

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 07/11/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50017</p> <p>Based on interview, and record review, the facility failed for two of six residents reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) (Residents 4 and 5) to:</p> <ol style="list-style-type: none"> 1. Ensure a copy of the Advance Directive (AD - written statement of a person's wishes regarding medical treatment) was available in the resident's record; and 2. Verify if the resident did have an advance directive or if the resident representative was provided information regarding formulation of the advance directive. <p>These failures had the potential for Residents 4 and 5's AD to not be readily retrievable by the staff and the physician, making them unaware of, and unable to honor the residents wishes regarding their medical treatment.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On July 8, 2024, at 3:50 p.m., Resident 5's record was reviewed. Resident 5 was admitted to the facility on [DATE]. <p>A review of Resident 5's History and Physical dated December 29, 2023, indicated Resident 5 does not have the capacity to understand and make decisions.</p> <p>A review of Resident 5's Minimum Data Set (an assessment tool), dated February 29, 2024, indicated Resident 5 had Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 4 (severe cognitive impairment).</p> <p>A review of Resident 5's Advance Directive Acknowledgement Form, dated December 9, 2022, indicated Resident 5 had executed an Advance Directive.</p> <p>There was no documented evidence a copy of the AD was provided in Residents 5's medical record.</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 555740	If continuation sheet Page 1 of 25

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 07/11/2024
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 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 10, 2024, at 2:17 p.m., during a concurrent interview and review of Resident 5's medical record with the Social Service Director (SSD), the SSD stated if the resident has an AD, a copy of the AD is obtained and placed in the resident's record. The SSD stated Resident 5 had an AD but was not available in the resident's record. The SSD further stated Resident 5's AD should have been available and accessible to the staff and physician.</p> <p>44270</p> <p>2. On July 9, 2024, at 12:03 p.m. Resident 4's record was reviewed. Resident 4 was admitted to the facility on [DATE].</p> <p>A review of Resident 15's History and Physical dated December 29, 2023, indicated, .does not have the capacity to understand and make decisions .</p> <p>A review of Resident 4's MDS dated [DATE], indicated Resident 4 had a BIMS Score of 3 (severe impairment in cognition).</p> <p>A review of Resident 4's Advance Directive Acknowledgement Form, dated December 16, 2022, indicated, .I have executed an Advance Directive .</p> <p>A review of Resident 4's Physician Orders for Life-Sustaining Treatment (POLST), dated December 16, 2022, indicated, .Advance Directive not available.</p> <p>A review of Resident 4's Social History Review, dated June 11, 2024, indicated, .Advance Directive . daughter is the responsible party.</p> <p>There was no documented evidence a copy of Residents 4's AD had been provided in medical record, or that Resident 4 and/or resident representative (RR) were given information about formulation of the AD.</p> <p>On July 10, 2024, at 2:27 p.m., during a concurrent interview and review of Resident 4's record with the SSD, the SSD stated it is her responsibility to ensure residents have an AD. The SSD stated, if the resident has an AD, a copy should be obtained and placed in the resident's record. The SSD further stated, the AD should be available and accessible to the staff and physician. The SSD stated Resident 4's AD was not in her medical record and it was unclear whether Resident 4 had an AD. The SSD stated during a quarterly meeting on May 30, 2024, with Resident 4's RR, Resident 4's representative was unclear if Resident 4 had an AD. The SSD stated the representative should be offered assistance with the AD during the quarterly review. She stated she did not offer it during the last SSD assessment and that it should have been offered.</p> <p>During a review of the facility Policy and Procedure titled, Advance Directives, dated December 2016, indicated, .Prior to or upon admission of a resident, the Social Service Director or designee will inquire of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .Information about .an advance directive shall be displayed prominently in the medical record .</p>		

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 07/11/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44270</p> <p>Based on interview and record review, the facility failed to notify the resident representatives (RP) and Office of the State Long-Term Care Ombudsman (LTC Ombudsman) of a transfer for one of three residents (Resident 57) reviewed for closed records.</p> <p>This failure had the potential to result in the RP and LTC Ombudsman not to be informed about Resident 57's plan of care and condition.</p> <p>Findings:</p> <p>On July 10, 2024, at 12:00 p.m., Resident 57's record was reviewed. Resident 57 was admitted to the facility on [DATE], with a diagnosis which included anxiety disorder (excessive worry and feelings of fear, dread, and uneasiness).</p> <p>A review of the document titled, Physicians Discharge Summary, dated April 16, 2024, indicated, .Sent to Hospital from Appointment .</p> <p>There was no documented evidence that the facility mailed or faxed a letter of transfer/discharge notice to Resident 57's RP and to the LTC Ombudsman.</p> <p>On July 10, 2024, at 2:04 p.m., a concurrent interview and record review was conducted with the Director of Medical Records (DMR). The DMR stated, residents who discharged from the facility should be sent a letter to indicate a discharge was initiated and that the Ombudsman should be notified in writing. The DMR stated there was no documentation that indicated a letter was sent to the resident RP and to the LTC Ombudsman to indicate a discharge/transfer from the facility.</p> <p>On July 11, 2024, at 8:19 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the process for transfer/discharge is the nurse in charge will process and send a letter of notification to the RP and Ombudsman. The DON stated Resident 57 was transferred to the hospital from a scheduled clinic appointment and did not return. The DON further stated there was no letter of notification sent and one should have been sent to Resident 57's RP and to the LTC Ombudsman after Resident 57 was discharged from the facility.</p> <p>On July 11, 2024 at 2:36 p.m. a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN 1). LVN 1 stated Resident 57 was sent to the Veterans Administration (VA) clinic on April 16, 2024 and was transferred to the hospital from the clinic. LVN 1 stated there was no letter of notification sent to Resident 57's RP and to the Ombudsman. LVN 1 further stated a letter of notification should have been sent.</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A review of the facility policy and procedure titled, Transfer or Discharge, dated October 2022, indicated, . Facility transfers and discharges, when necessary, must meet specific criteria and require resident/representatives notification and orientation, and documentation as specified in this policy .Notice to Transfer is provided to the resident and representative as soon as practicable before the transfer and to the long-term care (LTC) ombudsman when practicable (e.g., in a monthly list of residents that includes all notice content requirements) .The facility will send a copy of the discharge notice to a representative of the Office of the State LTC Ombudsman .</p>		

