STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to treat one of three residents (Resident 28) with dignity when an Activities Assistant (AA) stood over the resident while providing assistance with liquid nourishment during designated snack period. This failure had the potential to negatively impact the safety, dignity, and respect of Resident 28. Findings: On June 23, 2025, at 10:40 a.m., during an observation in the activities room, Resident 28 was observed to be seated in a Geri chair with the head tilted at a 45-degree angle, positioned at the corner of the room. The AA was observed standing directly over Resident 28, while assisting with liquid nourishment. The AA was not seated at eye level with the resident during assistance. A review of Resident 28's admission Record, indicated, Resident 28 was admitted to the facility on [DATE], with diagnoses of dementia without behavioral disturbance (mental disorder when a person loses the ability to think, remember, learn, make decisions, and solve problems). A review of Resident 28's Care Plan Report, indicated, .Requires assistance with ADL (Activities of Daily Living) functions .the resident will maintain current level of function through the review date .Geri chair while up out of bed for positioning .provided total assistance during meals . On June 23, 2025, at 10:45 a.m., during an interview with the AA, the AA stated he could either sit or stand while assisting Resident 28 with liquid nourishment. On June 25, 2025, at 8:20 a.m., during an interview with the Director of Nursing (DON), the DON stated, it was the facility's expectation that all staff should sit at the resident's eye level when assisting with nourishment to promote safety, dignity, and respect. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's Policy and Procedure titled, Assistance with Meals, with revised date of March 2022, indicated, .Residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Under Section titled, Dining Room Residents, .3. Residents who cannot feed themselves will be fed with attention to safety, comfort, and dignity, for example: a. not standing over residents while assisting them with meals; b. keeping interactions with other staff to a minimum while assisting residents with meals; c. avoiding the use of labels when referring to residents (e.g., feeders). Under the Section titled, Residents Requiring Full Assistance, .2. Residents who cannot feed themselves will be fed with attention to safety, comfort and dignity, for example: a. not standing over residents while assisting them with meals; b. keeping interactions with other staff to a minimum while assisting resident with meals .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure, seven of 14 residents reviewed for Advance Directive (AD - written statement of a person's wishes regarding medical treatment) (Residents 1, 6, 10, 21, 23, 32, 42) the resident or their resident representative (RP) had been provided follow up information regarding the formulation of an AD. This failure had the potential to result in the ADs for Residents 1, 6, 10, 21, 23, 32, and 42 not being readily accessible to staff and physicians, which could lead to the residents' wishes regarding medical treatment being unknown and ultimately not honored. Findings 1. On June 24, 2025, at 11:16 a.m., an interview was conducted with Resident 6. Resident 6 stated that he was unsure of having an AD and unsure if asked if he would like to formulate one. Resident 6's record was reviewed. Resident 6 was admitted to the facility on [DATE]. A review of Resident 6's Physician Orders for Life-Sustaining Treatment (POLST), dated October 29, 2024, did not indicate Resident 6 had an AD. A review of Resident 6's Social History Assessment, dated October 30, 2024, indicated, .No advance directive per resident . A review of Resident 6's History and Physical, dated November 2, 2024, indicated Resident 6 had the capacity to understand and make decisions. A review of Resident 6's Interdisciplinary Care Conference, (IDT) dated November 4, 2024, indicated, . resident POLST .discussed . A review of Resident 6's IDT Care Conference, dated February 6, 2025, indicated, .POLST .discussed . A review of Resident 6's Social History Review, dated April 29, 2025, indicated, .Advance Directive .none of the above .self-responsible . There was no documented evidence the resident or RP was provided information about the right to formulate an AD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 26, 2025, at 10:24 a.m. a concurrent interview and record review was conducted with the Social Service Director (SSD). A review of the IDT care conference dated November 4, 2024, and the Social History assessment dated [DATE] was reviewed. The SSD stated Resident 6 indicated they did not have an AD during the social history assessment. The SSD stated the protocols were for the SSD to determine if a resident had an AD upon admission, they would attempt to obtain it directly from the resident or from the RP. The SSD indicated if an AD was not present then they would offer the resident resources to formulate one. The SSD indicated if an AD was not determined upon admission, then a follow up would be done during the IDT care conference and then quarterly during the social history assessments conducted by the SSD. The SSD stated she did not follow up with Resident 6 or the RP to determine if they wished to formulate an AD after determining one was not formulated upon admission. The SSD stated she should have followed up with Resident 6 during the IDT care conference to provide him with the right to formulate an AD. The SSD further stated there was a risk for Resident 6's care preferences to not be honored if an AD was not present and available for review in the resident's medical record. 