

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 07/29/2025
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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a safe, functional and comfortable environment, when the ceiling of room [ROOM NUMBER] was observed damaged, and the television cable outlet was exposed and did not have a plate cover. This failure to maintain a functional environment had the potential to compromise resident safety. On July 9, 2025, at 1:28 p.m., an unannounced visit was conducted at the facility for several complaints including a complaint regarding a resident room. On July 9, 2025, at 4:20 p.m. room [ROOM NUMBER] was observed. room [ROOM NUMBER] was observed to have two beds occupied by two residents in bed A and bed B, respectively. The ceiling above bed B was observed to have an irregular, circular, warped protrusion, with paint peeling, and the center cracked exposing the board underneath. Towards the feet of the beds, a few inches above the counter, in the space between two closets, was one television cable outlet without a plate cover. The cable wire was exposed, and the inner wall was visible through the opening. On July 9, 2025, at 4:30 p.m., the Maintenance Director (MD) was interviewed, the MD stated the ceiling damage looked like it was from a past water leak, maybe from the heavy rains early in the year. The MD further stated this should have been identified and fixed. On July 9, 2025, at 4:36 p.m., in a concurrent observation in room [ROOM NUMBER] with the MD and Director of Nursing (DON), the MD confirmed the television cable outlet should have a cover. On July 9, 2025, at 4:43 p.m. The Administrator (ADM) was interviewed. The ADM stated he expected the MD and his assistants to conduct rounds in every room and check every crevice once a month. The ADM further stated the department heads should also be looking into environmental issues when they conducted their routine daily rounds, and expected all staff to report any observed issues to the MD or his assistant verbally or through the facility's electronic reporting system. A review of the facility's policy and procedure titled, Maintenance Service, revised December 2009, indicated, .Maintenance service shall be provided to all areas of the building, grounds, and equipment .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. Functions of the maintenance personnel include, but are not limited to. Maintaining the building in good repair and free from hazards.</p>

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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