

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 05/01/2025
NAME OF PROVIDER OR SUPPLIER Sundance Creek Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50309</p> <p>Based on observation, interview and record review, the facility failed to report an allegation of physical abuse within two hours to the California Department of Public Health (CDPH), for one of three sampled residents (Resident 1).</p> <p>This failure had the potential to place Resident 1 at continued risk of abuse and negatively impact her emotional and psychosocial well-being.</p> <p>Findings:</p> <p>On April 1, 2025, at 2:31 p.m., CDPH received a fax (facsimile - telephonic transmission of scanned-in printed material) report involving an allegation of physical abuse for Resident 1.</p> <p>On April 4, 2025, at 12:30 p.m., an unannounced visit to the facility was conducted to investigate an allegation of abuse.</p> <p>1. A review of Resident 1's Admission Record, indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included muscle weakness, pneumonia (a lung infection) and deaf nonspeaking.</p> <p>A review of Resident 1's History and Physical, dated December 31, 2024, indicated Resident 1 had capacity to understand and make decisions.</p> <p>A review of Resident 1's Minimum Data Set (an assessment tool) dated January 7, 2025, indicated a Brief Interview for Mental Status (used to identify the cognitive condition of a resident) score of 6 (severe cognitive impairment).</p> <p>A review of Resident 1s eINTERACT Change in Condition Evaluation, dated March 28, 2025, indicated, . At 2200 (10pm) on 3/28/25 (Resident 3) was outside their room when allegedly they saw (Resident 2) enter room of (Resident 1) and hit them in the back of the head. (Resident 3) then saw that (Resident 2) leave the room of (Resident 1). After the alleged witnessed abuse, Resident 3 came over to [NAME] side nurses' station and explained what she allegedly saw to the RN supervisor and LVN for the P.M. shift. No staff witnessed this event, only Resident 3 .</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
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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>A Review of Resident 1's Progress Notes, dated March 28, 2025, at 10:08 p.m., indicated .neuro checks for this resident for 72 hrs d/t (due to) allegedly being hit in the head by another resident .no new orders from MD .resident refused ice pack, severe pain was not present after the event occurred .will continue to monitor .</p> <p>A review of Resident 1's Progress Notes, dated March 28, 2025, at 3 a.m., indicated .resident resting in bed . no c/o (complaint of) pain or discomfort at this time .no acute distress noted .call light within reach .</p> <p>2. A review of Resident 2's Admission Record, indicated, Resident 2 was admitted to the facility on [DATE], with diagnoses which included Schizoaffective disorder, bipolar type (a mental health condition).</p> <p>A review of Resident 2's History and Physical, dated January 15, 2025, indicated Resident 2 had capacity to understand and make decisions.</p> <p>A review of Resident 2's Minimum Data Set (an assessment tool) dated March 31, 2025, indicated a BIMS score of 9 (moderate cognitive impairment).</p> <p>A Review of Resident 2's Progress Notes, dated March 28, 2025, at 10:08 p.m., indicated .at 2200 (10 p.m.) (Resident 3) informed this LVN that she witnessed (Resident 2) going into room [ROOM NUMBER]. When (Resident 2) entered the room, she hit (Resident 1) in the (resident's room) in the head and proceeded to leave the room. CNAs and other staff members redirected (Resident 2) back to her room. This nurse evaluated (Resident 1) after she was hit and had little to no pain after (Resident 2) had hit her. Will continue to watch resident for this behavior .</p> <p>A review of Resident 2's Progress Notes, dated March 29, 2025, at 3:00 a.m., indicated .(Resident 2) sitting on wheelchair at the station. No s/sx (sign and symptoms) of agitation at this time. No reports of pain or discomfort. No acute distress noted. Kept the environmental calm and quiet .</p> <p>A review of Resident 2's Progress Notes, dated March 29, 2025, at 8:00 a.m., indicated .(Resident 2) has been wheeling herself around facility, calmly asking for breakfast and coffee. Educated her of breakfast times and resident went back to her room. Will continue to monitor and follow POC .</p> <p>A further review of Residents 1 and 2's record indicated, there was no documented evidence that the facility reported the alleged abuse to CDPH or facility Ombudsman on March 28, 2025, at 10 p.m.</p> <p>On April 4, 2025, at 12:55 p.m. an interview was conducted with Resident 3. Resident 3 stated on March 28, 2025, at approximately 10 p.m., she was in her room and observed Resident 1, who was sitting in her wheelchair and facing the window, when Resident 2 entered Resident 1's room and hit her on the back of the head. Resident 3 stated, she went to check on Resident 1, who appeared tearful and scared. Resident 3 stated, she assisted Resident 1 to the nurses' station and reported the incident to the Licensed Vocational Nurse (LVN) 1.</p> <p>On April 4, 2025, at 1:15 p.m., a concurrent observation and interview were conducted with Resident 1. Although nonverbal, Resident 1 was able to communicate in writing. Resident 1 wrote that Resident 2 had hit her on the head at night. Resident 1 also wrote that she was scared. Resident 1 indicated that Resident 3 witnessed the incident and helped her report the incident to the staff.</p> <p>(continued on next page)</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On April 4, 2025, at 1:47 p.m., an interview was conducted with LVN 1. LVN 1 stated, she was assigned to both Residents 1 and 2 on the evening shift of March 28, 2025. LVN 1 stated, at 10 p.m., Resident 3 brought Resident 1 to the nurse's station and reported the witnessed incident. LVN 1 stated, she informed Registered Nurse (RN 1) and relied on RN 1 for direction and did not receive further assistance. LVN 1 stated, the incident was a physical abuse and should have been reported to CDPH within two hours. LVN 1 stated, the failure to report in a timely manner could have exposed Resident 1 to further abuse and emotional distress.</p> <p>On April 4, 2025, at 2:15 p.m., an interview was conducted with RN 1. RN 1 stated, she was informed of the incident by LVN 1 around 10 p.m. RN 1 stated, she assumed LVN 1 would handle the reporting of the alleged abuse to CDPH. RN 1 stated, she should have followed up and ensured the report was made within the required timeframe to CDPH, the Ombudsman, law enforcement, the physician, and the resident's representative.</p> <p>On April 4, 2025, at 4:02 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated she was first informed of the incident on March 29, 2025, at approximately 9:50 a.m. by LVN 2. The DON stated, the incident between Residents 1 and 2 should have been reported to CDPH and other required entities within two hours of staff awareness. The DON stated, all staff are mandated reporters and must report allegations of abuse promptly to ensure resident safety and prevent emotional or physical harm.</p> <p>A review of the facility policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigation, dated September 2022, indicated, . All reports of resident abuse .are reported to local, state, and federal agencies .immediately .within two hours of an allegation involving abuse or result in serious bodily injury .</p>		