

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555319	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/02/2025
NAME OF PROVIDER OR SUPPLIER Sunrise Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 3476 W. Wilson St. 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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on observation, interview, and record review, the facility failed, for one of three residents (Resident 1), to ensure an Advance Directive Acknowledgement (AD- written instruction such as living will or durable power of attorney for health care about the provision of care and services the resident preferred when he is no longer able to decide for himself), Consent to Treat, POLST (Physician Orders for Life Sustaining Treatment - a physician's order that outlines a plan for end of life care reflecting both a resident's preference and a physician's judgement based on medical evaluation), and Bed Hold Notification Policy were initiated and/or discussed with the resident, family member, and/or legal representative upon admission to the facility. This failure had the potential for the residents to receive unnecessary care/treatment and services. Findings: On January 2, 2025, at 10:55 a.m., an interview with a concurrent record review was conducted with the Social Service Director (SSD) regarding Resident 1. Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive disease that affects memory and other important mental functions). Resident 1's face sheet did not indicate an appointed responsible person (an individual authorized by the resident to act for him as an official delegate or agent) for Resident 1. The history and physical, dated December 18, 2024, indicated Resident 1 had a diagnosis of dementia and he can make needs known but cannot make medical decisions. The following records located in Resident 1's chart were undated, not completely filled out, and did not have a Resident Representative signature: - Advanced Directive Acknowledgement; - Bed Hold Notification Policy; - Consent To Treat; -Physician Orders for Life-Sustaining Treatment (POLST); (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following duplicate documents, dated December 27, 2024, and signed by Resident 1's family member, were also located in Resident 1's chart. - Consent to Treat; - Advance Directives/Medical Treatment Decision The document titled, (Name of acute Hospital), dated December 14, 2024 was reviewed. The document indicated Resident 1 was brought to the hospital on December 14, 2024, due to concerns of neglect by the appointed power of attorney (a court-ordered arrangement where a judge appoints a person to make decisions for another adult who cannot care for themselves) of Resident 1. The Adult Protective Services (APS - provides services to adults who are at risk of abuse, neglect, or exploitation) referred Resident 1's case to Public Guardians office for Conservatorship (a court-ordered arrangement where a judge appoints a person to make decisions for another adult who cannot care for themselves). In a concurrent interview the SSD stated Resident 1 did not have the capacity to make medical decisions for himself. The SSD further stated Resident 1 currently did not have an assigned Responsible Party since his admission to the facility on [DATE]. The SSD stated the facility should have contacted APS again within the first 24 hours of admission to check the status of the case and locate next of kin. The SSD stated this had not been done because she had been overwhelmed with other cases. The SSD stated the Consent to Treat and the Advance Directives/Medical Treatment Decisions, signed by Resident 1's family member on December 27, 2024, were invalid because the family member was not the legally appointed decision-maker. The SSD further stated when Resident 1's physician determined that Resident 1 did not have the capacity to make medical decisions, the facility should have made attempts to locate family members and apply for Conservatorship (a guardian or protector appointed by the judge to manage financial affairs and and/or daily life of another due to physical or mental limitations). On January 2, 2025, at 12:27 p.m., Registered Nurse (RN) 1 was interviewed. RN 1 stated she was aware, from admission, that Resident 1 did not have a legal representative to sign the Consent to treat, Advance Directive Acknowledgement, Bed Hold Notification Policy, and POLST. RN 1 stated Resident 1's lack of a legal representative should have been addressed with the bioethics committee (a group within the facility that is responsible for addressing and advising on issues related to patient care) and/or IDT team (is a group of professionals from various disciplines who collaborate to provide care for residents) as soon as it was identified upon admission. RN 1 stated this was not done. RN 1 stated the reason the Consent to Treat and other documents needed to be signed by a responsible party from the time of admission was due to the need for implied consent. The facility's policy and procedure titled,Bioethics Policy, dated December 2015 was reviewed. The policy indicated, (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.The Center will strive to uphold the resident's rights of individual choice regarding treatment options and life-sustaining measures .To provide an avenue for care providers, physicians, patients and/or their families to express concerns, participate in decision - making and see guidance in approaching situations that are actual or potential ethical dilemmas Issues that may necessitate Bioethics Council . A cognitively impaired resident without a surrogate decision maker needs specific medical treatment .		