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 _____	**03/04/2020**

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 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, for one of three sampled residents (Resident A), received care consistent with the physician's orders [REDACTED]. Multiple licensed nurses did not promptly notify the physician of a change in Resident A's condition; b. Multiple licensed nurses did not monitor and document the resident's change of condition (COC) as per the facility's policy and procedure; and c. Licensed staff did not administer Tylenol (medication for fever), as per physician's orders [REDACTED]. These failures increased the potential for the resident to not receive appropriate assessment, timely interventions and necessary medical care and services. Findings: On January 29, 2020, at 8:36 a.m., Resident A's Family Member (FM) was interviewed and stated the resident had episodes of on and off fever while in the facility. She stated the resident had been asking to see a doctor but the staff said the laboratory results would dictate if the doctors needed to come in and check the resident. She stated she contacted the resident's surgeon and requested that the resident be evaluated due to on and off fever and chills that occurred for three days in the skilled nursing facility. She stated the resident was eventually transferred out to the general acute care hospital (GACH) due to her persistent request for the resident to be evaluated by his surgeon. On January 30, 2020, at 9:09 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. The resident was no longer in the facility during the investigation. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED]. The vital signs record indicated Resident A had a temperature reading of 100.8 F on January 20, 2020, at 12:30 p.m. There was no documentation of Tylenol administration for fever in the resident's Medication Administration Record [REDACTED]. There was no documentation of the monitoring or interventions provided to address the resident's change of condition. The progress notes, dated January 23, 2020, at 2:08 a.m., indicated, .(Resident A) C/O (complained of) nausea .X 4 D (four days) .and having chills . A physician's orders [REDACTED].for further evaluation and treatment per surgeon . The progress notes, dated January 24, 2020, at 12:10 p.m., indicated, .Received a call from (name of surgeon) at (name of GACH) that pt. (patient) needs to be transfer(red) ASAP (as soon as possible), per pt., (he) had n/v (nausea and vomiting) with chills on Saturday (January 18, 2020) and (name of daughter) reported to (surgeon) yesterday. (Surgeon) put an order .that pt. needs to be admitted , bed is available . (Name of attending physician) called to transfer pt. to (GACH) per (surgeon) . On January 30, 2020, at 11:11 a.m., Licensed Vocational Nurse (LVN) 1 was interviewed and stated she was the nurse assigned to Resident A during the time of his transfer to the GACH on January 24, 2020. She stated Resident A was alert and oriented and independent with activities of daily living. She stated the resident had a recent surgery and was on total [MEDICATION NAME] nutrition (TPN- intravenous (administered through the vein) feeding that provides patients with all the fluid and the essential nutrients they need when they are unable to feed themselves by mouth) thru a peripheral-inserted central catheter (PICC line- type of long catheter that is inserted through a peripheral vein, often in the arm, into a larger vein in the body, for administration of medications and/or fluids). She stated the resident had informed his daughter that he had been having on and off chills and fever and that the daughter reported it to the resident's surgeon. She stated she did not receive a report from other staff that the resident had a change in his medical condition. On January 30, 2020, at 11:30 a.m., Certified Nursing Assistant (CNA) 1 was interviewed and stated she provided care for Resident A several times while he was in the facility. She stated the resident had fever couple of times but could not remember the exact dates. She stated the fever happened during different dates, and she had applied cool wash clothes on the resident's forehead. She stated there was a time when Resident A had a temperature reading of 100.7 (F). She stated she reported and informed her charge nurses about the resident's fever. On January 30, 2020, at 11:37 a.m., Resident A's record was reviewed with the Registered Nurse Supervisor (RNS) and confirmed there was no documentation of the resident's change of condition when the resident had episodes of elevated temperature. She confirmed there was no documentation that the COC was promptly communicated to the resident's attending physician. When asked about the facility's policy for COC, she stated the physician would be notified of any change in a resident's condition, and the staff would document the COC in the resident's record. On January 30, 2020, at 4:40 p.m., LVN 2 was interviewed and stated she was the nurse assigned to Resident A on January 20, 2020. She stated the resident had an episode of elevated temperature with a reading of 100.8 F that day. When asked if she reported it to the physician, she stated she did not report it because the temperature went down after providing interventions. She stated she gave the resident Tylenol but confirmed there was no documented evidence that the resident received the Tylenol medication. From the publication titled, Nursing 2020: The Peer-Reviewed Journal of Clinical Excellence, in its article titled, Critical Care: Understanding the Pathophysiology of Fever, dated (NAME)2008, it indicated: Fever, or pyrexia, is an elevation in body temperature caused by a cytokine-induced (cell signalling molecules that aid cell to cell communication in immune responses and stimulate the movement of cells towards sites of inflammation, infection and trauma) upward displacement of the set point of the hypothalamic thermoregulatory center (section of the brain that controls temperature regulation) . Fever can be caused by various microorganisms and substances collectively called pyrogens . The pattern of a fever can give you information about the fever's cause . In an intermittent fever, the patient's temperature returns to normal at least once every 24 hours. This type of fever is associated with .sepsis (life-threatening illness caused by the body's response to an infection), abscesses (pus that has built up within the tissue of the body), and [DIAGNOSES REDACTED] (infection of the lining of the heart) . The facility's policy and procedure titled, Notification of Change in Condition, dated November 2019, was reviewed and it indicated: .A Center must immediately inform the patient, consult with the patient's physician .(when) there is .a significant change in the patient's physical, mental, or psychosocial status (that is a deterioration in health, mental or psychosocial status in either life-threatening condition or clinical complications) .
