

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 04/14/2025
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 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure call light was within reach for use, for one of one resident reviewed for accommodations of needs (Resident 17).</p> <p>This failure had the potential to cause delay of care and to cause resident's needs to not be met in a timely manner.</p> <p>Findings:</p> <p>On April 7, 2025, at 9:54 a.m., Resident 17 was observed with Certified Nursing Assistant (CNA) 1 was conducted. Resident 17's call light was observed tucked in his bedside drawer which was located behind him.</p> <p>On April 9, 2025, Resident 17's record was reviewed. Resident 17 was admitted on [DATE], with diagnoses which included, cerebral infarction (lack of blood flow to the brain), seizures (disturbance of brain activity), and ulcerative colitis (inflammation of the inner lining of large intestines).</p> <p>Resident 17's History and Physical, dated October 27, 2024, indicated Resident 17 was alert and oriented to person, place, and situation and able to make his needs known.</p> <p>Resident 17's Minimum Data Set (MDS - an assessment tool), dated March 8, 2025, indicated Resident 17 had a BIMS (Brief Interview for Mental Status) score of 13 (cognitively intact), and Resident 17 required substantial/maximal assistance with activities of daily living (ADL). Resident 17 was also dependent for shower/bathe self, as well as putting on/taking off footwear.</p> <p>Resident 17's care plan, dated March 24, 2025, indicated a Focus that Resident 17 had ADL self-care performance deficits related to terminal illness for CVA (cerebral vascular accident) and seizure disorder.</p> <p>On April 9, 2025, at 12:40 p.m., a concurrent observation and interview was conducted with Resident 17. Resident 17 was observed lying in bed awake and alert. Resident 17 stated his call light was left out of reach in the past and it was concerning to him when he was not able to reach his call light when he needed something.</p> <p>(continued on next page)</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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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 9, 2025, at 12:50 p.m., an interview with CNA 1 was conducted. CNA 1 stated Resident 17's call light was not in reach, and it should always be within the resident's reach. CNA 1 stated it was her mistake, but she failed to put the call light back in place. CNA 1 also stated it was the expectation that the call light was in reach for all residents. CNA 1 further stated the resident might need something and could fall while trying to reach the call light.</p> <p>On April 11, 2025, at 4:07 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated after the CNA's had completed resident care, the call light should have been put within the resident's reach. The DON stated the residents could fall or their needs would not be met if they did not have access to the call light. The DON further stated it was the expectation the call light is placed within reach for all residents.</p> <p>A review of the facility's job description titled, Certified Nursing Assistant, dated October 2020, indicated, . Duties and Responsibilities .Keep the nurses' call system within easy reach of the resident .</p> <p>A review of the facility's policy and procedure titled, Answering the Call Light, dated October 24, 2024, indicated, .The purpose of this procedure is to ensure timely response to the resident's requests and needs . Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on interview and record review, the facility failed to ensure accurate documentation of the residents' wishes regarding their care were maintained for 12 of 18 residents reviewed for Advance Directives (AD - a written instruction relating to the provision of health care when the individual is incapacitated) (Residents 14, 21, 32, 40, 41, 50, 55, 59, 61, 71, 78, and 138), when:</p> <ol style="list-style-type: none"> 1. For Resident 14, the signing doctor was different from the physician's name on the Physician Orders for Life-Sustaining Treatment (POLST - documents a patient's preferences for end-of-life care in the face of serious illness or irreversible conditions); 2. For Resident 32, the POLST did not have the physician's information or license number on the form; 3. For Resident 41, the POLST was not signed by the physician since January 28, 2025; 4. For Resident 50, there was no physician information and physician signature on the POLST form; 5. For Residents 21, 55, 59 and 61, there was no documented evidence the POLST was reviewed periodically; and 6. For Residents 14, 21, 32, 40, 41, 50, 55, 59, 61, 71, 78, and 138, there was no documented evidence formulation of an Advance directive was offered to the residents and/or resident representatives. In addition, there was no documented evidence IDT reviews regarding advance directives for these residents were conducted quarterly and annually per facility policy. <p>These failures had the potential for the resident's decisions regarding their healthcare and treatment to not be honored.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. A review of Resident 14's record indicated Resident 14 was readmitted to the facility on [DATE], with an original admitted [DATE], with diagnosis of respiratory failure (not enough oxygen in the body) and metabolic encephalopathy (brain dysfunction). <p>A review of Resident 14's POLST, dated September 4, 2024, indicated the signing doctor was different from the physician's name on the POLST.</p> <p>On April 11, 2025, at 2:04 p.m., an interview was conducted with the Social Services Director. The SSD stated the POLST was uploaded at time of admission, and they review the POLST every 3 months (quarterly) to see if any changes.</p> <p>On April 14, 2025, at 10:02 a.m., an interview was conducted with the Director of Nursing, DON. The DON stated there should be documentation indicating an annual review of the POLST.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the policy and procedure titled, Do Not Resuscitate Order, dated March 2021, indicated, .Do not resuscitate orders must be signed by the resident's attending physician on the physician's order sheet maintained in the resident's medical record .a do not resuscitate (DNR) order from must be completed and signed by the attending physician .</p> <p>2. A review of Resident 32's record indicated Resident 32 was admitted to the facility on [DATE] with a diagnoses of multiple sclerosis (autoimmune disease).</p> <p>A review of Resident 32's Minimum Data Set (MDS - a resident assessment tool), dated March 7, 2025, indicated Resident 32's had a Brief Interview for Mental Status (BIMS) score of 15 (cognition intact).</p> <p>A review of Resident 32's POLST, dated _____, indicated Resident 32's POLST did not have the physician information or license number on the form.</p> <p>On April 11, 2025, at 2:06 p.m., an interview was conducted with the SSD. The SSD stated the POLST should consist of the physician name, license number, signature, and date. The SSD stated the POLST were uploaded at the time of admission and reviewed every three months.</p> <p>On April 14, 2025, at 10:04 p.m., an interview was conducted with the DON. The DON stated there should be documentation indicating an annual review of the POLST. The POLST should be reviewed at the quarterly care conference, any changes should be made at that time.</p> <p>A review of the policy an procedure titled, Do Not Resuscitate Order dated, March 2021, indicated, .a do not resuscitate (DR) order from must be completed and signed by the attending physician .</p> <p>3. A review of Resident 41's record, indicated Resident 41 was admitted to the facility on [DATE], with diagnoses of heart failure (heart doesn't pump as well as it should).</p> <p>A review of Resident 41's POLST, dated January 28, 2025, indicated the POLST was not signed by the physician.</p> <p>A review of Resident 41's MDS, dated [DATE], indicated Resident 41 had a BIMS score of 7 (cognition impaired).</p> <p>On April 11, 2025, at 2:07 p.m., an interview was conducted with the Social Services Director. The SSD stated the physician should have signed the POLST.</p> <p>On April 14, 2025, at 10:06 a.m., an interview was conducted with the Director of Nursing, DON. The DON stated the physician should have signed the POLST within 30 days of the POLST being filled out.</p> <p>A review of the policy and procedure titled, Physician Visits, dated April 2013, indicated, .attending physician must visit his/her patients at least once every 30 days for the first ninety days following the residents admission, and then at least every sixty days thereafter .</p> <p>A review of the policy and procedure titled, Do Not Resuscitate Order, dated March 2021, indicated, .a do not resuscitate order form must be completed and signed by the attending physician .</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>4. A review of Resident 50's record indicated, Resident 50 was admitted to the facility on [DATE] with a diagnoses of intraspinal abscess and granuloma (a collection of pus within the spinal canal).</p> <p>A review of Resident 50's POLST, dated January 5, 2025, indicated Resident 50's POLST had no physician information or physician signature on the POLST form.</p> <p>A review of Resident 50's MDS, dated [DATE], indicated Resident 50 has a BIMS score of 15 (cognition intact).</p> <p>On April 11, 2025, at 2:09 p.m., an interview was conducted with the Social Services Director. The SSD stated Resident 50's POLST should have the physician's information including the physician's signature.</p> <p>On April 14, 2025, at 10:06 a.m., an interview was conducted with the Director of Nursing, DON. The DON stated the physician should have filled out his section of the POLST at the time of his visit after admission.</p> <p>A review of the policy and procedure titled, Do Not Resuscitate Order, dated March 2021, indicated, .do not resuscitate orders must be signed by the residents attending physician on the physician's order sheet maintained in the resident's medical record .</p> <p>5a. A review of Resident 21's record indicated Resident 21 was admitted to the facility on [DATE], and readmitted on [DATE], with diagnoses of heart failure and chronic kidney disease (lose of ability to filter waste and fluid out of blood).</p> <p>A review of Resident 21's MDS, dated [DATE], indicated a BIMs score of 13 (cognition intact).</p> <p>A review of Resident 21's interdisciplinary case conference, dated February 10, 2025 indicated there was no documented evidence Resident 21's POLST was reviewed periodically.</p> <p>5b. A review of Resident 55's record indicated, Resident 55 was admitted to the facility on [DATE], with a diagnoses of delusional disorders (serious mental illness) and dementia (decline in cognition).</p> <p>A review of Resident 55's MDS, indicated a BIMS score of 15 (cognition intact).</p> <p>A review of Resident 55's record indicated there was no documented evidence Resident 55's POLST was reviewed periodically.</p> <p>5c. A review of Resident 59's record indicated Resident 59 was admitted to the facility on [DATE] with a readmitted [DATE], with a diagnoses of abscess of epididymis or testis (infection of the testicle) and chronic obstructive pulmonary disease (COPD - ongoing lung condition).</p> <p>A review of Resident 59's MDS, dated [DATE], indicated a BIMs score of 14 (cognition intact).</p> <p>A review of Resident 59's record indicated there was no documented evidence Resident 59's POLST was reviewed periodically.</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>6e. A review of Resident 41's record, indicated Resident 41 was admitted to the facility on [DATE], with diagnoses of heart failure (heart doesn't pump as well as it should).</p> <p>A review of Resident 41's MDS, dated [DATE], indicated a BIMs score of 7 (cognition impaired).</p> <p>6f. A review of Resident 50's record indicated Resident 50 was admitted to the facility on [DATE], with a diagnoses of intraspinal abscess and granuloma (a collection of pus within the spinal canal).</p> <p>A review of Resident 50's MDS, dated [DATE], indicated a BIMs score of 15 (cognition intact).</p> <p>6g. A review of Resident 55's record indicated Resident 55 was admitted to the facility on [DATE], with a diagnoses of delusional disorders (serious mental illness) and dementia (decline in cognition).</p> <p>A review of Resident 55's MDS, indicated a BIMs of 15 (cognition intact).</p> <p>6h. A review of Resident 59's record indicated Resident 59 was admitted to the facility on [DATE], and readmitted on [DATE], with a diagnoses of abscess of epididymis or testis (infection of the testicle) and chronic obstructive pulmonary disease (COPD - ongoing lung condition).</p> <p>A review of Resident 59's MDS, dated [DATE], indicated a BIMs score of 14 (cognition intact).</p> <p>6i. A review of Resident 61's record indicated Resident 61 was admitted to the facility on [DATE] with a readmit of June 17, 2025, with a diagnoses of hepatic encephalopathy (brain function that occurs as a result of liver dysfunction).</p> <p>A review of Resident 61's MDS, dated [DATE], brief interview for mental status indicated a BIMs score of 13 (cognition intact).</p> <p>6j. On April 7, 2025, Resident 71 record was reviewed. Resident 71 was admitted to the facility on [DATE], with diagnoses which included acute on chronic systolic congestive heart failure (the heart can't pump enough blood to meet the body's needs) and respiratory failure (not enough oxygen).</p> <p>A review of Resident 71's MDS, dated [DATE], indicated Resident 71 had a BIMs score of 14 (cognitive intact).</p> <p>6k. On April 7, 2025, Resident 78's record was reviewed. Resident 78 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis of the left ankle and foot (bone infection) and diabetes mellitus, type 2 (body has trouble controlling blood sugar).</p> <p>A review of Resident 78's MDS, dated [DATE], indicated a BIMs score of 15 (cognitive intact).</p> <p>6l. On April 7, 2025, Resident 138's record was reviewed. Resident 138 was admitted to the facility on [DATE], with diagnoses which indicated aftercare for joint replacement surgery and diabetes mellitus.</p> <p>A review of Resident 138's MDS, dated [DATE], indicated Resident 138 had a BIMs score of 15 (cognitive intact).</p> <p>(continued on next page)</p>