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 07/11/2024
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 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50304</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician recommendation for wound treatment was transcribed to an actual physician order for one of two residents (Resident 23) reviewed.</p> <p>This failure resulted in a gap in the communication regarding the physician's recommendation which affected the implementation of the recommended care or treatment.</p> <p>Findings:</p> <p>On July 11, 2024, Resident 23's record was reviewed. Resident 23 was admitted to the facility on [DATE], with diagnoses that included wheelchair dependent and severe debility (state of being weak).</p> <p>A review of the facility document titled, COC (Change of Condition) Progress Notes, dated June 4, 2024, indicated, . resident has skin tear on the right hand .Primary Provider Feedback: Primary Care Provider responded with the following feedback. A.Recommendations: Cleanse area with NS (normal saline - a sterile solution of salt in water); pat dry; apply Triple Antibiotic (a topical medication that inhibits the growth of bacteria on the skin) .</p> <p>Further review of Resident 23's Physician Order, for the month of June 2024 and July 2024, indicated, the physician's recommendation was not transcribed to an actual physician order for Resident 23.</p> <p>On July 11, 2024, at 1:02 p.m., a concurrent interview and record review of Resident 23's COC was conducted with the Infection Preventionist. The IP stated the physician recommendation during the resident's change of condition was not transcribed to an actual physician order. The IP stated there was no order from the physician to cleanse the area with NS, pat dry, and apply triple antibiotic. The IP stated the physician recommendation was not recorded in the treatment administration record and was not followed.</p> <p>On July 11, 2024, at 2:15 pm., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated physician's recommendation in the COC was not followed. The DON further stated the physician's recommendation should have been followed to prevent wound infection.</p> <p>The facility policy and procedure titled, Physician Orders, dated July 2016, indicated, .Verbal orders must be recorded immediately in the resident's chart by the person receiving the order and must include prescriber's last name, credentials, the date and the time of the order .</p> <p>The facility policy and procedure titled, Physician Orders, Accepting, Transcribing and Implementing (noting) . undated, indicated, .Licensed nursing personnel will ensure that written (noting), telephone, and verbal orders will be recorded and implemented .Telephone and Verbal orders .Record the actual order received from the physician .</p>		

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 07/11/2024
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 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>50204</p> <p>Based on observation, interview, and record review, the facility failed to provide nail care for one of six sampled residents (Resident 42).</p> <p>This failure had the potential to cause skin breakdown and infection for Resident 42.</p> <p>Findings:</p> <p>On July 8, 2024, at 9:49 a.m., a concurrent observation and interview was conducted with Resident 42 inside the room. Resident 42 was observed with long, untrimmed fingernails on both hands with black colored residue. Resident 42 stated my nails are dirty and needs to be trimmed</p> <p>On July 8, 2024, at 9:55 a.m., a concurrent observation and interview were conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated Resident 42 had long fingernails with black dirt under them. CNA 1 stated during daily body check, the resident's fingernails were checked, and when the fingernails were long, the CNA should have trimmed them. CNA 1 stated, Resident 42's fingernails should have been trimmed.</p> <p>On July 8, 2024 at 9:59 a.m., an interview was conducted with Registered Nurse (RN) 1. She stated Resident 42 had long fingernails, and if he scratched his skin, it could cause skin breakdown and infection.</p> <p>On July 8, 2024 at 10:00 a.m., an interview was conducted with the IP. The IP stated Resident 42's fingernails were long and untrimmed, with black dirt at the tip of each fingernail. The IP stated Resident 42's fingernails should be trimmed and cleaned by the CNA or the Nurse in charge. The IP further stated if Resident 42 scratched his skin, it could lead to skin breakdown and potential infection.</p> <p>The facility policy and procedure titled, Fingernails/Toenails, Care of, dated February 2018, indicated, .Nail care includes daily cleaning and regular trimming .Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin .</p>		

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 07/11/2024
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 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50017</p> <p>Based on observation, interview, and record review, the facility failed to follow the physician order for respiratory care and treatment for one of one resident reviewed for oxygen administration (Resident 56).</p> <p>This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and a decline in Resident 56's health condition.</p> <p>Findings:</p> <p>On July 8, 2024, Resident 56's record was reviewed. Resident 56 was admitted to the facility on [DATE] with diagnoses which included chronic obstructive pulmonary disease (COPD - lung disease that makes it difficult to breathe).</p> <p>A review of Resident 56's History and Physical dated June 26, 2024, indicated Resident 56 has the capacity to understand and make decisions.</p> <p>A review of Resident 56's Order Summary, dated June 24, 2024, indicated, .Titrate O2 (sic) (oxygen) between 1 LPM - 3 LPM (liters per minute) to keep saturation greater than or equal to 90% every shift for COPD via Nasal Cannula (a tube used to deliver oxygen through the nose) .</p> <p>On July 8, 2024, at 9:51 a.m., during a concurrent observation in Resident 56's room, interview, and review of resident's physician order with Licensed Vocational Nurse (LVN) 3, Resident 56 was observed in bed with oxygen via nasal cannula. Resident 56's oxygen administration was observed at four LPM. LVN 3 stated Resident 56 had a physician order for oxygen between one to three LPM for COPD. LVN 3 stated Resident 56's oxygen was at four LPM. LVN 3 further stated Resident 56 should not have received oxygen greater than three LPM due to resident's COPD, and it could lead to resident not being able to breath on her own. LVN 3 stated she did not follow the physician order.</p> <p>On July 11, 2024, at 8:39 a.m., during an interview with the Director of Nursing (DON), she stated a physician order should be in place prior to administration of oxygen. The DON further stated nursing staff should follow the physician order for oxygen therapy.</p> <p>During a review of the facility policy and procedure titled, Oxygen Administration, dated October 2010, .The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure .Review the physician's orders or facility protocol for oxygen administration .</p>		

