

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555740	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 12/16/2024
NAME OF PROVIDER OR SUPPLIER Vista Real Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 1665 East Eighth Street Beaumont, CA 92223	

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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</p> <p>Based on observations, interviews, and record review, the facility failed to provide effective supervision for one of five sampled residents (Resident 2), who had history of exhibiting unprovoked aggressive behavior towards staff members and had history of altercation with another resident.</p> <p>This failure resulted in Resident 2 to be able to hit a resident (Resident 1) on the left side of her face with a plastic plate cover. Resident 1 sustained a black bruise and swelling above the corner of the left upper lip.</p> <p>Findings:</p> <p>On November 19, 2024, at 11:13 am., an unannounced visit to the facility was conducted to investigate a complaint and facility Reported Incident on an allegation of abuse.</p> <p>A review of Resident 2's Admission Record, indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and schizoaffective disorder (a mental health condition with symptoms of delusions [believing things that are not real], hallucinations [seeing things or hearing voices] and mood disorder [affects the emotional state]).</p> <p>A review of Resident 2's History and Physical, dated August 28, 2024, indicated he had fluctuating capacity to make decisions.</p> <p>On November 19, 2024, at 1:29 p.m., Resident 2 was observed sitting in the hallway adjacent to the nurse's station, sitting in his wheelchair.</p> <p>In a concurrent interview with Resident 2, he stated that he hit a lady (Resident 1) with a plate cover because the resident stabbed him with a pen. However, Resident 2 was unable to recall the date of the incident nor the name of the resident he allegedly hit.</p> <p>On November 19, 2024, at 2:02 p.m., observed Resident 1 in the Activity room, sitting in a wheelchair at a table sipping on coffee. Resident 1 had a purple to black bruise above the corner of her left upper lip.</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 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>A review of Resident 2's Progress Notes, dated October 12, 2024, at 1:40 p.m., indicated At around 12:15 p. m., this resident barged into room [ROOM NUMBER] and started arguing with a CNA . Resident argues that room [ROOM NUMBER] is his room and that he needs to be assisted back to his bed immediately. CNA redirected resident (sic) by stating that he has been moved to another room and that he will be assisted right away after she is done feeding 32 B. This agitated the resident instantly. Resident then started to scream profanity; grabbed a stainless steel (sic) fork from his pants and physically assaulted the CNA towards the left side of her abdomen. CNA sustained fork- related superficial abrasions to said area . Resident then wheeled himself towards the activity area and started making verbal threats to other facility staff who are trying to stop him from grabbing more forks from the dining tables. Incident happened past noon time where other residents are still eating. Close supervision provided to ensure everyone's safety.</p> <p>A review of Resident 2's Care Plan, dated October 21, 2024, indicated Focus . Psychosocial- Behavior: Exhibits or is at risk for behavioral symptoms (i.e., striking out, grabbing others, combative, verbally, or physically abusive) due to: Schizoaffective disorder, impulse disorder >Another Resident claims he hit her on the left side of her face and head .Interventions . Observe whether the behavior endangers the resident and/or others. (Intervene if necessary: removing others from the surrounding area) .</p> <p>A review of Resident 2's progress notes titled Nurse Practitioner Note, dated October 24, 2024, indicated, . (Resident 2) was involved in an incident with a female peer (Resident 3) . the patient (Resident 2) entered a female peer's room, causing her to yell and scream .The female peer initially accused the patient of hitting her but later recanted upon police arrival. However, she (Resident 3) maintained that the patient (Resident 2) had grabbed her and made threats .Assessment and Plan Aggressive Behavior and Safety Concerns . Patient's impulsive and aggressive behavior poses a risk to himself and others in the facility .Plan .Implement increased supervision and safety measures .Consider 1:1 observation if aggressive behaviors escalate . Follow-up and monitoring .instruct staff to maintain detailed logs and r report any significant changes or incidents immediately .the overall goal is to stabilize the patient's mental state, reduce aggressive behaviors, and ensure the safety of both the patient and others in the facility. Close monitoring and frequent reassessment will be crucial in managing this complex case .