STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555921	A. Building B. Wing	01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Rancho Bellagio Post Acute	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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on interview and record review, the facility failed to ensure sufficient staff were provided to meet the needs of the residents when the facility did not meet the required minimum of actual total Certified Nurse Assistant (CNA) Direct Care Hours Per Patient Day (DHPPD - measure the numbers of hours of direct care given to residents in skilled nursing facility) of 2.4 hours for the months of October 2025, November 2025, December 2025, and January 2026.The failure to maintain the required minimum CNA DHPPD hours had the potential to place residents at risk for unmet needs, compromised safety, and decreased quality of care. Findings:On January 28, 2026, at 1:40 p.m., the facility staffing records were reviewed. The review indicated the facility's CNA staffing levels were below the minimum required DHPPD of 2.4 hours on the following dates:-October 1, 2025, through October 31, 2025-November 1, 2025, through November 30, 2025-December 1, 2025, through December 20, 2025-December 22, 2025, through December 30, 2025-January 1, 2026, through January 19, 2026-January 21, 2026-January 23, 2026, through January 25, 2026-January 27, 2026On January 28, 2026, at 1:40 p.m., a concurrent interview and record review of the facility's Census and Direct Care Service Hours Per Patient Day (DHPPD) report was conducted with the Director of Staff Development (DSD). The DSD stated the facility's CNA DHPPD hours were below 2.4 hours for the entire months of October 2025 and November 2025. The DSD further stated the CNA DHPPD hours were below 2.4 hours for 30 of 31 days reviewed in December 2025 and 24 of 27 days reviewed in January 2026. The DSD stated the CNA DHPPD hours should be maintained at 2.4 hours to ensure safe and quality resident care. On January 29, 2026, at 11:40 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated staff resignations, position changes, reductions in hours, and call-off contributed to the facility's inability to meet the required CNA DHPPD hours. The DON further stated CNA DHPPD hours should be maintained at 2.4 hours to ensure residents' needs were met and quality care was provided. A review of the facility's policy and procedure titled, Staffing, dated October 2017, indicated, .facility provides sufficient numbers of staff.to provide care and services for all residents.

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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Rancho Bellagio Post Acute	26940 E Hospital Road Moreno Valley, CA 92555

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to promptly notify the physician for a change in condition, for two of eight residents reviewed for changes in condition (Resident 8 and 110) when: 1. For Resident 8, licensed nurses did not notify the physician of multiple refusals of prescribed insulin [chemical in the body that helps move sugar from the blood into the body's cells]. 2. For Resident 110, licensed nurses did not notify the physician of the repeated episodes of blood pressure readings less than 100/60 mm Hg (millimeters per mercury - unit of measurement). These failures placed the residents at increased risk to their health and well-being due to the lack of physician oversight necessary to evaluate and address changes in their medical conditions. Findings: 1.On January 25, 2026, at 12:06 p.m., an interview was conducted with Resident 8 in his room. Resident 8 stated he had insulin ordered but had been refusing it because he believed he did not need it. On January 26, 2026, Resident 8's admission record was reviewed. The resident was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (high blood sugar) with diabetic neuropathy (nerve damage caused by high blood sugar). A review of Resident 8's Minimum Data Set (MDS – an assessment tool) dated December 28, 2025, indicated a Brief Interview for Mental Status (a tool to assess cognitive function) score of 12 (moderate cognitive impairment) A review of Resident 8's record, titled, Order Summary Report, dated January 28, 2026, indicated, .Humalog Solution 100 unit/ml (unit of measurement) Insulin Lispro [fast-acting insulin medication used to lower blood sugar quickly] Inject as per sliding scale. A review of Resident 8's Diabetic Administration Record for December 2025, indicated multiple consecutive refusals of prescribed insulin as follows: -December 17, 18, and 19, 2025, during the 9 p.m. dose -December 23, 24, 25, and 26, 2025, during the 9 p.m. dose. Further review of Resident 8's Diabetic Administration Record for January 2026, indicated additional consecutive insulin refusals, including: -January 5, 6, 7, and 8, 2026, during the 4:40 p.m. dose -January 9,10, 11, and 12, 2026, during the 6:30 a.m. dose -January 15,16, 17, 18, and 19, 2026, during the 6:30 a.m. dose -January 24, 25, 26, and 27, 2026, during the 6:30 a.m. and 11:30 a.m. doses A review of Resident 8's record indicated there was no documentation licensed nurses notified the physician of the consecutive insulin refusals during December 2025 or January 2026. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 29, 2026, at 10:13 a.m., an interview with the Licensed Vocational Nurse (LVN) 3 was conducted. LVN 3 stated, if a resident refused a medication multiple times, he would notify the physician and complete a change in condition assessment. On January 29, 2026, at 10:23 a.m., a concurrent interview and record review with the RN Supervisor (RNS) was conducted. The RNS stated the physician should have been notified of the repeated refusals. On January 29, 2026, at 1:56 p.m., an interview was conducted with the DON. The DON stated, when medications were refused three consecutive times, the physician should be notified, and documentation should be made in the progress notes for resident safety. A review of the facility's policy and procedure titled, Change in a Resident's Condition or Status, dated May 2017, indicated, .facility shall promptly notify.Attending Physician.of changes in the resident's medical.condition and/or status.refusal of treatment or medications two (2) or more consecutive times . 2. A review of Resident 110's admission Record dated January 29, 2026, indicated an admission date of December 30, 2025, with a diagnosis which included heart failure. A review of Resident 110's Minimum Data Set (an assessment tool) dated January 5, 2026, indicated a Brief Interview for Mental Status (a tool to assess cognitive function) score of 11 (moderate cognitive impairment). A review of Resident 110's Care Plan revised January 9, 2026, indicated, .Focus.ADL/Mobility.actual.at risk for ADL (activities of daily living) /mobility decline.related to.12/30/254 dx (diagnosis) [NAME] Syndrome (hypersensitivity reaction) .Interventions.Monitor vital signs and report abnormal findings to physician. A review of blood pressure records indicated Resident 110 had repeated blood pressure readings of less than 100/60 mm Hg (millimeters mercury- unit of measurement): -January 3, 2026, at 1:30 a.m.: 93/73 -January 4, 2026, at 9:26 a.m.: 68/49 -January 4, 2026, at 9:27 a.m.: 68/49 -January 4, 2026, at 1:57 p.m.: 96/52 -January 5, 2026, at 8:47 a.m.: 87/66 -January 5, 2026, at 8:48 a.m.: 87/66 -January 5, 2026, at 9:20 a.m.: 87/66 -January 5, 2026, at 1:01 p.m.: 98/68 -January 6, 2026, at 4:58 a.m.: 97/77; and (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-January 6, 2026, at 8:51 a.m.: 98/70 On January 29, 2026, at 9:29 a.m., an interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated if the resident had three consistent low blood pressure readings, it should be reported to the physician as a change in condition. LVN 1 stated there was no documentation indicating the physician was notified regarding Resident 110's low blood pressure readings. On January 29, 2026, at 10:56 a.m., an interview and record review was conducted with the Director of Nursing (DON). The DON stated there was no documented evidence the physician was notified of Resident 110's low blood pressure readings from January 3, 2026, to January 6, 2026. The facility's policy and procedure titled, Blood Pressure, Measuring, dated September 2010, indicated, .Hypotension. blood pressure less than 100/60 mm/Hg.should be reported to the physician.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to develop a comprehensive care plan to address a resident's repeated refusal of prescribed insulin (a chemical in the body which helps more sugar from the blood into the body's cells) for one of ten residents for care planning (Resident 8). This failure placed Resident 8 at risk for uncontrolled blood glucose levels and potential diabetic complications.Findings:On January 25, 2026, at 12:06 p.m., an interview was conducted with Resident 8 in his room. Resident 8 stated that he had insulin ordered but refuses to take it because he believed he did not need it. On January 26, 2026, Resident 8's admission record was reviewed. Resident 8 was admitted to the facility on [DATE], with diagnoses which included type 2 diabetes mellitus (high blood sugar) with diabetic Neuropathy (nerve damage caused by high blood sugar). A review of Resident 8's record, titled, Order Summary Report, dated January 28, 2026, indicated, .Humalog Solution 100 unit/ml (unit of measurement) Insulin Lispro [fast acting insulin medicine used to lower blood sugar quickly] Inject as pre sliding scale. A review of Resident 8's Diabetic Administration Record indicated the resident initially refused the prescribed insulin on December 16, 2025. Further review indicated the resident refused insulin a total of 23 times during December 2025. A review of the Resident 8's comprehensive care plan dated December 15, 2025, indicated, .Psychosocial- Refusal of care: Resident refuses care and services within their rights as manifested by non-compliance/ refusal of treatments.refusal to have BS check and insulin date-initiated January 16, 2026. Further review of Resident 8's comprehensive care plan indicated no care plan was initiated on or after December 16, 2025, when the resident