STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056095	A. BUILDING _____ B. WING _____	**05/13/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
DEVONSHIRE CARE CENTER	**1350 EAST DEVONSHIRE AVENUE HEMET, CA 92544**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0584 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**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.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement facility policy to safeguard residents' belongings for three of four sampled residents (Resident A, B, and C) when staff failed to document and report missing items. This failure increased the potential for misappropriation of residents property and caused emotional distress for residents and/or families. Findings: On February 12, 2020, at 10:03 a.m., a family member of Resident A (FM) 1 was interviewed, and stated she had concerns regarding the quality of care Resident A received at the facility, and the facility stole his clothes. On February 14, 2020, at 10 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On February 14, 2020, beginning at 10:45 a.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident A's Inventory of Personal Belongings form, dated January 24, 2020, indicated Resident A brought seven items of clothing, and other items on admission to the facility. Three items on the form were highlighted, and not further specified. The instructions on the form indicated, Upon admission, identify .personal belongings .Update as necessary .Upon discharge, use the (checkmark) columns to indicate that all personal belongings are accounted for . There were no documentation in the checkmark column to indicate all of Resident A's personal items were accounted for at discharge. The area of the form used to document missing or lost items was blank. On February 14, 2020, at 12 p.m., Resident B's record was reviewed and indicated Resident B was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Resident B's Inventory of Personal Belongings form, dated January 10, 2020, indicated Resident B brought multiple items that included cell phone with charger, and $8.00 cash to the facility on admission. The cell phone, charger, and cash were also listed in the area of the form marked, Use This Space To Record Miscellaneous Information .Lost, Stolen, Returned ., and had no documentation to indicate whether Resident B's cell phone, charger, and money were lost, stolen, or returned. There was no documentation to indicate all of Resident B's personal items were accounted for at discharge. On February 14, 2020, at 1:35 p.m., Certified Nursing Assistant (CNA) 1 was interviewed and stated if a residents' clothes were missing the CNAs checked the laundry, and if the resident's dentures or glasses were missing, the CNAs checked with Social Services staff. CNA 1 stated if the items were not found the staff was supposed to investigate, and check with the resident's family. On February 14, 2020, at 2:20 p.m., the Social Services staff (SS) was interviewed and stated she had no reports that Resident A or B's belongings were missing when they were discharged . On February 14, 2020, at 2:25 p.m., CNA 3 was interviewed and stated residents sometimes left belongings plugged in to the wall at discharge, and if the CNA found a resident's belongings they would give them to the nurse, and the nurse called the family. On February 14, 2020, at 2:30 p.m., the Administrator was interviewed, and stated missing belongings were supposed to be reported and the resident or family would be reimbursed. On February 14, 2020, at 2:45 a.m., a visitor (VS) was observed approaching the nurse's station and asking staff about Resident C's missing belongings. The VS had a copy of Resident C's Personal Belongings Inventory form and stated the the signature on the from was not Resident C's. The VS was visibly upset. On February 14, 2020, at 2:50 p.m., the VS was interviewed and stated Resident C was discharged from the facility five days ago and her clothes, hair dryer, and brush were missing, and he came back to the facility today to ask about her belongings. On February 18, 2020, at 2:02 p.m., the SS was interviewed and stated staff was supposed to list all missing items on the residents' belongings form and place a copy in the SS box. The SS stated if the residents' clothes were not found and the family had receipts, the facility would reimburse the resident for the lost clothes. The SS stated cell phones, hair dryers or other valuables were not reimbursed by the facility, only dentures, glasses's, and clothes. The facility policy and procedure titled, Personal Property:Patient's last revised July 24, 2018, was reviewed and indicated, Personnel will identify and record the patient's belongings upon admission .Patients will be encouraged to send valuables home: however .items can be stored in a secured area of the Center .The Center is prohibited from requesting or requiring patients to waive any potential Center liability for losses of personal property .All items brought into the Center will be listed on the .Inventory .form .Any loss or breakage of a .personal item will be properly documented on the property loss form .then referred to the CED .CED or designee will investigate the lost item .If the investigation identifies misappropriation .refer to Abuse Prohibition policy .results of the investigation will be given to the patient/family and documented .Per [ST] Title 22, in the event the Center fails to make reasonable efforts to safeguard patient property, the Center will reimburse a patient for, or replace stolen or lost property .
F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of four sampled resident's critically abnormal lab test results were reported to the resident's physician immediately. This failure increased the potential for harm and for the cause of the abnormal test result to not be identified or treated. Findings: On February 12, 2020, at 10:03 a.m., a family member of Resident A (FM) 1 was interviewed and stated Resident A was a diabetic (inability to metabolize sugar normally) and previously took oral medications to treat the diabetes and meal supplements. FM 1 stated while at the facility Resident A was given insulin and then not fed well which made him feel bad. On February 14, 2020, at 10 a.m., an unannounced visit was made to the facility for the investigation of the complaint. On February 14, 2020, at 10:45 a.m., Resident A's record was reviewed and indicated Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. The Lab Results Report dated January 28, 2020, at 10:25 a.m., were reviewed. The Report indicated Resident A had lab tests drawn January 27, 2020, that included a routine glucose level (used to determine blood sugar control and effect of diabetes medications). The Report indicated Resident A's blood sugar on January 27, 2020, at 4:25 p.m., was critically low at 47 mg/dl (normal range 70-99, mg/dl a unit of measure). There was no documented indication on the Report form that Resident A's critically low blood sugar was reported to the physician. The Nurse's Notes, dated January 28, 2020, at 7:42 a.m., indicated the nurse reviewed Resident A's lab test results, and, .Will call (name of doctor) due to abnormal labs. There was no documented indication in the nurses's notes that Resident A's physician was notified or that nursing staff asked the doctor whether Resident A's diabetes medications needed to be adjusted. On February 14, 2020, at 1:15 p.m., Registered Nurse (RN) 1 was interviewed and stated lab results were given to the facility by fax or electronically. When asked how soon the lab was supposed to report a critically abnormal value to the facility, RN 1 stated the time varied. RN 1 stated the nurse who received the critical lab result should call the resident's physician right away, document the results on the progress notes, and the call to the physician on the progress notes and Lab Report form. During a concurrent

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | 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.

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F 0773 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) review of Resident A's record, RN 1 verified the critical value, and stated she could not find documentation in the resident's record that his doctor was notified. On February 18, 2020, at 1:15 p.m., the Lab Staff member (LS) at (name of lab service) was interviewed and verified Resident A's critical lab results were called to the facility on [DATE], at 11:15 a.m., and (name of nurse) verified and read back the result. On February 18, 2020, at 3:05 p.m., the Lab Services QA staff member (LSQA) was interviewed and stated critical lab values are called to the facilities within one hour of the time the results were available. On March 19, 2020, at 11 a.m., the facility policy and procedure titled, Diagnostic Tests last revised November 01, 2019, was reviewed and indicated, .All diagnostic results are reported to attending physician .promptly .Notify immediately for any critical values .Document date and time of physician .notification and response in the medical record .