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 01/21/2026

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 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 notify the resident's representative of a change in condition (COC) when one of three sampled residents (Resident 1) experienced deterioration of two lower extremity wounds. This failure resulted in the responsible party being unaware of Resident 1's change in condition.Findings: On January 21, 2026, April 14, 2021, at 9:00 a.m., an unannounced visit to the facility was conducted to investigate allegations of poor quality of care. Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included acute osteomyelitis, left ankle and foot (bone infection). The History and Physical, dated October 7, 2025, indicated Resident 1 had a change in cognitive function which impacted her ability to make informed medical decisions. The resident's grandson was designated as the responsible party for medical decision-making. A review of Resident 1's COC from November through December 2025, indicated the following: -November 21, 2025, at 4:19 p.m., .COC.upon doing wound rounds, right heel DM (diabetic wound) and left heel DM wound noted to be deteriorating.Right heel deteriorating in size and quality. Left heel deteriorating in undermining in the wound. Treatment orders in place.primary care provider notified with orders in place.resident updated.-December 5, 2025, at 5:46 p.m., .COC .right heel diabetic wound noted deteriorating during wound rounds by wound specialist with updated treatment order.family or resident notified.self.-December 8, 2025, at 1:17 p.m., .COC .upon wound care right dorsum foot noted with dark brow/purple discoloration.MD notified.family or resident notified.self. There was no documented evidence the facility notified the resident's representative of Resident 1's change in condition on November 21, 2025, December 5, 2025, and December 8, 2025.On January 21, 2026, at 1:43 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 stated she recalled providing wound care and completing the COCs for Resident 1. LVN 1 stated the process for communicating a change in condition was to notify the resident, family or resident representative, and the primary care and wound care physicians. LVN 1 stated a COC was completed when wound deterioration was observed. LVN 1 stated, on November 21, 2025, December 5, 2025, and December 8, 2025, she notified only the resident and did not notify the resident's representative. LVN 1 stated she should have communicated the change in condition to the resident representative so the representative would be aware of the resident's condition changes. On January 21, 2026, at 3:59 p.m., a concurrent interview and record review was conducted with the Director of Nursing (DON). The DON stated Resident 1 experienced changes in condition on November 21, 2025, December 5, 2025, and December 8, 2025, and that Resident 1's representative should have been notified of these changes. The DON stated facility policy required staff to notify the resident, resident representative, and physician when a change in condition occurred. A review of the policy and procedure titled Change in a Resident's Condition or Status, dated February 2021, indicated, .A significant change of condition is a major decline.that will not normally resolve itself without (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intervention by staff or by implementing standard disease related clinical interventions.impacts more than one area of the resident's health status.a nurse will notify the residents representative when.there is a significant change in the resident's physical, mental, or psychosocial status.the nurse will record in the resident's medical record information relative to changes in the resident's medical/mental condition or status.

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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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to implement an effective intervention to prevent resident-to-resident physical altercation for two of three sampled residents (Resident 2 and 3).This failure resulted in Resident 2 sustaining minor injuries from the physical altercation with Resident 3, and putting both residents (Res 2 and 3) and other residents at risk for further [NAME] January 20, 2026, at 8:45 a.m., an unannounced visit was conducted at the facility to investigate an allegation of physical abuse.On January 20, 2026, 9:12 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated:- Resident 3 had a physical altercation with Resident 2 on January 11, 2026;- Resident 3 entered Resident 2's room and attempted to take Resident 2's personal belongings leading to the physical altercation;- Resident 2 sustained injuries after Resident 3 struck him in the face; and- A one on one (1:1 one staff member is assigned to watch and care for only one patient at all times) supervision was initiated on Resident 3 after the incident.On January 20, 2026, at 11:14 a.m., an observation with a concurrent interview was conducted with Resident 2. Resident 2 was in his room, alert, and interveiwable. Resident 2 stated:- On January 11, 2026, Resident 3 entered his room, and attempted to take his cup and blanket;- Resident 3 struck him twice punching him in the face when he tried to stop him. He sustained right upper lip swelling (puffiness or enlargement of a body part) and a nose scratch; and- He pressed the call light button for help but did not receive immediate staff response. He had to yell for help before the staff intervened.On January 20, 2026, at 11: 55 a.m., an observation with a concurrent interview was conducted with Resident 3. Resident 3 was observed in the activity room under staff supervision. Resident 3 did not recall the altercation incident with Resident 2 on