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>There was no documented evidence information regarding formulation of an Advance Directive was offered to the residents and/or resident representatives, for Residents 14, 21, 32, 40, 41, 50, 55, 59, 61, 71, 78, and 138. In addition, there was no documented evidence of an IDT review regarding advance directives for these residents was conducted quarterly and annually per facility policy.</p> <p>On April 11, 2025, at 2:18 p.m., an interview was conducted with the SSD. The SSD stated the POLST was uploaded at time of admission and reviewed quarterly (every 3 months) to see if any changes, there was no documentation a written information regarding formulating an AD was provided to the resident or resident's representative.</p> <p>On April 14, 2025, at 10:20 a.m., an interview was conducted with the Director of Nursing, DON. The DON stated the written information regarding formulation of advance directive was being provided due to no documentation during quarterly IDT meetings.</p> <p>A review of the job description for Social Worker, indicated, .Administrative functions .Provide residents with information concerning resident rights, living will, etc .</p> <p>A review of the facility's policy and procedure titled Advance Directives, dated December 2016, indicated, . Upon admission, the resident will be provided with written information concerning the right to refuse or accept medical or surgical treatment and to formulate an advance directive if he or she chooses to do so .If a resident is incapacitated and unable to receive information about his or her right to formulate an advance directive, the information may be provided to the resident's legal representative .The interdisciplinary team will conduct ongoing review of the resident's decision-making and communicate significant changes to the resident's legal representative. Such changes will be documented in the care plan and medical record .the interdisciplinary team will review annually with the resident his or her advance directive to ensure that such directives are still the wishes of the resident. Such reviews will be made during the annual assessment process and recorded on the resident assessment instrument .</p>

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47374</p> <p>Based on observation, interview, and record review, the facility failed to exercise reasonable care for the protection of the resident's property from theft or loss to occur, for one of one resident reviewed for personal property (Resident 27), when the resident's lower dentures were lost.</p> <p>This failure resulted in Resident 27 feeling distressed about the loss of her bottom dentures.</p> <p>Findings:</p> <p>On April 7, 2025, at 12:25 p.m., a concurrent observation and interview was conducted with Resident 27 in the room. Resident 27 was observed sitting in bed and watching television. Resident 27 stated she had lost her bottom teeth approximately two weeks ago. Resident 27 stated she believed her bottom dentures may have gone to the laundry and she told the nurse on the first morning the dentures were missing.</p> <p>On April 10, 2025, at 3 p.m., an interview with Resident 27 was conducted in the activity room at the resident's request. Resident 27 stated the CNA who worked yesterday had been unable to find them. A concurrent observation indicated Resident 27 had no bottom dentures present.</p> <p>On April 10, 2025, Resident 27's records was reviewed. Resident 27 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and depression (mood disorder of feeling sad).</p> <p>Resident 27's Minimum Data Set (MDS - a resident assessment tool), dated March 11, 2025, indicated Resident 27 had a BIMS (Brief Interview of Mental Status) score of 8 (moderately impaired cognition).</p> <p>Resident 27's care plan, dated March 5, 2025, indicated, .Resident exhibits at risk for oral health or dental care problems as evidence by Full upper and lower dentures, needs assistance with hygiene Brush/clean dentures .Encourage use or wear dentures .</p> <p>On April 10, 2025, at 4:15 p.m., the Director of Nursing (DON), was interviewed. The DON stated she had not heard of Resident 27's missing dentures. A concurrent review of Resident 27's record was conducted. Resident 27's Oral Health Evaluation, dated March 5, 2025, indicated, .Section A. Dentures Upper Full and Lower Full noted in resident's mouth .dentures in good health without any broken areas . The DON stated the staff member should have notified the Registered Nurse (RN) Supervisor or the DON immediately to allow for a quick search of the room, laundry, and trash. The DON further stated a notification of the resident's family and attempts to replace lower dentures by the administration should have been done.</p> <p>A review of Resident 27's record Physician Orders, dated March 5, 2025, indicated .Dental .Consult and treatment as needed for patient health and comfort .</p> <p>(continued on next page)</p>		

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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Investigating Incidents of Theft and Loss, dated February 2023, indicated, .all reports of theft .of resident property shall be promptly and thoroughly investigated . residents have the right to be free from .loss .the administrator will report the results of the investigation to local police, the ombudsman and state survey agency within 5 working days .</p> <p>A review of the facility's policy and procedure titled, Lost and Found, dated January 2001, .resident . complaints of missing items must be reported to the director of nursing services .lost and found records will be maintained .</p> <p>A review of the facility's undated policy and procedure titled, Dental Services, indicated .dentures will be protected from loss .while being stored .lost .dentures will be replaced .an employee or contractor of the facility is responsible for accidentally or intentionally damages the dentures .if dentures .are lost, residents will be referred for dental services within 3 days. If the referral is not made within 3 days, documentation will be provided regarding what is being done to ensure the resident can eat .adequately .</p>