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on observation, interview, and record review the facility failed to ensure, for two of three residents (Residents 1 and 2) a discharge plan was developed upon admission to meet the individual discharge planning needs. This failure had the potential for the residents to not receive necessary care and services to address resident's discharge needs and goals. Findings: On January 2, 2025, at 10:55 a.m., an interview with a concurrent record review was conducted Social Service Director (SSD). Resident 1 was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive disease that affects memory and other important mental functions). The document titled, Social History Assessment, printed on January 2, 2024, did not indicate a discharge plan was conducted for Resident 1. The discharge assessment section of the document was blank. Resident 1's Social History Assessment was 13 days past due. In a concurrent interview, the SSD stated a family member of Resident 1 called a few days after Resident 1's admission on December 17, 2024, regarding Resident 1's discharge plan. The SSD stated she informed the family member Resident 1 did not have a discharge plan. The SSD stated Resident 1's admitted was on December 17, 2024, and the discharge assessment with all other assessment required under the Social History Assessment form, should have been completed within the first 14 days of Resident 1's admission. The SSD stated she was responsible for completing this information for the discharge plan and it had not been done. The SSD stated she was aware the discharge assessment was overdue and Resident 1 did not have a discharge plan at this time. The SSD stated this should have been completed. 2. On January 5, 2025, at 8:26 a.m., an observation with a concurrent interview was conducted with Resident 2. Resident 2 was in his room, alert and interviewable. Resident 2 stated he was admitted to the facility sometime in December and he is ready to go home. Resident 2 stated he did not know his discharge plan and he did not recall discussing it with anyone from the facility. On January 2, 2025, Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses that included traumatic brain injury (a sudden, external, physical assault that damages the brain). The document titled, Social History Assessment, printed on January 2, 2024, did not indicate a discharge plan was conducted for Resident 1. The discharge assessment section of the document was blank. There was no documented evidence a discharge assessment was conducted for Resident 2. Resident 2's Social History Assessment was 13 days past due. (continued on next page)		

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On January 2, 2025, at 11:22 a.m., an interview with a concurrent record review was conducted with the Social Service Director (SSD). The SSD stated Resident 2's Social History Assessment was not completed. The SSD stated the discharge assessment should have been completed 13 days ago. The SSD stated a discharge assessment was not conducted for Resident 2. On January 2, 2025, at 12:27 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated the social history assessments were the responsibility of the SSD and should have been completed within 5-7 days, but no later than 14 days after admission, to ensure Residents 1 and 2 would have a completed discharge assessment in place. The facility's policy and procedure titled; Social Service Assessment, dated December 2015 was reviewed. The policy indicated, . Social Services Assessment are for the purpose to identify the resident's level of mental and psychosocial functioning and any related needs .will be completed per the MDS Schedule upon initial admission .		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50864 Based on interview and record review, the facility failed to ensure the appropriate medical transfer to an acute hospital emergency department was provided to one of two residents reviewed (Resident 3). This failure had the potential to result in actual or potential harm to Resident 3's physical, mental, and/or psychosocial well-being. Findings: On [DATE], at 9:19 a.m., an interview with a concurrent record review was conducted with Registered Nurse (RN) 1. Resident 1 was admitted to the facility on [DATE], with diagnoses including chronic obstructive pulmonary disease (COPD- type of lung disease that block airflow making it difficult to breathe). The History and Physical dated [DATE], indicated Resident 3 had the capacity to understand and make decisions. The Physician's Orders for Life sustaining Treatment (POLST- a physician's order that outlines a plan for end of life care reflecting both a resident's preference and a physician's judgement based on medical evaluation), dated [DATE], indicated Resident 1's preference was Attempt resuscitation/CPR (Cardiopulmonary resuscitation - emergency procedure that combines chest compressions and rescue breathing to keep blood circulating and oxygenated until medical help arrives) .Full Treatment- primary goal of prolonging life by all medically effective means . The following nursing progress indicated: - On [DATE], at 6:43 a.m., .Resident up and alert all shift. Able (sic.) to make simple needs known with confusion, with with (sic.) ABT (antibiotic) for PNA (Pneumonia) and on droplet precaution (type of isolation to help prevent the spread of a communicable disease) for flu. Resident (sic.) non-compliant with isolation, continues to come out of the room multiple times throughout shift without mask or gown .Resident continues on use of oxygen . ; - On [DATE], at 6:43 a.m., Licensed Vocational Nurse (LVN) 1 administered Norco (brand name of a narcotic pain medication) ,d+[DATE] milligrams (mg- unit of measurement) for moderate generalized body pain; - On [DATE], at 8:31 a.m., LVN 1 administered Ativan (brand name for anti-anxiety medication) 0.5 mg by mouth for restlessness and irritability; (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- On [DATE], at 10:49 a.m., the Director of Nursing (DON) documented, .Resident still noted with SOB (shortness of breath) after sending to the hospital 2x (twice) in this week with Dx (diagnosis) .Pneumonia, resident is on antibiotic azithromycin (type of antibiotic) x 5 days and its completed and no changes of his condition, still noted with shortness of breath, shaking and no Temp.