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	01/03/2025

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 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37536 Based on interview and record review, the facility failed to provide showers on scheduled shower days and bed baths on non-shower days, for one of three sampled residents (Resident A). This failure had the potential to negatively affect the resident ' s physical, emotional, and social well-being which included skin infections, body odor, and discomfort. Findings: Resident A ' s record was reviewed. Resident A was admitted to the facility on [DATE], with diagnoses which included bilateral lower extremities contractures (both legs experienced shortening of muscles leading to restricted movements) and history of cerebrovascular accident (stroke) with left-sided deficits (loss or impairment of function on the left side). A review of Resident A ' s care plan dated July 5, 2024, indicated, .ADL (activities of daily living)/Mobility: Resident .is at risk for ADL/mobility decline and requires assistance related to .HEMIPLEGIA (paralysis on one side of the body) AND HEMIPARESIS (weakness on one side of the body) .MUSCLE WEAKNESS . muscle wasting and Atrophy (gradual wasting away or decrease in size of a body part or tissue) .Encourage to participate in ADLs to promote independence .Monitor for .declines in ability to participate in ADLs . On December 18, 2024, at 10:21 a.m., Certified Nursing Assistant (CNA) 2 was interviewed. CNA 2 stated, residents were provided showers three to four times a week. CNA 2 stated, resident could be provided daily showers if the residents requested them. CNA 2 stated, if a resident refused a shower, she would offer the resident a bed bath. CNA 2 stated, if the resident refused twice, she would report this to the charge nurse. On December 18, 2024, at 11 am., CNA 4 was interviewed. CNA 4 stated, she was familiar with Resident A. CNA 4 stated, Resident A was dependent on all activities of daily living. CNA 4 stated residents were given bed bath if there was no scheduled shower. CNA 4 stated if a resident refused shower, it would be documented, and a bed bath would be provided according to facility protocol. On December 18, 2024, at 3:16 p.m., Licensed Vocational Nurse (LVN) 2 was interviewed. LVN 2 stated, she cared for Resident A. LVN 2 stated Resident A was non-verbal and required assistance with showering. LVN 2 stated Resident A preferred bed bath. (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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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident A's Documentation Survey Report, for July 2024 and August 2024, indicated that on July 25, August 1, and August 5, 2024, Resident A's scheduled shower days, the resident received bed bath instead of showers. In addition on July 29, 2024, Resident A was not provided showers nor a bed bath. There was no documentation indicating Resident A refused showers. Further review of Resident A ' s Follow-up Question Report, for the month of July 2024 and August 2024, indicated that on July 3, 5, 6, 7, 9, 10, 11, 12, 15, 16, 17, 18, 19, 20, 21, 23, 24, 26, 29, 30, 31, and August 4 and August 6, 2024, there was no documentation indicating that Resident A received a shower or bed bath. On December 23, 2024, at 3:19 p.m., the Director of Nursing (DON) was interviewed. The DON stated, residents were given a shower schedule, and if residents refused, the CNAs would notify the charge nurses. The DON, stated the licensed nurses should encourage residents to take a shower and if a resident refused, a bed bath would be provided instead. The DON stated, Resident A had a scheduled shower on Mondays and Thursdays. The DON stated, if Resident A refused a shower, it should be documented and included in the care plan. The DON stated on July 29, 2024, Resident A had a scheduled shower but there was no documentation indicating that the resident received a shower or a bed bath. The DON further stated that there were occasions when Resident A was not provided either a shower or a bed bath. The DON stated Resident A should have received showers on scheduled days and a bed bath on non-shower days.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 36038 Based on interview and record review, the facility failed to ensure one of three sampled residents (Resident A) was repositioned and turned every two hours. This failure had resulted in the development of Resident A's pressure ulcer (bed sore). Findings: On December 4, 2024, at 8:40 a.m., an unannounced visit to the facility was conducted to investigate a quality care issue. A review of Resident A's Admission Record, indicated, Resident A was admitted to the facility on [DATE], with diagnoses which included hemiplegia (complete paralysis) and hemiparesis (partial weakness) of left side of the body. A review of Resident A's history and physical examination dated July 3, 2024, indicated Resident A did not have the capacity to make decisions. A review of Resident A's BRADEN SCALE FOR PREDICTING PRESSURE CORE RISK, dated July 30, 2024, indicated, .Score: 12 .HIGH RISK .Activity .Bedfast: Confined to bed .Mobility .completely immobile . does not make even slight changes in body or extremity position without assistance .Friction & (and) shear . Problem .Requires moderate to maximum assistance in moving. complete lifting without sliding against sheets is impossible . A review of Resident A's Nursing Comprehensive Skin Assessment/Evaluation indicated the following: - Dated August 2, 2024, Site- Sacrum (triangular bone at the base of the spine); Type- Pressure; Length- 13; Width 7.5 (centimeters - unit of measurement); Stage I (skin is not broken but is red or discolored. When you press on it, it stays red and does not lighten or turn white) - Dated August 7, 2024, Site- Sacrum; Type- Pressure; Length- 13; Width 7.5; Stage II (pressure injuries are open wounds. The skin breaks open). On December 4, 2024, at 10:20 a.m., an interview was conducted with Certified Nurse Assistant (CNA) 1. CNA 1 stated residents who were at high risk for pressure ulcer should be repositioned and turned every two hours, as per facility protocol. CNA 1 stated, she was not aware of when the resident was last turned, as it was not documented. CNA 1 further stated there was no log to indicate the position or time the resident was turned. On December 4, 2024, at 10:50 a.m., an interview was conducted with the Treatment Nurse (TN). The TN stated they do not document when a resident was last turned or repositioned by nurses. The TN stated nurses should turned and repositioned the residents every two hours to prevent the wound from worsening. The TN further stated the facility did not have a turning and repositioning schedule. The TN stated, there was no way to determine when the resident was last turned. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Further review of Resident A's Documentation Survey Report, for July 2024 and August 2024, indicated, Resident A was not repositioned and turned every two hours as required. On December 6, 2024, at 1: 51 p.m., a concurrent interview and review of Resident A's Documentation Survey Report, for July 2024 to August 2024, was conducted with the Director of Nursing (DON). The DON stated the CNAs were expected to document under turn and repositioning task section. The DON stated, there was no way to determine when and what position the resident was last turned. The DON stated, there were gaps in the CNA's documentation. The DON further stated, if turning and repositioning were not documented, it was assumed that the task had not been completed. A review of the facility policy and procedure titled Repositioning, dated May 2013, indicated .The purpose of this procedure is to provide guidelines for the evaluation of resident repositioning needs, to aid in the development of an individualized care plan for repositioning, to promote comfort for all bed-or chair-bound resident and to prevent skin breakdown .Repositioning is critical for a resident who is immobile or dependent upon staff for repositioning .interventions .Residents who are in bed should be on every two hour (q 2 hour) repositioning schedule .For Residents with a Stage 1 or above pressure ulcer an every two hour (q 2 hour) repositioning is inadequate .Documentation .The position in which the resident was placed .The name and title of the individual who gave the care .