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	06/04/2025

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, interview, and record review, the facility failed to ensure services provided met professional standards, when two nursing staff members were observed using their personal cell phones in the patient care areas. This failure had the potential to affect the quality of care the residents would receive in the facility. Findings: On April 29, 2025, at 10 a.m. an unannounced visit was made to the facility for the investigation of a complaint regarding quality of care. On April 29, 2025, at 10:20 a.m., an observation and concurrent interview was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 was observed looking at her personal cell phone, with an earbud in her right ear, sitting at nurse ' s station two. LVN 1 stated she should not have been on her cell phone, or have an ear bud in, the facility has rules about personal cell phone use. On April 29, 2025, at 12 p.m., an observation and concurrent interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 was observed at nurse ' s station one, leaning onto countertop, texting on her cell phone. CNA 1 stated she was not supposed to use her cell phone when she is on the floor working. CNA 1 further stated they were supposed to go into the break room if they need to use their cellphones. On April 29, 2025, at 4:45 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated personal cell phone use is discouraged on the floor as the staff would be distracted, and not pay attention to their residents. The DSD further stated personal cell phone use is allowed before and after their shift, or while on break. A review of the facility ' s employee handbook titled Personal Electronic Devices, dated November 1, 2023, indicated, .workplace use of these devices can raise a number of issues involving safety, security, privacy, and productivity .rules regarding the use of personal communication devices in the workplace during working hours .employees should conduct personal business during meal breaks and other rest periods .phones and other devices with cameras or recording capabilities are strictly prohibited in all work areas that contain proprietary information . (continued on next page)

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

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of an article, published by Hospital Topics, titled Use of Personal Cell Phones by Nurses is Barrier to Effective Nursing Care in Hospitals: A Qualitative Research, published August 14, 2024, indicated, .using cell phones by nurses can affect the quality of care .using a cell phone during work could jeopardize patients ' safety and ruins the nursing profession image .

