

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  12/23/2024
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)
F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47202</b></p> <p>Based on interview and record review the facility failed to provide an environment free of physical abuse for one of five residents (Resident 2) when staff did not intervene and redirect Resident 2 away from Resident 3, who had previously alleged that Resident 2 had taken his belongings.</p> <p>This failure resulted in Resident 3 punching Resident 2 on the right side of the face, causing Resident 2 to fall and sustain a laceration (broken skin) and swelling on the right side of the face.</p> <p>Findings:</p> <p>On December 23, 2024, Resident 2's admission record was reviewed. Resident 2 was admitted to the facility on [DATE] with diagnoses which included dementia (memory loss).</p> <p>A review of Resident 2's Minimum data Set (an assessment tool), dated September 24, 2024, indicated a Brief Interview for Mental Status (used to identify the cognitive condition of a resident) score of 12 (moderate cognitive impairment).</p> <p>A review of Resident 2's IDT (Interdisciplinary Team) Note, dated December 18, 2024, indicated, .At 6:15am resident (Resident 3) was accusing this resident (Resident 2) of taking some of his belongings .At 10:55am other resident (Resident 3) swung his right hand towards this resident (Resident 2) and hit him in the face .</p> <p>A review of Resident 2's Progress Notes, dated December 18, 2024, indicated:</p> <ul style="list-style-type: none"> <li>- .At around 10:55am at the hallway in front of the dining room, (Resident 3) was with activity director . (Resident 2) was walking towards the dining room .(Resident 3) just suddenly swung his right hand towards (Resident 2) .(Resident 2) was hit on the right side of his face and sustained a small cut and swelling.</li> <li>- .Addendum to the incident: resident loss balance and fell on the floor when he was hit by (Resident 3) .</li> </ul> <p>On December 23, 2024, Resident 3's admission record was reviewed. Resident 3 was admitted to facility on November 11, 2024 with diagnoses which included schizophrenia (a severe mental disorder affecting a person's emotions and perception of reality).</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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F 0600  Level of Harm - Actual harm  Residents Affected - Few	<p>A review of Resident 3's History and Physical, dated November 17, 2024, indicated Resident 3 has the capacity to understand and make decisions.</p> <p>A review of Resident 3's eINTERACT Change of Condition Form, indicated the following:</p> <ul style="list-style-type: none"> <li>- On December 18, 2024, indicated, .At 0615H (6:15 a.m.), (Resident 3) approached (Resident 2) who was sitting on the chair across nursing station .(Resident 3) asked (Resident 2) about his missing item/thing .with angry voice .(Resident 2) ignored him and went towards his room .(Resident 3) get upset and punched the wall along the nurse station .</li> <li>- On December 18, 2024 at 10:55 a.m., indicated, .Physical aggression towards another resident (Resident 2) .</li> </ul> <p>A review of Resident 3's Progress Notes, dated December 18, 2024, indicated, .At around 10:55am at the hallway in front of the dining room, (Resident 3) was with activity director .(Resident 2) was walking towards the dining room .(Resident 3) suddenly swung his right hand towards (Resident 2) .(Resident 2) was hit on the right side of his face .</p> <p>A review of Resident 3's Care Plan, dated December 18, 2024, indicated, .Focus: Accused other resident of taking belongings and punched the wall .Interventions: Observe whether the behavior endangers .other resident .Intervene if necessary .removing others from the surrounding area.</p> <p>On December 23, 2024 at 10:12 a.m., during a concurrent interview and review of the progress notes for Residents' 2 and 3 with Registered Nurse (RN) 1, she stated on December 18, 2024, at 6:15 a.m., Resident 3 was agitated and accused Resident 2 of taking his belongings. RN 1 further stated Resident 3 became upset and punched a wall. RN 1 stated at 10:55 a.m. on December 18, 2024, (four hours after the allegation), Resident 3 was in the hallway in front of the dining room with the Activity Director (AD) when Resident 2 walked down the hallway toward them. RN 1 further stated when Resident 3 saw Resident 2, he swung his hand and hit Resident 2 on the right side of the face, causing a laceration. RN 1 stated activity and nursing staff were aware Residents 2 and 3 had an interaction at 6:15 a.m., and were instructed to keep the two residents apart at all times to prevent an altercation. RN 1 further stated staff should have redirected Resident 2 away from Resident 3 to avoid any interaction which could have prevented the incident.</p> <p>On December 23, 2024 at 10:55 a.m., during an interview with Resident 2, he stated on the morning of December 18, 2024, Resident 3 accused him of taking his belongings and became upset. Resident 2 further stated later that morning, at around 10 a.m., he was walking down the hallway in front of the dining room when Resident 3 suddenly punched him on the right side of the face, causing a laceration.</p> <p>On December 23, 2024 at 11:12 a.m., during an interview with the AD, she stated she was aware Residents 2 and 3 had an interaction on December 18, 2024 at 6:15 a.m., during which Resident 3 was agitated, accused Resident 2 of taking his belongings, and punched a wall. The AD further stated on December 18, 2024, at 10:55 a.m., she was with Resident 3 at the hallway outside the dining room when she saw Resident 2 walking down the hallway towards them. The AD stated she redirected Resident 3, but the resident refused. The AD further stated no facility staff redirected Resident 2 away from the hallway where Resident 3 was located. The AD stated when Resident 3 saw Resident 2, Resident 3 stood up and punched Resident 2 on the right side of the face, causing a laceration.</p> <p>(continued on next page)</p>		

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<p>F 0600</p> <p>Level of Harm - Actual harm</p> <p>Residents Affected - Few</p>	<p>On December 23, 2024 at 11:30 a.m., during an interview with the Director of Nursing (DON), she stated Residents 2 and 3 had an interaction on December 18, 2024 at 6:15 a.m., and activity and nursing staff were aware that both residents should be kept apart to prevent an altercation. The DON further stated Residents 2 and 3 had an altercation at 10:55 a.m. on December 18, 2024, in the hallway in front of the dining room, where Resident 3 punched Resident 2 on the right side of the face causing a laceration. The DON stated the altercation was preventable and the facility staff should have intervened, redirected, and removed Resident 2 from the hallway where Resident 3 was located, preventing the residents from seeing each other and avoiding the altercation.</p> <p>A review of the facility policy and procedure titled, Abuse, Neglect, Exploitation and Misappropriation Prevention Program, dated April 2021, indicated, .Residents have the right to be free from abuse .This includes but is not limited to freedom from .Physical abuse .by anyone including .Other residents .</p> <p>A review of the facility policy and procedure titled, Resident-to-Resident Abuse, undated, indicated, .If a resident-to-resident incident occurs, staff should immediately intervene .Separate the residents and take them to areas away from each other until the situation subsided .</p>		