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NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 East Devonshire Avenue Hemet, CA 92544	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on interview and record review, the facility failed to ensure the Minimum Data Set (MDS - a clinical assessment tool) was accurately coded, for one of three residents reviewed for dialysis (Resident 52).</p> <p>This failure resulted in an inaccurate MDS assessment to be submitted to CMS (Centers for Medicare and Medicaid Services).</p> <p>Findings:</p> <p>On April 8, 2025, Resident 52's record was reviewed. Resident 52 was admitted to the facility on [DATE] with diagnoses which included congestive heart failure (serious condition where the heart does not pump blood efficiently), chronic (persisting for a long time) kidney disease stage 3 (moderate damage), and presence of an automatic cardiac defibrillator (a small battery-powered device placed in the chest which detects and stops irregular heartbeats).</p> <p>Review of Resident 52's indicated the resident was placed under hospice services and was not receiving dialysis services.</p> <p>A review of Resident 52's MDS Section O, dated September 11, 2024, indicated Resident 52 was neither on hospice care (end of life care) or dialysis.</p> <p>A review of Resident 52's MDS Section O, dated October 29, 2024, indicated Resident 52 was on hospice care and not on dialysis.</p> <p>A review of Resident 52's MDS Section O, dated January 22, 2025, indicated Resident 52 was on dialysis.</p> <p>On April 10, 2025, at 4:16 p.m., a concurrent interview and review of Resident 52's record was conducted with the MDS Nurse. The MDS Nurse stated Resident 52 was admitted to the facility on [DATE] and neither was he on dialysis or hospice services at that time. The MDS Nurse stated Resident 52 became hospice on October 18, 2024, and this change was reflected in the MDS assessment dated [DATE] which was a Significant Change in Status Assessment (SCSA). The MDS Nurse stated she completed this assessment, as well as the assessment dated [DATE]. The MDS Nurse stated Resident 52 was never on dialysis, only hospice, and she had coded the January 22, 2025 assessment wrong. The MDS Nurse stated Resident 52's assessment should have been coded as hospice. The MDS Nurse stated MDS assessments should be accurate, and the care plan should have matched the assessment.</p> <p>On April 11, 2025, at 10:02 a.m., the Director of Nursing (DON) was interviewed. The DON stated the MDS needed to be coded to reflect the actual status of the resident, and Resident 52 should have been coded as hospice and not dialysis.</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Resident Assessments, dated October 2023, indicated, . A comprehensive assessment of each resident is completed at intervals designated by OBRA (Omnibus Budget Reconciliation Act) regulations and PPS (Prospective Payment System) requirements .All persons who have completed any portion of the MDS resident assessment form must sign the document attesting to the accuracy of such information .Information in the MDS assessments will consistently reflect information in the progress notes, plans of care and resident observations/interviews .</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on interview and record review, the facility failed to ensure resident care plans were initiated and/or updated when:</p> <ol style="list-style-type: none"> 1. No discharge care plans were developed and/or updated for Residents 33, 71, 78 and 139. This failure had the potential for the residents' pre and post-discharge needs to not be anticipated and addressed by the facility staff; 2. No care plan was developed for the use of a indwelling catheter (a flexible tube inserted into the bladder to drain urine) for Resident 13. This failure had the potential to result in Resident 13's indwelling catheter care issues to not be addressed and monitored by the facility staff; and 3. No care plan was developed regarding the change in condition on April 3, 2025, regarding a urinary tract infection (UTI) for Resident 138. This failure had the potential for Resident 138's UTI to not be addressed and monitored by the facility staff. <p>Findings:</p> <p>1a. On April 8, 2025, at 1:30 p.m., the (name on county) Ombudsman (OMB) was present in the facility to assist residents with discharge issues, including Resident 33.</p> <p>On April 10, 2025, at 2:43 p.m., Resident 33's FM was interviewed. The FM stated Resident 33 was admitted to the facility around July 2024, and a previous Social Services Director (SSD) had initially assisted with the Assisted Living Waiver program (ALW- allows eligible seniors and individuals with disabilities who need a nursing facility level of care to receive care in a residential care facility for the elderly (RCFE) or other participating assisted living setting instead of a nursing home) application process, but has since left the facility. The FM stated they had been reaching out to the facility since September 2024 to get Resident 33 to a permanent care home.</p> <p>On April 10, 2025, Resident 33's record was reviewed. Resident 33 was admitted to the facility on [DATE], with diagnoses which included mood disorder and dementia.</p> <p>A review of Resident 33's History and Physical Examination, dated August 11, 2024, indicated Resident 33 had fluctuating capacity to understand and make decisions due to dementia.</p> <p>A review of Resident 33's care plan, dated August 12, 2024, indicated, .Resident/patient has potential for discharge, or is expected to be discharged related to .Resident's desire to discharge to community .</p> <p>A review of Resident 33's Minimum Data Set (MDS- a clinical assessment tool), dated January 31, 2025, indicated Resident 33 had a Brief Interview of Mental Status (BIMS- a brief screening tool that aids in detecting cognitive status) score of 9 (moderate impairment).</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 33's Progress Notes, dated March 4, 2025, at 4:14 p.m., indicated the facility had arranged with the Assisted Living facility but was declined several times due to the resident's aggressive behavior and was referred to another placement that would better addressed Resident 33's behavior.</p> <p>Further review of Resident 33's care plan indicated there was no documented evidence the interventions of the care plan for discharge were updated to reflect changes or developments in Resident 33's discharge planning process.</p> <p>1b. A review of Resident 71's record indicated Resident 71 was admitted to the facility on [DATE], with diagnoses which included acute on chronic systolic congestive heart failure (the heart can't pump enough blood to meet the body's needs) and respiratory failure (not enough oxygen in the blood).</p> <p>A review of Resident 71's MDS dated [DATE], indicated Resident 71 had a BIMS score of 14 (cognitively intact).</p> <p>A review of Resident 71's interdisciplinary (IDT) progress note, dated March 11, 2025, indicated Resident 71 was interviewed by the SSD. The progress note indicated the Social Services Director (SSD) went over a welcome letter stating to Resident 71 he was at the facility under HMO (health maintenance organization-network or organization that provides health insurance coverage for a monthly or annual fee) insurance. The SSD stated to Resident 71, his estimated time frame of stay could be one to three weeks. The SSD stated Resident 71 had a CM (Case Manager) and a physician, and the three would collaborate and determine the course of action for his care while in the facility.</p> <p>A review of Resident 71's CM progress notes, dated April 4, 2025, indicated a CM from IEHP had provided the facility's CM a list of recuperative care programs for Resident 71 to choose from, as well as programs with resources such as how to apply for EBT (Electronic Benefit Transfer- system used in the United States to deliver government benefits to eligible recipients, such as SNAP (food stamps) and cash assistance, via a debit-like card), and even food banks in the area.</p> <p>A review of Resident 71's CM progress notes, dated April 7, 2025, indicated the CM from IEHP requested the facility to request the required DME (durable medical equipment- medical devices, equipment, or supplies that can be used repeatedly and are primarily used for medical purposes, especially at home) that would be needed prior to Resident 71 going to a recuperative care program.</p> <p>Further review of Resident 71's record indicated there was no documented evidence a care plan was initiated regarding discharge plans.</p> <p>On April 10, 2025, at 3:10 p.m. an interview was conducted with the facility CM. The CM stated Resident 71 was told on the day of admission he would be at the facility for 1 to 3 weeks, and IEHP had been covering his current stay. The CM stated a care plan should be started the day of admission and updated as discharge process continued. The CM further stated Resident 71 was shown how to take his blood sugars and the facility had requested the DME required for him to be placed in a recuperative care program. The CM further stated Resident 71 had an appeal, but that would only delay the discharge for a few days, and the facility was just waiting for the authorization from IEHP for the care program.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>1c. A review of Resident 78's record indicated Resident 78 was admitted to the facility on [DATE], with diagnoses which included osteomyelitis of the left ankle and foot (bone infection) and diabetes mellitus, type 2 (body has trouble controlling blood sugar).</p> <p>A review of Resident 78's MDS, dated [DATE], indicated Resident 78 had a BIMS score of 15 (cognitively intact).</p> <p>A review of Resident 78's IDT care conference notes, dated April 2, 2025, indicated the SSD provided Resident 78 with needed resources for discharge back to the community. Resident 78 had no income and was trying to get Supplemental Security Income (SSI- a program run by the Social Security Administration (SSA) that provides monthly benefits to individuals with limited income and resources who are blind, age 65 or older, or have a qualifying disability).</p> <p>A review of Resident 78's Social Services (SS) progress note, dated April 3, 2025, indicated the SSD spoke with Resident 78 and provided her with the website to go to and start her application process for disability. The SSD stated that once Resident 78 was discharged from the facility, she could go see her primary doctor, and her doctor could assist with the rest of the information needed for the disability paperwork.</p> <p>A review of Resident 78's care plans indicated there was no documented evidence a discharge care plan was initiated.</p> <p>On April 7, 2025, at 2:40 p.m., an interview was conducted with Resident 78. Resident 78 stated she was homeless and got an infection on her foot. Resident 78 stated she was supposed to get discharged on ce the antibiotics (medicine that fights bacterial infections by either killing the bacteria or preventing them from growing and multiplying) were done. Resident 78 stated the SSD gave her websites and printouts to try and get Social Security benefits.</p> <p>On April 9, 2025, at 10:22 a.m., an interview was conducted with the SSD. The SSD stated she provided information for the residents and their CM would follow up.</p> <p>On April 11, 2025, at 2:43 p.m., an interview was conducted with CM. The CM stated, We create a plan of care as we go. Long term care plan is started with updates when I have an actual discharge date .</p> <p>1d. On April 10, 2025, Resident 139's record was reviewed. Resident 139 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (brain dysfunction), kidney failure, and diabetes (abnormal blood sugars). Resident 139 was discharged from the facility on February 3, 2025.</p> <p>A review of Resident 139's History and Physical Examination, dated December 23,2024, indicated Resident 139 had fluctuating capacity to understand make decisions.</p> <p>A review of Resident 139's MDS, dated [DATE], indicated Resident 139 had a BIMS score of 15 (cognitively intact).</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the Social Service Progress Note, dated January 30, 2025, indicated Resident 139's family member had found placement for the resident at board and care, the Social Service Director (SSD) stated resident could still benefit from more rehabilitative therapy but due to high share of cost and resident not wanting to apply for MediCal, the discharge would move forward, and the IDT create a plan of care.</p> <p>A review of Resident 139's care plans indicated no discharge care plan was initiated since Resident 139's admission to the facility on [DATE].</p> <p>On April 11, 2025, at 2:54 p.m., a concurrent interview was conducted with the SSD. The SSD further stated Resident 139's discharge care plan should have been updated.</p> <p>On April 14, 2025, at 10:02 a.m., the DON stated residents' discharge care plans should be initiated on day one of care and the initial care plan should be updated as needed. The DON stated if the resident was going to discharge to the community, the care plan should be updated. The DON further stated the Ombudsman should be included in discharge planning, and a care conference conducted within 72 hours from the time the SSD or case manager communicated the planned discharge.</p> <p>A review of the job description for Case Manager, indicated, .Administrative Functions .Implement and monitor the care plan to ensure effectiveness of appropriate services as part of the interdisciplinary team (IDT) and discharge planning process .Ensure that discharge needs of each resident are identified and result in the development of a discharge plan for each resident .Include regular re-evaluation of residents to identify changes that require modifications of the discharge plan; update the discharge plan as needed to reflect these changes .Ensure residents care plans accurately reflect appropriate goals, problems, and approaches and revisions based on resident needs .</p> <p>A review of the job description for Social Worker, indicated, .Care Plan and Assessment Functions . Participate in the development of a resident-centered care plan for each resident .Involve the resident/family in planning individualized goals for the resident .Communicate the social, psychological and emotional needs of the resident/family to other members of the IDT .</p> <p>A review of the policy and procedure titled, Care Planning-Interdisciplinary Team, dated August 25, 2021, indicated, .a comprehensive care plan for each resident is developed within seven (7) days of completion of the comprehensive assessment (MDS) .</p> <p>49113</p> <p>2. On April 7, 2025, at 9:59 a.m., Resident 13's foley catheter was observed to be cloudy with excessive sediments in the tubing.</p> <p>Resident 13's record was reviewed. Resident 13 was admitted on [DATE], with diagnoses which included benign prostatic hyperplasia (enlarged prostate), obstructive and reflex uropathy (blockage in the urinary tract with back flow from the bladder) and retention of urine (difficulty emptying the bladder).</p> <p>Resident 13's History and Physical, dated June 26, 2024, indicated Resident 13 had fluctuating capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 13's Minimum Data Set (MDS - an assessment tool), dated January 25, 2025, indicated Resident 13 had a BIMS (Brief Interview for Mental Status) score of 12 which indicated moderate cognition, The MDS also indicated Resident 13 was dependent for toileting hygiene, substantial to maximal assistance with lower body dressing and putting on and taking off footwear.</p> <p>Resident 13's Order Listing Report, included a physician's order, dated November 9, 2024, to Perform Foley (indwelling) Catheter Care every day shift and perform Foley Catheter Care as needed. A further order dated March 13, 2025, indicated, Indwelling Catheter: Foley catheter; change for blockage, leaking, pulled out, excessive sedimentation.</p> <p>Further review of Resident 13's record indicated there was no plan of care developed to address the use of an indwelling catheter.</p> <p>On April 9, 2025, at 2:08 p.m., a concurrent observation of Resident 13 and interview with Licensed Vocational Nurse (LVN) 1 was conducted. LVN 1 observed Resident 13 and stated Resident 13's foley catheter was cloudy with sediments. LVN 1 stated there was no care plan initiated regarding Resident 13's indwelling catheter. LVN 1 stated there should be a care plan developed to address the use of the indwelling catheter.</p> <p>On April 10, 2025, at 3:25 p.m., a concurrent record review and interview with the Director of Nursing (DON) was conducted. The DON stated there was no current care plan for foley catheter care or current daily treatment documentation. The DON stated the expectation was there should be a care plan to address Resident 13's use of the indwelling catheter.</p> <p>3. On April 7, 2025, Resident 138's record was reviewed. Resident 138 was admitted to the facility on [DATE], with diagnoses which included diabetes (abnormal blood sugars) and chronic (persisting for a long time) kidney disease stage 3b (moderate kidney damage).</p> <p>A review of Resident 138's eINTERACT Change in Condition, dated April 3, 2025, indicated Resident 138 complained of burning during urination. Subsequently the physician was notified and the physician recommended a urinalysis.</p> <p>A review of Resident 138's urinalysis report indicated the urine specimen was collected on April 4, 2025, at 6 a.m., and the result was reported to the facility on [DATE], at 6:06 p.m. The result indicated Resident 138 had a signs of urinary tract infection (UTI) and the culture of the urine specimen was pending.</p> <p>A review of Resident 138's urine culture report, reported to the facility on [DATE], at 2:39 p.m., indicated Resident 138 had a urinary tract infection (UTI) caused by the bacteria Escherichia coli and was sensitive to several antibiotics (medication to treat infection).</p> <p>A review of Resident 138's care plan indicated there was no documented evidence a care plan for the change in condition identified on April 3, 2025 regarding the UTI, was initiated.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 8, 2025, at 2:57 p.m., Resident 138 was interviewed. Resident 138 stated a few days ago she thought she had a UTI because she had a burning sensation when urinating. Resident 138 further stated she gave a sample for urine culture, but They haven't told me about the results, so I don't know if I had it or not, and they haven't started any antibiotics (medicine that stops or destroys microorganisms that cause infection).</p> <p>On April 10, 2025, at 3:11 p.m., a concurrent interview and review of Resident 138's record was conducted with the Director of Nursing (DON). The DON stated there was no care plan developed when Resident 138 had a change of condition on April 3, 2025, to address signs of UTI. The DON further stated a care plan should have been developed when Resident 138 had a change in condition due to the UTI.</p> <p>A review of the facility's policy and procedure titled, Care Planning-Interdisciplinary Team, dated August 25, 2021, indicated, .Our facility's Interdisciplinary Team is responsible for the development of an individualized comprehensive care plan for each resident .care plan is based on the resident's comprehensive assessment and is developed by an Interdisciplinary Team which includes .a Registered Nurse, with responsibility for the resident, Social Services Worker responsible for the resident, the Charge Nurse Nursing Assistants with responsibility for the resident .</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, for four of four residents, (Residents 14, 18, 49, and 8), the facility failed to ensure the residents were not left soiled, wet, and unchanged by staff.</p> <p>These failures resulted in Resident 8, 14, 18, and 49, being left soiled in their urine, feces, and wet linen for hours and feeling ignored and not cared for. In addition, the failure has the potential for the residents to develop skin conditions and infection which could affect the resident's overall health condition.</p> <p>Findings:</p> <p>1. On April 9, 2025, at 12:50 p.m., an interview with Certified Nursing Assistant, (CNA) 1 was conducted. CNA 1 stated Resident 8 complained to her she was soiled and CNA 2 answered the light, came into the room, did not acknowledge her need, walked out and never came back to change her. CNA 1 stated she observed Resident 8 entire bed linen was soiled.</p> <p>On April 9, 2025, Resident 8's record was reviewed. Resident 8 was admitted on [DATE], with diagnoses which included, type 2 diabetes mellitus (body doesn't produce enough blood sugar), dementia (decline in mental abilities), and malignant neoplasm of right breast (cancer in the breast).</p> <p>Resident 8's care plan, revised on September 19, 2023, indicated at risk for decreased ability to perform Activity of Daily Living (ADL(s)-self care tasks) in bathing, grooming, personal hygiene, dressing and eating.</p> <p>Resident 8's Nursing Documentation Evaluation, dated November 12, 2024, indicated Resident 8 was incontinent for bowel and bladder.</p> <p>Resident 8's History and Physical, dated November 30, 2024, indicated Resident 8 had the capacity to understand and make decisions.</p> <p>Resident 8's Minimum Data Set (MDS-an assessment tool), dated February 5, 2025, indicated Resident 8 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact) and Resident 8 required substantial to maximal assistance with oral and personal hygiene, and was dependent for toileting hygiene, shower/bathe self, lower body dressing, putting on and taking off footwear and tub/shower transfer.</p> <p>On April 9, 2025, at 1:04 p.m., an interview with Resident 8 was conducted. Resident 8 stated she called for CNA 2 to clean her, CNA 2 came in the room, left and never came back to change her. Resident 8 also stated she laid in her own urine and feces for about 35-40 minutes until another CNA came and cleaned her. Resident 8 further stated she and her linen was left soiled, and she felt like she was at their mercy and not being cared for.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 9, 2025, at 1:09 p.m., an interview CNA 2 was conducted. CNA 2 stated he was assigned to Resident 8 on April 8, 2025. CNA 2 stated Resident 8 asked for help to be cleaned, and he did not clean her as Resident 8 was due for a shower. CNA 2 stated he should have cleaned the resident and changed her linen. CNA 2 also stated, Resident 8 should not have had to wait to be cleaned, and it probably did not make her feel good. CNA 2 further stated it was not respectful to leave Resident 8 soiled in her urine and stool.</p> <p>On April 9, 2025, at 1:11 p.m., an interview with Resident 8's roommate (Resident 50) was conducted. Resident 50 stated CNA 2 came into the room and did not respond to Resident's 8 need. Resident 50 stated CNA 2 came in the room, left out and did not come back to clean Resident 8. Resident 50 stated it happened all the time.</p> <p>On April 9, 2025, Resident 50 record was reviewed. Resident 50 was admitted to the facility on [DATE], with diagnoses which included local infection of the skin, depression (mental health disorder characterized by persistent sadness) and asthma (lung disease).</p> <p>Resident 50's History and Physical, dated January 5, 2025, indicated Resident 50 had the capacity to understand and make decisions.</p> <p>Resident 50's 'Minimum Data Set (MDS), dated [DATE], indicated Resident 50 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact).</p> <p>On April 9, 2025, at 4:47 p.m., an interview with , CNA 3 was conducted. CNA 3 stated she cared for Resident 8 on April 8, 2025 (3 p.m. to 11 p.m. shift), and Resident 8 informed her that she was left soiled and was not changed since before lunch. CNA 3 further stated Resident 8 stated she was not happy about the situation. CNA 3 stated she immediately cleaned Resident 8 as Resident 8's linens were soiled all over.</p> <p>2. On April 7, 2025, at 1:11 p.m., an interview with Resident 14 was conducted. Resident 14 stated her call light was night answered in a timely manner. Resident 14 stated on April 6, 2025, the CNA on the day shift never changed her from morning until 2:30 p.m. Resident 14 stated she was incontinent, and her bed was wet from the top of her back to the bottom end of the bed. Resident 14 stated she felt terrible, and she felt like a dog.</p> <p>On April 9, 2025, Resident 14's record was reviewed. Resident 14 had an initial admitted [DATE], and was readmitted on [DATE], with diagnoses which included, acute respiratory failure (difficulty breathing), morbid obesity (too much body fat), signs involving the genitourinary system (conditions affecting the urinary systems) and lower back pain.</p> <p>Resident 14's History and Physical, dated September 14, 2024, indicated Resident 14 had the capacity to understand and make decisions.</p> <p>Resident 14's Minimum Data Set, dated dated [DATE], indicated Resident 14 had a BIMS score of 15 (cognitively intact) and Resident 14 was dependent for Activities of Daily Living (ADL) toileting hygiene, shower/bathe self, lower body dressing and putting on and taking off footwear. required substantial /maximal assistance with oral and personal hygiene, and was dependent for toileting hygiene, shower/bathe self, lower body dressing.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 14's care plan, revised on September 4, 2024, indicated Resident 14 required extensive assistance for ADL care in bathing, grooming, personal hygiene, dressing bed mobility, toileting related to functional decline. The care plan indicated intervention such as to provide dependent assist for toileting for Resident 14.</p> <p>3. On April 7, 2025, at 4:05 p.m., an interview with Resident 18 was conducted. Resident 18 stated on April 6, 2025, he and his roommate was left wet and soiled in their urine the entire day shift from morning until 2 p. m. Resident 18 stated two weeks ago he was left soiled in his own stool and he felt like an ass. Resident 18 stated he felt neglected and ignored. Resident 18 further stated he used the call light, and no one answered. Resident 18 further stated he told staff and administration but know one came back to update him.</p> <p>On April 9, 2025, Resident 18's record was reviewed. Resident 18 initial admitted was June 5, 2020, with a readmitted on March 31, 2024, with diagnoses which included heart failure, morbid obesity (too much body fat), diabetes mellitus and foot ulcer (sore on the foot).</p> <p>Resident 18's History and Physical, dated November 30, 2024, indicated Resident 18 had the capacity to understand and make decisions.</p> <p>Resident 18's Minimum Data Set (MDS), dated [DATE], indicated Resident 18 had a BIMS score of 15 (cognitively intact) and Resident 18 was dependent for Activities of Daily Living (ADL) toileting hygiene, shower/bathe self, lower body dressing and putting on and taking off footwear, and required substantial/maximal assistance with shower/bathe self.</p> <p>Resident 18's care plan, initiated June 7, 2020, indicated a focus that Resident 18 required/is dependent for ADL care in bathing, grooming, personal hygiene, dressing eating, bed mobility, transfer, locomotion, toileting related diabetic foot infection, sepsis, general weakness, physical debility, decreased circulation, and use of diuretic.</p> <p>On April 14, 2025, at 10:26 a.m., an interview with Registered Nurse (RN) 1 was conducted. RN 1 stated staff reported to her that Resident 18 was left soiled. RN 1 stated she went to the room and saw the soiled stains on Resident 18 sheets. RN 1 stated she paged the CNA at 2:30 p.m. but she did not respond. RN 1 stated her expectations was that the CNA's should check all their residents to see if they are dry and clean before their shift ends.</p> <p>4. On April 7, 2025, at 9:19 a.m., an anonymous online complaint was submitted. The complaint indicated Resident 49 was not touched all day as witnessed by his roommate. The complaint further indicated Resident 49 was nonverbal and could speak for himself.</p> <p>On April 9, 2025, Resident 49's record was reviewed. Resident 49 was admitted to the facility on [DATE], with diagnoses which included hemiplegia (one sided paralysis) and hemiparesis (partial weakness), hear failure, and encephalopathy (disease of the brain).</p> <p>Resident 49's History and Physical, dated August 14, 2024, indicated Resident 49 had fluctuating capacity to understand and make decisions.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 49's Minimum Data Set (MDS), dated [DATE], indicated Resident 49 was dependent for Activities of Daily Living (ADL) toileting hygiene, and required substantial/maximal assist with oral hygiene, shower/bathe self, upper and lower body dressing and putting on and taking off footwear, and personal hygiene.</p> <p>Resident 49's care plan, initiated August 12, 2023, indicated a focus that Resident 49 required/is dependent for ADL care in bathing, grooming, personal hygiene, dressing eating, bed mobility, transfer, locomotion, toileting related recent illness, fall, hospitalization resulting in fatigue, activity intolerance and confusion.</p> <p>On April 10, 2024, at 8:41 a.m., an interview with CNA 4 was conducted. CNA 4 stated she worked the day shift from 6:30 a.m. to 2:30 p.m. CNA 4 stated her duties was to get residents up, dressed, groom and help with hygiene. Stated she also helps with bathing and keeping the room clean. CNA 4 stated everyone was responsible for answering the call lights. CNA 4 stated she worked the day shift on April 6, 2025, and no resident complained to her about not receiving care. CNA 4 stated she cared for all the residents assigned to her on April 6, 2025. CNA 4 also stated no staff or licensed nurse informed her of any residents complaint of not receiving care. CNA 4 stated she did not observe call lights not being answered. CNA 4 denied leaving the residents assigned to her soiled and in wet linen.</p> <p>On April 10, 2025, at 4:01 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the expectation was all staff can answer call lights. The DON stated no residents should have to wait pass 10 minutes to be changed and should not be left in their own stool. The DON also stated residents call light should be answered and acknowledge and the expectation was that staff would clean and change residents when made aware.</p> <p>On April 14, 2025, at 10:29 a.m. an interview with RN 1 was conducted. RN 1 stated the CNAs should answer the call light right away and acknowledge the resident's request. RN 1 stated the expectation was for CNAs to be attentive to the needs of the patients. RN 1 stated the CNA should have answered and acknowledged Resident's 8 call light. RN 1 also stated Resident 8 should not have had to wait to be cleaned.</p> <p>A review of the facility's job description titled, Certified Nursing Assistant, dated October 2020, indicated . Duties and Responsibilities .Keep the nurses' call system within easy reach of the resident .</p> <p>A review of the facility's policy and procedure titled, Answering the Call Light, dated October 24, 2024, indicated .The purpose of this procedure is to ensure timely response to the resident's requests and needs . Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .</p> <p>A review of the facility's policy and procedure titled, Dignity, dated February 2021, indicated .Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being .level of satisfaction with life .and feelings of self-worth and self-esteem .Demeaning practices and standards of care that compromise dignity are prohibited. Staff are expected to promote dignity and assist residents; for example: promptly responding to a resident's request for toileting assistance .</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's policy and procedure titled, Resident Rights: dated February 2021, indicated . Employees shall treat all residents with kindness, respect, and dignity .Federal and state laws guarantee certain basic rights to all residents of this facility .these rights include the resident's right to: a dignified existence .be treated with respect, kindness, and dignity .</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on observation, interview, and record review, for one of 21 residents reviewed (Resident 138), the facility failed to ensure the physician was notified timely of Resident 138's urine culture and sensitivity result.</p> <p>This failure resulted in Resident 138 not receiving prompt treatment for the urinary tract infection.</p> <p>Findings:</p> <p>On April 7, 2025, Resident 138's record was reviewed. Resident 138 was admitted to the facility on [DATE], with diagnoses which included diabetes (abnormal blood sugars) and chronic (persisting for a long time) kidney disease stage 3b (moderate kidney damage).</p> <p>A review of Resident 138's eINTERACT Change in Condition, dated April 3, 2025, at 7:14 p.m., indicated Resident 138 complained of burning during urination. Subsequently the physician was notified and the physician recommended a urinalysis with culture and sensitivity if indicated.</p> <p>A review of Resident 138's urinalysis report indicated the urine specimen was collected on April 4, 2025, at 6 a.m., and the result was reported to the facility on [DATE], at 6:06 p.m. The result indicated Resident 138 had few bacteria, WBC 16 (reference range is 0-5) and moderate mucus (reference range is none - few) with signs of urinary tract infection (UTI) and the culture of the urine specimen was pending.</p> <p>A review of Resident 138's urine culture report, reported to the facility on [DATE], at 2:39 p.m., indicated Resident 138 had a urinary tract infection (UTI) caused by the bacteria Escherichia coli and was sensitive to several antibiotics (medication to treat infection).</p> <p>Further review of Resident 138's record indicated there was no documented evidence the physician was notified of the urinalysis and urine culture results.</p> <p>A review of Residents 138's physician's orders for April 2025 indicated there was no medication was prescribed for UTI.</p> <p>A review of Resident 138's care plan indicated there was no documented evidence a care plan for the change in condition identified on April 3, 2025 regarding the UTI, was initiated.</p> <p>On April 8, 2025, at 2:57 p.m., Resident 138 was interviewed. Resident 138 stated a few days ago she thought she had a UTI because she had a burning sensation when urinating. Resident 138 further stated she gave a sample for urine culture, but They have not told me about the results, so I do not know if I had it or not, and they have not started any antibiotics (medicine that stops or destroys microorganisms that cause infection).</p> <p>(continued on next page)</p>

