STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	065150	A. Building B. Wing	03/20/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Devonshire Care Center	1330 Sidney Ave Sterling, CO 80751

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. 48458 Based on observations, record review and interviews, the facility failed to ensure residents had the right to a dignified existence for four (#7, #17, #18 and #13) of seven residents out of 16 sample residents. Specifically, the facility failed to ensure Resident #7, Resident #17, Resident #18 and Resident #13's call lights were answered in a timely manner. Findings include: I. Facility policy and procedure The Answering the Call Light policy, revised September 2022, was provided by the nursing home administrator (NHA) on 3/20/25 at 11:08 a.m. It read in pertinent part, Answer the resident call system immediately. If the resident needs assistance, indicate the approximate time it will take for you to respond. If the resident's request is something you can fulfill, complete the task within five minutes if possible. Document any significant requests or complaints made by the resident and how the request or complaint was addressed. II. Observations and resident interviews Resident #7 was interviewed on 3/19/25 at 11:45 a.m. Resident #7 said at times, she waited for 20 to 40 minutes for the staff to answer her call light. Resident #7 said she filed a grievance about the long call light response times. Resident #7 said when staff did not respond to call lights in a timely manner, it made her anxious and insecure that something serious could happen while she waited. Resident #7 was observed pointing to her left forearm. The forearm had a scar, approximately one inch by one half inch in size. She said in January 2025, she cut her left forearm on the door latch of her bathroom. She said she pressed her call light and then applied tissue to the bleeding wound. Resident #7 said staff did not respond to her call light, so after 30 minutes she walked to the nurses station to request first aid for the wound. Resident #18 and Resident #17, who resided in the same room, were interviewed together on 3/19/25 at 3:47 p.m. Resident #18 said there had been times when she was unable to wait and she had a bowel movement accident because staff did not respond to her call light. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0550

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Resident #17 said he and Resident #18 had waited 45 minutes or more for staff to respond to their call lights.

Resident #18 and Resident #17 were interviewed together a second time on 3/20/25 at 10:55 a.m. Resident #18 said it made her anxious when staff did not respond quickly to her call light because she was afraid she might have a urine or bowel movement accident. Resident #18 said she had a urine accident the morning of 3/20/25 while she waited for staff to answer her call light.

Resident #17 said it made him feel like staff thought other residents were more important than him and Resident #18 Resident #17 said he sometimes felt angry when he and Resident #18 waited for extended periods of time for staff to answer their call lights.

Resident #13 was interviewed on 3/20/25 at 11:35 a.m. Resident #13 said she was aggravated when staff did not answer her call light timely. Resident #13 said she had waited extended periods of time for staff to respond to her call light.

III. Record review

Resident council meeting minutes were provided by the assistant director of nursing (ADON) on 3/19/25 at 1:35 p.m. The resident council meeting minutes revealed the following:

On 10/9/24 at the 10:00 a.m. meeting, residents said that call lights were still slow and took over 30 minutes to be answered.

On 11/13/24 at 10:00 a.m., residents said call lights were taking too long. A frequent visitor at the meeting said the call light issues had been ongoing for seven months.

On 12/11/24 at 10:00 a.m, residents reported call lights took a long time to be answered and certified nurse aides (CNAs) were not responding quickly when the residents yelled for assistance.

On 1/8/25 at 10:00 a.m., residents said call lights took a long time to be answered.

On 2/28/25 at 11:00 a.m., there was one resident compliment that the call light response times were improving.

On 3/12/25 at 10:00 a.m., call lights were not mentioned in the meeting minutes.

-However, despite the February 2025 and March 2025 resident council meeting minutes indicating call light response times were not a concern, Resident #7, Resident #17, Resident #18 and Resident #13 all expressed continued concerns with call light response times during the survey (see resident interviews above).