</p> <p>A review of Resident 2's progress notes titled, Behavior Note, dated October 28, 2024, indicated, .At 6:30 pm CNA (name) called me (RN Supervisor) .I immediately went to the room and found the resident (Resident 2) inside the bathroom .which is not his room. Resident was agitated, combative, and always cursing/yelling disturbing other residents inside the room .the resident insistently stayed inside the bathroom .The resident was holding a shaving cream bottle, he removed the cap, threw it at the CNA and when the CNA tried to get the cap he punched the CNA in the face .Resident won't listen to the any staff and he continued yelling inside .Reported to MD (physician) with no new order .Assigned another CNA and will do buddy system when providing care to the resident .</p> <p>A review of Resident 2's progress notes titled, Nurses Notes, indicated the following:</p> <p>- November 2, 2024, .At about 8 PM, resident became aggressive, yelling and trying to open the exit door in hallway 2. CN and other staffs redirected him unsuccessful, due to resident swung his arms to hit staffs. Resident stood up, exit door opened, the alarm sounded, resident startled and dropped him down back to w/c, at that time the door closed and somehow caused an abrasion (scrape against a rough surface) on his left knee and s/t (skin tear) on his left forearm .</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On November 19, 2024, at 2:47 p.m., an interview was conducted with a Licensed Vocational Nurse (LVN). The LVN stated she was assigned to Resident 2, and she stated Resident 2 had been more aggressive and the resident needed constant supervision. The LVN stated, Resident 2 was a danger to other residents during his episodes of aggressive behavior. The LVN stated that a one on one (1:1) supervision would require one staff member to be supervising one resident, and Resident 2 was not on 1:1 supervision.</p> <p>On November 19, 2024, at 3:11 p.m., an interview was conducted with a Registered Nurse (RN). The RN stated when Resident 2 had aggressive behavior, Resident 2 was a danger to other residents. The RN stated Resident 2 was previously accused of hitting a female resident (a resident different from Resident 1). The RN stated the resident should have been on close supervision.</p> <p>On November 19, 2024, at 4:49 p.m., an interview was conducted with CNA 3. CNA 3 stated, she was assigned to Resident 2 on November 16, 2024, and she was to supervise Resident 2 due to the resident's violent behavior. CNA 3 stated on November 16, 2024; she left Resident 2 in the dining room to provide care to another resident. CNA 3 stated Resident 2 was sitting in his wheelchair one table away from Resident 1. CNA 3 stated she returned to the activity room when she heard Resident 2 in his wheelchair, yelling, and holding a plastic cover, near a crying Resident 1. CNA 3 stated she did not feel safe caring for Resident 2, as his behavior had been becoming increasingly violent.</p> <p>On November 19, 2024, at 5:47 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated on November 16, 2024, the Activity Assistant (AA) was not within arm's length of Resident 2 and was unable to prevent Resident 2 from hitting Resident 1 with the plate cover.</p> <p>On November 27, 2024, at 12:38 p.m., a telephone interview was conducted with the AA. The AA stated on November 16, 2024, at approximately 3 p.m., he was in the dining room. However, he stated he left the dining area to return empty dinner trays, and as he came back to the dining area, he witnessed Resident 2 wheel himself over to Resident 1 and hit her in the face with a plastic plate cover. The AA stated he was not close enough to physically intervene, so he shouted at Resident 2 to stop.</p> <p>On December 9, 2024, at 3:46 p.m., a telephone interview was conducted with the DON. The DON stated that if the resident could not be re-directed, the staff should have notified the physician. The DON stated that supervision for Resident 2 should be for a staff to be close enough to intervene.</p> <p>A review of the facility policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, revised March 2019, indicated, .The interdisciplinary team will evaluate behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident, and develop a plan of care accordingly. Safety strategies will be implemented immediately if necessary to protect the resident and other from harm .Atypical behavior will be differentiated from behavior that is dangerous or problematic for the resident(s) or staff, or behavior that signals underlying distress .Interventions and approached will be based on a detailed assessment of physical, psychological, and behavioral symptoms and their underlying causes .</p>		