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	08/28/2025

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtained written consent for the use of a bed/chair sensor alarm (a device that detects movement or pressure changes to alert staff for residents at risk of falling) [Resident 51] and for the use of an antipsychotropic medication (treats mental health illnesses such psychosis and schizophrenia) [Resident 1] for two of seven residents reviewed for Resident Rights. This failure had the potential for residents and their responsible parties (RP-a designated person chosen by the resident to represent them in medical and financial decisions), to be uninformed of the risk versus the benefits, for the recommended treatment.1. Resident 51 was admitted to the facility 7/25/2025, after multiple falls at home per the facility's admission Record. Resident 51 had an RP listed on the admission Record. An observation was conducted of Resident 51 in her room on 8/25/25 at 11:06 A.M. Two staff were in the room, assisting the resident to a wheelchair. A sensor alarm was observed attached to the wheelchair. Resident 51's medical record was reviewed on 8/26/25. The physician's order contained no documentation for the use of a sensor alarm. According to the nurses note dated 8/24/25 at 10:05 A.M., Licensed Nurse 1 (LN 1) documented Resident 51's family attempted to get the resident up from bed and the sensor alarm sounded. There was no documented evidence in the electronic or paper medical record that the RP for Resident 51 had consented to the use of a sensor alarm. An Interview and record review was conducted with the Director of Nursing (DON) on 8/26/25 at 12:15 P.M. The DON stated Resident 51 had three previous falls at her assisted living facility and was admitted for a higher level of care. The DON stated Resident 51 was found to have a fracture of the left elbow and left hip, and the fractures appeared old and were believed to be caused by the previous falls. The DON stated because of the risk for falls, Resident 51 was moved to a room closer to the nurse's station and sensor alarms were implemented. The DON reviewed Resident 51's electronic medical record, along with the paper medical record. The DON stated she could not locate any documentation the RP had consented to the sensor alarm, and there should have been written consent. The DON stated there was no documentation from nursing staff that nurses were monitoring the alarm, to ensure it was working. An interview was conducted with LN 1 on 8/27/25 at 9:45 A.M. LN 1 stated before a sensor alarm could be implemented, LNs needed to ensure there was a physician's order and written consent from the resident or RP. LN 1 stated sensor alarms could be considered a restraint, so residents and (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	families needed to understand what they were being used for and why. LN 1 stated once the sensor alarm was implemented, staff needed to monitor it to ensure it was working every shift. According to the facility's policy, titled Resident Rights, undated, .You have the right to.be informed in advance by the physician.of the risk and benefits of proposed care, of treatment and treatment alternatives.be informed, in advance of the care to be furnished. Findings: 2. A review of Resident 1's Face Sheet record indicated the resident was admitted on [DATE] with diagnoses including major depressive disorder (also known as depression). Resident 1 had physician's orders for the following psychotropic medications: -bupropion hydrochloride (HCl) tablet extended release 24 hr.(hour) (generic for Wellbutrin XL, a medication to treat depression) 150 milligram (mg) 1 tablet by mouth once a day: Special Instructions: dx:(diagnosis) depression AEB (as evidenced by) decreased motivation and self-isolation, Start date 6/30/25. -escitalopram oxalate tablet; (generic for Lexapro, a medication to treat depression) 10 milligrams (mg) 1 by mouth once a day: Special Instructions: dx: Depression AEB feeling helpless, hopelessness and disinterested, Start date 6/30/25. A review of Resident 1's EMAR (electronic medical administration record) indicated Resident 1 was administered first dose of bupropion HCl 150 mg tab and first dose of escitalopram 10 mg on 7/1/25. On 8/27/2025 11 A.M., Reviewed informed consents titled Informed Consent- Anti-Depressant Medication Therapy for bupropion and escitalopram, dated by physician on 7/3/25, no date when signed by Resident 1 or Responsible Party. On 8/27/2025 11:06 A.M., an interview and review of Resident 1's clinical record was conducted with the Director of Nursing (DON). The DON stated she was not able to provide evidence that Resident 1's informed consent for psychotropic medication was obtained earlier than 7/3/25. The DON stated informed consent needed to be obtained before starting the psychotropic medications, acknowledged they did not follow their process for Resident 1 and should have. Per facility policy titled Behavioral Management-Psychotropic/Antipsychotic Drugs, revised 10/2023, indicated . 