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 10, 2025, at 9:34 a.m., a concurrent interview and review of Resident 138's record was conducted with LVN 1. LVN 1 stated Resident 138 was not on any oral or intravenous antibiotics, and currently had no infection documented.</p> <p>On April 10, 2025, at 10 a.m., a concurrent interview and review of Resident 183's record was conducted with Registered Nurse (RN) 2. RN 2 stated there was no documentation in Resident 138's record the physician was notified of the urine culture result, but stated she had notified the physician twice, once when the physician was in the building, and once via a secure text message regarding the urine culture result, however there was still no response from the physician at this time (three days since the urine culture was reported to the facility by the laboratory).</p> <p>On April 10, 2025, at 3:11 p.m., a concurrent interview and review of Resident 138's record was conducted with the Director of Nursing (DON). The DON stated the routine was once the licensed nurses see the lab results, they would review it and report any abnormality to the physician and obtain an order to address the issue. The DON stated there was no documentation the physician was notified of Resident 138's urine culture result, no antibiotic order was obtained, nor was there a care plan developed for UTI. The DON stated for the change in condition, she expected the licensed staff to do a change in condition report, notify the physician and resident representative (if resident unable to decide for self), get a physician's order for the urinalysis, and create a care plan. Once the urinalysis was done, check the lab result, notify the physician of the result as soon as possible, obtain an order for medication, and carry out the order. The DON further stated, by this time there should have been a follow up with the physician, and there should have been an order obtained to address Resident 138's UTI.</p> <p>A review of the facility's policy and procedure titled, Change in Condition: Notification of, dated August 25, 2021, indicated, . PURPOSE To ensure residents, family .and physicians are informed of changes in the resident's condition .Facility must immediately inform the resident, consult with the Resident's physician and/or NP (nurse practitioner), and notify .where there is .A significant change in the Resident's physical, mental or psychosocial status .</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459</p> <p>Based on observation, interview, and record review the facility failed to coordinate optometry services when the resident requested it for one of one Residents, (Resident 40), reviewed for vision/hearing. In addition, Resident 40 was admitted on [DATE], with a pair of glasses that was missing the right lens.</p> <p>This failure could have caused Resident 40 sensory deprivation and had the potential to result in physical discomfort.</p> <p>Findings:</p> <p>On April 8, 2025, at 10:23 a.m., Resident 40 was observed to be wearing his eyeglasses on with the right lens missing. In a concurrent interview with Resident 40, he stated he had waited months to see the optometrist (an eye specialist).</p> <p>A review of Resident 40's record indicated Resident 40 was readmitted to the facility on [DATE], with diagnoses which included major depressive disorder (feelings of sadness and loss of interest), and diabetes cellulitis (high blood sugar levels).</p> <p>A review of Resident 40's Inventory of Personal Effects, dated January 17, 2025, indicated Resident 40 had black glasses with a right lens missing.</p> <p>A review of Resident 40's Minimum Data Set (MDS - a resident assessment tool), dated March 26, 2025, indicated Resident 40 had a Brief Interview for Medical Status (BIMS) score of 15 (cognitively intact).</p> <p>A review of Resident 40's, Order Summary Report, included a physician's order, dated January 18, 2025, which indicated, .ophthalmology (eye specialist) consult and treatment as needed for patient health and comfort .</p> <p>On April 10, 2025, at 11:13 a.m. and interview was conducted with the Social Services Director (SSD). The SSD stated the optometrist comes in the facility every two months, and next schedule is on April 11, 2025. The SSD stated Resident 40 told a Certified Nursing Assistant (CNA) earlier this month that he needed to see the eye specialist.</p> <p>On April 11, 2025, at 3:56 p.m., an interview was conducted with the SSD. The SSD stated the eye specialist did not come to see Resident 40.</p> <p>On April 14, 2025, at 10:49 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated there was a standing order for ancillary care, once a resident mentions needing ancillary services it should be arranged once the facility gets the authorization. The DON further stated Resident 40's broken glasses should have been identified and an authorization should have been requested sooner after the eyeglasses was identified broken on January 17, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Referrals, Social Services, indicated, .Social services shall coordinate most resident referrals .Referrals for medical services must be based on physician evaluation of resident need and a related physician order .Social services will document the referral in the residents medical record .Social services and administration will maintain a listing of referral agencies that may provide assistance or therapy to residents with special problems and/or needs .</p>

