

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 03/21/2025
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 - Minimal harm or potential for 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** 47202</p> <p>Based on interview and record review, the facility failed to ensure that one of four sampled residents (Resident 2) received continuous supervision and assistance, when the staff assigned to monitor Resident 2 left the resident unattended while he was sitting in a chair and had fallen asleep.</p> <p>This failure had the potential to result in harm to Resident 2, including injury from an unassisted fall.</p> <p>Findings:</p> <p>A review of Resident 2's Admission Record, indicated Resident 2 was admitted to the facility on [DATE], with diagnoses which included muscle wasting and atrophy (a disease that causes loss and weakening of muscles).</p> <p>A review of Resident 2's Minimum Data Set (an assessment tool), dated January 26, 2025, indicated Resident 2 had a Brief Interview for Mental Status (tool used to assess a resident's cognitive function) score of 6 (severe cognitive impairment).</p> <p>A review of Resident 2's Nurse's Notes, dated February 7, 2025, at 5:42 p.m., indicated, (Certified Nurse Assistant [CNA] 4's name) assigned 1 on 1 to resident .Resident was found on the floor .Per (CNA 4) she went to grab resident dinner from the food cart in the hallways .upon arriving to resident room she found resident .in the floor .Resident stated that he fell asleep sitting on the chair in his room and fell .Resident sustained a 3 cm (centimeter - unit of measurement) cut and bump to left forehead .complained of .pain on the stated site .Send to ER (emergency room) for further eval (evaluation) and treatment .</p> <p>On March 18, 2025, at 3:46 p.m., during an interview with the Director of Nursing (DON), she stated residents on one-on-one monitoring require the assigned staff to continuously monitor them to ensure their safety. The DON further stated Resident 2 was on one-on-one monitoring due to elopement behavior and had a fall on February 7, 2025, at 5:42 p.m., sustaining a 3 cm laceration and bump on the left forehead.</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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(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 - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The DON stated Resident 2 was sitting on a chair inside his room when CNA 4 stepped out to grab Resident 2's dinner from the food cart located in the hallway in front of Resident 2's door. The DON further stated when CNA 4 returned to the room, she found Resident 2 on the floor. The DON stated Resident 2 had fallen asleep, slid out of the chair, and fell .</p> <p>The DON stated CNA 4 should not have left Resident 2 unattended and could have intervened immediately to prevent Resident 2 from sliding out of the chair, which could have prevented the fall and injury. The DON further stated the fall was preventable.</p> <p>On March 18, 2025, at 4:12 p.m., during an interview with License Vocational Nurse (LVN) 1, she stated she assessed Resident 2 after his fall on February 7, 2025, at around 5 p.m. LVN 1 further stated CNA 4 informed her that while Resident 2 was sitting in his chair, she (CNA 4) stepped out of the room to grab his dinner tray from the food cart in the hallway. LVN 1 stated, when CNA 4 returned to the room, Resident 2 was on the floor. LVN 1 stated Resident 2 had fallen asleep while sitting in his chair in his room, slid sideways and fell to the floor, causing a laceration and bump to his left forehead.</p> <p>LVN 1 stated Resident 2 was placed on one-on-one monitoring, where the assigned staff needed to stay close and maintain a constant visual on the resident for safety. LVN 1 further stated CNA 4 should not have left Resident 2 unattended in his chair and could have intervened sooner which might have prevented the fall and injury.</p> <p>On March 20, 2025, at 10:11 a.m., during an interview with CNA 4, she stated residents on one-on-one monitoring were to be continuously observed, and the assigned staff had to stay close and within arms reach of the resident to intervene if needed for safety. CNA 4 stated, she was assigned to provide one-on-one monitoring for Resident 2 on February 7, 2025, around 5 p.m., when Resident 2 fell and sustained laceration on his left forehead</p> <p>CNA 4 stated she and Resident 2 were sitting inside his room watching TV when she heard the food cart rolling in the hallway. CNA 4 further stated she left Resident 2 to grab his dinner tray from the hallway, and when she returned to the room, she found Resident 2 on the floor. CNA 4 stated she should not have left Resident 2 unattended in the chair, and further stated if she had stayed close by and not left, she could have intervened right away and prevented Resident 2 from falling.</p> <p>A review of the facility document titled, Responsibilities of a Sitter, undated, indicated, .Patients at high risk for falls, confusion, impaired mobility, or other safety concerns may require a 1:1 sitter .The sitter will provide continuous bedside observation .maintain patient safety .to prevent falls or injuries .</p> <p>A review of the facility policy and procedure titled, Safety and Supervision of Residents, dated July 2017, indicated, .Our facility strives to make the environment as free from accident hazards as possible .Resident safety and supervision and assistance to prevent accidents are facility-wide priorities .Our individualized, resident-centered approach to safety addresses safety .for individual residents .The care team shall target interventions to reduce individual risk .including adequate supervision .Ensuring the interventions are implemented correctly and constantly .</p>		