3. Psychotropic medications are not prescribed or administered without the informed consent of the resident and/or the responsible agent.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure non-pharmacological interventions (NPI) were done related to the use of an antidepressant (medication used to treat depression) for one of five residents (Resident 1) reviewed for unnecessary medications.This failure had the potential for Resident 1 to receive unnecessary medications, or more medication than necessary to treat depression (feelings of sadness, hopelessness, and loss of interest in activities).Findings:A review of Resident 1's Face Sheet record indicated the resident was admitted on [DATE] with diagnoses including major depressive disorder (also known as depression). A review of Resident 1's physician's orders indicated the following psychotropic medications:-bupropion hydrochloride tablet extended release 24 hr. (hour); (generic for Wellbutrin XL, a medication to treat depression) 150 milligrams (mg) 1 tablet by mouth, once a day: Special Instructions: dx:(diagnosis) depression AEB (as evidenced by) decreased motivation and self-isolation, Start date 6/30/25.-escitalopram oxalate tablet; (generic for Lexapro, a medication to treat depression) 10 milligrams (mg) 1 tablet by mouth once a day: Special Instructions: dx: Depression AEB feeling helpless, hopelessness and disinterested, Start date 6/30/25.A review of Resident 1's MAR (medication administration record) for 8/1/25-8/26/25 indicated the resident did not exhibit depression behaviors [decreased motivation and self-isolation] for bupropion and [feeling helpless, hopelessness and disinterested] for escitalopram, with no evidence of NPI implemented.A review of Resident 1's care plan for Psychotropic Drug use, dated 7/8/25, indicated .Assess for underlying cause for depressive disorder; Lifestyles: Offer and encourage resident to attend programs of choice.provide 1:1 visit, group activities, provide daily verbal reminders of activities.On 8/27/2025 at 11:06 A.M., an interview and review of Resident 1's clinical record was conducted with the Director of Nursing (DON). The DON acknowledged there were no documented evidence that non-pharmacological interventions were provided prior to use of the psychotropic medications. The DON stated Resident 1 should have orders for NPI such as encouragement to attend activities if self-isolating. The DON stated Resident 1 had a care plan for depression which included NPI's. The DON stated since there was no order from Resident 1's physician to provide NPI to the resident, NPI were not provided to Resident 1. Per facility policy titled Behavioral Management-Psychotropic/Antipsychotic Drugs, revised 10/2023, indicated .4. A resident receiving psychotropic medication is reviewed for implementation of behavior interventions to reduce/eliminate the medication usage.6. Behavioral management interventions may be utilized either as directed by a healthcare provider with prescriptive authority or as part of an interdisciplinary plan of care.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to provide an activity program to meet the interests of one of one residents reviewed for activities (Resident 3). As a result, Resident 3 was at risk for psychosocial isolation and boredom. Findings:Resident 3 was admitted to the facility on [DATE] with diagnoses to include dementia (loss of memory, language, problem solving and other thinking abilities), per the Resident Face Sheet.An observation and interview was conducted on 8/25/25 at 9:49 A.M. with Resident 3 and his private duty caregiver (PCG 1). Resident 3 was in bed, asleep. PCG 1 stated he was with the Resident 3 five days a week to ensure he was safe and getting good care from the facility. PCG 1 stated Resident 3 was from the Memory Care unit due to his dementia, and he normally was very engaged in activities there. PCG 1 stated since Resident 3 had been on the skilled nursing unit, the Life Enrichment staff dropped off a paper with a list of activities for the day, but they usually left the paper on the bed, or with him, and did not discuss opportunities for Resident 3 to participate or discuss Resident 3's interests. Per PCG 1, He mostly just sits here. He needs engagement to keep his mind busy.An observation and interview was conducted on 8/26/25 at 11:38 A.M. with Resident 3 and PCG 1. Resident 3 was sitting on the side of the bed and did not respond to questions asked. The television was off, and no books or magazines were visible on the bedside table. PCG 1 stated the Life Enrichment staff had dropped off the