, gloves, gown, and eye protection . A review of the facility ' s policy and procedure titled, N95 Fit Testing, effective January 1, 2021, indicated, . Fit testing will be performed initially and then to be performed annually. If the employee has any change in [physical appearance due to weigh (sic) loss or recent dental work, a new fit test should be performed .the fit tester should document the results of the fit test for which the model the staff member was successfully tested .The fit tester should also maintain a log of all the staff fit tested and when the annual test will be needed . According to the web article published by the CDC titled, Proper N95 Respirator Use for Respiratory Protection Preparedness, dated March 16, 2020, indicated, .OSHA (Occupational Safety and Health Administration) requires healthcare workers who are expected to perform patient activities with those suspected or confirmed with COVID-19 to wear respiratory protection, such as an N95 respirator .Fit testing is a critical component to a respiraotry protection program whenever workers use tight-fitting respirators. OSHA requires an initial respirator fit test to identify the right model, style, and size respirator for each worker. Annual fit tests ensure that users continue to receive the expected level of protection. A fit test confirms that a respirator correctly fits the user . 3. On January 30, 2025, beginning at 11:10 a.m., an observation of the resident care areas was conducted with the IP. Rooms 14, 15, 16, 93, 92, 77, 75, and 71, had SPECIAL DROPLET CONTACT PRECAUTIONS signs posted at the doorways due to COVID-19 positive residents in these rooms. The doors to these rooms were observed open. In a concurrent interview, the IP stated the doors to these rooms should be kept closed to prevent the spread of infection. A review of the facility ' s undated policy and procedure titled, COVID-19 Management, indicated, .To provide a safe environment and to prevent the development and tramission (sic) of COVID-19 .Isolation .Confirmed COVID-19 case .Isolate in a dedicated Covid-19 isolation area .Suspected cases .Symtomatic (sic) pending test results may be isolated in place under transmission based precautions for Covid-19 . (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility ' s document titled, SPECIAL DROPLET CONTACT PRECAUTIONS, which was posted outside each room identified as isolation rooms, included the instructions, .Place in private room. Keep door closed (if safe to do so) . According to the CDC 2007 Guidelines for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, updated September 2024, transmission based precautions include airborne precautions which .prevent transmission of infectious agents that remain infectious over long distances when suspended in the air (e.g., rubeola virus [measles], varicella virus [chickenpox], .and possibly SARS-CoV [COVID-19]) .the preferred placement for patients who require Airborne Precautions .is a single-patient room that is equipped with special air handling and ventilation capacity .In settings where Airborne Precautions cannot be implemented due to limited engineering resources .masking the patient, placing the patient in a private room with the door closed, and providing N95 or higher level respirators .for healthcare personnel will reduce the likelihood of airborne transmission . 4. On January 30, 2025, at 11:30 a.m., the IP was interviewed. The IP stated the COVID-19 Outbreak was not reported to the CDPH when the outbreak started on January 20, 2025. On January 30, 2025, at 4:35 p.m. the ADM and DON were concurrently interviewed. The ADM and the DON both stated they did not report the facility ' s COVID-19 outbreak to CDPH, and were both unaware that the IP did not report it to the CDPH. The ADM and DON were also unaware that the facility ' s COVID-19 outbreak was reportable to the CDPH. A review of the facility ' s undated policy and procedure titled, COVID-19 Management, indicated, .Reporting of COVID-19 results will be done based on Local Public Health and State reporting guidelines . A review of AFL (All Facilities Letter- a CDPH communication letter to all facility types including Skilled Nursing Facilities [Nursing Homes]) 23-08, dated January 18, 2023, indicated, .This AFL reminds providers of the requirements to report outbreaks and unusual infectious disease occurrences to the local public health officer and the California Department of Public Health (CDPH) and provides definitions and updated examples of reportable incidents .Health facilities licensed by CDPH Licensing and Certification (L&C) are required to report outbreaks (occurrence of cases of a disease or condition above the expected or baseline level, usually over a given period of time, in a geographic area or facility, or in a specific population group) and unusual infectious disease occurrences to the local public health officer and their respective District Office (DO) .Examples of Reportable Incidents .Facility outbreak of COVID-19, influenza (lung infection caused by influenza viruses), pneumonia (bacterial lung infection), other respiratory viral pathogen (e.g., respiratory syncytial virus), or gastroenteritis (e.g., norovirus- virus causing abdominal symptoms) . A review of the Council for Outbreak Response: Healthcare-Associated Infections and Antimicrobial-Resistant Pathogens (CORHA) and the Council of State and Territorial Epidemiologists ' (CSTE) article titled Proposed Investigation/Reporting Thresholds and Outbreak Definitions for COVID-19 in Healthcare Settings, dated January 2, 2024, indicated thresholds for reporting to Public Health for Long Term Care Facilities (LTCFs- includes nursing homes) is two or more cases of probable or confirmed COVID-19 among residents identified within seven days, OR two or more cases of suspect, probable, or confirmed COVID-19 among health care providers (facility staff) and one or more case of probable or confirmed COVID-19 among residents .