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 07/11/2024
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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide routine and 24-hour emergency dental care for each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50204</p> <p>Based on observation, interview, and record review, the facility failed to provide dental referral and dental care services for one of one resident reviewed for dental (Resident 55).</p> <p>This failure had the potential to negatively effect the resident's physical and psychosocial well-being.</p> <p>Findings:</p> <p>On July 8, 2024 at 9:55 a.m., a concurrent observation and interview were conducted with Resident 55 in his room. Resident 55 was observed to have missing upper and lower teeth. Resident 55 stated he needed dentures and he had not seen a dentist since he came to the facility. Resident 55 further stated, he was embarassed talking to others and he could not smile because he did not have teeth. Resident 55 stated he told a licensed nurse about his dental issues but was not being helped.</p> <p>On July 9, 2024, at 3:10 p.m., a concurrent interview and record review were conducted with Registered Nurse (RN) 1. RN 1 stated if dental issues were identified upon admission, the licensed nurse would notify the physician and social services for a dental service referral. RN 1 further stated if dental services were not provided for Resident 55, there would be a potential for weight loss due to inability to chew, and he could have a decrease in self- confidence and feel embarrassed.</p> <p>On July 9, 2024, Resident 55's record was reviewed. Resident 55 was admitted to the facility on [DATE] with diagnoses which included anxiety (feelings of fear, dread, and uneasiness).</p> <p>A review of Resident 55's Physician's Order titled, Order Summary, dated June 23, 2024, indicated, .Dental Consult .</p> <p>A review of Resident 55's Social History Assessment, dated June 23, 2024 indicated, .Dental: No dentures/will be refer as needed .</p> <p>A review of Resident 55's Admission/Readmission Evaluation/Assessment, dated June 23,2024, indicated, . Head/Eyes/Ears/Oral .Resident does not have any teeth and does not have dentures .</p> <p>A review of Resident 55's Minimum Data Set (MDS - an assessment tool) with an assessment reference date of June 25, 2024, indicated, Resident 55 did not have natural teeth or dentures.</p> <p>On July 9, 2024 at 3:35 p.m., an interview was conducted with the Social Service Director (SSD). The SSD stated Resident 55 was identified upon admission as not having teeth. The SSD stated Resident 55 should have been referred to dental services.</p> <p>On July 10, 2024 at 3:45 p.m., an interview was conducted with DON. The DON stated Resident 55 should have been referred to social services for a dental referral.</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0790</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility policy and procedure titled, .Availability of services, Dental . dated 2007, indicated, .Social service will be responsible for making necessary dental appointments .dental services should be directed to Social Services to assure that appointments can be made in timely manner .</p>		

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 07/11/2024
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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.</p> <p>44504</p> <p>Based on observation, interview, and record review the facility failed to ensure Dietary staff were able to carry out the functions of food and nutrition services safely and effectively when:</p> <p>1. The [NAME] used a slotted spoon to scoop out meatloaf without measuring the portion when preparing pureed meat during the lunch service on July 8, 2024. (Cross referred F 803)</p> <p>This failure had the potential for four out of four residents who received pureed meat prepared in the kitchen to not meet their nutritional needs, which could lead to nutrition-related health complications.</p> <p>2. Diet Aide 2 served ice cream instead of diet cookies to Resident 7, who had a physician-ordered renal controlled carbohydrate during the lunch service on July 8, 2024. (Cross referred F 808)</p> <p>This failure had the potential for Resident 7, to receive a dessert prepared in the kitchen that did not meet their nutritional needs which may lead to nutrition-related health complications.</p> <p>Findings:</p> <p>On July 8, 2024, at 9:54 a.m., a concurrent observation and interview were conducted with [NAME] 1 (CK) in the kitchen. CK 1 was observed preparing pureed meat. CK 1 was observed preparing pureed meat and using a slotted spoon to scoop the meat loaf portion instead of using a measuring cup. CK 1 did not refer to the pureed meat recipe.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated Cooks should follow recipes and use a measuring spoon for serving portions when preparing meals. The RD explained that not measuring the meatloaf portion would affect the nutritonal values of the prepared pureed meat.</p> <p>A review of the facility recipe titled, PUREED MEATS, undated, indicated, DIRECTIONS: 1 Measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) needed for puree diets .</p> <p>A review of the facility Policy and Procedure titled, MENU PLANNING, dated 2015, indicated, . PROCEDURES: .4 .Standardized recipes .shall be .used in food preparation .</p> <p>A review of the facility Job Description, titled Cook, dated 2023, indicated, .Duties and Responsibilities: 1. Responsible for the preparation of food ., 2. Attend menu conferences .to meet serving needs of the residents.</p> <p>2. On July 8, 2024, at 11:30 a.m., an observation of the lunch meal plating service was conducted with Diet Aide 2 (DA) in front of the trayline (a system of food preparation in which trays move along an assembly line). DA 2 was observed serving ice cream on the meal tray for Resident 7 instead of diet cookies.</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0802</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility document titled, Cooks spreadsheet (the menu document used to guide dietary staff on food items, portions, texture of foods and therapeutic diet), dated July 8, 2024, indicated, .Diet Cookies was to be served to Renal Controlled Carbohydrate diet (CCHO) [a meal plan for Renal Diabetic residents] .</p> <p>On July 8, 2024, at 12:15 p.m., a concurrent interview and record review was conducted with the Dietary Supervisor (DS) in the dining room. A review of Resident 7's Meal tray ticket (menu based on the resident's diet physician order), indicated Renal CCHO. Resident 7 was served ice cream. The DS reviewed the Cooks spreadsheet and stated Resident 7 should have received diet cookies instead of ice cream.</p> <p>A review of Resident 7's physician diet ordered, dated July 8, 2024, indicated, .Dietary - Diet .CCHO, Renal diet (a meal plan for kidney failure residents) .Dietary to give .120 milliliter (ml- a unit of measurement) at lunch .</p> <p>On July 9, 2024, at 2:06 p.m., a concurrent interview and record review were conducted with the Registered Dietitian (RD). The RD stated according to the Cooks spreadsheet, Resident 7 should have received diet cookies instead of ice cream. The RD stated Resident 7's physician-ordered diet indicated Resident 7 fluid intake provided should be 120 ml equivalent to 4 oz during lunch meal. The RD stated if Dietary Aide 2 served 4 oz of ice cream to Resident 7, Resident 7 would receive an extra 120 ml fluid from the ice cream. The RD stated if Resident 7 consumed the extra fluid, there was a potential risk for fluid overload. The RD further stated residents with renal failure should limit their intake of dairy products (including ice cream) due to high levels of phosphorus (natural mineral find in dairy products) and potassium (natural mineral) found in these products. The RD stated serving ice cream to a renal failure resident like Resident 7 could negatively affect their electrolyte levels and overall health.</p> <p>A review of the facility provided document, titled VERIFICATION OF JOB COMPETENCY DEMONSTRATION -DIETARY AIDE, dated 2024, the job competency indicated, Name: Diet Aide 2, . Competency Demonstrated knowledge of : .Diet Manual, .by Demonstrate or verbal had a check mark (mean competent), verified by the DS . But from the observation showed the Diet Aide 2 was not competent to follow the Cooks spreadsheet (the menu document used to guide dietary staff on food items and therapeutic diet).</p>		

