STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555793	A. Building B. Wing	05/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VI at LA Jolla Village	4171 Las Palmas Square San Diego, CA 92122

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39448 Based on interview and record review, the facility failed to administer medications to the correct resident for one of two sampled residents (1). This failure placed Resident 1 at an increased risk of low blood pressure. Findings: Per the facility's Resident Face Sheet, Resident 1 was admitted to the facility on [DATE] with diagnoses to include heart failure, atrial fibrillation (abnormal heart rhythm). On 5/7/25 at 9:40 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated, on 4/25/25 Licensed Nurse (LN) 2 administered propranolol (a medication to treat heart problems and high blood pressure) and losartan (a medication to treat high blood pressure) to the wrong resident (Resident 1). The DON further stated, the error occurred because LN 2 thought Resident 1 was a different resident, and gave him the other resident's medications by mistake. LN 2 was not available for interview. Per the facility's Physician Order Report, dated 5/7/25, Resident 1 did not have any orders for propranolol or losartan. Per the facility's Resident Progress Notes, there was a note on 4/25/25 at 5:31 P.M., by LN 2, which indicated that LN 2 realized she gave Resident 1 the wrong medication when she gave him losartan and propranolol. The note further indicated that Resident 1's blood pressure at the time of administration was 92/55 (a low blood pressure reading). A review of the facility's policy and procedure, revised October 2023, was conducted. The policy indicated, . Administration of Medications/Treatments . 4. The resident's identity is confirmed prior to administering the medications/treatments .

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