PRINTED: 03/13/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
056095		056095	B. WING		C 03/10/2023	
NAME OF PROVIDER OR SUPPLIER DEVONSHIRE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 EAST DEVONSHIRE AVENUE HEMET, CA 92544	03/10/2023	
(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 000	INITIAL COMMENT	-s	F 00	00		
	Representing the D Health Facilities Eva 41348 The inspection was complaint and does	epartment: aluator Nurse: limited to the specific not represent the findings of		This plan of correction constitutes the facility's credible allegation of compliance. Preparation and/or execu of this plan of correction does not constitute admission or agreement by provider of the truth of the facts alleg or conclusions set forth in the statement of deficiencies. This plan of correction prepared and/or executed solely becar	the ed ent n is	
	number: CA008223 Quality of Care CFR(s): 483.25	identified for the complaint 29	F 68	required by statute.		
	applies to all treatment facility residents. Bate assessment of a rest that residents received accordance with propractice, the compressor plan, and the restriction of the resident plan, and the restriction of the resident plan. Based on observation review, the facility fatreatment was provicentinuous episodes.	fundamental principle that ent and care provided to used on the comprehensive sident, the facility must ensure the treatment and care in ofessional standards of ehensive person-centered		1. Resident #1 laboratory for diff was ordered and comple on 2/10/2023 with a positive result. A private room was provided, and MD initiated antibiotic treatment for 10 days. 2. Resident #1 treatment was completed on 2/20/2023 with a positive result. A private room was provided, and MD initiated antibiotic treatment for 10 days. 3. Resident #1 treatment was completed on 2/20/2023 with a positive result. 3. Resident #1 is provided an education regarding refusal	eted e th ms	
ABORATORY	DIRECTOR'S OR PROMID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE	(X6) DATE	

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.

Administrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
	056095	B. WING		C 03/10/2023		
NAME OF PROVIDER OR SUPPLIER DEVONSHIRE CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1350 EAST DEVONSHIRE AVENUE HEMET, CA 92544		71012020	
PREFIX (EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
appropriate intervere pisodes of loose/with physician was not more of loperamide (media). This failure had the of the necessary care Resident 1. Findings: On January 23, 202 unannounced visit with for a complaint inverse of a complaint inverse on January 23, 202 was observed lying television. During a Resident 1 stated hid days and would go eight times a day. Hair eferral to the gas (physician to treat a schedule had been staff had offered him stools but it was not on January 23, 202 reviewed. Resident on January 7, 2023, included chronic obsequences. Review of the facility Physical Examination.	thoroughly assessed and ntions implemented to address vatery stools. In addition, the otified of the resident's refusal lication to treat diarrhea). potential to result in the delay re and treatment needed for a state of the facility stigation. 3, at 10:30 a.m., an exact conducted at the facility stigation. 3, at 10:53 a.m., Resident 1 in bed and watching concurrent interview, he had the "runs" for several to the bathroom about four to be stated he was trying to get trointestinal (GI) specialist bdominal problems) and no made. Resident 1 stated the medication to help the loose	F 6	treatments specific to the bowel management on by a licensed nurse and plan was completed registre the refusals. How to Identify Other Resider may be at risk: a. On 3/20/2023, the ADO conducted a review of residents potentially affected sign and symptoloose bowel movement b. All other residents are potentially affected by deficient practice ident Systemic Changes: 1. DON and ADON conducted a review of residents are potentially affected by deficient practice ident Systemic Changes: 1. DON and ADON conducted and and an education in-service to licensed nurses on 1/2-1/26/2023 and 2/01/20 regarding the following an providing timely control to the conducted and an education in the service with loose bowel movement.	1/23/23 I care garding At who ON other fected found oms of the ified.		

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		056095	B. WING					C 03/10/2023	
NAME OF PROVIDER OR SUPPLIER DEVONSHIRE CARE CENTER				1350		SS, CITY, STATE, ZIP CODE /ONSHIRE AVENUE	<u> </u>	10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		(EACH	OVIDER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULD REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
	and make decision Review of "Order S January 23, 2023, i physician's order: - "Loperamide HCL unit of measuremen mouth every 6 hour dated January 12, 2 - "GI consult re: (reper patient's requ Review of Resident living) Record," incl consistency of bowd for the month of Jan following: - January 12, 2023; consistency (2 for N [morning shift]; - January 13, 2023; consistency [3 for N watery (W) for PM [- January 14, 2023; SF [soft formed] for - January 15, 2023; none documented for - January 16, 2023; SL for AM, 2 SF for	s. Summary Report," dated included the following Capsule 2 MG (milligrams - nt) Give 2 (two) tablet by as a needed for diarrhea, "2023; and garding) on and off diarrhea est," dated January 20, 2023. 1's "ADL (activities of daily uded the frequency and el movements (BM's)/stools nuary 2023, indicated the 5 episodes of soft/loose (SL) IOC [night shift] and 3 for AM 8 episodes (4 episodes of SL IOC and 1 for AM] and 4 evening shift]); 9 episodes (4 SL for NOC, 1 AM, 4 W for PM); 6 episodes (4 SL for NOC, or AM, 2 W for PM); 8 episodes (3 SL for NOC, 3	F6	884		b. Notifying MD of medication/treatmen refusal c. Documentation of refusal of treatments /medications d. Providing education to residents refusing medications/treatment DON and/designee will conduct random audit week x1 month of all residents will conse stool to ensure timel treatments and MD notification completed. Department managers will conduct person centered refusions to capture any residents having concerns to bowel movement and discustingings during daily standmeetings on Monday through for further review and interventions. License nurse will conduct huddle rounds every shift during weekends to identificant residents with symptom of loose bowel movements report findings to DON for further recommendations.	usal o nts kly ith y oon uss up gh nd		

