STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555754	A. BUILDING _____ B. WING _____	**08/11/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
VILLAGE SQUARE HEALTHCARE CENTER	**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)
F 0689 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure smoking paraphernalia was securely stored for a resident (1) who smoked cigarettes. In addition, the facility failed to ensure a resident (1) was supervised when they smoked cigarettes. These failures had the potential to cause a serious injury to the resident and/or residents of the facility. Findings: Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. Face Sheet. A review of Resident 1's MDS (an assessment tool), dated 2/19/20, Section C, indicated Resident 1 had a BIMS (brief interview for mental status) score of 13. A BIMS score of 13 indicated a person was intellectually intact. On 4/21/20 at 11:30 A.M., a telephone interview was conducted with the ADM. The ADM stated Resident 1 was a non-compliant smoker who refused to give her cigarettes and lighter to the facility for safe keeping. The ADM stated Resident 1 was not supervised when she went outside the facility in the middle of the night, to smoke cigarettes. The ADM stated Resident 1 had no safety awareness and it was the facility's responsibility to ensure Resident 1 was supervised when she smoked. The ADM stated because Resident 1 refused to abide by the facility's smoking policy of supervised smoking, and secured smoking materials, Resident 1 put the safety of other residents' in jeopardy. The ADM stated the Resident Council had lodged a grievance against Resident 1 because Resident 1 posed a safety risk to self and others. The ADM stated it was the policy of the facility that residents could not keep their smoking paraphernalia with them. The ADM stated it had been an issue for some time that Resident 1 kept her smoking materials with her, refused to give them to the staff for safe keeping, and consistently went outside the building to smoke unsupervised in the middle of the night. On 4/27/20 at 10:05 A.M., a telephone interview was conducted with Resident 2. Resident 2 stated Resident 1 went outside to smoke in the middle of the night, and left the front door propped open with a pillow. On 4/27/20 at 10 A.M., a telephone interview was conducted with CNA 1. CNA 1 stated he supervised the residents who were in the smoking group. CNA 1 stated during the day the receptionist locked the smoking residents' cigarettes and lighters in a box for safe keeping. CNA 1 stated at night the LNs locked the residents' cigarettes and lighters in the medication cart. CNA 1 stated all the residents who smoked complied with the smoking rules, except Resident 1. On 4/27/20 at 4:45 P.M., a telephone interview was conducted with RCP 1. RCP 1 stated he supervised the smokers at the designated smoking times. RCP 1 stated Resident 1 never gave her cigarettes and lighter back to RCP 1 after smoking. RCP 1 stated this had been happening over a long period of time. RCP I stated he informed the ADM about the situation. On 4/28/20 at 6:30 A.M., a telephone interview was conducted with LN 1. LN 1 stated Resident 1 had been going outside unsupervised in the middle of the night to smoke, for approximately one month. LN 1 stated the unsupervised smoking was documented every day in the 24 hours report that went to the Department Heads of the facility. On 4/28/20 at 6:40 A.M., a telephone interview was conducted with LN 2. LN 2 stated Resident 1 had gone out of the facility to smoke in the middle of the night, for a long time. LN 2 stated because there were less staff who worked on night shift, no-one could take time away from their work assignments to supervise Resident 1 while she smoked outside at night. LN 2 stated she documented Resident 1's behavior in the 24 hours report, and in Resident 1's Progress Notes. LN 2 stated since the elevators were now locked at night, Resident 1 could not go outside to smoke. LN 2 stated now Resident 1 went outside to smoke unsupervised at 5 A.M., when the elevators were unlocked. On 5/4/2020 a record review was conducted. Resident 1's Safe Smoking Assessment on Admission, observation and recorded date 8/12/19, included, IDT Determination - Resident 1 required supervision while smoking .Resident 1 was NOT deemed a safe independent smoker . Care Plan to include the degree of supervision needed and where smoking materials will be stored . Resident 1's Quarterly Safe Smoking Assessment, observation date 2/18/20, and recorded date 4/24/20, included, IDT Determination - Resident 1 was NOT deemed a safe independent smoker . Care Plan to include smoking designation . Resident 1's Care Plan, dated 8/26/19, included, Problem - Resident is non-compliant with: smoking policy, aeb (as exhibited by), attempts to keep cigarettes with her. Goal - Resident will understand the risk associated with being non-compliant. Approach - .Provide information regarding risk and complications