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 the ordering physician was promptly notified of the abnormal laboratory result for one of three sampled residents (Resident A). This failure increased the potential for delayed evaluation, medical treatment, and management for Resident A. Findings: On January 29, 2020, at 8:36 a.m., Resident A's Family Member (FM) was interviewed and stated the resident had episodes of on and off fever while in the facility. She stated the resident had been asking to see a doctor but the staff said the laboratory results would dictate

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) if the doctors needed to come in and check the resident. On January 30, 2020, at 9:09 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to quality of care concerns. Resident A's record was reviewed. Resident A was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A physician's orders [REDACTED].CBC (complete blood count- blood test used to evaluate a patient's overall health and detect a wide range of disorders, including [MEDICAL CONDITION], infection and [MEDICAL CONDITION]) on .1/20 (January 20, 2020) . The vital signs record indicated Resident A had a fever with a temperature reading of 100.8 F on January 20, 2020, at 12:30 p.m. The CBC test was completed and the results were reported by the laboratory to the facility on [DATE], at 8:17 a.m. The results indicated the white blood cell count (WBC/leukocytes- colorless cells that circulate in the blood and body fluids and is involved in counteracting foreign substances and diseases) was elevated at 14.67 (reference range: 4.00-10.00; an elevated WBC may indicate an underlying infection, stress, inflammation, trauma, allergy, or certain disease). There was no documented evidence that the physician was promptly notified of the elevated WBC on January 21, 2020. The progress notes, dated January 23, 2020, at 2:08 a.m., indicated, .(Resident A) C/O (complained of) nausea .X 4 D (four days) .and having chills . A physician's orders [REDACTED].for further evaluation and treatment per surgeon . The progress notes, dated January 24, 2020, at 12:10 p.m., indicated, .Received a call from (name of surgeon) at (name of GACH) that pt. (patient) needs to be transfer(red) ASAP (as soon as possible), per pt., (he) had n/v (nausea and vomiting) with chills on Saturday (January 18, 2020) and (name of daughter) reported to (surgeon) yesterday. (Surgeon) put an order .that pt. needs to be admitted , bed is available . (Name of attending physician) called to transfer pt. to (GACH) per (surgeon) . On January 30, 2020, at 11:37 a.m., Resident A's record was reviewed with the Registered Nurse Supervisor (RNS) and confirmed there was no documentation that the physician was promptly notified of the abnormal laboratory results on January 21, 2020. In a concurrent interview with the RNS, she stated abnormal laboratory results should be reported to the physician as soon as results are received by the facility staff. She further stated the communication with the physician would then be documented in the progress notes. The facility's policy and procedure titled, Diagnostic Tests, dated November 2019, was reviewed and it indicated: POLICY . All diagnostic results are reported to (the) attending physician/advanced practice nurse (APN)/physician assistant (PA) promptly. PRACTICE STANDARDS . Notify (the) physician/APN/PA of (the) diagnostic test results . Notify immediately for any critical values . Document (the) date and time of physician/APN/PA notification and response in the medical record . According to the US National Library of Medicine National Institutes of Health, in its publication titled, Evaluation of Patients with Leukocytosis, dated December 2015, it indicated, An elevated white blood cell count has many potential etiologies (cause of disease or abnormal condition) . Leukocytosis is a common sign of infection, particularly bacterial, and should prompt physicians to identify other signs and symptoms of infection .