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 07/11/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.</p> <p>44504</p> <p>Based on observation, interview, and record review, the facility failed to ensure the menus were followed and resident nutritional needs were met when:</p> <p>1. The [NAME] did not follow puree recipes when preparing pureed diet during the lunch service on July 8, 2024; (Cross referred F 802)</p> <p>This failure had the potential for 4 out of 4 residents who had physician ordered pureed diets, as the pureed food prepared in the kitchen did not meet their nutritional needs which may lead to nutrition-related health complications.</p> <p>2. The [NAME] served biscuit instead of wheat roll for Carbohydrate Control diet Residents during the lunch service on July 8, 2024;</p> <p>This failure had the potential for 12 out of 12 residents who had physician-ordered Carbohydrate Control diets, as the food prepared in the kitchen did not meet their nutritional needs which may lead to nutrition-related health complications.</p> <p>3. The [NAME] was not supposed to serve biscuits to Mechanical Soft diet residents during the lunch service on July 8, 2024.</p> <p>This failure had the potential for 14 out of 14 residents who had physician-ordered Mechanical Soft diets, as the food prepared in the kitchen did not meet their nutritional needs which may lead to chewing and swallowing difficulties.</p> <p>Findings:</p> <p>1. On July 8, 2024, at 9:54 a.m., a concurrent observation and interview were conducted with [NAME] 1 (CK) in the kitchen. The CK 1 was observed preparing pureed meat. CK 1 used a slotted spoon to scoop out three servings of meatloaf without measuring the portion and then put the meatloaf into the blender. CK 1 stated he added 2 cups of beef broth into the blender with meatloaf and blended them together. After blending, the pureed meatloaf became watery. CK 1 stated to achieve a pudding-like consistency, he needed to add 1/2 cup of thickener. During the entire process of preparing pureed meat, CK 1 did not refer to the pureed meat recipe.</p> <p>On July 8, 2024, at 10:05 a.m., a concurrent observation and interview were conducted with CK 1 in the kitchen. CK 1 was observed preparing pureed biscuits. CK 1 stated he put 3 pieces of biscuits, 2 cups of chicken broth, and 1/2 cup thickener into the blender. Then CK 1 blended the biscuit, chicken broth and thickener together to make pureed biscuits. During the entire process of preparing the pureed biscuits, CK 1 did not refer to the pureed biscuit recipe.</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 8, 2024, at 10:17 a.m., a concurrent observation and interview were conducted with CK 1 in the kitchen. CK 1 was observed preparing pureed vegetables. CK 1 used a 1/2 cup scoop to place 3 servings of vegetables into the blender. He then added 2 cups of chicken broth and 1/2 cup thickener into the blender with the vegetables. Afterwards CK 1 blended the vegetables, chicken broth, and thickener together to make pureed vegetables. During the entire process of preparing pureed vegetable, CK 1 did not refer to the pureed vegetable recipe.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated Cooks should follow recipes when preparing meals, as deviating from the recipe could affect the nutritional value of the meals. The RD stated since CK 1 did not follow recipe by adding extra fluid and thickener, the volume of the pureed foods was increased, but the concentration of nutrients per serving was diluted. The RD further stated residents on pureed diets who received this diluted concentration of pureed foods would not receive the correct amount of calories and protein which could result in weight loss.</p> <p>A review of Resident 11, 33, 40, and 50 's physician diet order, dated July 9, 2024, indicated, .Resident 11, 33, 40, and 50 were on .pureed diet .</p> <p>A review of the facility recipe titled, PUREED MEATS, undated, indicated, DIRECTIONS: 1 .Measure out the total number of portions (based on the portion size indicated on the cook's spreadsheet) needed for puree diets. 2. Puree on low speed to a paste consistency before adding any liquid. 3. Gradually add warm liquid (low sodium broth or gravy) .starting with the smaller amount and adding in more as needed to achieve the desired consistency .5. Add stabilizer (food thickener) to increase the density of the pureed food if needed .</p> <p>A review of the facility recipe titled, PUREED BREAD PRODUCTS, undated, indicated, DIRECTIONS: .2. Puree on low speed adding milk gradually .starting with the smaller amount and adding in more as needed to achieve the desired consistency .4. Add stabilizer to increase the density of the pureed food if needed .</p> <p>A review of the facility recipe titled, PUREED VEGETABLES, undated, indicated, DIRECTIONS: .2 .Puree on low speed to a paste consistency before adding any liquid. 3. Gradually add warm liquid (low sodium broth or milk) if needed .starting with the smaller amount and adding in more as needed to achieve the desired consistency . 4. Puree on low speed, adding stabilizer where needed .</p> <p>A review of the facility Policy and Procedure titled, MENU PLANNING, dated 2023, indicated, . PROCEDURES: .4 .Standardized recipes .shall be .used in food preparation .</p> <p>2. On July 8, 2024, at 11:15 a.m., an observation of the lunch meal plating service was conducted with the CK 1 at the Trayline (a system of food preparation in which trays move along an assembly line). There was no wheat roll available in Trayline. The CK 1 was observed serve biscuit to all residents including Controlled Carbohydrate diet [(CCHO) a meal plan for diabetic residents] residents.</p> <p>A review of the facility document titled, Cooks spreadsheet (the menu document used to guide dietary staff on food items, portions, texture of foods and therapeutic diet), dated July 8, 2024, indicated, .Wheat roll was to be served to CCHO diet .</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 8, 2024, at 12:10 p.m., an interview was conducted with CK 1. CK 1 stated he only prepared and served biscuits to all residents.</p> <p>On July 9, 2024, at 2:06 p.m., a concurrent interview and Cooks July 8, 2024 spreadsheet review was conducted with the Registered Dietitian (RD). The RD stated according to Cooks spreadsheet, residents on CCHO diet should receive a wheat roll instead of a biscuit. The RD stated the plan menu for the CCHO diet as indicated on the Cooks' spreadsheet is to serve wheat roll to evenly distribute carbohydrates throughout the meals which helps control blood sugar levels for diabetic residents. The RD stated cooks should follow the Cooks spreadsheet.</p> <p>A review of Resident 2, 7, 12, 13, 33, 34, 40, 42, 43, 45, 49, and 110 's physician diet order, dated July 9, 2024, the physician diet order indicated, .CCHO diet .</p> <p>A review of the facility document titled, Diet Menu - Controlled Carbohydrate Diet, dated 2023, indicated, A controlled carbohydrate diet, is a meal plan .used for diabetic residents and those with other metabolic concerns . Instead of counting calories, the carbohydrate are evenly, systematically, and consistently distributing through three meals and evening snack in an effort to maintain a stable blood sugar level throughout the day .</p> <p>A review of the facility Policy and Procedure titled, Menu Planning, dated 2023, indicated, .Policy: .The menu are planned to meet nutritional needs of residents in accordance with .Physician's orders and, to extent medically possible .</p> <p>A review of the facility Policy and Procedure titled, Menu Service, dated 2023, indicated, .Policy: Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner .</p> <p>3. On July 8, 2024, at 11:15 a.m., an observation of the lunch meal plating service was conducted with CK 1 at the Trayline. CK 1 served biscuits to all residents including residents on Mechanical soft diets.</p> <p>A review of the facility document titled Cooks spreadsheet, dated 7/8/24, indicated, .Mechanical soft diet residents not supposed served biscuit .</p> <p>On July 8, 2024, at 12:10 p.m., an interview was conducted with CK 1. CK 1 stated he had only prepared and served biscuits to all residents.</p> <p>On July 9, 2024, at 2:06 p.m., a concurrent interview and Cooks' July 8, 2024 spreadsheet review were conducted with the Registered Dietitian (RD). The RD stated according to the Cook's spreadsheet, residents on Mechanical Soft diet should not receive biscuits. The RD further stated a biscuit was hard and residents on Mechanical soft diets residents could have difficulty to chew and swallow the biscuit.</p> <p>A review of Resident 3, 9, 7, 13, 32, 35, 43, 44, 46, 48, 47, 49, 55, and 56's physician diet order, dated July 9, 2024, indicated, .Mechanical Soft diet .</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0803</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility document titled, Diet Menu - Mechanical Soft Diet dated 2023, indicated, .Description: The mechanical soft diet is designed for residents who experience chewing or swallowing limitations .Grains: .Avoid: Breads with hard crusts .</p> <p>A review of the facility Policy and Procedure titled, Menu Planning, dated 2023, indicated, Policy: .The menu are planned to meet nutritional needs of residents in accordance with .Physician's orders and, to extent medically possible .</p> <p>A review of the facility Policy and Procedure titled, Menu Service, dated 2023, indicated, Policy: Meals that meet the nutritional needs of the resident will be served in an accurate and efficient manner .</p>		

