

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 10/31/2024
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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Reasonably accommodate the needs and preferences of each resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309</p> <p>Based on observation, interview, and record review, the facility failed to ensure one of seven residents' (Resident 7) call light was answered timely.</p> <p>This failure had the potential to not meet the resident's needs.</p> <p>Findings:</p> <p>On October 31, 2024, at 8:44 a.m., an unannounced visit was conducted to the facility for a quality of care issue.</p> <p>On October 31, 2024, at 12:02 p.m., during a concurrent observation and interview with Certified Nursing Assistant (CNA) 2, CNA 2 was observed to not answer Resident 7's call light after walking past the resident's room twice. CNA 2 stated he had just finished taking his morning break and did not have any residents to assist at the time. CNA 2 stated he saw the call light on and thought the nurse assigned to that room would answer it. CNA 2 stated he should have answered the call right away, even if the room was not on his assignment list. CNA 2 further stated he should have checked on the resident and communicated the resident's needs to the other CNA or licensed nurse. CNA 2 stated, had the resident needed immediate help, it would not have been known, which placed the resident at risk for harm or injury.</p> <p>On October 31, 2024, at 12:17 p.m., an interview was conducted with Resident 7 in her room. Resident 7 was alert and oriented and stated she had pressed her call light more than 20 minutes ago. Resident stated, sometimes it took a while for staff to respond. She stated a nurse eventually came in to help reposition her in bed because she was not comfortable. Resident 7 stated, she was weak and needed assistance with repositioning.</p> <p>On October 31, 2024, at 12:27 p.m., during a concurrent observation and interview with a Licensed Vocational Nurse (LVN) 1, LVN 1 stated he was the charge nurse on that wing that day. LVN 1 further stated one way staff were alerted when a call light was activated was through a wall board system mounted on the wall in the nursing station. LVN 1 stated, when the call light was activated, the resident 's room would light up, accompanied by an alarm sound, to alert staff that resident needed assistance. LVN 1 stated all staff were expected to respond to a call light whether the room was not assigned to them. LVN 1 further stated, if the call light was not answered immediately, it could delay meeting the resident 's needs.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 31, 2024, at 3:28 p.m., the Director of Staff Development (DSD) was interviewed. The DSD stated staff members were expected to answer the call light as soon as possible and should never ignore it. She stated CNA 2 should have answered the call light to avoid delays in providing care to residents.</p> <p>On October 31, 2024, at 4:15 p.m., the Director of Nursing (DON) was interviewed. The DON stated, staff members were expected to answer the call light immediately to ensure the needs of residents were met. The DON further stated, CNA 2 should have answered the call light even if the room was not assigned to him, and communicated the resident's needs to the appropriate staff.</p> <p>On October 31, 2024, Resident 7's record was reviewed. Resident 7 was admitted to the facility on [DATE], with diagnoses which included bilateral osteoarthritis of knee, muscle weakness, and asthma (a type of lung disease).</p> <p>A review of Resident 7's Brief Interview for Mental Status (BIMS -a tool used to screen and identify cognitive condition of residents), dated September 23, 2024, indicated a score of 13 (cognitively intact).</p> <p>A review of Resident 7's care plan, dated June 17, 2024, indicated, .ADL (activities of daily living)/Mobility: Resident has actual risk for ADL/mobility decline and requires assistance .Will have needs anticipated and met by staff .</p> <p>A review of facility policy and procedure titled, Answering the Call Light, dated October 2010, indicated, . Answer the resident's call as soon as possible .If you are uncertain as to whether or not a request can be fulfilled or if you cannot fulfill the resident' s request, ask the nurse supervisor for assistance .</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309</p> <p>Based on observation, interview, and record review, the facility failed to ensure the correct size bed rails were installed on one resident's bed as indicated on the resident's bed rails admission assessment, for one of seven sampled residents (Resident 2).</p> <p>This failure had the potential to result in negative outcomes including accident, physical restraint, decline in mobility and function, and psychosocial outcome.</p> <p>Findings:</p> <p>On October 31, 2024, at 12:02 p.m., a concurrent observation and interview were conducted with Resident 2. Resident 2 stated her bed was comfortable, but she did not like her side rails. Resident 2 stated she initially had short side rails but after she returned from the hospital, they changed her bed to one with longer side rails. She further stated that she felt closed in and she could not transfer easily to her wheelchair.</p> <p>A review of Resident 2's medical records indicated she was originally admitted on [DATE], with diagnoses of left knee and hip effusion (when fluids collect around a joint and cause swelling), muscle weakness, and was readmitted on [DATE].