resulting from non-compliance. Respect resident's wishes and refusal of procedure. The Resident Council Meeting Minutes, dated January 2020, included, . Social Services: .New Business: .The safety concerns are during the noc (night) shift hours between 10 P.M., and 6:30 A.M. Residents have observed or been told by other various individuals of the residents who go outside to smoke, propping open the lobby door .To the majority of residents this issue presents a serious security and safety concern . The Resident Council Meeting Minutes, dated February 2020, included, .Social Services: Old Business: The issue of smokers living in our facility causing safety and health violations for the residents and staff as a work in process as there is no immediate resolution at this time Resident 1's Progress Notes, dated 4/15/20, included, 3:47 A.M., Resident used Out of Order elevator tonight to go out and smoke several times . Resident 1's Progress Notes, dated 4/17/20, included, 1:49 A.M., Resident still uses the Out of Order elevator at 5 A.M., to go outside to smoke . The facility's policy titled Smoking, dated October 2010, included, . Procedure: Residents who wish to smoke in the Nursing Facility will be allowed to do so subject to the following rules: .2. The IDT will determine if the resident is a safe smoker and the amount of supervision needed .following the admission of the patient .6. Residents, regardless of Safe Smoking Assessment result, will need to keep smoking materials in the nurses' station .8. Violation of this policy or the smoking contract will bring restrictions of smoking privileges or possible discharge from the facility if behaviors present a danger to others
F 0921 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide a safe and secure environment for residents, and staff, when a resident (1) repeatedly unlocked, and left ajar, the facility's main entrance doorway, in the middle of the night. This failure provided an opportunity for an intruder (or intruders) to access the building where vulnerable residents slept, and staff worked. Findings: Resident 1 was admitted to the facility on [DATE], with [DIAGNOSES REDACTED]. A review of Resident 1's MDS (an assessment tool), dated 2/19/20, Section C, indicated Resident 1 had a BIMS (brief interview for mental status) score of 13. A BIMS score of 13 indicated a person was intellectually intact. On 4/21/20 at 11:30 A.M., a telephone interview was conducted with the ADM. The ADM stated other facility residents safety was in jeopardy because Resident 1 refused to abide by the facility's security policy. The ADM stated the Resident Council had lodged a grievance against Resident 1 because Resident 1 posed a safety risk to self and others. The ADM stated it had been an issue for some time. The ADM stated Resident 1 would consistently leave the front entrance door propped open with a pillow, when Resident 1 went outside the building to smoke in the middle of the night. On 4/27/20 at 10:05 A.M., a

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 0921 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 1) telephone interview was conducted with Resident 2. Resident 2 stated Resident 1 went outside to smoke in the middle of the night, and left the front door propped open with a pillow. Resident 2 stated members of the Resident Council were concerned because anyone could enter the building through the opened front door. On 4/28/20 at 6:30 A.M., a telephone interview was conducted with LN 1. LN 1 stated Resident 1 had been going outside unsupervised in the middle of the night, for approximately one month. On 4/28/20 at 6:40 A.M., a telephone interview was conducted with LN 2. LN 2 stated Resident 1 had gone out of the facility to smoke in the middle of the night, for a long time. LN 2 stated because there were less staff who worked on night shift, no-one could take time away from their work assignments to supervise Resident 1. On 5/4/2020, a record review was conducted. The Resident Council Meeting Minutes, dated January 2020, included, . Social Services: .New Business: .The safety concerns are during the noc (night) shift hours between 10 P.M., and 6:30 A.M. Residents have observed or been told by other various individuals of the residents who go outside to smoke, propping open the lobby door .To the majority of residents this issue presents a serious security and safety concern . The Resident Council Meeting Minutes, dated February 2020, included, .Social Services: Old Business: The issue of smokers living in our facility causing safety and health violations for the residents and staff as a work in process as there is no immediate resolution at this time On 7/31/20 at 3:41 P.M., a record request was made for the facility's policy on a safe and secure environment. On 8/5/20 at 12:37 P.M., the ADM stated the facility did not have a policy for a safe and secure resident environment. The ADM stated the facility had a flexible protocol for the security of the building.