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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555921 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 07/02/2024 |
| NAME OF PROVIDER OR SUPPLIER Rancho Bellagio Post Acute | | STREET ADDRESS, CITY, STATE, ZIP CODE 26940 E Hospital Road Moreno Valley, CA 92555 | |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) |
| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038</p> <p>Based on interview and record review, the facility failed to report an allegation of sexual abuse within two hours to the California Department of Public Health (CDPH) after the allegation was made for two of three sampled residents (Residents A and C).</p> <p>This failure had the potential to result in further abuse.</p> <p>Findings:</p> <p>On May 29, 2024, at 9:40 a.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse.</p> <p>a. During an interview on May 29, 2024, at 1:17 p.m., with Resident A, she stated she was touched inappropriately three weeks ago by Resident B. Resident A further stated she felt dirty.</p> <p>During a review of Resident A's ADMISSION RECORD, indicated Resident A was admitted on [DATE], with diagnoses which included depression (feelings of sadness) and schizoaffective disorder (a mental health disorder).</p> <p>During a review of Resident A's MDS (minimum data set- an assessment tool) dated April 30, 2024, indicated Brief Interview of Mental Status (a tool used to screen and identify the cognitive condition of residents) score of 10 (Moderately Impaired Cognition).</p> <p>During a review of Resident A's Interdisciplinary Team (IDT- includes the nurse, social worker, dietician, physician, and the resident working together to assess, coordinate and manage each resident's care) Note dated May 28, 2024, indicated, . in regard to Resident A reported incident on 5/26/24 involving another male resident (Resident B). Resident (Resident A) had reported to staff that male resident (Resident B) kissed her and touched her breast about 3 weeks ago .Resident A stated at the time that male resident approached and was flirting with her. Stating that she was beautiful and wanted to kiss her. Resident A stated to staff that it was consensual, and she allowed him to kiss her and then he touched her breast .</p> <p>During a review of Resident A's Progress Notes, titled 72-hour Charting, dated May 26, 2024, indicated, .</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>RESIDENT LATER INFORMED STAFF THAT SAME MALE RESIDENT KISSED HER AND TOUCHED HER BREAST 3 WEEKS AGO .</p> <p>Further review of Resident A's Progress Notes, from May 26, 2024 to May 30, 2024, indicated, there was no documentation the allegation of sexual abuse between Residents A and B was reported to CDPH within two hours after the allegation was made.</p> <p>During an interview on May 29, 2024, at 4:30 p.m., with the Registered Nurse (RN), she stated she heard Resident A talking to another resident about being kissed and inappropriately touched by Resident B. The RN stated Resident A reported to her and the Licensed Vocational Nurse (LVN) that she was touched inappropriately and kissed by Resident B three weeks ago. The RN stated she reported the incident to the Director of Nursing (DON) on May 26, 2024, but did not report the allegation of abuse to CDPH within two hours. The RN stated Resident A was monitored to prevent further abuse. The RN further stated the allegation should have been reported to CDPH within two hours.</p> <p>During an interview on May 29, 2024, at 4:45 p.m., with the LVN, she stated on May 26, 2024, Resident A reported to her and the RN that she was touched by Resident B. The LVN stated the allegation of inappropriate touching by Resident B should have been reported to the CDPH within two hours for the safety of the resident.</p> <p>During an interview on May 30, 2024, at 4 p.m., with the DON, she stated any allegation of abuse should be reported within two hours. The DON stated, on May 26, 2024, the LVN reported to her that Resident A was kissed and touched by Resident A. The DON stated the alleged incident did not happen, so she did not report to CDPH.</p> <p>b. During an interview on May 30, 2024, at 12:30 p.m., with Certified Nursing Assistant (CNA) 1, CNA 1 stated, she was familiar with Resident C. CNA 1 stated, on May 27, 2024, at around 10 a.m., Resident D told her Resident C was inappropriately touched by Resident B. CNA 1 stated she did not report to her supervisor regarding the allegation made by Resident D because she thought the incident had already been reported. CNA 1 stated any allegation of abuse should be reported immediately.</p> <p>A review of Resident C's ADMISSION RECORD, indicated, Resident C was admitted to the facility on [DATE], with diagnoses which included major depressive disorder (a mental health condition that causes a persistently low mood and a loss of interest in activities).</p> <p>During a review of Resident C's Progress Notes, from May 27, 2024 to May 30, 2024, indicated, there was no documentation that the allegation of inappropriate touching by Resident B was investigated or reported to CDPH within two hours after the allegation was made.</p> <p>During an interview on June 19, 2024, at 2:30 p.m., with the DON, the DON, stated she was not aware of the incident involving Resident B inappropriately touching Resident C. The DON stated, the staff did not report the allegation to her. The DON stated any allegation of abuse should be reported to CDPH within two hours after being reported by a resident to the staff.</p> <p>During a review of facility policy and procedure (P&P) titled, Abuse Prevention, dated December 21, 2015, indicated, .REPORTING .The facility is required to report all allegations of abuse .must report even if no reasonable suspicion with in 2 hours .</p> | | |