January 11, 2026.On January 20, 2026, at 12:05 p.m., an interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she was the CNA assigned to monitor Resident 3 on a 1:1 since after the incident on January 11, 2026. CNA 1 stated Resident 3 had a history of wandering behavior and occasional aggressive behavior by wandering into other resident's rooms and slapping the hands of staff.On January 20, 2026, at 3:21 p.m., an interview was conducted with Licensed Vocational Nurse (LVN) 2. LVN 2 stated:-She was the licensed nurse assigned to Resident 2 when the physical altercation occurred between Residents 2 and 3 on January 11, 2026 at 8:05 pm;- Resident 2 sustained right upper lip swelling and a scratch on the nose as a result of the physical altercation;-Resident 3 was removed from Resident 2's room and was placed on 1:1 supervision after the incident; and- Resident 3 had a history of wandering behavior, entering other resident's rooms and she was not aware of any written interventions to address his wandering behavior.On January 20, 2026, at 3:50 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated:- She was the RN assigned as charge nurse (team leader of nursing unit) on January 11, 2026 and was at the nurses station during the time of the altercation; and- She was not sure of the facility's policy and procedure on residents with wandering behavior and she was unaware of the interventions in place to address Resident 3's wandering behavior, prior to the incident with Resident 2 on January 11, 2026.On January 20, 2026, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE]Resident 2's Brief Interview for Mental Status (BIMS) dated October 10th, 2025, Indicated, Resident 2 had does have the capacity to understand and make medical decisions.The document titled, .Change of Condition, dated January 11, 2026, indicated, Signs and Symptoms identified .Resident 2 Punched in the face.Resident 2 stated Resident 3 came to his room and attempted to take his cup and upon stopping he was punched on his face, and then Resident 3 still tried to take Resident 2 blanket upon stopping he was punched on his face. Resident 2 wheeled Resident 3 out of (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	his room and closed the door.Ice pack given on the lip of Resident 2.On January 20, 2026, Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE] with diagnoses including delusional disorder (a mental health condition where a person holds a strong, fixed, and false belief that they refuse to give up, even when given clear, logical and factual evidence that they are wrong) and impulse disorder (a behavioral condition characterized by the inability to resist a powerful urge to act in a way that is harmful).The History and Physical, dated November 15, 2025, Indicated, Resident 3 was not able to make decisions.The electronic medication Administration Record (eMAR) dated January 1 to 31, 2026, indicated a physician's order to monitor Resident 3 for episodes for Impulse Control Disorder manifested by wandering and danger to self and others. The EMAR did not indicate Resident 3 exhibited these behaviors on January 11, 2026, when the incident occurred.The Care Plan dated October 9, 2025, indicated, .Elopement/Wandering: Resident is at risk for elopement/exit seeking/wandering related to altered cognitive status, forgetfulness.wanders aimlessly.Goal.Resident's safety will not be endangered related to behaviors.Resident 3's care plan for elopement/wandering indicated a general intervention that did not include the type of supervision or monitoring needed to address this behavior.The document titled, .Change of Condition. indicated, .Resident 2 punched in the face.no active bleeding noted .ice pack given on the lip of Resident 2.On January 20, 2026, at 4:15 p.m., an interview with a concurrent record review was conducted with the DON. The DON stated:- Resident 3's care plan for elopement and wandering lacked specific prevention intervention;- There was no documentation from the CNAs that monitoring on the wandering behavior was completed. In addition, the DON stated their internal communication board (a designated spot where a company shares important updates) did not list Resident 3 as a resident at risk for wandering prior to the incident on January 11, 2026; and- Resident 3 had a physician order to monitor for episodes of impulse disorder manifested by wandering and danger to self and others. The DON was unable to provide documented evidence a wandering or elopement prevention intervention was implemented on Resident 3 prior to the incident on January 11, 2026;On January 22, 2026, at 10:22 a.m., an interview was conducted with CNA 3. CNA 3 stated she was the CNA assigned to Resident 3 when the incident happened on January 11, 2026, during the pm shift. CNA 2 stated Resident 3 frequently wandered and needed to be checked every 15 to 30 minutes. CNA 3 stated she was on her lunch break when the altercation between Residents 2 and 3 occurred and no one was assigned to check on Resident 3 during her break.The facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation, revised April 2021was reviewed. The policy indicated .The facility must protect residents from abuse and take immediate action to ensure resident safety when abuse or risk of abuse is identified.The administrator is responsible for determining and implementing protective measures to prevent further harm to residents.The facility's policy and procedure titled, Wandering and Elopements, revised March 2019 was reviewed. The policy indicated, .Residents identified as at risk for wandering or elopement must have individualized strategies and interventions included in the care plan to maintain resident safety .The facility must identify residents at risk and implement interventions to prevent harm while maintaining the least restrictive environment.