

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 02/06/2025
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 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37536</p> <p>Based on observation, interview, and record review, the facility failed to provide adequate supervision to one of six sampled residents (Resident 1), who was diagnosed with dementia (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning) and had history of elopement (incident when a resident leaves the facility without authorization). In addition, the facility failed to frequently monitor the whereabouts of Resident 1 in accordance with the care plan.</p> <p>Resident 1 exited the facility on December 20, 2024, via the BC wing (name of a facility wing) automatic sliding door. It was observed that the sliding door led directly to the facility's parking lot, which led to a two-way street. This failure exposed the resident to immediate danger, accidents, serious harm, or death. Resident 1 returned to the facility on [DATE] (18 days after the resident eloped).</p> <p>On January 24, 2025, at 12:23 p.m., the Director of Nursing (DON) and the Director of Staff Development (DSD), were provided a copy of the CMS Immediate Jeopardy (IJ) template and notified them an immediate jeopardy (IJ) existed on December 20, 2024, related to Title 42 Code of Federal Regulation 483.25-Accidents (F 689).</p> <p>On January 24, 2025, at 1:32 p.m., the facility provided the corrective action plan dated January 15, 2025. On January 24, 2025, at 4:03 p.m., the surveyor validated that the facility removed the IJ (the facility has taken the necessary corrective actions to address and resolve the seriousness and urgent risk) before the survey entrance on December 24, 2024. IJ at F 689, severity J, cited as Past non-compliance (at some point, the facility did not meet the established rules).</p> <p>Findings:</p> <p>A review of Resident 1's admission record indicated Resident 1 was admitted on [DATE], with diagnoses of dementia, paranoid schizophrenia (a mental illness that is characterized by disturbances in thought), and psychoactive substance abuse (a strong desire or sense of compulsion to take a drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior).</p> <p>A review of Resident 1's History and Physical, dated November 7, 2024, indicated Resident 1 did not have the capacity to understand and make decisions.</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: 555921
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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>A review of Resident 1's Elopement and Wandering (the behavior of moving about without clear purpose) Risk Observation/Assessment, dated November 6, 2024, indicated, Instructions: Evaluate/Assess the resident status in the seven clinical areas listed below. If the total score is 10 or greater, the resident would be considered At Risk for Wandering or Elopement. Interventions implemented as determined by the facility IDT .A. MOBILITY STATUS . 4. Does the resident ambulate (move from one place to another) independently with or without the use of assistive devices (tools or equipment to help resident perform task that might be difficult) . B. COGNITIVE STATUS .2. Is the resident disoriented or has periods of confusion and/or impaired attention span but does not wander . C. DISEASE DIAGNOSIS .Does the resident have a diagnosis that may impact cognition? (i.e. Alzheimer's disease [a progressive, neurodegenerative disorder that affects memory, thinking, and behavior], Anxiety Disorder [a mental health condition characterized by excessive and persistent worry, fear, and unease that can interfere with daily life] . 4. Two or more present .E. MEDICATION (Does the resident take medications that could increase restlessness or agitation . 4. Takes two or more medications . I. INTERVENTIONS . 1. Has the care plan been initiated/updated to reflect interventions aimed at reducing the risk of unsafe wandering or an elopement a. Yes .</p> <p>A review of Resident 1's eINTERACT Change in Condition Evaluation, dated November 12, 2024, at 6:24 p. m., indicated .Resident wanders around. Found resident outside facility along (name of the street - which was 2.2 miles from the facility) .</p> <p>A review of Resident 1's eINTERACT Change in Condition Evaluation, dated December 20, 2024, at 6 p.m., indicated, .charge nurse reported to RN [Registered Nurse], patient was not located in her room around 1700 (5p.m.), patient was last seen at 16:00 (4 p.m.) in-patients (sic) room. All nursing staff looked all around facility and could not find the patient. police dept (department) was notified at 17:45 (5:45 p.m.). Md (Medical Doctor), notified. No family or emergency contact phone number is listed on patient face sheet.