

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  555754	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  02/28/2025
NAME OF PROVIDER OR SUPPLIER  Village Square Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  1586 W. San Marcos Blvd San Marcos, CA 92078	

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 0550</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 dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 48263</p> <p>Based on observation, interview and record review, the facility failed to promote dignity for one of 10 sampled residents (Resident 9) when Certified Nursing Assistant (CNA) 1 was observed standing over Resident (9) while assisting in bed to eat.</p> <p>This deficient practice had the potential to not promote dignity and respect for Resident 9 to cause emotional distress.</p> <p>Findings:</p> <p>A review of Resident 9's Admission Record indicated, Resident 9 was admitted to the facility on [DATE] with diagnoses which included history of schizoaffective disorder (a mental health disorder with a mix of hallucinations and delusions).</p> <p>A record review of Resident 9's minimum data set (MDS - a federally mandated resident assessment tool) dated 12/18/24 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points which indicated Resident 9 did not have cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>On 2/26/25 at 1:11 P.M., an observation was conducted inside of Resident 9 ' s room. CNA 1 was standing over Resident 9 at the side of the bed while feeding Resident 9 in bed. Resident 9 later threw a pitcher across the room toward her roommate ' s side of the room which landed on the floor, and rolled outside of Resident 9 ' s room.</p> <p>On 2/26/25 at 1:13 A.M., an interview was conducted with Licensed Nurse (LN) 2. LN 2 stated Resident 9 is alert but will make non-sensical statements and say random things while talking to her and usually not able to answer questions fully. LN 1 stated CNA 1 should be sitting down at eye-level while feeding Resident 9 to promote dignity and respect.</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 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 2/28/25 at 10:53 A.M., an interview was conducted with CNA 1, in the conference room. CNA 1 stated she was also an restorative nurse assistant (RNA) and does RNA exercises with Resident 9. CNA 1 stated she was helping Resident 9 because Resident 9 had a hard time getting food on her spoon. CNA 1 stated while Resident 9 was eating she was talking about peasants and that did not make sense. CNA 1 stated Resident 9 can also get physical with staff. CNA 1 stated she should have gotten a chair when she was feeding Resident 9 to be at an eye-level which promoted dignity and better communication.</p> <p>On 2/28/25 at 11:40 P.M., an interview was conducted with the Director of Nursing (DON). The DON stated standing over a resident while feeding them can be intimidating for any resident. The DON stated her expectations were for the nursing staff to promote dignity while feeding residents by not standing over them and making eye-contact to promote dignity and respect.</p> <p>A review of the undated facility ' s policy and procedure titled, ASSISTING THE RESIDENT TO EAT indicated, .If the resident needs to be fed: a. Sit at eye level in front of the resident .</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide for the safe, appropriate administration of IV fluids for a resident when needed.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</b></p> <p>Based on observation, interview, and record review, the facility failed to follow the physician ' s order to infuse the intravenous fluid [IVF] (IV- plastic tube inserted in the vein to deliver hydration, medications or nutrition) within 20-hour time for one of 10 residents (Resident 2) receiving an IVF. As a result, Resident 2's IV fluid was consumed over 26 hours. In addition, the IV tubing was not labeled with date and time it was used.</p> <p>This deficient practice had the potential for Resident 2 to experience IV related complications and infections that would impact resident's health and well-being.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated; Resident 2 was admitted to the facility on [DATE] with diagnoses which included history of heart failure (when the heart muscle doesn't pump blood as well as it should).</p> <p>A record review of Resident 2's minimum data set (MDS - a federally mandated resident assessment tool) dated 2/2/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points indicated, Resident 2 did not have cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>A review of Resident 2 ' s physician's orders dated, 2/26/25 indicated, .sodium chloride 0.9 % parenteral solution; amt: 50 ml [milliliters]/[per] hr [hour]; intravenous Special Instructions: 1 liter for HYPERKALEMIA [high potassium: a mineral that is essential to the human body] .</p> <p>On 2/26/25 at 2:10 P.M., a concurrent observation and interview was conducted with Resident 2, in Resident 2 ' s room. Resident 2 had an IV on his left hand with Sodium Chloride 0.9% via IVF controlled by a flow regulator. Resident 2 stated the IVF was started in the morning. Resident 2 had a remaining IVF of approximately 700 ml in the bag. The IV tubing was not labeled with date and time it was used.</p> <p>On 2/27/25 at 12:05 P.M., an observation was conducted on Resident 2 ' s IVF, in Resident 2 ' s room. Resident 2 ' s IVF contained approximately 300 ml of fluid remaining in the bag.</p> <p>On 2/28/25 at 11:11 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1, in the conference room. LN 1 stated she was the IV nurse for Resident 2. LN 1 stated Resident 2 had an order for IVF dated 2/26/25 for 1 liter (1000 ml) of Sodium Chloride 0.9% at 50 ml/hr. LN 1 stated the IVF should have been infused within 20 hours. LN 1 stated that Resident 2 ' s IVF was started at 9:45 A.M. and should have been completed by 5:45 A.M. on 2/27/25 during the night shift. The IVF had been running over 26 hours.</p> <p>(continued on next page)</p>		