2. A review of Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE]. A review of the Social Service Assessment, dated January 15, 2020, indicated that Resident 1 did not have an AD. A review of Resident 1's History and Physical dated February 23, 2025, indicated Resident 1 had the capacity to understand and make decisions. On June 24, 2025, at 9:14 a.m., during an interview with Resident 1, he stated he was not sure if he had an AD. On June 26, 2025, at 10:30 a.m., during a concurrent interview and review of Resident 1's Social History Assessment with the SSD, she stated if a resident did not have an AD, she would offer resources and education to the resident or the RP. The SSD stated Resident 1 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 1 or the RP in order to honor their care preferences. 3. A review of Resident 32's admission Record, indicated Resident 32 was admitted to the facility on [DATE]. A review of Resident 32's Social Service Assessment, dated October 19, 2023, indicated that Resident 32 did not have an AD. A review of Resident 32's History and Physical dated October 22, 2023, indicated Resident 32 does not have the capacity to understand and make decisions. On June 24, 2025, at 11:34 a.m., during an interview with Resident 32, he was not able to verbalize if he had an AD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 26, 2025, at 10:30 a.m., during a concurrent interview and review of Resident 32's Social History Assessment with the SSD, she stated if a resident did not have an AD, she would offer resources and education to the resident or the RP. The SSD stated Resident 32 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 32 or the RP in order to honor their care preferences. 4. A review of Resident 42's admission Record, indicated Resident 42 was admitted to the facility on [DATE]. A review of Resident 42's Social Service Assessment, dated September 25, 2024, indicated that Resident 42 did not have an AD. A review of Resident 42's History and Physical dated September 30, 2024, indicated Resident 42 has fluctuating capacity to understand and make decisions. On June 24, 2025, at 8:46 a.m., during an interview with Resident 42, he stated he did not know if he has an AD or what is an AD. On June 26, 2025, at 10:30 a.m., during a concurrent interview and review of Resident 42's Social History Assessment with the SSD, she stated if a resident did not have an AD, she would offer resources and education to the resident or the RP. The SSD stated Resident 42 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 42 or the RP in order to honor their care preferences. 5. A review of Resident 21's admission Record, indicated Resident 21 was admitted to the facility on [DATE]. A review of the Social Service Assessment, dated September 19, 2024, indicated that Resident 21 did not have an AD. A review of Resident 21's History and Physical dated September 20, 2024, indicated Resident 21 has fluctuating capacity to understand and make decisions. On June 24, 2025, at 8:35 a.m., during an interview with Resident 21, he stated he did not know if he has an AD. On June 26, 2025, at 10:30 a.m., during a concurrent interview and review of Resident 21's Social History Assessment with the SSD, she stated if a resident did not have an AD, she would offer resources and education to the resident or the RP. The SSD stated Resident 21 had no AD, was not provided education, and was not reviewed for AD. The SSD further stated she should have followed up and provided AD education to Resident 21 or the RP in order to honor their care preferences. 6. On June 23, 2025, at 10:21 a.m., an interview was conducted with Resident 10. Resident 10 stated he could not recall if he was offered information about an AD. A review of Resident 10's admission Record, indicated Resident 10 was admitted to the facility on [DATE]. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident 10's POLST, dated February 20, 2025, did not indicate Resident 10 had an AD. A review of Resident 10's History and Physical, dated February 21, 2025, indicated Resident 10 had the capacity to understand and make decisions. A review of Resident 10's Social History Review, dated May 20, 2025, indicated, .Self responsible .Advance directives .none of the above . A review of Resident 10's IDT Care Summary, dated May 27, 2025, indicated, .POLST discussed . There was no documented evidence that Resident 10 or RP were provided with follow up information or education about the right to formulate an AD. On June 26, 2025, at 10:40 a.m., a concurrent interview and record review of Resident 10's Social History Review and IDT Care Summary was conducted with the SSD. The SSD stated upon admission, she would check with residents or RP if they had an AD, and if they had one, she would request a copy to be available in the