

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

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 07/16/2026
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)		
F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to implement their policy and procedure on abuse for one of three residents, Resident 1, when:1. Resident 1's allegation of physical abuse by the Certified Nursing Assistant (CNA) towards Resident 1 on July 4, 2026, was not investigated timely; and2. The alleged CNA was not suspended pending investigation of an allegation of abuse and continued to have provide care and services to the residents. These failures resulted in the delay of providing safety and protection for Resident 1 and other vulnerable residents and placed them at risk for further abuse.Findings:1. On July 16, 2026, at 8:24 a.m., an unannounced visit was conducted at the facility to investigate an allegation of physical abuse.On July 16, 2026, at 9:23 a.m., an interview was conducted with Resident 1. Resident 1 stated an unidentified staff pushed both of her front shoulders towards the bed when she was receiving care and then the staff suddenly walked away. Resident 1 stated she told the incident to Registered Nurse (RN) 1 and she reported the incident through text message to her son. Resident 1 further stated it was not ordinary shoulders tapped, I felt it. Resident 1 stated she verbally told her family member (FM) the following day (Sunday) then the morning shift nurse talked to her about the allegation. Resident 1 stated her FM called the police and will talk to the person in charge in the facility. On July 16, 2026, a review of Resident 1's medical record was conducted. Resident 1 was admitted to the facility on [DATE], with diagnoses which included surgical aftercare following surgery and muscle weakness.A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated July 2, 2026, indicated Resident 2 had a BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact).A review of Resident 1's eInteract Change of Condition Evaluation, dated July 8, 2026, indicated, .ALLEGATION REGARDING STAFF.A review of Resident 1's Interdisciplinary Care Conference, dated July 8, 2026, indicated, .Resident made an allegation that a staff member went to her room and pushed her shoulder.On July 16, 2026, at 1:35 p.m., during an interview with RN 1, RN 1 stated on July 4, 2026, Resident 1 told her about a lady dressed in red clothes in night shift pushed Resident 1's shoulders towards the bed while receiving care. RN 1 stated she did not see anyone wearing red clothes that night, so she waited for the morning shift to relay the allegation of Resident 1. RN 1 further stated she did not report the allegation of abuse right away and should have been reported.On July 16, 2026, at 2 p.m., during an interview with RN 2, RN 2 stated the police came to the facility on July 5, 2026, to inform her a staff pushed Resident 1 to her shoulders. RN 2 stated she interviewed Resident 1 about the alleged physical abuse but did not report the incident to agencies. RN 2 further stated the allegation of physical abuse should been reported and initiated investigations on Resident 1. RN 2 stated the alleged CNA remained working on the following two (2) days after the allegation was reported. RN 2 stated the alleged abuser (CNA) should have been suspended if there is an allegation of abuse involving the staff. On July 16, 2026, at 2:10 p.m., a concurrent interview and record review was conducted with the (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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Licensed Vocational Nurse (LVN). The LVN stated the police came to the facility on July 5, 2026, in the morning and was talking to her supervisor (RN 1) regarding allegation of abuse. The LVN stated there was no documentation for Resident 1 of the reported allegation of physical abuse on July 4, 2026. The LVN further stated the facility should have documented and reported the allegation of physical abuse to outside agencies (police department) on July 4, 2026, to keep Resident 1 safe and to prevent further abuse. On July 16, 2026, at 2:40 p.m., during concurrent interview and record review with alleged CNA. The CNA stated she remained working on the following days after the incident occurred. The CNA further stated, nobody told her that she was suspended and she continued to work on the following dates: -July 5, 2026, from 2:25 p.m., to 10:28 p.m. and; -July 6, 2026, from 2:24 p.m., to 10:31 p.m. On July 16, 2026, at 2:55 p.m., during an interview with the Director of Nursing (DON), the DON stated any alleged abuse in the facility should have been investigated and reported as soon as the incident occurred and identified. The DON stated the Certified Nursing Assistant (CNA) involved remained working after the incident occurred and should have been suspended. The DON further stated if any allegation of abuse was not reported and investigated, and the staff involved was not suspended, there was a potential for recurrence, or continuous abuse would happen to Resident 1. On July 16, 2026, at 3:02 p.m., the Administrator (ADM) was interviewed. The ADM stated any allegation of abuse in the facility should have been investigated and reported in a timely manner as soon as it was identified. The ADM further stated the facility should have been reported the allegation of physical abuse immediately and prevent delay to avoid potential reoccurrence of abuse. The ADM stated the alleged abuser staff should have been suspended pending investigation. A review of the facility's policy and procedure titled, Abuse Prevention Program, dated December 2016, indicated, .Our Resident have the right to be free from abuse. As part of the resident abuse prevention, the administration will protect our residents from abuse by anyone including facility staff. Investigate and report any allegations of abuse within timeframes as required by federal requirements. Protect residents during abuse investigations. A review of the Facility's policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated, .If an incident or suspected incident of resident abuse. The Administrator will suspend immediately any employee who has been accused of resident abuse, pending the outcome of the investigation. The Administrator will ensure that any further potential abuse, neglect exploitation or mistreatment is prevented. A review of the facility's policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated, .All reports of resident abuse shall be promptly reported to local, state and federal agencies and thoroughly investigated by facility management. If an incident or suspected incident of resident abuse. The Administrator will ensure that any further potential abuse is prevented.		