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<p>F 0694</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>LN 1 stated Resident 2 ' s IV site and IVF should have been monitored for complications such as IV site pain, redness, inflammation (immune response to infection or irritation), third spacing caused by IV not being in the vein, or IV tubing/line blockages. LN 1 stated an IVF that has been on for too long or too slow of a flow could lead to irritation and infection on Resident 2 ' s hand and an inadequate IVF to be administered as prescribed. LN 1 further stated that Resident 2 ' s IV tubing should have been labeled for infection control measures.</p> <p>On 2/28/25 at 11:58 A.M., an interview with the Director of Nursing (DON) was conducted. The DON stated the RNs could have identified any IVF flow issues or complications such as inadequate fluid delivery, phlebitis [inflammation of the vein, and/or infiltration [leaking from the vein in surrounding tissues] and infection. The DON stated Resident 2 ' s IV tubing should have been labeled with date and time to determine when to replace the tubing to prevent infection control issues. The DON stated Resident 2 ' s IV fluid should have been completed timely and discarded appropriately as prescribed within 20 hours (5:45 A.M. on 2/27/25) and not over 26 hours (12:05 P.M. on 2/27/25).</p> <p>A review of the facility ' s policy and procedure titled IV THERAPY undated indicated, .Once started, completely use all parenteral fluids within 24 hours, or discard .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48263</b></p> <p>Based on observation, interview, and record review, the facility failed to follow the physician ' s order to infuse the intravenous fluid [IVF] (IV- plastic tube inserted in the vein to deliver hydration, medications or nutrition) within 20-hour time for one of 10 residents (Resident 2) receiving an IVF. As a result, Resident 2's IV fluid was consumed over 26 hours. In addition, the IV tubing was not labeled with date and time it was used.</p> <p>This deficient practice had the potential for Resident 2 to experience IV related complications and infections that would impact resident's health and well-being.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record indicated; Resident 2 was admitted to the facility on [DATE] with diagnoses which included history of heart failure (when the heart muscle doesn't pump blood as well as it should).</p> <p>A record review of Resident 2's minimum data set (MDS - a federally mandated resident assessment tool) dated 2/2/25 indicated, a Brief Interview for Mental Status (BIMS- developed by reviewing the resident's status during the prior seven-day period) score of 15 points out of 15 possible points indicated, Resident 2 did not have cognitive (pertaining to memory, judgement and reasoning ability) deficits.</p> <p>A review of Resident 2 ' s physician's orders dated, 2/26/25 indicated, .sodium chloride 0.9 % parenteral solution; amt: 50 ml [milliliters]/[per] hr [hour]; intravenous Special Instructions: 1 liter for HYPERKALEMIA [high potassium: a mineral that is essential to the human body] .</p> <p>On 2/26/25 at 2:10 P.M., a concurrent observation and interview was conducted with Resident 2, in Resident 2 ' s room. Resident 2 had an IV on his left hand with Sodium Chloride 0.9% via IVF controlled by a flow regulator. Resident 2 stated the IVF was started in the morning. Resident 2 had a remaining IVF of approximately 700 ml in the bag. The IV tubing was not labeled with date and time it was used.</p> <p>On 2/27/25 at 12:05 P.M., an observation was conducted on Resident 2 ' s IVF, in Resident 2 ' s room. Resident 2 ' s IVF contained approximately 300 ml of fluid remaining in the bag.</p> <p>On 2/28/25 at 11:11 A.M., an interview and record review was conducted with Licensed Nurse (LN) 1, in the conference room. LN 1 stated she was the IV nurse for Resident 2. LN 1 stated Resident 2 had an order for IVF dated 2/26/25 for 1 liter (1000 ml) of Sodium Chloride 0.9% at 50 ml/hr. LN 1 stated the IVF should have been infused within 20 hours. LN 1 stated that Resident 2 ' s IVF was started at 9:45 A.M. and should have been completed by 5:45 A.M. on 2/27/25 during the night shift. The IVF had been running over 26 hours.</p> <p>(continued on next page)</p>		

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