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	07/02/2025

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 - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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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(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 - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure an IV (intravenous - administered into a vein) antibiotic (medication to treat infection) for septic arthritis (a serious joint infection, often caused by bacteria, that can lead to significant joint damage and even sepsis if left untreated) was administered in accordance with the physician's order and the orthopedic surgeon's (OS - a medical doctor specializing in the diagnosis, treatment, and prevention of musculoskeletal system injuries and diseases) recommendation, for one of three residents reviewed (Resident 1), when the orthopedic physician ordered for Resident 1 to start on Rocephin (medication to treat infection) on May 23, 2025, for septic arthritis. The IV Rocephin was not administered to Resident 1 from May 23, 2025, to June 27, 2025 (35 days). In addition, the facility failed to arrange a follow up appointment with the OS in three weeks after the appointment on May 23, 2025.On June 27, 2025, at 6:07 p.m., the Administrator (ADM) was verbally notified of the Immediate Jeopardy (IJ - situation in which the provider's noncompliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death to a resident), due to the facility's failure to administer the IV antibiotic to Resident 1 for 35 days.This failure resulted in a delay in the care and treatment of Resident 1's septic arthritis which could lead to severe and permanent joint damage, chronic pain, and even life-threatening conditions like sepsis or death.On June 30, 2025, at 12:05 p.m., the ADM presented an acceptable removal plan which included the following:-Resident 1 was assessed and examined by the primary physician on June 27, 2025, with order to discontinue IV Rocephin;-Resident 1 was scheduled for a follow up appointment with the orthopedic physician on June 30, 2025, at 9:30 a.m.;-A triple check audit (compare the physician's orders, Medication Administration Record [MAR], and the medications at hand) was conducted on June 27, 2025;-All residents medical records were reviewed on June 27, 2025, to ensure IV orders were administered as ordered;-Resident's care plans were audited by the Registered Nurse Supervisor (RNS) and ADM to ensure active IV orders were included in the care plan and were being followed;-The Medical Director (MD) was notified by the ADM of the IJ on June 27, 2025;-An in-service to the licensed nurses (LN) was conducted by the ADM on June 27, 2025, regarding administration of IV orders;-The Pharmacy Nurse Consultant will conduct skills competencies to the RN and LN on June 28, 2025, regarding following physician orders with emphasis on IV medication administration;-The Regional Nurse Consultant (RNC) will provide in-service training to LN on June 28, 2025, to review policy and procedure on proper and timely follow up, and clarify the physician's orders;-The [NAME] President for Operations and the RNC provided in-service training on June 27, 2025, to the ADM and IDT (Interdisciplinary Team - a group of healthcare professionals) on June 27, 2025, regarding the facility's process on conducting daily stand up to include review of new physician's orders, 24-hour summary, chart review of new admissions, and order listing report; and-A Quality Assurance and Performance Improvement (QAPI) has been initiated to discuss the monitoring and auditing procedures regarding ensuring IV orders were carried out as ordered.On July 1, 2025, at 1:35 p.m., the IJ was removed in the presence of the ADM and the current Director of Nursing (CDON) during the onsite survey, upon verification of the implementation of the IJ removal plan. The facility was notified an extended survey would be conducted due to substandard quality of care issues. Findings:On June 19, 2025, at 10 a.m., an unannounced visit was conducted at the facility to investigate a complaint on quality of care. On June 19, 2025, at 1:14 p.m., Resident 1 was observed sitting on a wheelchair in the smoking area, and was able to maneuver self throughout the facility. In a concurrent interview with Resident 1, she stated she was supposed to receive IV antibiotics and the orthopedic consultation notes from a follow up appointment on May 23, 2025 was concurrently reviewed with Resident 1 which indicated the following:- Rocephin 1 (one) gram daily for 6 (six) weeks through IV midline (a type of peripheral IV catheter [PIVC] that is longer than a standard IV, inserted into a vein in the upper arm, and the tip of the catheter resides in a larger vein near the shoulder) with (name of home health agency); and-RTC (Return to clinic) in three (3) weeks.Resident 1 further stated she had not received the IV antibiotic order of Rocephin since the orthopedic appointment on May 23, 2025. Resident 1 stated she was sent to the general acute hospital (GACH) on June 11, 2025, for the IV line placement but the hospital was not able to start the IV line and did not know why it was not done. On June 19, 2025, at 1:50 p.m., during a concurrent interview and record review with Registered Nurse (RN) 1, RN 1 stated when she received the orthopedic consult notes on May 23, 2025, after Resident 1 went to the follow up appointment on May 23, 2025, she placed the