</p> <p>A review of Resident 2's History and Physical, dated September 18, 2024, indicated .patient has intermittent capacity to make decisions .</p> <p>A review of Resident 2's Bed Rail and Entrapment Risk Observation/assessment dated [DATE], and October 26, 2024, both indicated .quarter (1/4 - unit of measurement) bed rail type .left and upper locations .for mobility .</p> <p>On October 31, 2024, at 1:09 p.m., a concurrent observation, interview and record review were conducted with the Minimum Data Set (MDS) coordinator (a person who coordinates assessments in long-term care facilities). The MDS stated the admitting nurse would complete a bed rails assessment for each resident upon admission. The MDS stated, if the resident or family wished to make a change, a re-assessment of the resident would be done, and the physician would be informed. The MDS verified that Resident 2 had half side rails installed on her bed, instead of the quarter side rails as indicated on her bed rails assessment. The MDS stated Resident 2 should not have had half side rails installed on her bed because they could potentially make the resident feel entrapped and may have limited her mobility on the bed.</p> <p>On October 31, 2024, at 1:37 p.m., a concurrent observation and interview were conducted with the Maintenance Director (MTD). The MTD stated most of the facility beds came with the quarter side rails, which measured at 10 inches (a unit of measurement) long and half side rails, which measured at 32 inches long. The MTD verified that Resident 2 had half side rails installed on her bed.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On October 31, 2024, at 4:15 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated upon admission, all residents were assessed for side rail use. The DON stated in the facility, quarter side rails were standard but if a resident or family requested a change, the licensed nurse would re-assess the resident and inform the physician. The DON stated according to Resident 2's re-admission assessment, Resident 2 should have had quarter side rails, not the half side rails, on her bed. The DON stated Resident 2's bed rails assessment was not accurate and should have been followed up. The DON further stated the resident could potentially have felt uncomfortable and entrapped in her bed, which could have limited her mobility.</p> <p>A review of facility policy and procedure titled, Bed Safety and Bed Rails, dated August 2022, indicated, .The use of bed rails or side rails is prohibited unless the criteria for use of bed rails have been met .including resident assessments .The resident assessments to determine risk of entrapment includes .mobilit .accident hazards .barrier to perform routine activities .contributes to feelings of isolation .or anxiety .The staff shall report to the director or nursing and administrator any incidents associated with side or bed rails .</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309</p> <p>Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when a Certified Nurse Assistant (CNA) did not perform handwashing after leaving the room of a resident on Enhanced Barrier Precautions (EBP - infection prevention and control practices that can help reduce the spread of infection).</p> <p>This failure had the potential to increase the spread of pathogens (germs) from staff to residents which could lead to infections and illness.</p> <p>Findings:</p> <p>On October 31, 2024, at 9:29 a.m., a Certified Nursing Assistant (CNA) 1 was observed providing care to a resident on EBP. CNA 1 removed her gown and gloves and did not perform hand hygiene after exiting the resident's room. CNA 1 was observed grabbing a meal tray cart from outside and pushing the cart down the hallway.</p> <p>On October 31, 2024, at 9:31 a.m., CNA 1 was interviewed. CNA 1 stated she had forgotten to wash her hands and that she should have used the gel sanitizer outside in the hallway after leaving the resident's room. She further stated, not washing her hands could spread germs through cross contamination and potentially cause infections in the residents.</p> <p>On October 31, 2024, at 3:15 p.m., the Infection Preventionist (IP) was interviewed. The IP stated that all staff should wash their hands before and after any patient care or procedures. The IP further stated that CNA 1 should have washed her hands to prevent the spread of infection to the residents.</p> <p>On October 31, 2024, at 4:15 p.m., the Director of Nursing (DON) was interviewed. The DON stated all staff members were expected to perform hand washing before and after patient care. The DON stated that CNA 1 should have washed her hands or used the gel sanitizers available in the hallway. The DON further stated unwashed hands could transmit and spread infection to other residents.</p> <p>On October 31, 2024, Resident 6's record was reviewed. Resident 6 was admitted to the facility on [DATE], with diagnoses which included left hip replacement surgery and right breast cancer with mastectomy (surgery to remove a breast).</p> <p>A review of Resident 6's care plan, dated August 2, 2024, indicated, .Vascular Access: Resident is at risk for complications due to presence of a peripherally inserted central catheter (PICC - a long, thin tube that's inserted through a vein in your arm and passed through to the larger veins near your heart and used to deliver fluids and medications) .Utilize Enhanced Barrier Precautions (EBP) during high-contact resident care activities .</p> <p>A review of facility policy and procedure titled, Handwashing/Hand Hygiene, dated August 2019, indicated, . All personnel shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors .</p>		