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459</p> <p>Based on observation, interview, and record review, for two of three residents reviewed for urinary catheter (used to drain urine from the bladder) (Residents 13 and 59), the facility failed to identify, assess, and address signs and symptoms related to urinary catheter complications, when:</p> <ol style="list-style-type: none"> 1. Resident 13's suprapubic catheter (a tube placed through the abdominal wall directly into the bladder) tubing was found to have an excessive amount of sediment. In addition, the follow up appointment with the urologist was not done timely; and 2. Resident 59's indwelling foley catheter (urinary catheter used for continuous drainage of the bladder) tubing was found to have an excessive amount of sediment. In addition, the follow up urology appointment scheduled on November 19, 2024, was not done accordingly. <p>These failures had increased the risk of urinary tract infection for Residents 13 and 59.</p> <p>Findings:</p> <p>1. On April 7, 2025, at 10:28 a.m., Resident 59 was observed sitting in his wheelchair. Resident 59's urinary catheter tubing was observed attached to the wheelchair was observed to have small white sediments. In a concurrent interview with Resident 59, he stated he had surgery and still had stitches to his scrotum which needed to be removed. Resident 59 further stated he did not notice the particles in his urinary catheter tubing.</p> <p>On April 9, 2025, at 8:13 a.m., a follow up observation was conducted of Resident 59's urinary catheter tubing. Resident 59's urinary catheter tubing had an increased amount of small white sediments.</p> <p>On April 9, 2025, at 8:17 a.m., an interview was conducted with the Treatment Nurse (TN). The TN stated there was a lot of sediments in Resident 59's urinary tubing. The TN stated someone should have reported the increase of white sediments in Resident 59's urinary catheter tubing to the physician.</p> <p>Resident 59's record was reviewed. Resident 59's record indicated the resident was admitted to the facility on [DATE], with a diagnoses which included abscess of epididymis or testis (infection in the scrotum), and retention of urine (difficulty urinating).</p> <p>A review of Resident 59's care plan, dated March 14, 2025, indicated, .Resident requires indwelling foley catheter care .report to physician promptly if the urine contains any sediment, or blood, is cloudy, or odorous, or if the resident has a fever .</p> <p>A review of Resident 59's Minimum Data Set (MDS - a resident assessment tool), dated March 19, 2025, indicated Resident 59 had a Brief Interview for Mental Status (BIMS) score of 14 (cognitively intact.)</p> <p>(continued on next page)</p>		

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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 59's physician order, dated March 17, 2025, indicated Resident 59 needed follow up with his urologist (a doctor who specializes in disorders of the urinary tract) in 2 weeks.</p> <p>A review of Resident 59's physician order, dated April 9, 2025 (23 days after it was ordered), indicated an appointment with urologist on April 25, 2025 (39 days after it was ordered on March 17, 2025).</p> <p>On April 11, 2025, at 11:47 a.m., an interview was conducted with the Infection Preventionist (IP). The IP stated There should never be a delay in care especially if there's a risk for infection. I expect both the CNA's (Certified Nursing Assistants) and the licensed nurses to notice if a foley catheter tubing has changed especially if with sediments, that could start an infection.</p> <p>On April 11, 2025, at 5:01 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated the staff should have noticed the increase in sediment and followed through with calling the doctor. The DON further stated, the follow-up appointment with the urologist should have been made at the time of admission.</p> <p>A review of an article from the National Library of Medicine titled, Exploring Relationships of Catheter Associated Urinary Tract Infection and Blockage in People with Long Term Indwelling Urinary Catheters dated September 2018 indicated, .other catheter</p> <p>related problems are of concern also, such as leakage of urine, sediment, and catheter related pain .nurses can develop care management strategies to identify catheter blockage prior to its occurrence by tracking the amount of sediment and frequency of leakage .urinary sediment which causes encrustation and blockage of the catheter lumen is caused by the precipitation .</p> <p>49113</p> <p>2. On April 7, 2025, at 9:59 a.m., Resident 13 was observed awake and lying in bed. Resident 13's foley catheter was observed cloudy with excessive sediments in the urinary tubing. In a concurrent interview with Resident 13, he stated his catheter hurts.</p> <p>Resident 13's record was reviewed. Resident 13 was admitted on [DATE], with diagnoses which included benign prostatic hyperplasia (enlarged prostate), obstructive and reflex uropathy (blockage in the urinary tract with back flow from the bladder) and retention of urine (difficulty emptying the bladder).</p> <p>Resident 13's History and Physical, dated June 26, 2024, indicated Resident 13 had fluctuating capacity to understand and make decisions.</p> <p>Resident 13's Minimum Data Set (MDS- an assessment tool), dated January 25, 2025, indicated Resident 13 had a BIMS (Brief Interview for Mental Status) score of 12 (moderate cognition) and section GG indicated Resident 13 was dependent for toileting hygiene.</p> <p>Resident 13's Order Listing Report, included an active physician's order, dated November 9, 2024, which indicated, .perform foley catheter care every day shift and perform Foley Catheter Care as needed . A subsequent order dated March 13, 2025, indicated Indwelling Catheter: Foley catheter; change for blockage, leaking, pulled out, excessive sedimentation .</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 East Devonshire Avenue Hemet, CA 92544	
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<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident 13's physician's order, dated October 30, 2024, at 10:19 a.m. indicated a urology (diseases of the urinary tract) follow up appointment on November 19, 2024, at 2:30 p.m. related to suprapubic catheter (a type of urinary catheter inserted directly into the bladder through a small incision in the lower abdomen, rather than through the urethra) care .</p> <p>On April 8, 2025, at 10:26 a.m., a follow up observation of Resident 13's foley catheter was conducted. Resident 13's foley catheter remained cloudy with excessive sediments.</p> <p>On April 9, 2025, at 10:30 a.m., a concurrent observation and interview with CNA 5 was conducted. CNA 5 stated the foley catheter was foggy and had buildup inside the tubing. CNA 5 stated he was Resident 13's CNA on April 8, 2025, the night shift. CNA 5 stated he previously reported the resident's complaint of abdominal pain and the sediments to the Licensed Vocational Nurse (LVN) 1. CNA 2 further stated Resident 13's foley had been like that for 3 months, and he and other CNAs made reports to different nurses over different shifts and until now nothing has been done.</p> <p>On April 9, 2025, at 2:08 p.m., a concurrent observation with LVN 1 of Resident 13's foley catheter was conducted. LVN 1 stated Resident 13's foley catheter was cloudy with sediments. In a concurrent interview LVN 1 stated she had not previously observed the foley catheter nor had she ever irrigated the foley catheter. LVN 1 stated the facility's process is to report any change of condition to the supervisor and doctor. LVN 1 further stated a care plan should have been initiated.</p> <p>On April 10, 2025, at 3 p.m., a concurrent record review and interview with the Treatment Nurse (TN) was conducted. The TN verified there was no weekly notes for Resident 13's foley catheter care and no current care plan. The TN confirmed Resident 13 was not sent to the urologist follow up appointment scheduled on November 19, 2024. The TN also was not able to provide documentation for assessment and care of Resident 13's foley catheter. The TN further stated changes in the foley catheter should be reported to the doctor.</p> <p>On April 10, 2025, at 3:25 p.m., a concurrent record review and interview with the Director of Nursing (DON) was conducted. The DON stated there were no recent documentation regarding the foley catheter in the treatment record. The DON confirmed Resident 13 missed a follow up urology appointment on November 19, 2024. The DON also stated she called the urologist and was informed the missed appointment was documented as no show. The DON stated Social Services should have arranged for Resident 13's appointment and transportation to the urologist. The DON also stated foley catheter care was part of the resident's daily assessment and should be checked for drainage, unusual color, clogs/blockage and sediments. The DON further stated the expectation for a change of condition should be reported to the charge nurse and the doctor. The DON stated the resident could have pain, discomfort, or infection if foley catheter assessments and care were not done daily.</p> <p>A review of the facility's policy and procedure titled, Suprapubic Catheter Care dated October 2010, indicated, .the purpose of this procedure is to prevent skin irritation .and to prevent infection of the resident's urinary tract .check the urine for unusual appearance (i.e., color, blood etc.) .Check the resident frequently to be sure the tubing is free of kinks .Observe the resident for signs and symptoms of urinary tract infection and urinary retention. Report findings to your supervisor .Document character of urine, such as color (dark, or red .clarity (cloudy, solid particles) .</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41459</p> <p>Based on observation, interview, and record review the facility failed to follow Resident 289's physician order to provide a regular textured, thin liquid consistency diet.</p> <p>This deficit practice had the potential for Resident 289's needs to not be met and placed the resident at risk for weight loss.</p> <p>Findings:</p> <p>On April 7, 2025, at 11:33 a.m., a concurrent observation and interview was conducted with Resident 289. Resident 289 was sitting in bed. In a concurrent interview, Resident 289 stated he could eat whatever he wants even without teeth when he was at home. Resident 289 stated he had been receiving a pureed diet since his admit to the facility and he should be getting a regular diet.</p> <p>A review of Resident 289's record was reviewed. Resident 289 was admitted to the facility on [DATE], with diagnoses which included open wound of left cheek and temporomandibular area (the joint that connects the lower jaw (mandible) to the skull), sequela (limited jaw movement, clicking or popping sounds, and even long-term complications).</p> <p>A review of Resident 289's Minimum Data Set (MDS - a resident assessment tool), dated March 28, 2025, indicated Resident 289 had a Brief Interview for Mental Status (BIMS) score of 12 (cognition is mildly impaired).</p> <p>A review of Resident 289's dietary profile, dated March 26, 2025, indicated, Resident 289 was to be provided a pureed texture diet. The dietary profile further indicated Resident 289 consumed 25% of his meals.</p> <p>A review of Resident 289's Speech Therapy Evaluation, dated March 31, 2025, indicated the speech therapist recommended for Resident 289 to receive a Regular Texture (chopped meat) diet.</p> <p>A review of Resident 289's physician order, dated April 7, 2025, indicated, Resident 289 was to receive a Regular, No Added Salt diet, Regular texture. Thin consistency, diet.</p> <p>A review of Resident 289's physician order, dated April 7, 2025, indicated, Resident 289 was to receive Speech Therapy three times a week for four weeks.</p> <p>On April 9, 2025, at 12:41 p.m., a concurrent observation and interview was conducted with Resident 289 Resident 289 was observed consuming a Regular Texture, Thin Liquid Consistency Diet, Resident 289 stated he was very happy with his diet now.</p> <p>On April 9, 2025, at 4:50 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated Resident 289 should have been on the regular textured, thin Liquid consistency following the recommendations from his speech therapy evaluation on March 31, 2025.</p> <p>(continued on next page)</p>		

