STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555246	A. BUILDING _____ B. WING _____	**04/22/2020**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
LIFE CARE CENTER OF VISTA	**304 N. MELROSE DR VISTA, CA 92083**

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 observation, interview and record review, the facility failed to provide an accident free environment for one of one sampled residents (1). This failure had the potential for Resident 1 to sustain injuries. Findings: Resident 1 was admitted to the facility with [DIAGNOSES REDACTED]. Record. A report of an injury of unknown origin was received in the department on 1/3/19 at 1:41 P.M. An unannounced visit to the facility was conducted on 1/12/19 at 8 A.M. An interview was conducted with the Director of Nursing (DON) on 1/12/19 at 8:41 A.M. The DON stated that during the night, Resident 1 needed to be changed and was noted to be crying. A licensed nurse (LN) 1 assessed the resident and there was swelling and bruising to the left ankle. An x-ray report, dated, 1/31/9, indicated a complex [MEDICAL CONDITION] tibia and fibula (left). An interview was conducted with the Social Services Director (SSD) on 1/12/19 at 9:35 A.M. The SSD stated that during the night, during care, Resident 1 was crying and noted to have swelling and bruising of the left ankle; there was no fall, no other bruising or marks. Certified nursing assistant (CNA)1 was not available for interview. CNA 1 was on suspension pending the facility investigation. A review of Resident 1's Minimal Data Set (MDS- an assessment tool), Section G: Functional Status, dated, 12/25/18, indicated: .Transfer-how resident moves from wheelchair-bed: total dependence (level 4); Support needed: Two+ persons physical assist . A review of the facility's document, dated 1/8/19, titled Investigation Notice, indicated: .CNA 1 lifted Resident from her wheelchair (unassisted) into bed . and rolled the resident from side-side A joint interview was conducted with the DON and the Administrator (admin). The Admin stated, We think it (the fracture) happened during the transfer/turning . No policy was available

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.