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 07/11/2024
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law.</p> <p>50304</p> <p>Based on observation, interview, and record review, the facility failed to ensure the physician orders were followed for one of four sampled residents (Resident 7) during a dining observation when:</p> <p>1. Resident 7, who had a physician order for thin liquid (liquids that take little or no effort to drink) received honey- thick (slightly thicker, like honey or a milkshake) liquid during lunch on July 8, 2024.</p> <p>This failure had the potential to result in Resident 7 becoming discouraged with his fluid intake, further compromising his nutritional and medical status.</p> <p>2. Resident 7, who had a 120 ml fluid restriction (liquid allowed to drink) for the lunch meal per physician order, received 240 ml fluid during lunch on July 8, 2024.</p> <p>This failure had the potential to result in fluid overload (when there is too much fluid in your body), further compromising the nutritional and medical status of Resident 7 who is undergoing dialysis (a procedure to remove waste products and excess fluid from the blood when the kidneys stop working properly).</p> <p>Findings:</p> <p>1. A review of Resident 7's physician diet order, dated July 8, 2024, indicated, .Dietary - Diet . CCHO (Controlled Carbohydrate Diet - a meal plan for diabetic residents), Renal diet (a meal plan for kidney failure residents) thin liquids consistency Dietary to give .120 milliliter (ml- a unit of measurement) at lunch .</p> <p>A review of Resident 7's meal ticket indicated, . Special Diets: .thin liquids .Standing: 4 fluid ounce (oz- a unit of measurement) apple juice -Honey .</p> <p>On July 8, 2024, at 12 p.m., a concurrent dining hall observation, interview, and review of Resident 7's Meal tray ticket (menu based on the resident's diet physician order) were conducted with the Dietary Supervisor (DS). Resident 7 received 4 oz honey thick apple juice. The DS stated the current physician order for Resident 7 was for thin liquids and Resident 7 should not have received honey-thick apple juice. The DS stated she had missed updating the meal tray ticket to match the physician's order because Resident 7 had previously been on thickened liquids.</p> <p>On July 9, 2024, at 2:06 p.m. an interview was conducted with the Registered Dietitian (RD). The RD stated physician orders need to be followed. The RD stated Resident 7, who received honey-thick liquid, could be discouraged from drinking. The RD stated her expectation was for the DS to update the meal tray ticket to reflect current physician diet order.</p> <p>During a review of the facility policy and procedure (P&P) titled, Diet Orders undated, the P&P indicated, Policy: Diet orders as prescribed by the Physician will be provided by the Food and Nutrition Services Department .</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0808</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. A review of the facility document titled, Cooks spreadsheet (the menu document used to guide dietary staff on food items, portions, texture of foods and therapeutic diet), dated July 8, 2024, indicated, Diet Cookies was to be served to Renal CCHO diet.</p> <p>A Review of Resident 7's meal tray ticket, indicated Renal CCHO, Notes: Fluid restriction. No more than 4 oz at lunch.</p> <p>On July 8, 2024, at 12:15 p.m., a concurrent interview and review of Cooks spreadsheet were conducted with the DS in the dining hall. Resident 7 was served 4 oz ice cream. The DS stated Resident 7 was supposed to receive diet cookies instead of ice cream. The DS stated since the 4 oz of ice cream was considered as fluid, Resident 7 was served an extra 4 oz of fluid. The DS stated, serving extra fluid for Resident 7 could potentially cause fluid overload.</p> <p>On July 9, 2024, at 2:06 p.m., a concurrent interview and record review were conducted with the Registered Dietitian (RD). The RD stated according to the Cooks spreadsheet, Resident 7 was supposed to be served diet cookies instead of ice cream. The RD stated according to the Cooks spreadsheet, Resident 7 could only receive 120 ml (equals 4 oz) of fluid during lunch, according to the physician order. The RD stated since Diet Aide 2 served ice cream to Resident 7, Resident 7 received an extra 120 ml fluid from the served ice cream, which could lead to fluid overload.</p> <p>A review of the facility policy and procedure titled, Diet Orders undated, indicated, Policy: Diet orders as prescribed by the Physician will be provided by the Food and Nutrition Services Department .</p> <p>A review of the facility policy and procedure titled, Fluid restrictions undated, indicated, Policy: The physician will order the fluid restriction .</p> <p>A review of the facility policy and procedure (P&P) titled, Fluid Restricted Diets undated, the P&P indicated, Fluid restrictions are usually ordered to treat . renal failure . fluid items include all foods that are liquid at room temperature: .ice cream .</p>		