The facility's call light system data for Resident #7, Resident #18 and Resident #13, from 12/20/24 to 3/19/25, was provided by the assistant director of nursing (ADON) on 3/20/25 at 8:22 a.m. The call light data revealed the following:

Staff response time to Resident #7's call light was greater than 20 minutes 55 times out of 539 calls, or 10.2% of the time.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Staff response time to Resident #18's call light was greater than 20 minutes 105 times out of 768 calls, or 13.6% of the time. Staff response time to Resident 13's call light was greater than 20 minutes 44 times out of 341 calls, or 12.9% of the time. IV. Staff interviews CNA #6 was interviewed on 3/20/25 at 11:47 a.m. CNA #6 initially said she was not sure how quickly the response time to call lights should be, but then said she thought 15 minutes was the correct response time. CNA #4 was interviewed on 3/20/25 at 11:56 a.m. CNA #4 said call lights should be answered in less than five to seven minutes. CNA #4 said there had been safety issues in the past because call lights had not been answered in a timely manner. CNA #5 was interviewed on 3/20/25 at 1:33 p.m. CNA #5 said she was not always able to meet the residents' needs, particularly taking the time to address emotional needs. CNA #5 said the call lights should be answered in seven to 10 minutes and she said that residents' call lights were not always answered in less than 10 minutes if staff were busy with other residents. She said there were instances of residents not being able to hold their bowel or bladder because the call light response time was too long. CNA #5 said long call light response times were very frustrating for both residents and staff. Licensed practical nurse (LPN) #2 was interviewed on 3/20/25 at 2:13 p.m. LPN #2 said the response time to call lights should be under three minutes. LPN #2 said she monitored call lights and answered them, but she said there were nurses who did not answer call lights. CNA #7 was interviewed on 3/20/25 at 2:25 p.m. CNA #7 said call lights should be answered in five to 10 minutes, however this did not always happen. CNA #7 said residents had told her it took too long for the call lights to be answered. Registered nurse (RN) #1 was interviewed on 3/20/25 at 3:52 p.m. RN #1 said the response time to call lights should be less than two to three minutes. She said residents had told her it took too long for the call lights to be answered. RN #1 said that Resident #7 injured her arm on 1/2/25. She said Resident #7 told RN #1 she had turned her call light on, however nobody responded, so she went to the nurses station to have the wound treated. RN #1 said she had seen call lights on for a long time and said she knew there was at least one resident's call light without a prompt response on 3/19/25. The ADON and the NHA were interviewed together on 3/20/25 at 4:40 p.m. The ADON said call lights should be answered in less than 15 minutes. The ADON said residents had complained to her about long call light waiting times and some residents had complained about soiling themselves due to long call light response times. The ADON said if the call lights were not answered in a timely manner, the residents could soil themselves, experience falls or experience other injuries. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The NHA said the facility was aware the call light response times were longer than they should be. The NHA said the facility planned to address extended call light response times at the quality assurance and performance improvement (QAPI) meetings and would perform audits of the call light response times and elicit input from the staff for improvement.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 19262 Based on observations, record review and interviews, the facility failed to provide written notification of room changes and roommate changes for three (#7, #8 and #13) of five residents reviewed for notifications out of 16 sample residents. Specifically, the facility failed to provide Resident #7, Resident #8 and Resident #13 with.timely written and/or verbal notification of room and/or roommate changes. Findings include: I. Facility policy and procedure The Room Change/Roommate Assignment policy, undated, was provided by the assistant director of nursing (ADON) on 3/20/25 at 9:33 a.m. The policy revealed changes in room or roommate assignments were made when the facility deemed it necessary or when the resident requested the change. Resident preferences were taken into account when such changes were considered. Prior to changing a room or roommate assignment, all parties involved in the change/assignment (residents and their representatives) were given at least a five-day advance written notice of such change. Advance written notice of a roommate change included why the change was being made and any information that would assist the roommate in becoming acquainted with his or her new roommate. Residents had the right to refuse to move to another room in the facility if the purpose of the move was to relocate the resident from a skilled nursing unit within the facility to one that was not a skilled nursing unit. Residents had the right to refuse to relocate the resident from a nursing unit within the facility to one that was a skilled nursing unit. Residents had the right to refuse to move solely for the convenience of the staff. If a resident exercised his or her right to refuse a room change, this would not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits. Documentation of a room change would be recorded in the resident's medical record. II. Resident #7 A. Resident status Resident #7, age greater than 65, was admitted on [DATE] and readmitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included mild cognitive impairment, major depression, chronic pain syndrome, fibromyalgia, asthma, edema, diabetes mellitus and chronic embolism and thrombosis of deep veins of the right lower extremity. The 2/20/25 minimum data set (MDS) assessment revealed the resident was cognitively intact with a brief interview for mental status (BIMS) score of 15 out of 15. The resident was independent for toileting, upper and lower body dressing. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	B. Resident representative's interview On 3/19/25 at 2:55 p.m., Resident #7 was asleep in her room. The resident's representative was in the room. The representative said Resident #7 was moved from a room on one hall to a different room on another hall because the hall that the initial room was on was being converted to private pay rooms. C. Record review -Review of Residents #7's electronic medical record (EMR) revealed no documentation to indicate the resident or the resident's representative was informed of the room change, that the resident had the right to refuse relocation from a nursing unit within the facility to one that was a skilled nursing unit or that the resident had the right to refuse to move rooms solely for the convenience of the staff. III. Resident #8 A. Resident status Resident #8, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included dementia, diabetes mellitus, anxiety, chronic pain syndrome, polyneuropathy and macular degeneration. The 2/20/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 14 out of 15. The resident required partial/moderate staff assistance (staff member did less than half of the effort) for toileting. The resident required substantial/maximal staff assistance (staff member did more than half of the effort) for upper and lower body dressing. B. Resident's representative interview On 3/19/25 at 2:55 p.m., Resident #8 was asleep in his room, which he shared with Resident #7. The resident's representative was in the room. The representative said Resident #8 was moved from a room on one hall to a different room on another hall because the hall that the initial room was on was being converted to private pay rooms. C. Record review -Review of Residents #8's EMR revealed no documentation to indicate the resident or the resident's representative was informed of the room change, that the resident had the right to refuse relocation from a nursing unit within the facility to one that was a skilled nursing unit or that the resident had the right to refuse to move rooms solely for the convenience of the staff. IV. Resident #13 A. Resident status (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #13, age greater than 65, was admitted on [DATE]. According to the March 2025 computerized physician orders (CPO), diagnoses included stage 4 chronic kidney disease, lymphedema, gout, polyarthritis and history of malignant neoplasm of the breast. The 1/17/25 MDS assessment revealed the resident was cognitively intact with a BIMS score of 15 out of 15. The resident was independent for toileting, upper and lower body dressing. B. Resident interview Resident #13 was interviewed on 3/19/25 at 3:20 p.m. Resident #13 said she did not know why she was moved from her previous room, which was a private room, or why she now had a roommate. She said the facility did not give her a written notice before they moved her to her current semi-private (shared) room. C. Record review -Review of Residents #13's EMR revealed no documentation to indicate the resident or the resident's representative was informed of the room change, that the resident had the right to refuse relocation from a nursing unit within the facility to one that was a skilled nursing unit or that the resident had the right to refuse to move rooms solely for the convenience of the staff. V. Staff interviews The nursing home administrator (NHA), the ADON, and the regional director of operations (RDO) were interviewed together on 3/20/25 at 3:37 p.m. The NHA, the ADON and the RDO agreed the Resident #7 was moved from one room to another room on a different hall. The NHA, the ADON and the RDO agreed there were no progress notes in Resident #7's EMR about the room move and there was no documentation to indicate that a room/roommate change form had been completed. The NHA, the ADON and the RDO agreed there should have been progress notes and/or documentation of the completion of the form. The NHA, the ADON and the RDO agreed Resident #8 was moved from one room to another room on a different hall. The NHA, the ADON and the RDO agreed there were no progress notes in Resident #8's EMR about the room move and there was no documentation to indicate that a room/roommate change form had been completed. The NHA, the ADON and the RDO agreed there should have been progress notes and/or documentation of the completion of the form. The NHA, the ADON and the RDO agreed the Resident #13 was moved from a private resident room to a semi- private room room. The NHA, the ADON and the RDO agreed there were no progress notes in Resident #13's EMR about the room move and there was no documentation to indicate that a room/roommate change form had been completed. The NHA, the ADON and the RDO agreed there should have been progress notes and/or documentation of the completion of the form. The NHA, the ADON and the RDO agreed there were no progress notes to indicate Resident #13 was introduced to her new roommate before the room move occurred or that the two residents agreed to the room change.