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<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility's policy and procedure titled, Dining and Food Preferences, dated September 2017, indicated, .individual dining, food preferences are identified for all residents .the dining service director . will interview the resident .to complete a food preference interview .the registered dietician .will review, and after consult with resident, adjust the individual meal plan . any resident with expressed or observed refusal of food .will be offered an alternative selection .alternative meal .will be provided in a timely manner .</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure sufficient staff were provided to meet the needs of the residents,</p> <ol style="list-style-type: none"> For four of 88 residents (Residents 14, 18, 46, and 51) complained that staff failed to assist with activities of daily living (ADL- daily care activities) in a timely manner; and The facility did not meet the required minimum of Actual Total Direct Care Service Hours (Actual DCSH) of 3.5 and the actual CNA DCSH of 2.4 hours for the month of March 2025. <p>These deficient practices caused feelings of frustrations and anger, among the residents, and negatively affected the quality of care for the residents.</p> <p>Findings:</p> <ol style="list-style-type: none"> On April 7, 2025, at 1:11 p.m., during an interview with Resident 14, Resident 14 stated the call light was not answered in a timely manner. Resident 14 stated 30 percent of the time the call light is not answered at all. Resident 14 stated the CNA's go to lunch and no one covered them. Resident 14 further stated there was no teamwork, and she used the call light because she needed assistance with ice water or toileting. Resident 14 stated the CNA never changes her for the morning shift of April 6, 2025, [NAME] bed was wet from top of her back all the way down to the bottom of her bed. <p>On April 9, 2025, Resident 14's record was reviewed. Resident 14 had an initial admitted [DATE], and was readmitted on [DATE], with diagnoses which included, acute respiratory failure (difficulty breathing), morbid obesity (too much body fat), signs involving the genitourinary system (conditions affecting the urinary systems) and lower back pain.</p> <p>Resident 14's History and Physical, dated September 14, 2024, indicated Resident 14 had the capacity to understand and make decisions.</p> <p>Resident 14's Minimum Data Set (MDS - an assessment tool), dated March 27, 2025, indicated Resident 14 had a BIMS (Brief Interview for Mental Status) score of 15 cognitively intact and Resident 14 was dependent for Activities of Daily Living (ADL) toileting hygiene, shower/bathe self, lower body dressing and putting on and taking off footwear. required substantial /maximal assistance.</p> <ol style="list-style-type: none"> On April 7, 2025, at 4:05 p.m. during an interview with Resident 18, Resident 18 stated he and his roommate (Resident 49) was left wet and soiled in their urine the entire day shift, from the morning until 2 p. m. on April 6, 2025. Resident 18 stated Resident 49 needed assistance and he would speak up for him because Resident 49 was non - verbal. Resident 18 also stated he was left soiled in his own bowel, two weeks ago. Resident 18 stated he used the call light, and no one would answer, and by 2:30 p.m. staff was gone. Resident 18 also stated he complained to staff, and no one responded to him. <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 9, 2025, Resident 18's record was reviewed. Resident 18 initial admitted was June 5, 2020, with a readmitted on March 31, 2024, with diagnoses which included heart failure, morbid obesity (too much body fat), diabetes mellitus (too much sugar in the blood) and foot ulcer (sore on the foot).</p> <p>Resident 18's History and Physical, dated November 30, 2024, indicated Resident 18 had the capacity to understand and make decisions.</p> <p>Resident 18's Minimum Data Set (MDS-an assessment tool), dated January 15, 2025, indicated Resident 18 had a BIMS (Brief Interview for Mental Status) score of 15 cognitively intact and Resident 18 was dependent for Activities of Daily Living (ADL) toileting hygiene, shoer/bathe self, lower body dressing and putting on and taking off footwear, and required substantial/maximal assistance with shower/bathe self.</p> <p>Resident 18's care plan, initiated June 7, 2020, indicated Resident 18 required/is dependent for ADL care in bathing, grooming, personal hygiene, dressing eating, bed mobility, transfer, locomotion, toileting related diabetic foot infection, sepsis, general weakness, physical debility, decreased circulation, and use of diuretic.</p> <p>3. On April 8, 2025, at 8:25 a.m., during an interview with Resident 46, Resident 46 stated she had been left soiled in her own urine and stool more than three times. Resident 46 stated it t been happening so long until you feel like this was the way it was in the facility. Resident 46 stated she had told administration before that she was left in her urine and stool, and she felt like they did not care for the people in the facility. Resident 46 also stated the weekends were the worst.</p> <p>Resident 46's record was reviewed. Resident 46's was admitted to the facility on [DATE], with diagnoses which included lymphedema (swelling caused by blockage), muscle weakness, morbid obesity (too much body fat), right leg above knee amputation, and ulcer (sore) to left lower leg.</p> <p>Resident 46's History and Physical, dated June 26, 2024, indicated Resident 46 had the capacity to understand and make decisions.</p> <p>A review of Resident 46's MDS, dated [DATE], indicated Resident 46 had a BIMS (Brief Interview for Mental Status) score of 15 (cognitively intact), and Resident 46 was dependent for toileting hygiene, shower/bathing, and lower and upper body dressing.</p> <p>A review of Resident 46's care plan, initiated January 6, 2023, indicated a focus that Resident 46 was at risk for decreased ability to perform ADLs (activity of daily living) in bathing, grooming, personal hygiene, dressing, eating, bed mobility, transfers, locomotion, toileting related to history of right above knee amputation, multiple wounds to left lower extremity, and infection with lymphedema.</p> <p>4. On April 9, 2025, at 8:37 a.m., during an interview with Resident 51, Resident 51 stated the facility was short of CNAs and she had been left in her urine and stool for hours. Resident 51 stated it got so bad she told a supervisor. Resident 51 stated she had asked CNA's for things, but the staff never came back. Resident 51 stated when 2 o'clock comes you can be sure the CNA's were gone.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Resident 51's record was reviewed. Resident 51 was admitted to the facility on [DATE], with diagnoses which included peripheral autonomic neuropathy (damaged nerves), hypertension (high blood pressure), and disorders of the diaphragm (health issues with the muscle that helps you breath).</p> <p>Resident 51's History and Physical, dated February 24, 2023, indicated Resident 51 had intermittent capacity to make decisions.</p> <p>A review of Resident's 51's MDS, dated [DATE], indicated Resident 51 had a BIMS score of 13 (cognitively intact), and Resident 51 was dependent for toileting hygiene, and lower body dressing.</p> <p>A review of Resident 51's care plan, initiated February 21, 2025, indicated Resident 51 had an ADLs (activity of daily living) self-care performance deficit related to activity intolerance.</p> <p>On April 9, 2025, at 12:50 p.m. during an interview with Certified Nursing Assistant (CNA) 1, CNA 1 stated call lights should be answered as soon as possible.</p> <p>On April 11, 2025, at 5:53 p.m. a concurrent interview and record review of the facility's Census and Direct Care Service Hours Per Patient Day, (DHPPD - measures the number of hours of direct care given to patients in skilled nursing facilities) was conducted with the Director of Staff Development (DSD). The DSD acknowledged and confirmed records for multiple days in March 2025, indicated the Actual Total Direct Care Service Hours (Actual DCSH) were below the required minimum of 3.5 for seven (7) of 30 days reviewed and the actual CNA DCSH were below the stated required minimum of 2.4 hours for seventeen (17) of the 30 days reviewed.</p> <p>The Actual Total DCSH hours were below 3.5, and the CNA DHPPD was below 2.4 on the following dates:</p> <ul style="list-style-type: none"> - March 1, 2025 (Saturday): 3.22 hrs (DCSH); 2.06 (CNA DCSH) - March 5, 2025 (Wednesday): 3.28 hrs (DCSH); 2.21 (CNA DCSH); - March 7, 2025 (Wednesday): 3.48 hrs (DCSH); 2.29 (CNA DCSH); - March 8, 2025 (Saturday): 3.37 hrs (DCSH); 2.38 (CNA DCSH); - March 9, 2025, (Monday): 2.34 hrs (CNA DCSH); - March 10, 2025 (Sunday): 2.29 hrs (CNA DCSH); - March 11, 2025 (Sunday): 2.26 hrs (CNA DCSH); - March 12, 2025 (Sunday): 2.32 hrs (CNA DCSH); - March 13, 2025 (Sunday): 2.34 hrs (CNA DCSH); - March 16, 2025 (Sunday): 3.41 hrs (DCSH); 2.28 (CNA DCSH); - March 18, 2025 (Tuesday): 3.25 hrs (DCSH); 2.10 (CNA DCSH); <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- March 19, 2025 (Sunday): 2.14 hrs (CNA DCSH);</p> <p>- March 20, 2025 (Sunday): 2.38 hrs (CNA DCSH);</p> <p>- March 22, 2025 (Sunday): 2.39 hrs (CNA DCSH);</p> <p>- March 24, 2025 (Sunday): 2.38 hrs (CNA DCSH);</p> <p>- March 25, 2025 (Sunday): 2.33 hrs (CNA DCSH); and</p> <p>- March 30, 2025 (Sunday): 3.09 hrs. (DCSH); 2.27 (CNA DCSH).</p> <p>On April 11, 2025, at 8:29 p.m., during an interview with the DSD, she stated CNAs should not get more than 8 residents on the a.m. shift (7 a.m. to 3 p.m.), 10 residents on the p.m. shift (3 p.m. to 11 p.m.) and 12 CNAs on the noc shift (11 p.m. to 7 a.m.). A concurrent record review and interview with the DSD of the Nursing Staff Assignment and Sign-In Sheet, for the mentioned dates indicated one CNA provided more than the projected number of residents per shift on the following dates:</p> <p>-March 1, 2025 (Saturday): AM shift - 10 residents each; PM shift - 13 residents each;</p> <p>- March 5, 2025 (Wednesday): AM shift - 9 residents each; PM shift - 11 residents each; NOC shift -15 residents each;</p> <p>- March 8, 2025 (Saturday): AM shift - 9 residents each; PM shift -11 residents each; NOC shift -10 residents each;</p> <p>- March 16, 2025 (Sunday): AM shift - 9 residents each; PM shift -11 residents each; NOC shift - 11 residents each;</p> <p>- March 18, 2025 (Tuesday): AM shift - 9 residents each; PM shift -11 residents each; NOC shift - 16 residents each;</p> <p>- March 30, 2025 (Sunday): AM shift -10 residents each; PM shift - 10 residents each; NOC shift -15 residents each.</p> <p>The DSD also stated some concerns was staff burn out, and residents can experience possible neglect. The DSD stated the DHPPD for Actual Total Direct Care Service Hours and Actual Total CNA Direct Are Service Hours were not met on documented dates reviewed. The DSD further stated the expectation was that the facility meets the DHPPD. The DSD stated possible causes of not meeting was challenges in the pay offered, and no hiring bonuses.</p> <p>(continued on next page)</p>		