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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** Based on interview and record review, the facility failed to ensure follow-up appointments and laboratory work were completed according to the discharge instructions from the acute hospital, for one of six residents (Resident A). This failure resulted in a delay in care and treatment for Resident A and had a potential to affect the resident's overall health condition. Findings: On April 29, 2025, at 10:00 a.m. an unannounced visit was conducted to the facility for the investigation of a complaint regarding quality of care. On April 29, 2025, at 12:20 p.m., an interview was conducted with Resident A. Resident A stated he was admitted to the facility for rehabilitation services after he had surgical repair of a hernia (a bulging of an organ or tissue through an abnormal opening). On April 29, 2025, at 2:25 p.m., a follow up interview was conducted with Resident A. Resident A stated he had not had a follow up appointment with the surgeon since his surgery. Resident A stated he has heart and breathing problems, and none of the staff have told anything about following up with a cardiologist or pulmonologist. Resident A stated he had blood draw done about three weeks ago, but that was the last time, and he was not aware what the blood test was for. On April 29, 2025, a review of Resident A ' s medical record was conducted. Resident A was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (COPD- a group of lung diseases that block airflow and make it difficult to breathe), inguinal hernia repair (a surgical procedure to repair, where part of the intestine or fatty tissue pushes through a weak spot in the abdominal wall near the groin), and atherosclerotic heart disease (damage or disease in the heart ' s major blood vessels). A review of Resident A's History and Physical Examination, dated March 29, 2025, indicated Resident A had the capacity to understand and make decisions. A review of Resident A ' s SNF (Skilled Nursing Facility) Transfer Orders & (and) Report, dated March 25, 2025, indicated CBC (complete blood count - blood draw to check blood cell levels) every week. A review of Resident A ' s Order Summary Report, included a physician's order for CBC to be completed on March 28, 2025. A review of Resident A ' s CBC results indicated the following: - RBC (red blood cell) count was 2.24 million cells per microliter (a type of measurement) of blood, a normal range is between 4.2 to 5.5. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- HGB (hemoglobin - an iron rich protein found in red blood cells that is responsible for transporting oxygen throughout the body) was 7.9 grams per deciliter (a unit of measurement), a normal range is 12.0 to 18.0; and - HCT (hematocrit - a percentage of red blood cells in the blood) was 25.1%, a normal range is 38-52%. A review of Resident A ' s hospital summary, dated March 26, 2025, indicated Resident A needed to have follow up appointment with the surgeon in two weeks and as well with the cardiologist (a physician who focuses on treating the heart and blood vessels) and pulmonologist (a physician who focuses on the respiratory system, including the lungs and airway). Further review of Resident A's record indicated there was no documented evidence follow up physician appointments were ordered and scheduled for the resident. On April 29, 2025, at 2:40 p.m., an interview was conducted with the Social Services Director (SSD). The SSD stated when a resident was admitted to the facility, the admitting nurse should review the admission orders, put in any needed services, consults, or appointments. The SSD stated the nursing department will contact social services once the appointments were made and would arrange the transportation to the appointment. The SSD stated social services were not responsible in scheduling the appointments for the residents, it was the responsibility of the nursing staff. The SSD stated there was no documentation follow up physician appointments were made for Resident A and there have been no requests for transportation. On April 29, 2025, at 3:00 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated when residents are admitted , the Registered Nurse (RN) supervisor normally reviews all orders, and the discharge plan of care from the acute care facility. LVN 2 stated all hospital orders, medications, laboratory orders were to be verified with the physician who will be caring for the resident while in the facility, after verification, orders were to be placed in the computer, any additional tasks may be completed by nursing if requested. On April 29, 2025, at 3:15 p.m., an interview and concurrent record review were conducted with the RN supervisor (RNS). The RNS stated the admission packet was given to the front desk, station one, when the resident was admitted . The RNS or if there was a desk nurse, will begin to review the resident ' s diet and medications first, to ensure continuity of care, and verify all the orders with the primary physician. The RN stated then consults, appointments, treatments and labs were to be reviewed and placed into the system. The RNS stated Resident A ' s admission orders from the hospital indicated there was recommendation for the resident to consult with the surgeon in two (2) weeks, and follow ups with the cardiologist and pulmonologist ordered, as well as a CBC every week. The RNS stated Resident A had a CBC done on March 28, 2025, he had a medication ordered for his low hemoglobin and hematocrit, but no additional orders for labs to continue every week. The RNS stated there was no documentation appointments were scheduled for Resident A to see the surgeon, cardiologist, and pulmonologist. The RNS reviewed who entered the orders, she stated our interim MDS (Minimum Data Set - a standardized assessment tool used in nursing homes to collect basic, essential information about the resident) nurse entered the orders and could give more information. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On April 29, 2025, at 3:25 p.m., an interview and concurrent record review were conducted with the MDS nurse. The MDS nurse stated the admission nurse was to follow up with a resident ' s orders, their discharge summary, and plan of care from the hospital, and place the information in the electronic health record of the resident, such as follow up appointments, ordered labs. The MDS nurse stated once the admission nurse had scheduled the follow up appointments, a copy of the order with the appointment time, place, and date was to be given to the social services department to arrange transportation. The MDS nurse reviewed Resident A ' s admission orders and his discharge summary from the hospital and stated she did not see the order for the CBC weekly nor the follow up appointments with the surgeon, cardiologist, and pulmonologist, they should have been put in and were missed. A review of the undated facility ' s policy and procedure titled Appointments, indicated, .the support a facility provides to residents in accessing specialty healthcare services to enhance their health and wellbeing. The facility will help residents contact specialty providers as needed, based on healthcare recommendations . assist in scheduling appointments and arranging necessary transportation for residents .Requests for appointments are documented in the electronic medical record .Licensed nurse informs the social service department or designee about the appointment order .The licensed nurse or designee schedule appointments based on medical necessity .This structured approach ensures that resident receive the necessary support and resources for their healthcare appointments, thereby promoting better health outcomes .