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. (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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate nursing services were provided to carry out the physician and orthopedic surgeon (OS - a medical doctor specializing in the diagnosis, treatment, and prevention of musculoskeletal system injuries and diseases) orders to administer IV antibiotic, for one of four residents reviewed (Resident 1), when:1.Registered Nurse (RN) 1 did not clarify with the physician or the OS regarding the IV orders after Resident 1's follow up appointment on May 23, 2025. In addition RN 1 did not endorse to the following RN the need to clarify the IV order, and there was no documentation other licensed nurses (RNs and Licensed Vocational Nurses), followed up or clarified the IV order with the OS from May 23, 2025, to June 11, 2025; 2. RN 1 was not knowledgeable regarding other routes of administration of Rocephin (a medication to treat infection);These failures resulted to Resident 1 to not receive the IV antibiotic as ordered by the physician and the OS and had the potential to experience pain or discomfort, infection, joint stiffness, and affect overall health condition.Cross Reference F684Findings:On June 19, 2025, at 10 a.m., an unannounced visit was conducted at the facility to investigate a complaint on quality of care.On June 19, 2025, at 1:14 p.m., Resident 1 was observed sitting on a wheelchair in the smoking area, and was able to maneuver self throughout the facility. In a concurrent interview with Resident 1, she stated she was supposed to receive IV antibiotics and the orthopedic consultation notes from a follow up appointment on May 23, 2025 was concurrently reviewed with Resident 1 which indicated the following:- Rocephin 1 (one) gram daily for 6 (six) weeks through IV midline (a type of peripheral IV catheter [PIVC] that is longer than a standard IV, inserted into a vein in the upper arm, and the tip of the catheter resides in a larger vein near the shoulder) with (name of home health agency); and-RTC (Return to clinic) in three (3) weeks.Resident 1 further stated she had not received the IV antibiotic order of Rocephin since the orthopedic appointment on May 23, 2025. Resident 1 stated she was sent to the general acute hospital (GACH) on June 11, 2025, for the IV line placement but the hospital was not able to start the IV line and did not know why it was not done. On June 19, 2025, at 1:50 p.m., during a concurrent interview and record review with Registered Nurse (RN) 1, RN 1 stated when she received the orthopedic consult notes on May 23, 2025, after Resident 1 went to the follow up appointment on May 23, 2025, she placed the order for IV antibiotics in the system. RN 1 stated Resident 1 should have been sent to the hospital to have the IV antibiotic be administered since it was to be given through IV midline. RN 1 stated the following shift should have followed up as the order also indicated with home health agency to administer. RN 1 stated she thought Resident 1 would be getting too much antibiotic since the resident was on oral antibiotic as well. A review of Resident 1's admission Record, indicated Resident 1 is a [AGE] year old female admitted to the facility on [DATE], with diagnoses which included left elbow fracture (broken bone), left knee ORIF (open reduction with internal fixation - a surgical procedure used to treat fractures, particularly those that are severely displaced or unstable), and lupus (a chronic autoimmune disease where the body's immune system mistakenly attacks healthy tissue which could lead to inflammation and damage in various parts of the body, including the skin, joints, kidneys, heart, lungs, and blood cells).A review of Resident 1's physician's orders, date ordered May 16, 2025, indicated, . RESIDENT HAS F/U (follow up) ORTHO APPOINTMENT ON 5/23 (May 23, 2025) AT 8:30 AM (a.m.) WITH (name of orthopedic surgeon) AT (address of orthopedic clinic). A review of Resident 1's orthopedic consult notes, dated May 23, 2025, indicated, .Pt (patient) doesn't (does not) have IV access.Left knee septic arthritis.Plan.IV midline.IV Rocephin 1 gm q (every) daily x 6 weeks.A review of the facility document titled Progress Record, documented by the OS, sent with Resident 1 when she came back from appointment, dated May 23, 2025, indicated, .ordering IV midline and IV Rocephin 1 (one) gram QD (daily) x 6 wks (weeks) w/ (with) (name of home health agency).RTC (return to clinic) in 3 (three) weeks (around June 13, 2025).A review of Resident 1's physician order, date ordered May 23, 2025, .ORDER FOR IV MIDLINE AND IV ROCEPHIN 1 (one) GRAM (unit of measurement) DAILY X (times) 6 (six) WEEKS WITH (name of home health agency)., A review of Resident 1's Progress Notes, dated May 23, 2025, at 10:51 a.m., documented by RN 1, indicated the order from the orthopedic appointment for IV Rocephin, IV midline, and return to clinic in 3 weeks.Further review of Resident 1's record indicated there was no documented evidence of the OS orders for IV midline and IV Rocephin was clarified with the OS when to start the IV antibiotic and indication for the IV antibiotic. There was no documented evidence the physician's order for IV midline and IV Rocephin were carried out as ordered and administered to Resident 1 since May 23, 2025. On June 26, 2025, at 4: 20

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on interview and facility record review, the facility failed to have a written Quality Assurance Performance Improved (QAPI - a systematic, interdisciplinary, comprehensive, and data - driven approach to maintain and improve safety, quality of care, and quality of life of the residents) plan in place to address issue on carrying out physician's order for IV antibiotics, when the facility identified the resident did not receive the IV antibiotic the orthopedic surgeon (OS - a medical director specializing in the diagnosis, treatment, and prevention of musculoskeletal system injuries and diseases) ordered.This failure resulted to the resident not to receive the appropriate care and treatment after a surgical procedure and had the potential for the resident to develop complications such as pain or discomfort, infection, joint stiffness, and affect overall health condition. Findings:On June 27, 2025, at 6:07 p.m., the Administrator (ADM) was verbally notified of the Immediate Jeopardy (IJ - situation in which the provider's noncompliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death to a resident), due to the facility's failure to administer the IV antibiotic to Resident 1 for 35 days. A substandard quality of care (SQC) was identified related to the facility's failure to administer IV antibiotic to Resident 1. See findings under F684. On July 1, 2025, at 2:33 p.m., an interview was conducted with the ADM to discuss regarding the facility's QAPI program. The ADM stated the facility did not proceed to conduct a QAPI program to address the issue on the IV medications order not carried out as ordered by the physician and the OS on May 23, 2025, after it was identified as a missed administration on June 11, 2025 (19 days after the IV medication was initially ordered). A review of the facility's QAPI program meeting information, indicated QAPI meetings were held on February 6, 2025, April 24, 2025, and June 19, 2025, which was attended by the Medical Director, ADM, Director of Nursing (DON), Director of Staff Development (DSD), Infection Preventionist, Activity Director, Dietary Director, Social Services Director, Medical Records Designee, Maintenance Supervisor, Pharmacy Consultant, and [NAME] President of Operations. On July 2, 2025, at 10:45 a.m., a follow up interview and concurrent review of QAPI meetings was conducted with the ADM. The ADM stated the facility had a QAPI meeting on June 19, 2025, but did not discuss the IV medication order not carried out since May 23, 2025. The ADM stated the facility should have included the issue on IV medication during their QAPI meeting on June 19, 2025. The ADM stated he thought the previous DON had taken cared of the issue. The ADM stated he was not aware the facility had an issue on IV medication order not carried out until it was brought to their attention on June 19, 2025, during the investigation of the complaint.A review of the facility's policy and procedure titled, Quality Assurance and Performance and Improvement (QAPI) Program - Governance and Leadership), dated March 2020, indicated, .The Quality Assurance and Performance Improvement Program is overseen and implemented by the QAPI Committee, which reports its findings, actions and results to the Administrator and governing body . The Administrator .is ultimately responsible for the QAPI program, and for interpreting the results and findings to the governing body .The governing body is responsible for ensuring that the QAPI program . Focused on problems and opportunities that reflect processess, functions and services provided to the residents .

