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	03/26/2025

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 ensure appropriate monitoring was conducted according to the facility's policy and procedure, for three of six residents (Residents A, B, and C), when the residents sustained a fall. This failure had the potential for a delay in the care and treatment to address possible neurological complications related to fall incident for Residents A, B, and C. Findings: On February 19, 2025, at 8:45 a.m., an unannounced visit to the facility was conducted to investigate complaints of quality of care. 1. On February 19, 2025, a review of Resident A's medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included Parkinson ' s (a disorder of the central nervous system that affects movement and includes tremors) disease, subdural hemorrhage (caused by a head injury, bursts blood vessels and blood pools, pushing the brain), and aphasia (language disorder, unable to communicate effectively). A review of Resident A ' s Progress Notes, indicated the following: - February 4, 2025, at 2:42 p.m., indicated, .Fall .pain? Yes .resident observed on ground laying [sic] next to wall w/ (with) head on bottom of vitals machine in dining room. Resident reportedly walked into dining room and walked into trash can and fell . Resident was assessed by RN (registered nurse) and Administrator and found no apparent injuries. Resident VS (vital signs-heart rate, blood pressure, respiratory rate) WNL (within normal limits) and neuro checks (a series of tests and examinations used to assess the function of the nervous system-includes the brain, spinal cord, and nerves) in place .MD (medical doctor) made aware . - February 4, 2025, at 6:08 p.m., indicated, .Pt (patient) fell at approximately 2:30 PM (p.m.) today and is now c/o (complain of) moderate to severe neck pain. Pt (patient) is unable to tilt head side to side d/t (due to) pain .send to ER (emergency room) for further evaluation and treatment . A review of Resident A's Neurological Evaluation Flow Sheet (an assessment tool used to evaluate the level of consciousness after a brain injury), dated February 4, no year found, at 2:00 p.m., indicated to check Resident A's neurological status on the following recommended schedule: (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Every 1 (one) hour x (times) 4; - Every 4 (four) hours x 4; then - Every shift to make total of 72 hour evaluation period. Further review of Resident A's Neurological Evaluation Flow Sheet, indicated Resident A was monitored for neurological changes every hour from 2 p.m. to 6 p.m. (until Resident A was transferred to the acute hospital). On February 21, 2025, at 2:30 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated towards the end of his shift on February 4, 2025, he was informed by the treatment nurse of Resident A had fallen in the dining area. LVN 1 stated he had gone to assess Resident A and found him laying on his side, when he assessed him, Resident A complained of pain to his neck, the RN came along and assessed Resident A and stated he has no injuries. LVN 1 stated we got Resident A up in a chair and took his vital signs, Resident A continued to complain of pain. LVN 1 stated, he asked about sending Resident A to the hospital for an evaluation and the RN and administrator stated, his vital signs are stable, we don ' t need to send him out. LVN 1 stated he began neuro checks on Resident A and gave Resident A medication for pain. 2. On February 20, 2025, at 10:20 a.m., a review of Resident B's record was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain disease which alters function or structure) and cerebral infarct (a stroke-blood flow to the brain is interrupted, leading to brain tissue death). A review of Resident B ' s Progress Notes titled Summary for Providers, - dated January 14, 2025, at 6:54 p.m., indicated .Falls .resident was found on the side of the bed laying on his right side. Resident was eating dinner .asked if he had pain and stated 'no' .frequent visual checks made, floor mat placed .recommendations: visual checks, floor mat . - dated February 8, 2025, at 5:20 p.m., indicated, .falls .Pt (patient) sitting in w/c (wheelchair) in front of nurse station. Observed PT (patient) trying to get up from w/c (wheelchair) then fell forward landing on knees and hands .no visible injuries .recommendations .monitor Q (every) shift x (times) 72 hours . A review of Resident B's care plan, dated February 8, 2025, indicated, .witnessed fall with no injury . interventions: COC (change in condition-a change in a person's health, physical, mental or psychosocial) initiated, MD (medical doctor) and family aware, monitor Q (every) shift x 72 hours . Further review of Resident B's record indicated there was no documented evidence Resident B was monitored after his fall on January 14, 2025, or February 8, 2025. 3. On February 20, 2025, at 12:10 p.m., a review of Resident C's medical record was conducted. Resident C was admitted to the facility on [DATE], with diagnoses which included encephalopathy and dementia (a group of conditions where two or more brain functions are impaired-memory loss, lack of judgment). (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident C's SBAR Communication Form, dated February 3, 2025, indicated, .4:45 pm (p.m.) . resident was observed to be laying on the floor to the right of his bed . A review of Resident C's Interdisciplinary Team Care Conference, dated February 6, 2025, at 12:30 p.m., indicated, .Fall incident .date and time of fall 02/03/2025 (February 3, 2025), at 4:25 p.m . resident was observed laying on the floor, on the left of the bed with the neck and head resting on the mattress .asked resident was unable to remember the reason why he was out of bed .stat (immediately) xray [sic] requested . results negative . Further review of Resident C's record indicated there was no monitoring of Resident C after the resident sustained a fall on February 3, 2025. A review of Resident C's document titled Change in Condition Evaluation, dated February 9, 2025, indicated, .02/09/2025 (February 9, 2025) .Falls .found on floor, resident unable to explain what happened .MD (medical doctor) notified will start 72 hr (hour) monitoring and neurochecks [sic] .initiate neurochecks [sic] per facility protocol . A review of Resident C's care plans indicated the following: - COC (Change in Condition) 02/03/2025 (February 3, 2025) found on floor .Interventions .frequent check on the resident (dated 02/10/2025-February 10, 2025) .Q (every)15 (minute) rounds x 3 (three) days, neuro checks x 3 days . - COC (Change in Condition) 2/9/25 (February 9, 2025) resident had an actual fall .Interventions . neuro-checks x 72 hours . A review of Resident C's document titled Neurological Evaluation Flow Sheet, dated February 9 and 10, no year, indicated the resident was evaluated to be evaluated every hour x 4, every 4 hours x 4, then every shift to make of total 72 hours. The document indicated Resident C neurological status was evaluated on the following date and times: - February 9, 2025, at 2:12 a.m., 3:12 a.m., 4:12 a.m.; and 5:12 a.m., 5:12 p.m., and 9:12 p.m.; - February 10, 2025, at 3 p.m. and 11 p.m. Further review of the document indicated there was no evaluation of Resident C's neurological status was not documented as conducted on February 9, 2025, at 9:12 a.m., 1:12 p.m., and on February 10, 2025, at 2 a.m., and 7 a.m. as indicated in the neurological recommended schedule . On February 21, 2025, at 4:40 p.m., a concurrent interview and record review was conducted with the Administrator (ADM). The ADM stated residents who have fallen in the facility should have neuro checks done, if the policy states they were needed. Residents A, B, C's records were review with the ADM. The ADM stated Residents A, B, and C should have been monitored after they sustained a fall according to the facility's policy and procedure. A review of the facility's policy titled Fall Management, dated May 26, 2021, indicated, (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.patients experiencing a fall will receive appropriate care and investigation of the cause .review and revise care plans as indicated. If patient falls: observe/check for injury perform neurological evaluation for all unwitnessed falls and witnessed falls with injury to the head or face. Document accident/incident in the clinical record . A review of the facility's policy titled Neurological Assessment, dated June 1, 2023, indicated, .Neurological evaluation will be performed as indicated or ordered. When a resident sustains an injury to the head or face and/or unwitnessed fall, neurological evaluation will be performed: every 15 minutes x two hours, then every 30 minutes x two hours, then every 60 minutes x four hours, then every eight hours until at least 72 hours .

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000 Based on interview and record review, the facility failed to ensure pain management was provided according to the physician's order and plan of care, for two of six residents (Residents B and D). This failure had the potential to result in Residents B and D's pain to not be managed. Findings: On February 19. 2025, at 8:45 a.m., an unannounced visit to the facility was conducted to investigate complaints of quality of care. 1. On February 20, 2025, at 10:20 a.m., a review of Resident B ' s medical record was conducted. Resident B was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain disease which alters function or structure) and cerebral infarct (a stroke-blood flow to the brain is interrupted, leading to brain tissue death). A review of Resident B ' s Medication Administration Record (MAR), included a physician's order, dated January 6, 2025, which indicated, Acetaminophen (pain medication) Tablet 325 MG (milligram - unit of measurement) Give 2 (two) tablet by mouth every 4 (four) hours as needed for mild to moderate pain (1 - 7). A review of Resident B ' s document titled Interdisciplinary Team Care Conference, dated January 15, 2025, at 11:54 a.m., indicated .fall incident .during the assessment by the LVN (licensed vocational nurse) and RN (registered nurse), resident was unable to use pain scale .resident was being resistive during the assessment .resident was saying negative vocalization while moving right hip .Resident is showing guarding behavior of the right lower extremity .send the resident to ER (emergency room) for further evaluation . A review of Resident B ' s document titled Nurse Progress Note, January 15, 2025, at 12:17 p.m., indicated . Transferred .by ambulance for right hip pain. On assessment, resident was .groaning in pain when being moved . Further review of Resident B's record indicated there was no documented evidence acetaminophen was administered to Resident B when the resident complained of pain after sustaining a fall. 2. On February 19, 2025, a review of Resident D ' s medical record was conducted. Resident D was admitted on [DATE], with diagnoses which included congestive heart failure (a condition in which the heart does not pump blood adequately) and cardiac defibrillator (an implanted device that monitors and treats dangerous heart rhythms and abnormalities). On February 19, 2025, at 10:20 a.m., an interview with Resident D was conducted. Resident D stated he had weakness in his legs and could move around without assistance. Resident D stated he needed help in turning, and the wound on his backside could be painful at times, especially when they change his diaper. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident D ' s Order Summary Report, included the following physician's orders: - Monitor and Document pain levels, pain rating scale: 1-4 = mild, 5-7 = moderate, 8-10 = severe; - Acetaminophen tablet 325 mg, give two tablets every four hours as needed for mild pain of 1-4; - Tramadol (medication given for pain) tablet 50 mg every six hours as needed for moderate pain of 5-7. A review of Resident D ' s Medication Administration Record (MAR), for the month of February 2025, indicated Resident D received Tramadol 50 mg tablet on February 4, 2025, at 1:08 p.m., and on February 17, 2025, at 9:39 a.m., for a pain level of 8 (severe pain). There was no documented evidence pain medication was ordered to address severe pain level of 8 -10, or a call to the provider for further orders. On February 21, 2024, at 4:40 p.m., an interview with the Administrator (ADM) was conducted. The ADM stated the facility should have orders to manage pain, and the nurses should be following the physician ' s orders for pain management. A review of the facility ' s policy titled Pain Management, dated August 25, 2021, indicated, .maintain the highest possible level of comfort for residents by providing a system to identify, assess, treat, and evaluate pain .a plan of care to achieve an optimal balance between pain relief and preservation of function .pain management that is consistent with professional standards of practice, the comprehensive person-centered care plan .the nurse will notify the .provider as appropriate and obtain treatment orders as indicated .resident will be evaluated for the presence of pain by making an inquiry .or by observing for signs of pain .