paper with the days' activities, but the staff had not reviewed the offerings or encouraged Resident 3 to attend. PCG 1 stated Resident 3 liked the music programs best, although he had not gone recently. PCG 1 stated Resident 3 used to be a high-level executive at a technology company, so he liked to be busy helping people. PCG 1 stated Resident 3 liked to doodle things on paper, or help with folding or filing things. Per PCG 1, if Resident 3 went to an activity with an art project, he just sat in the back of the room and did not engage with the group unless individually provided with materials and encouraged to stay on task. PCG 1 stated, It's not worth taking him to a different floor for something that he doesn't enjoy doing. Nobody takes him, they expect the caregiver to bring him to the activity. I am willing to do that, but if he isn't going to participate in the activity, maybe they should be finding him something more appropriate to do instead. An interview was conducted on 8/26/25 at 11:15 A.M. with Lifestyle Assistant (LA) 1. LA 1 stated most of the activities were conducted on this floor of the nursing facility since more residents participated there versus on the other floors. LA 1 stated Resident 3 was well known to her, and he liked to participate in trivia, sing alongs, and travel videos. LA 1 stated if they did not have a program scheduled which Resident 3 would enjoy, the Lifestyles staff would do room visits with more appropriate activities. LA 1 stated room visits should occur several times a week if he did not attend group activities. Per LA 1, the caregivers should be bringing Resident 3 to any groups he might enjoy. LA 1 stated there was a Tuesday Trivia activity later the same day, and Resident 3 should attend as he usually enjoyed trivia. An observation and interview was conducted with Resident 3 and PCG 2 on 8/26/25 at 3 P.M. PCG 2 was walking with Resident 3 in the hallway. PCG 2 stated she was a caregiver for Resident 3 four days a week, for six hours each day. PCG 2 stated she had not been told to bring Resident 3 to the Tuesday Trivia program. PCG 2 stated it was difficult to get Resident 3 to go to another floor for activities due to his dementia, and he needed to stay busy. PCG 2 stated she was not aware the caregivers were supposed to take residents to the activity programs, and she assumed the facility staff would inform her of activities appropriate for Resident 3. An interview was conducted with Certified Nursing Assistant (CNA) 11 on 8/26/25 at 4:30 P.M. CNA 11 stated the PCGs primary responsibility was to keep the residents safe and to provide companionship. CNA 11 stated it was the facility CNA's responsibility to identify activities which might be interesting to the residents, and assist them in attending the program as needed. CNA 11 stated the PCG could also assist, but it was not their job to do so. CNA 11 stated, That's what a care plan is for. It informs facility staff of the care needs and interests of the resident. On 8/27/25, a (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	record review was conducted. Resident 3's Brief Interview for Mental Status (BIMS) score was 0, indicating severe cognition impairment. The Activity Staff assessment of daily activity preferences was blank. Sections on education level and past occupations were blank. Preferred program frequency was listed as Daily, watches golf. Has PDA [PCG] who encourages to go to group programs. Leisure Interest checked were walking/wheeling outdoors and watching TV, music, reading and helping others were not checked. Resident 3's care plan for Activities, dated 8/1/25, indicated the facility would escort Resident 1 to activities as needed, and would inform Resident 1 of upcoming events with daily verbal reminders of the day's programs that might be of interest, including providing an escort to programs of choice. In addition, the care plan indicated Activity staff would provide materials for independent use, such as books, magazines or puzzles. The care plan indicated staff would provide one to one visits three times weekly, and monitor for level of participation in preferred activities. The Activity Participation Log was reviewed for June, July and August 2025. Room visits were checked daily, with Conversation and TV Viewing listed as the primary interventions during the room visits in June. In July, room visits were checked daily, with Visitors and TV Viewing as the primary interventions. In August, room visits were checked daily, with TV Viewing listed as the primary intervention. The Notes section for Activities team discussions was blank. An interview was conducted on 8/27/25 at 9:30 A.M. with LA 2 outside of Resident 3's room. LA 2 stated he had just dropped off the daily list of activities for Resident 3. LA 2 stated he had dropped off the papers but did not