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement a program that monitors antibiotic use. (continued on next page)

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure an effective antibiotic surveillance program (program to help monitor the effectiveness of antibiotics, identify emerging resistance patterns, and inform strategies for infection prevention and control) was conducted, for four of four residents (Residents 1, 2, 3, and 4) according to the facility's policy and procedure, when:1.For Resident 1, there was no appropriate indication for the use of Levaquin (medication to treat infection). In addition, there was no antibiotic surveillance assessment completed for the use of Levaquin;2.For Resident 2, the physician was not notified the use of Cipro (medication to treat infection) did not meet the criteria of the symptoms of urinary tract infection;3.For Resident3, there was no appropriate indication for the use of Macrobid (medication to treat infection). In addition, there was no antibiotic surveillance assessment completed for the use of Macrobid; and4.For Resident 4, there was no appropriate indication for the use of Cirpo (medication to treat infection). In addition, there was no antibiotic surveillance assessment completed for the use of Cipro and Doxycycline (medication to treat infection).These failures resulted to the residents' use of antibiotic not to be evaluated for the appropriateness of its use, which could lead to development of complications related to use of the antibiotics. Findings:On June 25, 2025, at 1:11 p.m., during an interview with the Infection Preventionist (IP), the IP stated the facility conducts antibiotic surveillance of the residents who were prescribed antibiotics on admission and during their stay in the facility to ensure the antibiotic is necessary for the resident to be administered. The IP stated she would run a report indicating a list of residents on antibiotic. The IP stated the facility form titled, Antibiotic Surveillance Data Collection, was to be completed by the licensed nurse who initiated the antibiotic order either during admission or during the resident stay in the facility. The IP stated the document utilizes McGeer's criteria (a standardized definitions of infection used primarily for surveillance in long-term care facilities) or Loeb's criteria (a set of minimum clinical guidelines used in long-term care facilities to help determine when antibiotic treatment is appropriate for residents) to determine if the antibiotic is appropriate for the resident. The IP stated if the antibiotic surveillance indicated the criteria was not met, they will proceed with a time out to call the physician if still needed for the antibiotic to be administered to the resident. The IP stated it was her responsibility to ensure the antibiotic surveillance form was completed accurately and implement the antibiotic surveillance program according to the guidelines.On June 25, 2025, at 1:32 p.m., a concurrent interview and review of Residents 1, 2, 3, and 4's records were conducted with the IP. The following indicated:1.Resident 1 was admitted to the facility on [DATE], with diagnoses which included aftercare following joint replacement and fracture of right elbow.A review of Resident 1's physician order, dated May 23, 2025, indicated the following:- .Levaquin (antibiotic) Tablet 500 MG (milligram - unit of measurement).Give 1 (one) tablet by mouth one time day for R/O (rule out) FRACTURE for 20 days.; and- . Order for IV Midline and IV Rocephin 1 (one) gram (unit of measurement) daily x (times) 6 (six) weeks with (name of home health).A review of Resident 1's Progress Notes, indicated, .RESIDENT CAME BACK FROM APPOINTMENT WITH A STAFF MEMBER AND TRANSPORT COMPANY. SUTURE WAS REMOVED, STERISTRIPS APPLIED.ORDER FOR IV MIDLIN (sic) AND IV ROCEPHIN 1 GRAM DAILY X 6 WEEKS WITH (name of home health).LEVAQUIN 500MG PO DAILY X 20.In a concurrent interview with the IP, the IP she stated there was no antibiotic surveillance form completed for the use of Levaquin for Resident 1. The IP stated she thought the indication for the antibiotic was for prophylaxis (prevent disease) related to the fracture. The IP stated she did not review the orthopedic consult notes to check why the physician ordered Levaquin for Resident 1. The IP stated the indication for Levaquin use was not appropriate and should have been clarified and reviewed. The IP stated she was not aware Resident 1 was ordered for IV Rocephin.2. Resident 2 was admitted to the facility on [DATE], with diagnoses which included chronic obstructive pulmonary disease (lung disease) and diabetes mellitus (abnormal blood sugar).A review of Resident 2's Progress Notes, dated June 15, 2025, at 5:49 a.m., indicated, .Pt (patient) had episode of delirious (an acutely disturbed state of mind resulting from illness or intoxication and characterized by restlessness, illusions, and incoherence of thought and speech). Pt was sitting on edge of bed stating she was going to jump off to start walking.A review of Resident 2's lab Results Report, dated June 16, 2025, indicated cloudy urine, and many bacteria.A review of Resident 2's Progress Notes, dated June 18, 2025, at 12:32 a.m., indicated, .(name of physician) reviewed urine test result and he ordered Cipro 500 mg tab (tablet) bid (twice a day) x 10 days.A review of Resident 2's physician order, dated June 18, 2025, indicated, .Cipro Oral Tablet