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 07/11/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44504</p> <p>Based on observation, interview, and record review, the facility failed to ensure safe and sanitary food preparation and storage practices in the kitchen when:</p> <ol style="list-style-type: none"> 1. There was buildup found on the ice maker; 2. Wear and tear were observed on the mixer in the kitchen; 3. The milk refrigerator's gasket was found to have black grime; 4. [NAME] grime was found on equipment; 5. Open food items were found on exposed to the air; 6. Three serving scoops were stored wet with other dry scoops, and one plastic container was stacked wet with other dry containers; 7. The vent hoods were covered with grease and dust; 8. The ceiling above the steam table was covered with dust. <p>These failures had the potential to cause foodborne illness (stomach illness acquired from ingesting contaminated food) in a medically vulnerable population of 51 out of 52 residents who received food prepared in the kitchen.</p> <p>Findings:</p> <p>1. On July 8, 2024, at 2:19 p.m., a concurrent observation and interview were conducted with the Dietary Supervisor (DS) and Maintenance Assistant (MA) in the kitchen in front of the ice machine. The Surveyor used a white paper towel to wipe the inside of the ice maker. The white paper towel turned black. The DS and MA stated the ice maker was not clean.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated, the ice maker should not be soiled and should be kept clean. The RD stated a soiled ice maker could potentially contaminate the ice.</p> <p>A review of the facility policy and procedure titled, SANITATION, dated 2018, indicated, .9. All .equipment shall be kept clean .14. Ice which is used in connection with food and drink shall be from a sanitary source .</p> <p>2. On July 8, 2024, at 9:29 a.m., a concurrent observation and interview were conducted with the DS in the kitchen. The stationary mixer was observed to be missing a coating of paint with exposed brown grime. The DS stated the mixer was super old and had wear and tear.</p> <p>(continued on next page)</p>

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 07/11/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated the wear and tear mixer did not have smooth surface, which made it difficult to clean and needed to be replaced.</p> <p>A review of the facility policy and procedure titled, SANITATION, dated 2018, indicated, .9. All .equipment shall be kept clean .and shall be free from breaks, corrosions, open seam, cracks and chipped areas .</p> <p>3. On July 8, 2024, at 10:43 a.m., a concurrent observation and interview were conducted with the DS in front of milk refrigerator in the kitchen. Black grime buildup was found on the milk refrigerator's gasket (the rubber piece that lines along refrigerator door to prevent cool air from sipping out). The DS stated dietary staff missed cleaning the milk refrigerator's gasket.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated the milk refrigerator's gasket needed to be cleaned thoroughly to prevent cross-contamination.</p> <p>A review of the facility's policy and procedure titled, SANITATION, dated 2018, the indicated, .9.All . equipment shall be kept clean .</p> <p>4. During kitchen initial tour on July 8, 2024, at 9:14 a.m., a concurrent observation and interview were conducted with the DS. Several pieces of equipment in the kitchen were found to have brown grime. The equipment listed below were affected:</p> <ul style="list-style-type: none"> i) Silver storage shelves used to store cans in the storage room; ii) The base of the can opener; iii) The storage shelves used to store clean domes (a piece of kitchen equipment used as a cover to keep food hot); iv) The silver storage shelves used to store spices. <p>The DS stated brown grime was found on the observed equipments.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated equipment with brown grime did not have smooth surfaces making it difficult to sanitize.</p> <p>A review of the facility's policy and procedure titled, SANITATION, dated 2018, indicated, .9. All .equipment shall be kept clean .and shall be free from breaks, corrosions, open seam, cracks and chipped areas .</p> <p>5. On July 8, 2024, at 9:14 a.m., a concurrent observation and interview were conducted with the DS in front of the reach-in freezer in the kitchen. There were two opened food items ([NAME] fish and beef patties) exposed to the air. The DS stated opened food items should be wrapped or sealed to prevent freezer burn.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated opened food items stored in the freezer should be sealed or closed, otherwise there was a potential for freezer burn and contamination.</p> <p>(continued on next page)</p>