facility. The SSD stated if they did not have one, she would provide residents or RP with information and education on how to formulate one. The SSD stated if the resident did not wish to have an AD, a follow up with the resident or RP about AD would be conducted quarterly during a resident's IDT care conference. The SSD stated there was no documentation which indicated Resident 10 was provided with follow up information during the IDT care conference on May 27, 2025. The SSD stated if there was no AD on file there was potential for the facility to not be able to honor their preferences for care. 7. On June 23, 2025, at 11:10 a.m., an interview was conducted with Resident 23. Resident 23 stated he was not sure if he had an AD and could not recall if he or his RP were offered information about an AD. A review of Resident 23's admission Record, indicated Resident 23 was admitted to the facility on [DATE]. A review of Resident 23's POLST, dated January 15, 2025, did not indicate Resident 23 had an AD. A review of Resident 23's History and Physical, dated January 16, 2025, indicated Resident 23 had the capacity to understand and make decisions. A review of Resident 23's Social History Review, dated April 15, 2025, indicated, .Family member responsible .Advance directives .none of the above . A review of Resident 23's IDT Care Summary, dated April 29, 2025, indicated the IDT team met with resident's RP and discussed current plan of care and POLST. There was no documented evidence that Resident 23 or RP were provided with follow up information or education about the right to formulate an AD. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 26, 2025, at 10:40 a.m., a concurrent interview and record review of Resident 23's Social History Review and IDT Care Summary was conducted with the SSD. The SSD stated upon admission, she would check with residents or RP if they had an AD, and if they had one, she would request a copy to be available in the facility. The SSD stated if they did not have one, she would provide residents or RP with information and education on how to formulate one. The SSD stated if the resident did not wish to have an AD, a follow up with the resident or RP about AD would be conducted quarterly during a resident's IDT care conference. The SSD stated there was no documentation which indicated Resident 23 or RP was provided with follow up information during the IDT care conference on May 27, 2025. The SSD stated if there was no AD on file there was potential for the facility to not be able to honor their preferences for care. A review of the facility's policy and procedure titled, Advance Directives, revised September 2022, indicated, . the resident has the right to formulate an advance directive, including the right to accept or refuse medical or surgical treatment .prior to or upon admission of a resident, the social services director or designee inquires of the resident, his/her family members and/or his or her legal representative, about the existence of any written advance directives .if the resident .indicates that he or she has not established advance directives, the facility staff will offer assistance .information whether or not the resident has executed an advance directive is displayed prominently in the medical record in a section of the record that is retrievable by any staff .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. 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 three dietary staff members did not follow the manufacturer's instructions for testing the red bucket (sanitizing solution) sanitizer. This failure had the potential to create unsafe and unsanitary kitchen conditions and could result in foodborne illness (stomach illness acquired from ingesting contaminated food). Findings: A review of the Quaternary Ammonium sanitizer (Quat - sanitizing solution used to sanitize food contact surfaces and equipment) test strip bottle's instructions indicated, Dip test strip into the solution for 1-2 seconds . On June 24, 2025, at 8:46 a.m., a concurrent observation and interview were conducted with the Dietary Aide (DA). The DA demonstrated how to check the Quat sanitizer in the red bucket and was observed placing the test strip in the solution for 10 seconds. The DA stated she should have dipped the test strip for only one to two seconds per the manufacturer's instructions. The DA further stated it was important to follow the manufacturer's instructions to ensure the sanitizer solution was at the proper concentration to prevent any cross contamination or foodborne illness for residents. On June 24, 2025, at 8:52 a.m., a concurrent observation and interview were conducted with the [NAME] (CK). The CK was observed placing the test strip in the Quat sanitizer solution for eight seconds. The CK stated he should have dipped the test strip for one to two seconds to ensure the solution was tested properly. On June 24, 2025, at 8:58 a.m., a concurrent observation and interview was conducted with the Dietary Supervisor (DS). The DS was observed placing the test strip in the solution for five seconds. The DS stated, she did not follow the manufacturer's instructions. The DS stated, she should have followed the manufacturer's guide on the bottle to avoid potential cross contamination and food borne illness. On June 26, 2025, at 1:55 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the Quat sanitizer test strips should be dipped for one to two seconds, per the manufacturer's instructions to ensure proper sanitation. The RD further stated, not following the instructions could compromise disinfection and could result in cross contamination and food borne illness to the residents. A review of the professional reference USDA Food Code 2022, Section 3-304.14 Wiping Cloths, Use Limitation .Proper sanitizer concentration should be ensured by checking the solution periodically with an appropriate chemical test kit. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the professional reference Food Code 2022, Section 4-501.114 Manual and Mechanical Ware washing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness, (C) A quaternary ammonium compound solution shall (2) Have a concentration as specified under § 7-204.11 and as indicated by the manufacturer's use directions included in the labeling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observation, interview, and record review, the facility failed to ensure proper disposal of garbage when multiple cardboard boxes were found on the ground outside of the designated container and not stored appropriately. This failure had the potential to attract pests and cause infection control issues. Findings: On June 23, 2025, at 10:55 a.m., during an observation of the garbage and refuse storage area, multiple cardboard boxes were found on the ground near the recycling container and not stored inside the container. On June 23, 2025, at 11:03 a.m., during a concurrent observation and interview with the Dietary Supervisor (DS), in front of the containers, the DS stated there should not be any debris or cardboard boxes on the ground around the containers. The DS further stated the boxes left outside of the container could attract pests and potentially lead to infection control issues. On June 26, 2025, at 1:55 p.m., during an interview with the Registered Dietitian (RD), the RD stated the garbage containers should be kept clean and inspected daily to ensure that no garbage or cardboard boxes were left on the ground in the surrounding area. The RD further stated, not adhering to the policy could result in potential pest infestation and infection control issues. A review of the facility policy and procedure titled Miscellaneous Areas: Garbage and Trash Procedure, dated 2023, indicated, .Garbage and trash cans must be inspected daily that no debris is on the ground or surrounding area, and that the lids are closed .The trash collection area is a potential feeding ground for vermin and rodents and must be kept clean .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555740	A. Building B. Wing	06/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vista Real Post Acute	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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview, and record review, the facility failed to ensure proper infection control measures were implemented when: 1. The Licensed Vocational Nurse (LVN) did not clean and disinfect a blood pressure machine between resident uses. 2. The LVN used gloves that had been stored inside her scrub pocket before administering medication. These failures had the potential to result in cross-contamination, increasing the risk of infection spread among an already vulnerable population of residents. Findings: 1. On June 25, 2025, from 9:25 a.m. to 9:55 a.m., an observation was conducted of the LVN checking the blood pressure of Residents 11, 20, and 33 in the residents' room. The LVN did not disinfect the blood pressure machine before or after use between residents. On June 25, 2025, at 10:10 a.m., during an interview with the LVN, the LVN stated, she should have cleaned and disinfected the blood pressure machine between resident uses. On June 26, 2025, at 8:51 a.m., during an interview with the Infection Preventionist (IP), the IP stated, medical devices used on residents should be disinfected after each use to reduce the risk of cross-contamination. A review of the facility policy and procedure titled, Blood Pressure Measuring, dated 2001, indicated, .clean and wipe the sphygmomanometer and cuff with antiseptic then roll up the blood pressure cuff . 2. On June 25, 2025, at 9:40 a.m., inside Resident 33's room, the LVN was observed donning (putting on) gloves that had been stored in her scrub pocket prior to administering medication. On June 25, 2025, at 10:10 a.m., during an interview with the LVN, the LVN stated she used gloves stored in her scrub pocket before administering medication and stated it was acceptable. On June 26, 2025, at 8:51 a.m., during an interview with the IP. The IP stated the facility protocol required staff to obtain gloves from the wall-mounted glove box. The IP stated, storing gloves in scrub pockets was not permitted as it posed a risk of contamination. A review of the facility policy and procedure titled, Personal Protective Equipment-Using Gloves, dated 2001, indicated, .to guide the use of gloves .to prevent the spread of infection, to protect wounds from contamination, to protect hands from potentially infectious materials .when to use gloves .when touching excretions, secretions, blood, body fluids, mucous membranes or non-intact skin .