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	056095	B. WING		C 02/40/0200		
NAME OF PROVIDER OR SUPPLIER DEVONSHIRE CARE CENTER			ST 13	REET ADDRESS, CITY, STATE, ZIP CODE 50 EAST DEVONSHIRE AVENUE EMET, CA 92544	03/	10/2023
PRÉFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
none documented for January 19, 2023; 3 SF for AM, none documented for January 20, 2023; 3 none documented for January 21, 2023; 7 SL for AM, 4 W for Planuary 22, 2023; 2 W for AM, none documented for January 23, 2023; 2 W for AM) Review of Resident 1 following: - " (name of resident as evidence (sic) by medications as ordered as evidence (sic) by medications as ordered and medicated in the stool Date Initiated 2023) Report any chimmediately " Review of "eInteract Codated January 15, 202 days after initial onset 12, 2023), indicated, "01/15/2023 (January CNA (Certified Nursing CNA (Certified N	4 episodes (2 SL for NOC, r AM, 2 SL for PM); 2 episodes (1 SL for NOC, 1 umented for PM); 3 episodes (1 SL for NOC, r AM, 2 SL for PM); 4 episodes (2 W for NOC, 1 M); 5 episodes (1 W for NOC, 1	F6	884	5. Medical Records designee vacontinue daily audit of eInteract Stop and Watch a Change in condition alert review and audit. Follow up findings will be completed by Licensed Nurse assigned. Monitoring DON and/or designee will report findings from weekly audit to the QA&A committ x1 month for further review and recommendations and continue till deficient practicis resolve. Completion Date 4/10/2023	nd of by ee or	

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		056095	B. WING	-		ı	C 10/2023	
	NAME OF PROVIDER OR SUPPLIER DEVONSHIRE CARE CENTER			13	REET ADDRESS, CITY, STATE, ZIP CODE 50 EAST DEVONSHIRE AVENUE EMET, CA 92544	1 00/	10/2020	
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F 684	(sic). Dr (name of preserved to the resider stools documented medication.	imented evidence Resident 1 nitored, and the physician was dent 1 presented with frequent on January 12, 2023. ion Administration Record, "nuary 2023, indicated ministered once a day on d 18, 2023. mented evidence Resident 1 nitored, and the physician was ad continuous episodes of e use of loperamide. 23, at 11:20 a.m., an interview of CNA 1. CNA 1 stated the obe notified when a resident. He stated Resident 1 had	F	884				

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		056095	B. WING			C 03/10/2023	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		03/10/2023	
DEVONSHIRE CARE CENTER				1350 EAST DEVONSHIRE AVENUE HEMET, CA 92544			
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F 684	She stated she created and corous watery 1 started with frequent 2, 2023, and the C January 15, 2023. Let have been created the frequent watery for monitoring. She refused to take lope documented. On January 23, 202 was conducted with (DON). The DON stanotified for orders we episodes of loose stassessment and more Resident 1 had a his difficile-a bacterial in diarrhea). She state documentation lope Resident 1 and had stated the staff should operamide was offered on January 23, 202 review was conducted the "ADL Recomposited the "ADL Recomposite	ated a COC on January 15, at 1 presented with frequent stools. LVN 1 stated Resident ent watery stools on January COC was not created not until LVN 1 stated the COC should when Resident 1 started with stools on January 12, 2023 stated Resident 1 had eramide but refusals were not at 2:30 p.m., an interview the Director of Nursing stated the physician should be then a resident had three tools, and a COC created for onitoring. The DON stated story of C-Diff (clostridium affection that can cause severe	F 6	84			

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OFC		056095	B. WING		С			
NAME OF PROVIDER OR SUPPLIER			D. WING _		03/	10/2023		
DEVONSHIRE CARE CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 1350 EAST DEVONSHIRE AVENUE HEMET, CA 92544				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				
F 684	assessed, monitore effectiveness of inte 1's continuous epison Review of the facility "Change in a Residerevised February 20 promptly notifies the physicianof change medical/mental condithe resident's attendable beensignificate physical/emotional/ralter the resident's n significantly, refusal two (2) or more conschange" of condition improvement in the	d, and evaluated the erventions to address Resident odes of loose stools. y's policy and procedure titled, ent's Condition or Status, "121, indicated, "Our facility eresident, his or her attending ges in the resident's ditionThe nurse will notify ling physicianwhen there in the change in the resident's mental conditionneed to	F 68	,				