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	07/08/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, and record review, the facility failed to ensure resident's medical records were accurate and complete in accordance with the accepted professional standards and practices, for one of three sampled residents (Resident 1), when the nursing weekly summary and the skin evaluations did not reflect the skin changes from May 21, 2025, to May 31, 2025. These failures could negatively impact patient care and prevent staff or representatives from being aware of the potential changes in the resident's skin condition. Findings: On June 19, 2025, at 12:30 p.m., an unannounced visit was conducted to investigate a quality-of-care concern. Resident 1's record was reviewed. Resident 1 was admitted on [DATE] with diagnoses which included diabetes type two (inability to process and control glucose sugar levels in the body). A review of Resident 1's History and Physical, indicated, Resident 1 had fluctuating capacity to understand and make decisions. A review of Resident 1's skin/wound note, indicated: - Dated May 21, 2025, .Resident seen by Wound NP (nurse practitioner) for sacrum pressure wound. NP reclassified wound from unstageable to stage 4 pressure injury. New Tx (treatment) order to collagen (medication) and therahoney (medication) . - Dated May 28, 2025, .Resident seen by wound specialist NP with NNO (no new orders) for sacrum wound, wound worsen continue with treatment as indicated PRN if soiled or dislodge, two new skin condition noted upon skin assessment and treatment with new tx (treatment) orders as follow: .Right heel DTI (deep tissue injury), cleanse with wound cleanser, pat dry, apply betadine and cover with foam dressing .every day shift . Right lateral malleolus DTI, cleanse with wound cleanser, pat dry, apply betadine and cover with foam dressing A review of Resident 1's Skin & (and) Wound Evaluation, indicated: (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Dated May 19, 2025, Sacrum pressure injury unstageable presenting about 40% slough (dead tissue) and 60% with very light serous drainage (fluid from wound) noted at this time, measuring 8 L (length) x9 W (width) cm (centimeters - unit of measure) with order for Medi honey (medication) and foam dressing . - Dated May 26, 2025, .Sacrum .Area 75.1 Length 10.8 Width 10.2 (change in size) .No c/o on wound but c/o generalized pain when turned or reposition .Sacrum pressure wound reclassified per NP as stage 4 presenting about 40% granulation, 20% slough and 40% epithelial tissue with light serious drainage noted with order for therahoney and collagen to wound bed . There were no skin and wound evaluations completed and no new measurements were obtained on May 21, 2025, and May 28, 2025, as required by facility protocol . A review of Resident 1's Nursing Weekly Summary, from May 15, 2025, to May 31, 2025, indicated the following: - May 15, 2025 .skin .any skin changes/breakdown? .NO (is checked) .other comments .continues tx to left lateral foot DTI, left lateral heel DTI, and coccyx . - May 22, 2025 skin .any skin changes/breakdown? .NO (is checked) .other comments .no new skin issues . - May 29, 2025 .skin .any skin changes/breakdown? .NO (is checked) .other comments NA . - May 31, 2025 .skin any skin changes/breakdown? .NO (is checked). Other comments .continues treatment to left lateral foot DTI, left lateral heel DTI and coccyx. No changes . There was no documented evidence that the nursing assessments described the progressive skin changes identified by the treatment team from May 22, 2025, to May 31, 2025. On June 19, 2025, at 2:00 p.m., a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN). The treatment records (TAR), skin treatment evaluations, and progress notes of Residents 1 were reviewed. The LVN stated any skin changes found during the evaluation of the skin and wounds should reflect in the resident's record. The LVN stated, the treatment team performing skin and wound evaluations should obtain two sets of measurements: one manually and one using a digital tablet. The LVN stated when Resident 1's wound assessment was completed on May 21, 2025 and May 28, 2025, a skin evaluation should have been completed but it was not. The LVN further stated all skin evaluations should include both measurements and a wound description, especially when there is a change in the wound condition. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 19, 2025, at 3:09 p.m. a concurrent interview and record review was conducted with the Director of Nursing (DON), she stated the licensed nurse should document in the TAR and skin evaluation that treatment was completed, including a description of the wound and measurements. The DON stated, the licensed nurse should have completed a skin evaluation on May 21, 2025, when the change in skin condition was identified. The DON stated, the weekly nursing summary for Resident 1 did not reflect the skin changes and should have been updated to include the most current description of the skin condition from May 21, 2025, to May 31, 2025. The DON stated if the skin condition is not documented accurately, there was a potential risk that the resident may not receive the necessary care and treatment, and the nursing staff and representative parities to be unaware of the changes and care provided. A review of the facility policy and procedure titled, Charting and Documentation, dated 2008 indicated, .All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record .all observations .services performed .must be documented in the resident's clinical record .the assessment data and/or any unusual findings obtained during the procedure/treatment .notification of family, physician or other staff .