STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555309	A. Building B. Wing	05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Permit a resident to return to the nursing home after hospitalization or therapeutic leave that exceeds bed-hold policy.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY 47832

Based on interview and record review, the facility failed to ascertain the current condition of one of three sampled residents (Resident 1), prior to refusing the resident's re-admission to the facility. The resident had been living at the facility for [AGE] years. This failure increased the potential for prolonged hospital stay and emotional distress to Resident 1 and his family.

Findings:

On May 13, 2024, at 9:05 a.m., an unannounced visit to the facility was conducted to investigate a complaint related to refusal to readmit.

On May 13, 2024, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with a diagnoses which included history of traumatic brain injury (when a sudden external physical assault damages the brain) and adjustment disorder with mixed disturbance of emotions and conduct. The facility history and physical indicated Resident 1 did not have the capacity to understand and make decisions.

Resident 1's medical record indicated that on April 9, 2024, resident was transferred to emergency room under 51-50 (a Code when an adult experiences a mental crisis and a danger to themselves and or others and detained for 72-hour psychiatric hospitalization) for psychiatric evaluation and treatment. The record also indicated no bed-hold.

A review of Resident 1's Progress Notes dated April 9, 2024, by the Activities Director indicated, Resident had a major behavior outburst today during bingo. He was upset because another resident won the game. Activity staff wheeled him outside to calm him down, but resident refused to be outside and wanted to go to his room to play on his play station. While he was wheeled back to his room, his behavior outburst escalated when he saw his med nurse and a CNA. Resident started to yell again, swearing and trying to hit staff, he tore down the big picture frame in the west hallway, throwing the barrels, chairs and broke the isolation carts. He was also banging the doors and punching the walls.

On May 13, 2024, at 8:41 a.m., during an interview, Resident 1's conservator (appointed to protect and or finances of an incapacitated adult) stated Resident 1 was living at the facility for [AGE] years and no one from the facility had contacted him to readmit his family member (Resident 1).

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555309	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sundance Creek Post Acute	5800 West Wilson Street Banning, CA 92220

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 0626 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On May 13, 2024, at 10:13 a.m., during an interview, Medical Records Director stated the Administrator gave an instruction on May 5, 2024, not to readmit Resident 1. On May 13, 2024, at 10:17 a.m., during an interview, Licensed Vocational Nurse (LVN) stated there was no adverse change in Resident 1's behavior in the last six months. On May 13, 2024, at 11:37 a.m., during an interview, the Director of Nursing (DON) stated the facility did not readmit Resident 1 as it was decided that he could not be safely taken care by the facility and the plan was to assist Resident 1 in finding a placement. On May 14, 2024, at 4:35 p.m., during an interview, the DON stated after Resident 1 was transferred to the hospital on April 9, 2024, she did not follow-up with the hospital if Resident 1's behavior had improved and been stabilized. On May 7, 2024, at 11:38 a.m., during an interview, the Administrator (ADM) stated a determination was made that the facility would be unable to take care of Resident 1 due to his behavior. The ADM stated in the best interest of other residents and employees, it was decided not to readmit Resident 1 to the facility. A review of Resident 1's psychologist note dated May 7, 2024, indicated Resident 1 is a danger to self and others. Due to his behavior, he would not be able to return to the facility. On May 7, 2024, during an interview, the treating Psychiatrist stated Resident 1 had agitation, aggressive behavior, was unable to follow directions which made him dangerous to others and older residents could not fight back to him. Treating Psychiatrist also stated Resident 1 needed to live with people closer to his age. The facility policy and procedure were reviewed. The policy titled, Bed-Holds and Returns revised October 2022, indicated, .the requirement that residents be permitted to return to the facility following hospitalization or therapeutic leave applies to all residents regardless of payer source .