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient number of nursing staff was provided to attend to the resident's needs and assure resident safety, when the nursing staff had an extended lunch break with no staff coverage. This failure had the potential to result in several residents to not have their needs met safely nor in a way to promote their rights. Findings: On April 29, 2025, at 10 a.m. an unannounced visit was made to the facility for the investigation of a complaint regarding quality of care and insufficient staffing. On April 29, 2025, at 4:45 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated all staff who were hourly employees must clock in and out for lunch breaks, payroll keeps track of their breaks, and it should be reflected in the payroll sheets. The DSD stated she received a phone call on April 27, 2025, from a staff member regarding a few Certified Nursing Assistants (CNAs) taking extended lunches, during the weekend, and the CNAs thought no one would notice. The DSD stated she would assign the lunch breaks for the CNAs with only one CNA to go on lunch break in their assigned area, leaving two CNAs on the floor to cover one another. The DSD stated CNAs do go to lunch together, but two CNAs need to be in each assigned area to care for residents, if one of the CNAs goes late, it could put the remaining lunches behind, and the CNAs need to wait until they come back and then can go on their break. On May 1, 2025, at 11:05 a.m., an email was received from the DSD. The document was reviewed and indicated, Following a comprehensive investigation into the reported incident of April 27, 2025, concerning Certified Nursing Assistants exceeding their allotted 30-minute lunch break. The findings indicated CNA 2 and CNA 3 took extended lunch breaks during the PM shift (2:30 p.m.-11 p.m.) on April 27, 2025. On May 1, 2025, a review of the documents, pertaining to CNA schedules and timecards, dated April 15, 2025, April 16, 2025, and April 27, 2025, were conducted. The documents indicated, on April 15, 2025, the facility census was 93, there were 10 CNAs, and one Restorative Nursing Assistant (RNA) scheduled to work the day shift from 6:30 a.m. until 2:30 p.m., nine or ten residents were assigned to each CNA. Four CNAs covering rooms 15C to 18C, and 53A to 74A, clocked out for lunch between 10:31 a.m. and 10:38 a.m. and clocked back in from lunch between 11:02 a.m. and 11:09 a.m., with no CNA coverage to the front hallway of the facility for approximately 20 minutes. Five CNAs covering rooms 10A to 15B, and 74B to 24C clocked out for lunch between 11 a.m. and 11:10 a.m. and clocked back in from lunch between 11:30 a.m. and 11:40 a.m., leaving the back hallway of the facility without CNA coverage for approximately 20 minutes. The PM shift (2:30 p.m. until 11:00 p.m.) had 8 CNAs scheduled to work, with a census of 92. Three of the CNAs clocked out for lunch between 7:05 p.m. and 7:17 p.m. and clocked back in from lunch between 7:43 p.m. and 7:49 p.m., with no CNA coverage to the station two hallway of the facility for approximately 20 minutes. (continued on next page)

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The documents indicated, on April 16, 2025, the facility census was 94, there were 11 CNAs and one RNA, scheduled to work the day shift. Five CNAs covering rooms 15A to 24C and 84A to 99B, clocked out for lunch between 11:00 a.m. and 11:14 a.m. and clocked back in from lunch between 11:30 a.m. and 11:46 a.m. , with no CNA coverage to the back hallway of the facility for approximately 16 minutes. The document indicated, on April 27, 2025, the facility census was 96, there were eight CNAs, and one RNA assigned to work the day shift from 6:30 a.m. until 2:30 p.m., 12 residents were assigned to each CNA. Six CNAs clocked out for lunch between 10:58 a.m. and 11:02 a.m. and clocked back in from lunch between 11:28 a.m. and 11:32 a.m., this left two CNAs and one RNA to care for 96 residents for approximately 30 minutes. On May 2, 2025, at 1:05 p.m., an interview and concurrent record review were conducted with the DSD. The DSD reviewed schedules, CNA break times, and timecards, dated April 15, 16, and 27, 2025. The DSD stated CNA 3 was written up for taking a long lunch and then going to payroll after to adjust his time, for his time out and time in for lunch, he was given a final warning. The DSD stated she does not know how long CNA 3 took his break; the timecard was adjusted by payroll from 7:08 p.m. until 7:43 p.m., and she stated it was longer than 30 minutes. The DSD stated two to three employees cannot care for 96 residents in a safe manner, this many CNAs should not have been at lunch at the same time, this is not safe for the residents. The DSD stated the CNAs should have varied their lunches, to ensure there was adequate coverage for all the residents in the facility. A review of the facility ' s job description titled Certified Nursing Assistant, dated June 27, 2017, indicated, . provides patient care in a manner conducive to safety and comfort .answer call light or bell promptly . promotes a culture of safety to ensure a healthy practice and living environment .contributes to an environment that is respectful, team-oriented, and responsive to the concerns of staff, patients and families .