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<p>F 0725</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 11, 2025, at 8:21 a.m. during an interview with the DSD, the DSD stated she determined staffing by using a facility software for (staffing labor projections) and the census to determine staffing needs. The DSD also stated if patient acuity is high, she balanced out the assignment between the CNAs and asks staff to stay over as a float to assist. The DSD stated the facility was impacted as the census increased. The DSD stated the facility required at least a two-hour notice for call offs. The DSD stated she did not use registry and offered facility staff double shifts. She stated some staff had brought some workload concerns to her attention and it was a process of weeding out the staff that did not meet the facility needs. The DSD also stated she determined resident's needs by listening to the residents, referred them to quality assurance and assessments, in-services, and exit interviews to determine the competency needs. The DSD stated she make sure staff are appropriately assigned by knowing the individual staff competencies and personally observing their skills.</p> <p>On April 11, 2025, at 9:22 p.m., during a concurrent record review and interview with the Director of Nursing (DON), the DON acknowledged and confirmed the facility did not meet the DHPPD for documented dates reviewed. The DON further stated not meeting the hours for patient care affect the quality of resident care.</p> <p>On April 14, 2025, at 11:20 a.m., an interview with Certified Nursing Assistant (CNA) 6 was conducted. CNA 6 stated she worked the day shifts 6:30 a.m. to 2:30 p.m. CNA 6 stated she was normally assigned 10 residents when the census was high. CNA 6 stated today she had 13. CNA 6 stated when the acuity was high, her workload was harder. CNA 6 stated she did her best to work safely, but she felt rushed to get her work done and felt pulled in many directions. CNA 6 stated when the census was 90 there was 9 to 10 CNAs assigned, but lately it was about 7 CNAs assigned. CNA 6 stated they had been short staffed during the weekdays and the weekend. CNA 6 stated the facility did not have enough staff and administration was made aware.</p> <p>A review of the facility's job description titled, Certified Nursing Assistant, dated October 2020, indicated . Duties and Responsibilities .Keep the nurses' call system within easy reach of the resident .</p> <p>A review of the facility's policy and procedure titled, Answering the Call Light, dated October 24, 2024, indicated, .The purpose of this procedure is to ensure timely response to the resident's requests and needs . Ensure that the call light is accessible to the resident when in bed, from the toilet, from the shower or bathing facility and from the floor .</p> <p>A review of the facility's policy and procedure titled, Staffing, revised October 2017, indicated, .Our facility provides sufficient numbers of staff with the skills and competency necessary to provide care and services for all residents in accordance with resident care plans and the facility assessment .Licensed nurses and certified nursing assistants are available 24 hours a day to provide direct resident care services .staffing numbers and the skill requirement of direct care staff are determined by the deeds of residents .</p>		

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<p>F 0730</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Observe each nurse aide's job performance and give regular training.</p> <p>49113</p> <p>Based on interview and facility document review, the facility failed to ensure the performance evaluation was completed annually, for one of eight direct care staff reviewed (DCS 5).</p> <p>Findings:</p> <p>On April 2025, 2:45 p.m., a concurrent interview and facility document review of DCS 5 personnel file was conducted with the Director of Staff Development (DSD). The DSD confirmed and acknowledged DCS 5 was hired on January 3, 2012, and no annual performance evaluation documentation was readily available in the employee personnel file.</p> <p>A review of the facility's policy and procedure titled, Performance Evaluations, dated November 1, 2023, indicated, .The first performance evaluations may be after completion of the first 90 days of employment . After that review, performance evaluation may be conducted annually, on or around your anniversary date.</p>

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 40988</p> <p>Based on observation, interview, and record review, the facility failed to ensure storage of medical supplies and medication conformed to national standards and the facility policy and procedure when:</p> <ol style="list-style-type: none"> Four Biopatch IV (intravenous- into the vein) dressings (used to absorb exudate and to cover a wound caused by IV lines) were found outdated inside the Station 1 IV cart, readily available for use; and Fluocinonide 0.05% (percent- unit of measurement) topical solution (used to treat the itching, redness, dryness, crusting, scaling, inflammation, and discomfort of various skin conditions) with an open date of [DATE], with the label torn and faded, was found in the treatment cart, readily available for use. <p>This had the potential for the IV dressings and outdated topical solution to be used on the vulnerable residents of the facility, which could lead to adverse effects from use of these outdated IV supplies and medication.</p> <p>Findings:</p> <ol style="list-style-type: none"> On [DATE], at 4:58 p.m., an inspection of Station 1 IV medication cart was conducted with Registered Nurse (RN) 3 . Inside the top drawer of the cart were two pieces of Biopatch IV dressings with an expiration date of [DATE], and two pieces of Biopatch IV dressings with an expiration date of February 28, 2025. <p>In a concurrent interview with RN 3, RN 3 stated the IV dressings were expired and should not have been in the IV cart, to prevent these from being used on residents.</p> <ol style="list-style-type: none"> On [DATE], at 5:15 p.m., the treatment cart was inspected with Licensed Vocational Nurse (LVN) 2. One bottle of Fluocinonide 0.05% topical solution with an open date of [DATE], with the label torn and faded, was found in top drawer of the treatment cart. <p>In a concurrent interview with LVN 2, LVN 2 stated the medication was expired and should not have been in the treatment cart.</p> <p>On [DATE], at 10:02 a.m., the Director of Nursing (DON) was interviewed. The DON stated the Biopatch and Fluocinonide should not have been in the IV and treatment carts, and should have already been discarded.</p> <p>A review of the facility's policy and procedure titled, STORAGE OF MEDICATIONS, dated [DATE], indicated, .Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from stock, disposed of according to procedures for medical disposal, and reordered from the pharmacy if a current order exists .</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.</p> <p>47374</p> <p>Based on observation, interview, and record review, the facility failed to provide food of the temperature, flavor, consistency, and appearance preferred by residents, when:</p> <p>1) Residents 14, 19, 41, 32, 50, 61, 71, and 289 complained of the food being tasteless, poor appearance, and temperatures were either too hot or too cold; and</p> <p>2) Resident 67 complained snacks were not available for most of the residents.</p> <p>These failures could potentially lead to weight loss and a general lack of enjoyment in daily living, which could lead to potentially negative clinical outcomes.</p> <p>Findings:</p> <p>On April 7, 2025, at 10:30 a.m., an interview was conducted with Resident 67. Resident 67 stated he recently had asked staff for a snack at night because he felt hungry. Resident 67 stated he was told by the night staff there was not anything for him as, they had run out of snacks five minutes before he asked.</p> <p>On April 7, 2025, at 11:33 a.m., an interview was conducted with Resident 289. Resident 289 stated he had been without teeth even prior to admission and could eat anything he wants. Resident 289 stated he could swallow without difficulty. Resident 289 stated the facility had him on a pureed diet, which he did not like the food that way and he would keep returning the food until he gets the correct diet. Resident 289 further stated he had requested a regular diet and had asked for someone to check his chart to see past for swallow study result so his diet could be changed without effect.</p> <p>On April 7, 2025, at 12 p.m., a lunch meal observation was conducted. Scheduled time for the lunch meal was 12 p.m The meal cart arrived at 12:55 p.m. Concurrent interview with several residents indicated food was not palatable and the presentation of the food was unappetizing.</p> <p>On April 7, 2025, at 1:11 p.m., an interview was conducted with Resident 14. Resident 14 stated the food was awful.</p> <p>On April 7, 2025, at 1:20 p.m., an interview with Resident 71 was conducted in the dining room. Resident 71 stated the lunch was tasteless and looked like something pureed instead of an enchilada. Resident 71 stated he complained to staff, and they took his tray away as he told them he would not eat that crap. Resident 71 further stated the food was always bad.</p> <p>On April 7, 2025, at 1:40 p.m., an interview was conducted with Resident 50. Resident 50 stated lunch arrived at 1:45 p.m., and her tray had cranberry juice, 4 ounces cheese enchiladas two each, Spanish rice 8 oz (ounce - unit of measurement), a scoop of fortified mash potatoes with gravy and pineapple. Resident 50 stated the fortified mash potatoes with gravy, peanut butter and jelly sandwich and pineapple were nasty. Resident 50 stated she did not know what the alternatives were for the day. Resident 50 further stated she opted to use her own ensure, granola bar and tangerines.</p> <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 7, 2025, at 1:50 p.m., an observation and concurrent interview with Resident 19 during lunch meal in the resident's room was conducted. During thee observation Resident 19 consumed 50% of his. Resident 19 stated the food was ok, not very good looking. Resident 19 further stated his preference was for chocolate flavored Ensure but the facility always gave him vanilla which he did not like.</p> <p>On April 8, 2025, at 10 a.m., an interview was conducted with Resident 61. Resident 61 stated he started out having three (3) eggs as his tray ticket indicated but he received only two (2), and lately no eggs at all. Resident 61 stated he was a breakfast person, and it was the most important meal of the day for him. Resident 61 stated he was told eggs were too expensive and the supplier did not have eggs. Resident 61 showed pictures of his breakfast entrees without any eggs on the plate, one waffle and bowl of fruit. Resident 61 stated the residents were not being informed of any changes in the menu items served and the food was a big problem. Resident 61 further stated there was often no meat in meals and sometimes he wanted beef.</p> <p>On April 8, 2025, at 10:22 a.m., an interview was conducted with Resident 41. Resident 41 stated sometimes the food, like the enchiladas were unrecognizable, stated he had never eaten it like that before. Resident 41 stated if he did not like the food the resident's wife would bring him a sandwich. Resident 41 stated there was a need to change the cook.</p> <p>On April 8, 2025, at 3:34 p.m. an interview was conducted with Resident 32. Resident 32 stated she had prepared food from home every three (3) days and the facility threw it out before the labeled date and she was upset.</p> <p>On April 10, 2025, at 10:30 a.m., an interview and concurrent record review was conducted with the Registered Dietician (RD), and Dietary Manager (DM), was conducted. A review of the resident's complaints from Resident Council and screening interviews related to food appearance, taste, and failure to arrive hot and ready to eat to the residents, a consistent lack of sufficient snacks available when requested and resident preferences not followed. The DM stated he had been monitoring the variables such as, time carts arrive to floor to resident and temperature of trays, monthly and results were being forwarded to corporate, the Director of Nursing (DON) and the Administrator (ADM). The RD and the DM stated the new menu, and dietary program had started this last week, and the resident preferences did not transfer into the system. The DM stated he had uploaded the preferences into the system himself and he must have missed or only entered part of some of the residents' preferences. The DM stated the residents should be able to have access to snacks through out the day and night.</p> <p>On April 10, 2025, at 2 p.m. and 8 p.m., an observation of snack carts was conducted. The facility document titled HS (bedtime) Snack, indicated the following snacks in the snack cart:</p> <ul style="list-style-type: none"> - 15 sandwiches cut in half; - 8 packs of graham crackers; - 9 fruits; apple, oranges, bananas; - any left over desserts. <p>(continued on next page)</p>		

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<p>F 0804</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 10, 2025 at 3:45 p.m., an interview was conducted with the DON. The DON stated snacks were passed to the residents at 10 a.m., 2 p.m., and 8 p.m., each day. The DON stated the CNA's or licensed nurses received the snacks on a cart, at the nurse station, at those times from the kitchen and the ordered snacks were labeled with resident name and room to assure safe contribution of snacks to appropriate residents. The DON further stated the snacks were available in the kitchen 24 hours a day for resident requests</p> <p>On April 10, 2025, 7:30 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated the snacks were delivered to the nurses' station and the Certified Nursing Assistants (CNAs) delivered the labeled ones to the residents. LVN 2 stated if a resident requested snacks, crackers, sandwich etc., the kitchen would bring to the nurse station 3, or if after kitchen closed the supervisor or licensed nurse would access snacks from the kitchen. LVN 2 further stated if the shift was busy some residents would miss if a snack was not labeled or the staff missed giving a snack to the resident.</p> <p>A review of the facility's policy and procedure titled, Dining and Food Preferences, dated September 2017, indicated, individual dining, food preferences are identified for all residents. the dining service director will interview the resident to complete a food preference interview. the registered dietician will review, and after consult with resident, adjust the individual meal plan. any resident with expressed or observed refusal of food will be offered an alternative selection. alternative meal will be provided in a timely manner.</p>		