</p> <p>A review of Resident 1 ' s Care Plan indicated the following:</p> <p>- On November 12, 2024, .Resident wanders around .Goal .Resident will stay in the facility until they find placement .Interventions .Did frequent visual check to resident. Placing resident close to nursing station . resident was placed to another room and station for closer monitoring and doors with alarms .</p> <p>- On November 27, 2024, .Elopement: Resident is at risk for elopement/exit seeking/wandering related to dementia or other cognitive impairment (decline or difficulty in mental abilities such as memory, thinking or decision making) .Goal .will not wander out of facility .Interventions .monitor whereabouts frequently .</p> <p>A review of the video surveillance footage of the whereabouts of Resident 1 with time stamped images with date and time indicated the following:</p> <p>.12-20-2024 .2:57 p.m. Resident 1 was standing in Hallway B lobby, in front of the nursing station located in the BC wing of the facility, with automatic doors open.</p> <p>.12-20-2024 .2:58 p.m. Resident 1 was walking out of the facility BC wing automatic sliding door.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>.12-20-2024 .3:02 p.m. Resident 1 was walking into the facility with BC wing automatic sliding door open and sitting in the front lobby with belonging bag in hand watching television.</p> <p>.12-20-2024 .3:08 p.m. Resident 1 was walking out of the facility BC wing automatic sliding door and did not re-enter the facility.</p> <p>Further review of the video surveillance footage dated December 20, 2024, from 2:57 to 3:08 p.m. did not show presence of facility staff to supervise the resident nor to redirect the resident away from the BC wing automatic sliding door.</p> <p>A review of Resident 1 ' s progress notes dated December 20, 2024, at 5:57 p.m., .CNA (Certified Nursing Assistant) alerted charge nurse of patient not being in room at 5:00 p.m. Patient was last seen at 3:45 p.m. in patients (sic) room, CNA stated she saw the patient at the beginning of her shift before she started doing patient care and after she was done with patient care went to go check on patient and noticed she was not in her room .We notified police at 5:45 p.m.</p> <p>Further review of Resident 1's progress notes dated November 16, 2024, to December 20, 2024, indicated there was no documented evidence that the facility frequently monitored Resident 1's whereabouts.</p> <p>On January 23, 2025, at 12:52 p.m., during an interview with CNA 1, CNA 1 stated on December 20, 2024, Resident 1 was assigned to her for the 7 a.m. to 3 p.m. shift. CNA 1 stated on December 20, 2024, prior to leaving for the day at 3 p.m., she had seen Resident 1 in her room. CNA 1 stated she was unaware Resident 1 had eloped from the facility on November 12, 2024, and would have considered the resident as high risk for elopement. CNA 1 stated residents at risk for elopement would require checking on the resident at least every two hours. CNA 1 stated that during her shift on December 20, 2024, BC wing automatic sliding door was opened and was being used by visitors to enter and exit the facility.</p> <p>On January 23, 2025, at 1:11 p.m., during an interview with Licensed Vocational Nurse (LVN 1), LVN 1 stated that he was working on December 20, 2024, 7 a.m. to 3 p.m., shift. LVN 1 stated that he had seen Resident 1, who was from Hallway A, sitting in a chair adjacent from Nursing station B, by the BC wing automatic sliding door before 3 p.m. LVN 1 stated that when residents have a history of elopement they should be placed on 1:1 (one staff to one resident) for 72 hours, they should be checked at least hourly, and the residents ' location should be known at all times. LVN 1 stated he was unaware that Resident 1 had a history of elopement and was unsure if the staff in Hallway A knew Resident 1 was by the BC wing automatic sliding door.</p> <p>On January 23, 2025, at 1:24 p.m., during an interview with CNA 2, CNA 2 stated if a resident is at risk for elopement, the staff should check on the resident every hour and the facility staff should know where the residents are at all times. CNA 2 stated that the BC wing automatic sliding door was open before, (prior to the elopement incident of Resident 1), but this door is now locked.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>On January 23, 2025, at 1:30 p.m., during a concurrent observation and interview, Resident 3 was sitting in a chair next to the BC wing automatic sliding door. Resident 3 stated that on December 20, 2024, he was sitting here in this location (near the BC wing with automatic sliding door) with Resident 1. Resident 3 stated that Resident 1 walked out the automatic door a little after 3 p.m. Resident 3 stated that there were staff at the nursing station across from the BC wing automatic sliding door.</p> <p>On January 23, 2025, at 4:21 p.m., during an interview with the Registered Nurse Supervisor (RN), the RN stated she was working on December 20, 2024, 3 p.m. to 11 p.m. shift. The RN stated Resident 1 was not able to be located on December 20, 2024. The RN stated they searched the premises, reported the elopement to the Director of Nursing, and the police department.