first refused insulin, to address the repeated refusal of prescribed insulin. There was no documentation of identified problem statements, measurable goals, interventions, or monitoring related to insulin refusal between December 16, 2025, and January16, 2026. On January 29, 2026, at 1:56 p.m., a concurrent interview and record review of Resident 8's care plan were conducted with the DON. The DON stated the resident's care plan should have been initiated on December 16, 2025, when the resident first refused insulin and not on January 16, 2026. The DON further stated, it was important to have continuation of care, so staff were aware of the plan and to prevent potential complications from occurring. The facility policy and procedure, titled, Care Plan Comprehensive Person Centered dated December 2016, indicated, .includes measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.incorporate identified problem areas.incorporate risk factors associated with identified problems.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of five residents (Resident 22) reviewed received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. For Resident 22, nursing staff did not follow the physician's insulin (medication to treat diabetes) sliding scale order (a chart with insulin doses to maintain blood sugar levels) to notify the physician when the blood sugar (BS) result was above 350. This failure had the potential to compromise Resident 22's health and well-being. Findings: A review of Resident 22's admission Record, dated January 28, 2026, indicated Resident 22 was admitted to the facility on [DATE], with diagnoses including diabetes. A review of Resident 22's Care Plan Report, dated May 8, 2025, indicated, Focus.Diabetes.Interventions.Administer medication as ordered.Blood glucose (sugar) checks as ordered. Report to physician if blood glucose is outside of set parameters. A review of Resident 22's blood sugar records dated December 3, 2025, at 21:08 (9:08 p.m.) indicated her BS was 438 mg (milligram, unit of measurement) /dl (deciliter, unit of measurement). A review of Resident 22's medical record indicated a provider's order dated May 5, 2025, for Insulin Lispro (medication for diabetes) Injection Solution 100 units/ml (milliliters, unit of measurement), Inject as per sliding scale if (BS):70 - 150 (mg/dl) = 0 No Correction; 151 - 200 (mg/dl) = 4 units; 201 - 250 (mg/dl) = 6 units; 251 - 300 (mg/dl) = 8 units; 301 - 350 (mg/dl) = 10 units; > (greater than) 350 = 12 units and Call and Notify MD (medical doctor),subcutaneously (SC, under the skin) three times a day for Diabetes Mellitus, Hold if BS < (less than) 70. A review of Resident 22's Medication Administration Record (MAR) dated December 2025 indicated nursing staff documented Insulin Lispro Injection Solution insulin sliding scale was not administered to Resident 22 on December 3, 2025, at 21:08 (9:08 p.m.) when her BS was 438 mg/dl. A review of Resident 22's electronic MAR (eMAR) Medication Administration Note dated December 3, 2025, at 21:08 (9:08 p.m.) indicated there was no evidence of nursing documentation that the doctor was notified when Resident 22's blood sugar level was above 350, as prescribed on the provider's order for Insulin Lispro sliding scale dated May 5, 2025. During a concurrent interview and record review on January 28, 2026, at 10:36 a.m., with Licensed Vocational Nurse (LVN) 2, Resident 22's physician's order dated May 5, 2025, and MAR dated December 2025 were reviewed. LVN 2 stated when Resident 22's BS was 438 mg/dl on December 3, 2025, at 21:08 (9:08 p.m.) he would have followed the physician's order, administered 12 units of insulin lispro and called the physician. Additionally, LVN 2 stated he would have documented in the nursing MAR note that the physician was notified and any additional instructions from the physician. LVN 2 stated he was unable to locate documentation in Resident 22's medical record that nursing staff notified the physician when her BS was 438 mg/dl on December 3, 2025, at 21:08 (9:08 p.m.). During a concurrent interview and record review on January 28, 2026, at 11:00 a.m., with the Director of Nursing (DON), Resident 22's physician's order dated May 5, 2025, MAR dated December 2025 and eMAR Medication Administration Note dated December 3, 2025, were reviewed. The DON stated when Resident 22's BS was 438 mg/dl, the nurse should have administered 12 units of insulin lispro and notified the physician as ordered. Additionally, the DON stated the nurse should have documented in the resident's medical record that the physician was notified. The DON acknowledged there was no evidence in Resident 22's medical record of documentation by nursing staff that the doctor was notified when BS was 438 mg/dl on December 3, 2025, at 21:08 (9:08 p.m.). The DON stated the expectation was for nursing staff to follow the physician's order and document in the resident's medical record. During a review of the facility's policy and procedure (P&P), titled Administering Medications, revised April 2019, the P&P indicated, Medications are administered in accordance with prescriber orders .