review the activities to identify programs that Resident 3 might enjoy. LA 2 stated Resident 3 liked music programs, where he sang along and appeared to enjoy himself. LA 2 stated the Lifestyles staff discussed patterns of engagement, and would document involvement or lack of involvement on the comment section of their documentation. LA 2 stated then the Lifestyles staff could discuss any changes as a team to make decisions about residents. LA 2 stated PCGs should bring residents to any activities they feel they may enjoy participating in. A concurrent interview and record review was conducted on 8/27/25 at 2 P.M. with Lifestyles Manager (LM) 1. LM 1 stated many of the group activities were conducted on the third floor since more people participated on that floor than on others. LM 1 stated the PCGs should be bringing the residents to the activities they enjoy, and the CNAs could assist them as needed. LM 1 stated the LA's should review the daily activities and use their knowledge of the residents to recommend specific activities to meet their needs. LM 1 reviewed the care plan for Resident 3 and stated, I do not see music on his Activity Log. I am aware he likes to listen to music, that should be documented, and we should make sure he attends any music programs. We should have updated the care plan after the team discussed his interests and current status. I don't remember discussing those specifics, and none of the documents include music. LM 1 stated she did not consider a check box indicating a room visit had been conducted was adequate engagement from Activities staff, and they should elaborate more in the comment section. An interview was conducted on 8/28/25 at 2:30 with the Administrator (Admin). The Admin stated she expected Activity staff to individually assess resident's interests and assist them (with the CNAs) to the activity programs. The Admin stated the goal of the activities provided was to meet the various interests of the residents. Per an undated facility policy, titled Daily Programming, It is the policy of this care center to provide an ongoing program of activities designed to meet.the interests and the physical, mental, and psychosocial well-being of each resident.The Activity Director/staff will: Identify each resident's interests and needs.Involve each resident in an ongoing program of activities that is designed to appeal to his or her interests. Per an undated facility program procedure, titled Independent Leisure Pursuits, It is the policy of this care facility to provide recreational and cognitively stimulating program.One to One Setting.Initiate the one to one discussion by explaining the topic to the resident which is relevant to the day's historical events. Offer any variety of programs per the resident's specific desires for each day.Highlight the information reviewed and each resident's contributions to the discussion. Per an undated facility policy, titled Individual & Room Visit Programs, .The in-room activity programs will directly reflect the residents' assessed individualized activity (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	interests.Maintain a record of residents receiving room visits. Include a summary of this information into the Resident progress records.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility did not ensure medications were documented according to professional standards of practice for two of five Resident (8,36) sampled residents reviewed for pharmacy services when:1. Documentation of controlled medication (drugs with high abuse potential) was not documented the same time as it was administered to Resident 36.2. Controlled medication prescribed to Resident 8 could not be accounted for when a controlled medication was wasted without a second nurse signature.Findings:1. A review of Resident 36's clinical record indicated the resident was admitted on [DATE].On 8/26/25 at 11:08 A.M., an interview and review of Resident 36's clinical record with Licensed Nurse (LN) 2 was conducted. A review of Resident 36's physician order for Tramadol (controlled medication used to alleviate pain) 50 mg, take half a tablet by mouth every eight hours as needed for pain. A review of July 2025 CDR (controlled drug record, an inventory sheet that keeps record of the usage of controlled medications) and EMAR (electronic medical administration record) did not have the same administration times. LN 2 acknowledged CDR had tramadol administration for July 22,2025, time as 3:40 P.M., and documented on the EMAR at 8:25 P.M. LN 2 stated when a controlled medication was given it should be documented on the CDR and the EMAR at the same time. 2. On 8/26/25 at 11:31 A.M., an interview and review of Resident 8's clinical record was conducted with LN 2. LN 2 stated the process for controlled medication disposal are to have two nurses