</p> <p>On January 24, 2025, at 10:40 a.m., during an interview with LVN 2, LVN 2 stated that she was working on December 20, 2024, from 7 a.m. to 11 p.m. LVN 2 stated that she had given Resident 1 her medications between 12:30 p.m. and 1 p.m., prior to attending the staff meeting, which ended at approximately 3 p.m. LVN 2 stated at approximately 5 p.m., CNA 3 reported to her that she could not locate Resident 1. LVN 2 stated that she was aware that Resident 1 was a risk for elopement, however, she did not report this information to CNA 3 as she (CNA 3) had cared for Resident 1 before. LVN 2 stated they should have been checking on Resident 1 every two hours. LVN 2 stated that they should have been aware that Resident 1 was off the unit.</p> <p>On January 24, 2025, at 2:49 p.m., a telephone interview was conducted with CNA 3. CNA 3 stated she was working on December 20, 2024, 3 p.m. to 11 p.m., and was assigned to care for Resident 1. CNA 3 stated that when she came on to her shift, she went room to room to check on her assigned residents but did not see Resident 1. CNA 3 stated did not know that Resident 1 was a high risk for elopement, as she never received that information.</p> <p>A review of the facility's policy and procedure titled Wandering and Elopements revised March 2019, indicated The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents .1. If identified as at risk for wandering, elopement, or other safety issues, the resident's care plan will include strategies and interventions to maintain the resident's safety .</p> <p>A review of the facility's Corrective Action Plan dated January 15, 2025, included the following:</p> <p>Immediate Actions:</p> <p>Facility followed the policy and procedure in searching for the resident missing upon knowledge of resident not being in the facility on December 20, 2024.</p> <p>Staff searched inside the facility while other staff searched around the vicinity. The facility notified the police department as well calling (emergency room s) ER around the area and called the homeless shelter where she was at prior, to see if she checked in there. Staff continued driving round the area to search for the resident on December 20, 2024.</p> <p>The facility created a plan to close BC wing sliding door between 8:30 am to 5 pm and have a designated staff to monitor the door between 6:00 am to 8:30 am. Signage was also placed of the time the sliding door will be closed and when it will be available for entrance and exit.</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Immediate jeopardy to resident health or safety</p> <p>Residents Affected - Few</p>	<p>In-services were given by the RN supervisor and the Director of Staff Development on December 21, 2024, to staff regarding the facility policy and protocol on elopement and wandering of the residents, as well as, providing staff an update on the plan discussed by IDT.</p> <p>Identification of others:</p> <p>The DON reviewed all current residents who were at high risk for elopement on December 21, 2024. The facility identified 1 resident. This resident was placed on I: I sitter immediately.</p> <p>Facility identified all residents who are considered high risk for elopement and necessary interventions were placed such as (I: I Sitter. activity monitoring Q hour, [every hour], Q 2 [every two] hours). The Emergency IDT [Interdisciplinary Team] meeting with all the department managers was held on December 21, 2024, to discuss a plan to prevent resident elopement.</p> <p>On December 21, 2024, the facility created an elopement risk binder with the face sheet and photos of residents who are high risk for elopement and this binder is kept in nursing station and in the front lobby with the receptionist, for the staff to be aware of the residents at risk for elopement. Binders are updated by the DON and updated as needed.</p> <p>On admission a wandering evaluation will be conducted and when resident scores 10 and above or noted to have high risk of wandering, staff will initiate preventative measures and ensure proper documentation and notify DON accordingly.</p> <p>The maintenance supervisor or designee will check all the emergency doors, making sure the alarm is placed and working daily. Any findings will be corrected immediately.</p> <p>On December 21, 2024, facility Administrator contacted wander guard vendor for installation quotes and installing schedule. Estimated installation schedule is anticipated to be completed by January 31, 2025.</p> <p>The maintenance supervisor will conduct random checks on different shifts to monitor the alarms of the emergency door and report the response time of the staff when the alarm goes off biweekly x 3 months. Findings will be reported during the QA Meeting to monitor trends and compliance.