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<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>47374</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe, sanitary food preparation and storage practices were followed in the kitchen when:</p> <ol style="list-style-type: none"> 1. One open box of breakfast patties was exposed and open to air in the walk-in freezer; and 2. Black wet debris was observed where the metal walls met the flooring on all four sides of the walk-in refrigerator. <p>These failures had the potential to cause food-borne illness in a highly susceptible resident population.</p> <p>Findings:</p> <p>1. On April 7, 2025, at 9:30 a.m., an observation with the Dietary Manager (DM) was conducted in the kitchen. One open box of breakfast patties was observed exposed and open to air in the walk-in freezer. During a concurrent interview the DM stated this could cause possible cross-contamination. The DM further stated all food items should be sealed to avoid food deterioration.</p> <p>A review of the facility's policy and procedure, titled Food Storage: Cold Food, dated September 2017, indicated .all foods will be stored wrapped or in a covered container .to prevent cross contamination .</p> <p>2. On April 7, 2025, at 9:40 a.m., an observation with the DM was conducted in the kitchen. Black wet debris was observed at where the metal walls met the flooring on all four sides of the walk-in refrigerator. During the concurrent interview with the DM, the DM described the substance as wet, black debris. The DM further stated this wet, black debris should not be in the walk-in refrigerator as the food stored here are at risk for cross-contamination and possibly lead to resident illness.</p> <p>A review of the facility's policy and procedure, titled Environment, dated September 2017, indicated, .Dietary Service director will ensure that the kitchen is maintained in a clean and sanitary manner, including floors and walls .ensure all employees are knowledgeable in the proper procedures for cleaning and sanitizing .that prevent cross contamination .</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49113</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection prevention and control practices were upheld when:</p> <ol style="list-style-type: none"> One staff was observed placing the ice scoop on top of the transport cart instead of the designated container, while refilling the residents' water pitchers with ice; Resident 236's peripheral (away from the center) intravenous line (IV- into the vein) was not labeled with a date and licensed nurse initials; <p>This had the potential for the IV site to not be changed timely, resulting in infiltration or infection of the IV site; and</p> <ol style="list-style-type: none"> During medication administration observation, Licensed Vocational Nurse (LVN) 1 was observed not disinfecting the blood pressure cuff in between patient use. In addition, LVN 1 did not follow infection control practices when administering medications to Resident 16. <p>These failures had the potential to spread infection among the vulnerable residents of the facility.</p> <p>1. On April 7, 2025, at 9:27 a.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 4. CNA 4 was observed scooping ice from the ice chest to place in the residents' water pitchers. CNA 4 placed the metal ice scooper on the top surface of the transportation cart, then picked up the ice scooper and placed it in the designated ice bag cover. CNA 4 stated she should not have placed the ice scooper on the top surface of transportation cart. CNA 4 further stated she should have put it back into the ice bag cover to prevent contamination.</p> <p>On April 7, 2025, at 4:30 p.m., the Director of Nursing (DON) was interviewed. The DON stated that the ice scooper should not have been placed on the top surface of the transportation cart. The DON stated the scooper should have been placed in the designated bag to prevent contamination. The DON stated the concern was the contaminated object could carry germs and bacteria. The DON further stated it was her expectation that staff follow the facility's infection control policies</p> <p>On April 14, 2025, at 10:19 a.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated staff should not have put the ice scoop on the top surface of the transportation cart because it was contaminated. RN 1 stated the ice scooper should have gone into the bag provided for the ice scooper, since that was why the bag was there, to prevent contamination with other surfaces. RN 1 also stated the facility's process was to place the scooper back in the bag and not left on open surfaces. RN 1 further stated residents could pick up bacteria or get an infection.</p> <p>2. On April 7, 2025, at 10:36 a.m., an observation of Resident 236 was conducted with the Director of Staff Development (DSD). Resident 236 was observed seated in her wheelchair with an IV- saline lock on top of her right hand. Resident 236's IV-saline lock did not have a date and the licensed nurse initial on it.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 10, 2025, Resident 236's record was reviewed. Resident 236 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (dysfunction of the brain) and fibromyalgia (widespread body pain).</p> <p>Resident 236's Minimum Data Set (MDS - an assessment tool), dated March 22, 2025, indicated Resident 236 had a BIMS (Brief Interview for Mental Status) score of 11 (moderate cognition status).</p> <p>A review of Resident 236's Medication Administration Record, dated April 1 to April 30, 2025, indicated, Sodium (Sodium Chloride Solution) administration use 500 ml (milliliter - unit of measurement) intravenously one time only for hydration for one day with a start date of April 4, 2025.</p> <p>On April 10, 2025, at 3:45 p.m., an interview with the Director of Nursing (DON) was conducted. The DON stated the facility process was for the licensed nurse to verify the doctor's order for the IV use and length of time. The DON stated at the time the IV was placed it should have been dated and signed by the licensed nurse who inserted it. The DON also stated it should have been dated to know when the IV was placed and when it needed to be changed. The DON further stated it was the expectation that whoever starts the IV should date and initial it. The DON further stated the resident could be at risk for infection.</p> <p>On April 10, 2025, at 4:16 p.m., an interview with the Director of Staff Development (DSD) was conducted. The DSD stated she observed Resident 236's IV site and it should have been dated and initialed. The DSD stated it was not the facility's policy to leave an IV saline lock inserted without the licensed staff initial or date. The DSD further stated the risk of not knowing the insertion date can lead to IV infiltration (when some of the fluid leaks out into the tissues under the skin where the tube has been put into your vein) or the cause of infection for the resident.</p> <p>A review of the facility's policy and procedure titled, Peripheral IV Dressing Changes, dated April 2016, indicated, .This purpose of the procedure is to prevent catheter-related infections associated with contaminated, loosened or soiled catheter-site dressings .Label dressing with date, time, and initials .</p> <p>40988</p> <p>3. On April 10, 2025, at 8:38 a.m., during a medication administration observation, Licensed Vocational Nurse (LVN) 1 was observed taking Resident 54's blood pressure using a wrist blood pressure (BP) machine. After obtaining Resident 54's blood pressure, LVN 1 placed the BP machine on top of the medication cart. LVN 1 then proceeded to administer Resident 54's medications, documented the medication administration and proceeded to the next patient. LVN 1 did not disinfect or sanitize the BP machine.</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 10, 2025, at 9:01 a.m., LVN 1 stopped in front of room [ROOM NUMBER] and reviewed Resident 16's Medication Administration Record (MAR). LVN 1 was observed putting on a yellow disposable gown and a pair of disposable gloves (types of PPE- personal protective equipment), following the instructions on the poster beside the door for enhanced barrier precautions (EBP- a CDC [Centers for Disease Control and Prevention] containment strategy recommending the use of gown and glove use for nursing home residents with wounds and indwelling devices during specific high-contact resident care activities associated with MDRO [multidrug resistant organisms] transmission). LVN 1 picked up the unsanitized blood pressure machine and entered the room, proceeding to take Resident 16's BP. After obtaining Resident 16's BP, LVN 1 hung the BP machine on the doorknob and removed her PPEs, picked up the BP machine with her bare hands, placed the BP machine on top of the medicine cart, and used alcohol based hand rub (ABHR) to sanitize her hands. With ungloved hands, LVN 1 took a Medline micro-kill (brand name) germicidal bleach wipe and disinfected the BP machine with it.</p> <p>LVN 1 prepared Resident 16's medications into two plastic medicine cups, withholding the blood pressure medicine per physician's order, and placed the prepared medications and a cup of water in a square plastic tray. LVN 1 put on her PPEs, entered the room, placed the plastic tray on top of Resident 16's over bed table, and administered the medications to Resident 16. With the gown and gloves still on, LVN 1 picked up the medicine cups and water cup and placed them on top of the TV stand near the door and removed her PPEs. LVN 1 proceeded to pick up the used medicine cups and water cup with bare hands and discarded them in the trash bin by the door. LVN 1 returned to the medicine cart, paused, and went back inside the room to pick up the used plastic tray on top of Resident 16's over bed table using her bare hands, and placed them on top of the medicine cart. The plastic tray was not disinfected after use.</p> <p>In a concurrent interview, LVN 1 stated she should have disinfected the BP machine between patient use, should not have hung the used BP machine on the doorknob, and should have disinfected the BP machine after using it on Resident 16 while using gloves. LVN 1 further stated she should have discarded the used medicine cups and water cup, as well as handled the plastic tray while still wearing PPEs, and disinfected the plastic tray after it was used.</p> <p>Resident 16's record was reviewed. Resident 16 was admitted to the facility on [DATE], with diagnoses which included urinary tract infection (UTI).</p> <p>Resident 16's HISTORY and PHYSICAL, dated March 19, 2025, indicated Resident 16 had a past medical history of ESBL (extended-spectrum beta-lactamase- enzymes produced by certain bacteria that can make infections harder to treat with certain antibiotics), E. coli UTI (UTI caused by the bacteria Escherichia Coli), and staph UTI (UTI caused by the staphylococcus bacteria).</p> <p>Resident 16's Order Summary Report, for April 2025, included a physician's order for enhanced barrier precautions related to history of ESBL/MDRO.</p> <p>A review of the Medline micro-kill bleach wipes' instructions for disinfection indicated, .Always use personal protective equipment .Open Micro-Kill Bleach Germicidal bleach Wipes canister .Remove pre-moistened 7 (inches) x 8 wipe .Apply pre-saturated towelette and wipe desired surface to be disinfected. A 30 second contact time is required to kill the bacteria and viruses on the label (specific instructions follow for certain microorganisms) .Reapply as necessary to ensure that the surface remains visibly wet for the entire contact time .Allow surfaces to air dry and discard used wipe and empty canister .</p> <p>(continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On April 14, 2025, at 10:02 a.m., the Director of Nursing (DON) was interviewed. The DON stated she expected staff to adhere to infection control practices and follow professional standards of care in practicing and implementing infection control practices. The DON stated there was already a break in infection control when the staff placed the ice scoop on the transport cart. The scoop should have been brought back to the kitchen and replaced with a new one. The DON stated LVN 2 should have followed professional standards of care for infection control during med pass. The licensed staff should have observed infection control practices, disinfected medical equipment between patients, performed hand hygiene, used PPE during disinfection of medical equipment and handling used medical equipment during med pass.</p> <p>A review of the facility's policy and procedure titled, Policies and Procedures- Infection Prevention and Control, dated December 2023, indicated, .The facility adopted infection prevention and control policies and procedures to help maintain a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections .Infection prevention and control apply to all personnel .All personnel are trained in infection prevention and control policies and procedures .including where and how to find and use pertinent procedures and equipment related to infection control .</p>		

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NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 East Devonshire Avenue Hemet, CA 92544	
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(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** 49113</p> <p>Based on observation, interview, and record review, the facility failed to provide a safe environment when loose wires were observed hanging at the base of the back wall in the room, for one of one resident reviewed for environment (Resident 67).</p> <p>This failure had the potential to affect the safety and wellbeing of the resident.</p> <p>Findings:</p> <p>On April 7, 2025, at 10:30 a.m., loose hanging wires were observed at the base of the back wall in Resident 67's room.</p> <p>Resident 67's record was reviewed. Resident 67's Admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included surgical amputation, muscle weakness, unsteady on his feet, and diabetes mellitus (body can't control sugar in the blood).</p> <p>Resident 67's History and Physical, dated February 21, 2025, indicated Resident 67 had the capacity to understand and make decisions.</p> <p>Resident 67's Minimum Data Set (MDS-an assessment tool), dated February 24, 2025, indicated Resident 67 had a BIMS (Brief Interview for Mental Status) of 15 which indicated cognitively intact and Resident 67 required use of a wheelchair and a walker. Resident 67 further required partial to moderate assistance with shower/bathing self, lower body dressing and putting on and taking off footwear.</p> <p>On April 7, 2025, at 11:29 a.m., a concurrent observation and interview with the Maintenance Director (MD) was conducted. The MD stated the wires were low voltage, but still should not be open. The MD stated a possible concern could be fire and it was not safe. The MD stated no one had reported the open loose wires to him. The MD stated anyone could report open wires via the facility's process using a Building Maintenance Software application, (TELS- building maintenance application).</p> <p>On April 7, 2025, at 11:33 a.m., an interview with Resident 67 was conducted. Resident 67 stated the open wires concerned him and that anything like a fire could happen.</p> <p>On April 11, 2025, at 4:10 p.m., an interview with Director of Nursing (DON) was conducted. The DON stated anyone can report open wires, inoperable equipment, or anything that could pose a risk to the resident or staff. The DON stated the facility's staff was trained to report via TELS. The DON also stated staff can call maintenance and were trained to look out and report unusual wiring or exposed wiring. The DON stated wires should not be left opened and should be sealed with electrical tape or properly covered and they were not. The DON also stated the wires should be secured and not hanging. The DON further stated the expectation was open wires should be secured or clamped to prevent trips, falls, accidents, or fires.</p> <p>(continued on next page)</p>		

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 04/14/2025
NAME OF PROVIDER OR SUPPLIER Devonshire Care Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1350 East Devonshire Avenue Hemet, CA 92544	
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(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>A review of the facility's policy and procedure titled, Hazardous Areas, Devices and Equipment, dated July 2017, indicated, .All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible .as part of the facility's overall safety and accident prevention program, hazardous areas and objects in the resident environment will be identified and addressed by the Safety Committee .Irregular floor surfaces (cords) .Any element of the resident environment that has the potential to cause injury and that is accessible to a vulnerable resident is considered hazardous.</p>		