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 07/11/2024
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 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility's procedure titled, FREEZER STORAGE, dated 2023, indicated, .5. Store frozen foods in an airtight moisture wrapper such as a plastic bag or freezer paper to prevent freezer burn .</p> <p>6. On July 8, 2024, at 10:07 a.m., a concurrent observation and interview were conducted with the DS in the kitchen. One wet plastic container was stacked with other dried containers on the shelf. The DS stated the wet plastic container should not be stacked with other dried containers because moisture could create bacteria.</p> <p>On July 8, 2024, at 10:20 a.m., a concurrent observation and interview were conducted with the DS in the kitchen. Three wet scoops with water droplets were stored with other dried scoops in the drawer. The DS stated, the wet scoops should not be stored with other dry scoops because moisture could create bacteria.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated plastic containers and scoops should completely air-dried before being stored otherwise, moisture could lead to organism growth.</p> <p>A review of the facility's policy and procedure titled, DISHWASHING, dated 2023, indicated, .5 .Dishes are to be air dried in racks before stacking and storing .</p> <p>A review of the facility's policy and procedure titled, 3-COMPARTMENT PROCEDURE FOR MANUAL DISHWASHING, dated 2023, indicated, .All items are air-dried, which means no water droplets are present .</p> <p>7. On July 8, 2024, at 10:24 a.m., a concurrent observation and interview were conducted with the DS in the kitchen. The hood vent above the stove was observed covered with grease and black grime. The DS referred to the grease and black grime as dust located on the hood vent above the stove.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated the hood vent above the stove should be keep clean.</p> <p>A review of the facility's policy and procedure titled, SANITATION, dated 2018, indicated, .9. All .equipment shall be kept clean .</p> <p>8. A review of the U.S Food and Drug Administration's (FDA) Food Code 2022, indicated, Nonfood-contact surfaces of equipment shall be kept free of an accumulation of dust, dirt, food residue, and other debris.</p> <p>On July 8, 2024, at 10:51 a.m., a concurrent observation and interview were conducted with the DS in the kitchen. The ceiling above the steam table was found to be covered with black debris. The DS referred to the black debris as dust. The DS stated that dust could possibly fall down.</p> <p>On July 9, 2024, at 2:06 p.m., an interview was conducted with the RD. The RD stated the kitchen needed to be keep clean and dust-free to prevent cross-contamination.</p>		

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 07/11/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide and implement an infection prevention and control program.</p> <p>50204</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented, when:</p> <ol style="list-style-type: none"> 1. Resident (55) was observed to have a pair of black shoes and blue pants on top of a commode (chair with a built-in toilet seat). 2. The Activity Director (AD) was observed to have long artificial nails when providing direct care to residents. <p>These failures had the potential to increase the risk of transmission of infectious disease (disorders caused by organisms) to vulnerable residents in the facility.</p> <p>Findings:</p> <ol style="list-style-type: none"> 1. On July 8, 2024, at 10:10 a.m., a concurrent observation and interview were conducted inside Resident 55's room. Resident 55's pair of black shoes and blue pants were on top of a commode. Resident 55 stated he asked the staff to place it in his big closet this morning. On July 8, 2024, at 10:20 a.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 1 inside Resident 55's room. CNA 1 stated, Resident 55's shoes and pants should not be on top of a commode. CNA 1 stated all clean clothes should be kept in the cabinet. On July 8, 2024, at 10:30 a.m., an interview was conducted with the Registered Nurse (RN) 1. The RN 1 stated resident's clothing should be placed in a designated cabinet or drawer. RN 1 stated clothing placed on top of a commode could become contaminated and spread infection. On July 9, 2024, at 2:30 p.m., an interview was conducted with the Infection Preventionist (IP) in Resident 55's room. The IP stated any clean clothes should not be placed on top of a commode. The IP further stated clothes placed top of a commode will become contaminated and could lead to infection. On July 9, 2024, at 3 p.m., the Director of Nursing (DON) was interviewed. The DON stated, CNAs should always make rounds and check for potential infection control issues. The DON stated any garment found in a dirty area should be removed, washed, and kept in a clean place. <p>A review of the facility policy and procedure titled, Infection Prevention and Control, dated December 2023, indicated, .The objectives of the infection prevention and control policies and procedures are to monitor, prevent, detect, investigate, and control infections in the facility .</p> <ol style="list-style-type: none"> 2. On July 9, 2024, at 11:00 a.m., an observation was conducted with the Activity Director (AD) during a Resident Council Meeting. The AD was observed to have long artificial nails, 11 millimeters long from the edge of the nail bed, while providing care to residents in the dining hall. <p>(continued on next page)</p>

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 07/11/2024
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 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On July 9, 2024, at 2:30 p.m., an interview was conducted with the AD. The AD stated she provided direct care to residents in the facility. The AD further stated she had artificial nails and was not aware of the facility policy regarding artificial nails.</p> <p>On July 9, 2024, at 3:57 p.m., an interview was conducted with the IP. The IP stated according to the facility's policy, nails must be of appropriate length and should not be too long for direct care staff. The IP further stated long nails could potentially damage the skin of residents, lead to skin breakdown, and cause infection.</p> <p>On July 10, 2024, at 8:04 a.m., an interview was conducted with the DON. The DON stated direct care staff should not have artificial nails and should follow the facility's policy.</p> <p>A review of the facility policy and procedure titled, Handwashing/Hand Hygiene, dated October 2023, indicated, .Personnel with direct-care resident responsibilities should maintain short, natural fingernails . Fingernails should not extend past fingertips .Wearing artificial fingernails is strongly discouraged with direct-care responsibilities, and is prohibited among those caring severely ill or immunocompromised residents .the infection preventionist may request the removal of artificial fingernails and/or nail polish at any time if it is determined that they present an infection control risk .</p>

