| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 056095 | A. Building<br>B. Wing | 05/21/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Devonshire Care Center | 1350 East Devonshire Avenue<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40000<br><br>Based on observation, interview, and record review, the facility failed to ensure the California Department of Health (CDPH - a state agency) was notified timely or within two hours after an abuse allegation against a Certified Nursing Assistant (CNA) was reported to the facility staff according to the facility's policy and procedure, for one of three residents reviewed (Resident A).<br><br>This failure had the potential for a delay in the investigation and implementation of the abuse protocol and exposed the vulnerable residents to further abuse.<br><br>Findings:<br><br>On March 9, 2025, at 1:30 p.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse.<br><br>On March 9, 2025, at 3:22 p.m., during an interview with Resident A and Resident A's family member, Resident A stated CNA 1 kept on putting her cellphone in his pocket on April 27, 2025. Resident A stated she told her family members about it when they visited her on April 28, 2025.<br><br>On March 9, 2025, Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with diagnoses which included end stage renal disease and diabetes mellitus (abnormal blood sugar).<br><br>Resident A's Minimum Data Set (MDS - a resident assessment tool), dated May 1, 2025, indicated Resident A had a BIMS (Brief Interview of Mental Status) score of 15 (indicating cognitively intact).<br><br>Review of Resident A's progress notes did not indicate the abuse allegation reported to the facility on [DATE].<br><br>(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 0609<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Resident A's Interdisciplinary Care Conference, dated April 30, 2025, at 8:45 a.m., indicated, .SSD (Social Service Director) DSD (Director of Staff Development) interview the patient .Per the resident, she is stating that on Sunday (April 27, 2025), the male CNA she describe as medium height lighter skin tone than the DSD with his hair in braids, entered her oom provided no patient care at the time and picked up her cell phone and proceeded to walk out of the room per the resident. She stated she got his attention by saying hey, hey, hey myc cell phone and he said oh I'm sorry and placed it back on the table .There was nothing on it besides her water pitcher, and her cell phone she stated that the CNA placed her cell phone in his pocket twice the third time he placed it in his pocket on his shirt each time she asked him to give her cell phone back and he would state. Oh, I'm sorry. Per the patient, she stated that her (family member) came into the facility on Monday (April 28, 2025) to bring her tablet (an electronic device) so she would be able to watch her shows on her tablet and she told the family to take it home because a male CNA had tried to steal her cell phone. According to CN (Charge Nurse) that was endorsed to the RN (Registered Nurse) Supervisor (RNS) on the PM (evening) shift on Monday. IDT (Interdisciplinary Team - a group of healthcare professionals) was made aware of the incident today around 9:45 a.m .<br><br>On May 21, 2025, at 11:07 a.m., during an interview conducted with the SSD, the SSD stated Licensed Vocational Nurse (LVN) 1 called LVN 2 on April 29, 2025, at around 9 a.m., about the abuse allegation reported by Resident A's family member on April 28, 2025. The SSD stated LVN 2 reported to her the abuse allegation reported by Resident A on April 29, 2025, at around 10 a.m. The SSD stated LVN 1 informed the RNS about Resident A family member's allegation of abuse toward CNA 1 on April 28, 2025. The SSD stated the RNS did not report to CDPH the abuse allegation immediately or within two hours after the abuse allegation was reported on the PM shift of April 28, 2025. The SSD stated the RNS should have reported Resident A's abuse allegation to CDPH immediately or within two hours after the report was made, according to the facility's policy and procedure.<br><br>On May 21, 2025, at 11:27 a.m., during an interview conducted with the Administrator (ADM), the ADM stated the abuse allegation reported by Resident A's family member should have been reported to CDPH immediately or within two hours from the facility's knowledge of the abuse allegation.<br><br>A review of the facility's policy and procedure titled, Abuse Prohibition, dated February 23, 2021, indicated, . Health Care Centers prohibit abuse, mistreatment, neglect, misappropriation of resident property, and exploitation for all residents .After receiving information concerning a report of suspected or alleged abuse, mistreatment, or neglect .designee will .Report allegations involving abuse .not later than two (2) hours after the allegation is made . |