

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  12/15/2025
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)
F 0573  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records.  (continued on next page)

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 0573</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on interview and record review the facility failed to ensure that upon written request, medical records were released within two working days, for one of two sampled residents (Resident 5). This failure had the potential to impact continuity of care, appeals, or legal matters. Findings: On November 20, 2025, at 11:30 a. m., an unannounced visit was conducted at the facility for the investigation of a complaint. On November 20, 2025, Resident 5's record was reviewed. Resident 5 was admitted on [DATE], and discharged [DATE], with diagnoses that included aftercare following surgical amputation (a medically approved removal of a part of the body). A review of the facility document titled, Released Records Log indicated that on May 14, 2025, the following records were to be released for Resident 5. .5/14 nursing notes.not picked up. There were no additional notations made on this log related to the records request for Resident 5's medical records being provided to or picked up by a representative party of Resident 5 until November 20, 2025. A review of the facility document titled Authorization form for the Release of Health Information dated May 14, 2025, indicated a request for medical records for Resident 5. The form indicated Resident 5 requested copies of nursing progress notes dated May 14, 2025, for personal use, and indicated that the records would be picked up at the facility. Resident 5's signature and the date May 14, 2025, were documented on the form. A review of the untitled electronic response from the facility legal analyst dated May 15, 2025, indicated .according to PCC (the online medical record) the resident only has a BIMS (Brief Interview for Mental Status) of 4 (0-7 signifies severe cognitive impairment) The wife, (name of wife), will need to sign the request form in order for records to be released. There was no documentation indicating that the resident's representative was notified that a signature was required to process the record's request. On November 20, 2025, at 12:01 p.m., an interview was conducted with the Medial Records Director (MRD). The MRD stated that once a request had been received, the facility had two days to process the request and have the records sent. The MRD continued, that once a request was received it would be forwarded to the legal for approval. The MRD stated once the legal team approved the request, the records would be prepared and sent. The MRD stated, the original request was forwarded to the legal department on May 15, 2025, but she did not follow up with Resident 5's wife when she did not arrive to pick up the records. The MRD acknowledged that she should have followed up within two days and did not do so. The MRD stated that the resident's wife contacted the facility on November 20, 2025, requesting all records, which were being processed and expected to be available on November 21, 2025. On 11/20/2025 at 4:50 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated when a records request is submitted, the MRD verifies the information, forwards the request to the legal department for authorization, and the records should be released within two business days following approval. The DON further stated, the records requested in May 2025, should have been provided to the requesting party within two business days of the request. A review of the facility policy titled, Release of Information dated April 1, 2020, indicated, .all information contained in the resident's medical record may only be released by written consent of the resident or his/her legal representative.the resident may initiate a request to release such information in his/her records and charts to anyone he/she wishes. Such requests will be honored only upon the receipt of a written, signed, and dated request form the resident or representative.long term care facilities to provide a copy of their records within two working days (when requested by the resident).Specifically, CMS is modifying the timeframe requirement to allow LTC facilities ten working days to provide a resident's record rather than two working days.</p>		