(temperature). Resident is noncompliance refusing treatment, kept removing his O2 (oxygen) and not easily redirected. With(sic.) order to send to hospital fgor(sic.) for further eval (evaluation) and management. Noted carried out and communicated . ; - On [DATE], at 11:04 a.m., LVN 1 documented, .resident alert and oriented x3 verbally responsive, resident pre medicated at 0831 with Ativan and Norco for pain at 0733, resident assisted stand up to gurney d/t (due to) transfer to (Name of acute hospital) for eval and treatment d/t O2 fluctuating 90 to 92% (O2 saturation - oxygen level in the blood normal level between 95 % to 100%) resident not compliance to keeping his NC (nasal cannula- plastic tube used to deliver oxygen via nostrils) at ,d+[DATE] LPM (Liters Per Minute). Resident left out of the facility via (Name of non-emergency medical transportation), 2 persons assist by (name of medical transportation), resident V/S (Vital Signs) ,d+[DATE] (blood pressure) T (temperature)- 98.0 (normal temperature range between 97 to 99 degrees Fahrenheit) P (Pulse Rate) - 64 (normal range between 60 to 100 beats per minute) R (Respiration Rate) 21 (normal respiration rate between 12 to 20 breaths per minute))@ Sat at 90% with NC at 2LPM, resident denies any pain, no distress noted, stating why he is going to the hospital, R/B (Risks and Benefits) explained . ; - On [DATE], at 11:10 a.m., the DON documented, .Resident send to (Name of cute hospital) pick up by (Name of non- emergency medical transportation) via gourny(sic.) awake alert and verbally responsive with no distress noted at this time . The following Physician's Order were reviewed: - Prednisone (medication used to decrease inflammation) 20 milligrams (mg) to be given orally one time a day for COPD for 10 days. Date ordered [DATE]; - Tamiflu (medication used to treat flu) Oral Capsule 75 mg two times a day for influenza for 5 days. Date ordered [DATE]. - Azithromycin Oral Tablet 250 mg give one tablet by mouth one time a day for pneumonia for five days. Date ordered [DATE].; and - Oxygen at 2 Liters Per Minute (LPM), may titrate O2 up to 5 LPM as needed to maintain SPO@ above 90% or for SOB. Date ordered [DATE]. - Transfer to (name of acute hospital) for further Evaluation and Management . Date ordered [DATE], at 9:57 a.m. In a concurrent interview, RN 1 stated the type of transportation used to transfer Resident 3 to (Name of Acute Hospital) emergency department on [DATE], was (name non-emergency transportation), a regular transportation service not equipped for emergency medical treatments. (continued on next page)		

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	RN 1 further stated prior to transfer to (Name of Acute Hospital) on [DATE], Resident 3 had been sent to the emergency room (ER) twice due to respiratory issues. RN 3 stated due to a failed course of antibiotic and fluctuating O2 saturation level of 90%, Resident 3's health status should have been considered unstable and emergency transport should have been used to transport the resident to the acute hospital. RN 1 stated Resident 3 was full code, and the (name of non-emergency transport) was not equipped to provide emergency medical treatment in the event of a medical emergency en-route to the acute hospital. RN 1 stated if a medical emergency occurred during transport, it would not have been favorable for Resident 3. On [DATE], at 10:09 a.m., an interview with a concurrent record review was conducted with LVN 1. LVN 1 stated he was the licensed nurse assigned to Resident 3 when the resident was transferred to the acute hospital on [DATE]. LVN 1 stated the appropriate method of transportation for Resident 3 at that time should have been an emergency. LVN 1 stated Resident 3 was not stable due to his pneumonia. LVN 1 stated Resident 3 should have been transported to the acute hospital via ambulance rather than a non-medical transport, to prevent unfavorable outcome for the resident. On [DATE], at 11:16 a.m., an interview was conducted with Non-Emergency Transportation Representative (NMTR) 1. NMTR 1 stated their company provides non-emergency transport services. NMTR 1 stated their drivers are only CPR trained and transport stable residents using either a wheelchair or gurney to medical facilities. On [DATE], at 4:03 p.m., an interview was conducted NMTR 2, the transportation driver who picked up Resident 3 at the facility for transport to the acute hospital on [DATE], at 11:10 a.m. NMTR 2 stated a facility licensed nurse was present at that time. NMTR 2 stated Resident 3 was hard to wake up and did not open his eyes. NMTR 2 stated upon arrival to (name of Acute Hospital) ER Resident 3 did not respond to verbal cues. The (Name of Acute Hospital) document titled, Emergency Provider Report, dated [DATE], indicated, .History of Present Illness XXX[AGE] year-old male with past history of .COPD on 4 L (liters) nasal cannula presents to the emergency department for shortness of breath .the patient was recently diagnosed with pneumonia . Upon initial arrival, patient appears to be somnolent (state of drowsiness), difficult to arouse. He was brought by BLS (Basic Life Support) crew who placed him on 6 L nasal cannula .PHYSICAL EXAM .General: Somnolent, difficult to arouse, mild-moderate respiratory distress .HR (heart rate) 105, 96% on 6 L NC . Patient arrived and was somnolent and difficult to arouse and was placed on BiPAP (bilevel positive airway pressure - non-invasive breathing device that helps people breathe when they have trouble breathing) . Overall presentation is consistent with encephalitis pneumonia (neurological condition that can be associated with pneumonia caused by number of pathogens.) .		