waste together and then they both sign off. LN 2 stated the CDR needed to have two nurse signatures, the CDR in the binder were the only place it's documented as far as she was aware. A review of July 2025 CDR for Resident 8's Tramadol 50mg tablets was reviewed with LN 2. LN 2 stated on 7/27/25, 7/28, and 7/29 the nurse did not get countersignature for the wasted 1/2 tab of tramadol and said the record was supposed to have two nurse signatures.On 8/26/25 at 2:25 P.M., an interview and review of Resident 36's and Resident 8's clinical record was conducted with the Director of Nursing (DON). The DON stated her expectation was for the nurse to sign out on MAR and CDR at the same time they administered the medication. The DON stated two nurses needed sign off all wasted controlled medications. The DON acknowledged missing witness signatures for Resident 8's tramadol on 7/27,7/28, and 7/29. The DON stated there needed to be two nurse signatures for controlled substance waste. Per facility policy and procedure titled Medication Administration, revised November 2016 indicated, .E. Charting doses administered-General Principles-(general principles apply to both paper and/or electronic MARs.1. Each dose administered to a resident shall be properly recorded in the resident's medical record.Per facility policy and procedure titled Disposal of Medication, revised 11/2016, indicated, .B. Single wasted controlled drug may be destroyed by two licensed nurses (in any combination) on count sheet or on back of med sheet.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five sampled resident (Resident 31) were free of unnecessary medications when Resident 31 received anticoagulant (blood thinner) medications without monitoring for signs and symptoms of side effects.This deficiency had the potential to cause harm due to lack of monitoring for negative side effects of anticoagulant therapy, including excessive bleeding or bruising.Findings: A review of Resident 31's admission record indicated the resident was admitted on [DATE] with diagnoses including congestive heart failure (chronic condition where the heart muscle cannot pump blood effectively) and atrial fibrillation (A-Fib, condition where the heart beats out of rhythm).A review of Resident 31's physician's order, dated 7/30/25, for Eliquis (apixaban, an anticoagulant) 5 milligrams (mg) take 1 tablet by mouth BID (twice a day) for A-Fib.A review or Resident 31's care plan dated 8/8/25, indicated, Approach: Observe for signs of active bleeding (nosebleeds, bleeding gums.blood in urine, blood in stools, elevated temp, pain in joints, abdominal pain. On 8/27/2025 at 10:35 A.M., an interview and review of Resident 31's clinical record was conducted with the Director of Nursing (DON). The DON stated the drug (Eliquis) can increase risk of bleeding, monitoring is important to make sure there were no signs and symptoms of internal bleeding like bleeding gums, blood in stool. The DON stated monitoring for bleeding needs to be documented every shift. The DON verified monitoring for bleeding was in the care plan but there was no monitoring for signs and symptoms of bleeding for Resident 31 and there should have been. A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Eliquis (apixaban), dated 4/17/25, retrieved from DailyMed, indicated, .Increased Risk of Hemorrhage [bleeding]. can cause serious, potentially fatal A review of facility policy titled Medication/Treatment Management Protocol-SN, revised October 2023, did not address high risk medication monitoring for adverse consequences.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review the facility did not ensure medication storage cabinet was free from an expired medication.This failure had the potential for medication to have reduced effectiveness and/or medication misuse.Findings: On 8/25/25 at 2:44 P.M., an observation and interview was conducted with a Licensed Nurse (LN) 1 during a medication storage room tour on the third floor. An expired medication bottle labeled Sodium Chloride (salt) Tablets with an expiration date 6/2025 was stored with unexpired medications in the same cabinet. LN 1 acknowledged the medication expired on 6/2025 and should have been discarded. On 8/25/25 at 2:53 P.M., an observation and interview was conducted with Assistant Director of Nursing (ADON) during a medication storage room tour on the third floor. The ADON acknowledged Sodium Chloride bottle was expired on 6/2025. The ADON stated medication cabinet should be checked monthly for expired medications. The ADON stated she would discard the medication. The ADON stated her expectation was for all expired medication to be discarded. Per facility policy and procedures titled Medication /Treatment Management Protocol-SN revised 10/2023 did not indicate a policy for checking or discarding expired medications.