</p> <p>The DON will report on monthly QA those residents at risk for elopement or any resident identify score of 10 or above on elopement assessment and discuss effectiveness of measure provided and monitor for trends.</p> <p>Completion date: January 13, 2025.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37536</p> <p>Based on observation, interview, and record review, the facility failed to ensure accurate documentation for one of six residents reviewed, (Resident 1), as the resident's record indicated Resident 1 was last seen at 3:45 p.m. on December 20, 2024, while the video surveillance showed Resident 1 left the facility at 3:08 p.m. on December 20, 2024.</p> <p>This failure resulted in an inaccurate account of Resident 1's whereabouts and potentially impacting the accuracy of their care documentation.</p> <p>Findings:</p> <p>On January 23, 2025, at 10:45 a.m., an unannounced visit to the facility on a facility reported incident was initiated.</p> <p>A review of Resident 1's medical records indicated she was admitted on [DATE], with diagnoses of dementia, (a chronic or persistent disorder of the mental processes caused by brain disease or injury and marked by memory disorders, personality changes, and impaired reasoning), paranoid schizophrenia, (a mental illness that is characterized by disturbances in thought), psychoactive substance abuse. (a strong desire or sense of compulsion to take a drug that affects how the brain works and causes changes in mood, awareness, thoughts, feelings, or behavior). Resident 1 eloped from the facility on December 20, 2024.</p> <p>A review of Resident 1's History and Physical dated November 7, 2024, indicated she did not have the capacity to understand and make decisions.</p> <p>A review of the video surveillance footage of the whereabouts of Resident 1 with time stamped images with date and time indicated the following:</p> <p>.12-20-2024 .3:08 p.m. Resident 1 was walking out of the facility through BC wing automatic sliding door and did not re-enter the facility.</p> <p>A review of Resident 1's Nurse's Note dated December 20, 2024, at 5:57 p.m., indicated, .CNA alerted charge nurse of patient (Resident 1) not being in room at 1700. Patient (Resident 1) was last seen at 15:45 (3:45 p.m.) in patients room. The CNA stated she saw the patient at the beginning of her shift before she started doing patient care and after she was done with patient care went to go check on patient and noticed she was not in her room .</p> <p>A review of Resident 1's eINTERACT Change in Condition Evaluation dated December 20, 2024, at 6 p.m., indicated, .charge nurse reported to RN, patient (Resident 1) was not located in her room around at 1700 (5 p.m.), patient (Resident 1) was last seen at 16:00 (4 p.m.) in-patients room. All nursing staff looked all around facility and could not find the patient. police dept was notified at 17:45. (5:45 p.m.) md notified. No family or emergency contact phone number is listed on patient face sheet .</p> <p>(continued on next page)</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On January 23, 2024, at 1:30 p.m., an interview was conducted with Resident 3. Resident 3 was sitting in a chair next to the automatic door in Hallway B. Resident 3 stated that on December 20, 2024, he was sitting here in this location with Resident 1. Resident 3 stated that Resident 1 walked out the automatic door a little after 3 p.m. and headed to the right. Resident 3 stated that there were staff at the nursing station across from the BC wing automatic sliding door.</p> <p>On January 24, 2024, at 10:40 a.m., an interview was conducted with LVN 2. LVN 2 stated that she was working on December 20, 2024, from 7 a.m. to 11 p.m. LVN2 stated that she had given Resident 1 her medications between 12:30 p.m. and 1 p.m. LVN2 stated she went to a staff meeting at 2:30 p.m. and saw Resident 1 in her room. LVN 2 stated the meeting ended approximately 3 p.m. LVN 2 stated that approximately 5 p.m. CNA 3 reported to her that she could not locate Resident 1. LVN 2 stated that CNA 3 had reported that she last saw Resident 1 in her room or nursing station between 3:45 p.m. and 4 p.m.</p> <p>On January 24, 2024, at 2:49 p.m., a telephone interview was conducted with CNA 3. CNA 3 stated she was working on December 20, 2024, 3 p.m. to 11 p.m., and was assigned to care for Resident 1. CNA 3 stated that when she came on to her shift, she goes room to room to check on her assigned residents. CNA 3 stated that she did not see Resident 1 on her first rounds. CNA 3 stated that after she provided care to a resident, she searched the facility for Resident 1. CNA 3 stated that she informed LVN 2 that she was unable to locate Resident 1 after she searched for her. CNA 3 stated that she was unsure that Resident 1 was a high risk for elopement as she never received that information.</p> <p>A review of the facility policy and procedure titled Charting and Documentation revised July 2017, indicated . 3. Documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate .</p>		