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 07/11/2024
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>44270</p> <p>Based on observation and interview, the facility failed to contain waste in a closed container, and provide a comfortable homelike environment for three of six residents reviewed (Residents 30, 42, and 43) when:</p> <ol style="list-style-type: none"> Multiple discarded medical equipment and non-medical materials surrounding the outside disposal bins. <p>This failure had the potential to attract insects and rodents, presenting a health risks to the vulnerable population in the facility.</p> <ol style="list-style-type: none"> The window blinds in resident rooms were damaged. <p>This failure had the potential to cause disruption of sleep, inability to properly control sunlight leading to increased heat.</p> <p>Findings:</p> <ol style="list-style-type: none"> On July 8, 2024, at 1:15 p.m. the outside waste disposal bins were observed to have multiple scattered debris of discarded and broken medical equipment and waste. <p>On July 10, 2024, at 09:13 a.m., a concurrent observation and interview were conducted with Maintenance Supervisor (MS). The MS was made aware of the buildup of scattered debris and discarded medical equipment outside near the large garbage bins. There were several broken medial equipment items, metal file cabinets, aluminum cans, worn wood planks, and spider webs. The MS stated he had know about the debris for nine months. The MS further stated all waste should be discarded and not left outside of disposal bins. The MS stated there was a potential to harbor pests in the areas with debris.</p> <p>On July 10, 2024, at 09:41 a.m. a concurrent observation and interview was conducted with Facility Administrator (FA) outside the facility near the waste disposal bins. The FA stated there should not be waste and debris build up around the disposal bins. The FA futher stated there was a potential for pests to harbor in the areas in and around the debris among the waste disposal bins.</p> <p>On July 11, 2024, at 09:24 a.m., an interview was conducted with the Infection Preventionist (IP) The IP stated all waste should be disposed of in the designated waste disposal bins and not left outside of the bins. The IP stated any large debris materials piled up around waste disposal areas had the potential to harbor pests and insects.</p> <p>A review of the facility policy and procedure titled, Waste disposal, dated January 2012, indicated, .All infectious and regulated waste shall be handled and disposed of in a safe and appropriate manner .The Infection Preventionist and Environmental Services Director will ensure that wast is properly disposed of .</p> <p>(continued on next page)</p>		

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 07/11/2024
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 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy and procedure titled, Pest Control, dated May 2008, indicated, .Garbage and trash are not permitted to accumulate and are removed from the facility daily.</p> <p>50204</p> <p>2a. On July 8, 2024, at 9:51 a.m., during concurrent observation in Resident 30's room and interview, multiple damaged blinds were observed. Resident 30 stated he had to cover his eyes with towel and that he could not sleep due to the bright light coming through the damaged blinds.</p> <p>2b. On July 8, 2024, at 10:10 a.m., Resident 42, was observed sitting in his wheelchair in his room. The room's horizontal window blinds were observed to be damaged. Resident 42 stated .it is getting warm again. Resident 42 stated the heat comes through the damaged spot, making the room warm in the afternoon.</p> <p>2c. On July 8, 2024, at 11:00 a.m., a concurrent observation and interview were conducted inside Resident 43's room. The room was observed to have damaged window blinds. Resident 43 stated .the heat from window pass through the broken blind that makes my room warm .</p> <p>On July 10, 2024, at 9 a.m., an interview was conducted with the MS. The MS stated he was aware of the condition of the window blinds. The MS stated, .the blinds needed to be replaced .</p> <p>On July 10, 2024, at 9:13 a.m., an interview was conducted with the FA. The FA was aware of the damaged window blinds and stated the blinds needed to be repaired.</p> <p>A review of facility policy and procedure titled, The Maintenance Service, undated, indicated, .The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times .Maintaining the building in good repair .</p>

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 07/11/2024
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 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>50304</p> <p>Based on observation, interview, and record review, the facility failed to ensure an effective pest control program was in place for the kitchen when house flies were observed flying and landing in the kitchen and dining hall.</p> <p>This failure had the potential to lead to food borne illnesses (illness caused by food contaminated with bacteria, viruses, parasites, or toxins) among the facility residents who eat food prepared in the kitchen.</p> <p>Findings:</p> <p>On July 8, 2024, at 8:59 a.m. a concurrent observation and interview were conducted with the Dietary Supervisor (DS) in the kitchen. Two house flies were observed flying around the kitchen and one was seen landing on the post next to the handwashing station. The DS stated, Yes, that is a house fly. The DS further stated dietary staff noticed house flies in the kitchen one month ago. She stated, We shoo them away or kill them with a fly swatter.</p> <p>On July 8, 2024, at 11:01 a.m., a concurrent observation and interview were conducted with Dietary Aide (DA) 1 in the kitchen. DA 1 stated a house fly landed on a cleaned red cutting board surface.</p> <p>On July 8, 2024, at 12:06 p.m., an observation was conducted with Resident 9 in the dining hall. A house fly was observed flying around Resident 9's served food. Resident 9 used his hand to swat away the house fly.</p> <p>On July 9, 2024, at 11:30 a.m., an observation was done with Activity Assistant (AA) 1 in the Dining Hall. Three house flies were seen on a post in the dining hall. The AA 1 swatted a house fly with a fly swatter. AA1 stated house flies enter the dining hall when residents exit to go outside to smoke.</p> <p>On July 9, 2024, at 11:32 a.m. a concurrent observation and interview were conducted with Certified Nurse Assistant (CNA) 2 in the Dining Hall. CNA 2 stated a house fly was present in the dining hall. CNA 2 stated house flies carry bacteria, which could lead to cross-contamination of food and food borne illnesses.</p> <p>On July 9, 2024, at 2:06 p.m. an interview was conducted with the Registered Dietitian (RD). The RD stated no pests should be in the kitchen at all. The RD stated pests including house flies pose a potential risk of causing cross- contamination issues that may result in food borne illnesses.</p> <p>A review of the facility policy and procedure titled, Miscellaneous Areas undated, indicated, .Fly and Vermin . Flies are carriers of disease and are a constant enemy of high standards of sanitation .</p> <p>A review of the facility policy and procedure titled, Pest Control undated, indicated, .Policy Statement .Our facility shall maintain an effective pest control program .1 .This facility maintains an ongoing pest control program to ensure that the building is kept free of insects and rodents .</p>