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to report an allegation of physical abuse to California Department of Public Health (CDPH) immediately or within two (2) hours after the allegation was made, for one of three residents (Resident 1). This failure had the potential to result in further abuse for Resident 1, affecting the resident's physical, emotional, and psychosocial well-being. Findings: On July 16, 2026, at 8:24 a.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse. On July 16, 2026, at 9:23 a.m., an interview was conducted with Resident 1. Resident 1 stated an unidentified staff pushed both of her front shoulders towards the bed when she was receiving care and then the staff suddenly walked away. Resident 1 stated she told the incident to Registered Nurse (RN) 1 and she reported the incident through text message to her son. Resident 1 further stated it was not ordinary shoulders tapped, I felt it. Resident 1 stated she verbally told her family member (FM) the following day (Sunday) then the morning shift nurse talked to her about the allegation. Resident 1 stated her FM called the police and would talk to the person in charge in the facility. A review of Resident 1's record indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included surgical aftercare following surgery and muscle weakness. A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated July 2, 2026, indicated Resident 2 had a BIMS (Brief Interview of Mental Status) score of 14 (cognitively intact). A review of Resident 1's eInteract Change of Condition Evaluation, dated July 8, 2026, indicated, .ALLEGATION REGARDING STAFF. A review of Resident 1's Interdisciplinary Care Conference, dated July 8, 2026, indicated, .Resident made an allegation that a staff member went to her room and pushed her shoulder. On July 16, 2026, at 1:35 p.m., during an interview with RN 1, RN 1 stated Resident 1 reported to her on July 4, 2026, at around 11 p.m., that a lady wearing red clothes pushed Resident 1's shoulders towards the bed. RN 1 stated she did not report the alleged abuse. RN 1 further stated that she should have reported the incident immediately or within two (2) hours to CDPH. On July 16, 2026, at 2 p.m., during an interview with RN 2, RN 2 stated she was notified of the abuse allegation incident on July 5, 2026, around 10 a.m., when the police and Resident 1's family member came. RN 2 stated any allegation of abuse should be reported immediately or within two hours (2) from the time the allegation was reported. RN 2 further stated she did not report the allegation of abuse incident to CDPH or any outside agencies and she should have been reported immediately within two hours. On July 16, 2026, at 2:55 p.m., during an interview with the Director of Nursing (DON), the DON stated she was made aware of the incident on July 8, 2026, around 5 p.m. (90 hours from the time it was initially reported to RN 1 on July 4, 2026, at 11 p.m.). The DON stated any alleged or suspicion of abuse should be reported to CDPH within two hours. The DON stated the incident should have been reported immediately or within 2 hours for resident safety. A review of the facility's policy and procedure titled, Abuse Prohibition, revision dated October 25, 2024, indicated, .Upon receiving information concerning a report of suspected or alleged abuse, designee will perform the following. Report allegations involving abuse, not later than two (2) hours after allegation is made.		