STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0600 Level of Harm - Immediate jeopardy to resident health or safety 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 interview and record review, the facility failed for one of two sampled residents (Resident 2), to protect the resident ' s rights to be free from physical abuse by a resident, when a resident (Resident 1), diagnosed with dementia, and anxiety with no identified behavioral triggers, was moved rooms multiple times due to intolerance to noise without assessing the resident ' s individual needs. The failure of the facility in assessing resident ' s need for appropriate room placement resulted in Resident 1 assaulting Resident 2 who exhibited frequent moaning, mumbling, and yelling. Resident 2 sustained lacerations (a cut in the skin) to the head, extensive facial fractures (a break in a bone), two right rib fractures and L1 vertebra fracture (a break on the first bone on the lower back) and later passed away in the hospital. On May 13, 2025, at 4:45 p.m., the Administrator (ADM) and Director of Nursing (DON) were verbally notified of an Immediate Jeopardy (IJ- situation in which the provider's noncompliance with one or more requirements of participation has caused or likely to cause serious injury, harm, impairment, or death to a resident), due to the facility's failure to assess residents ' needs and preferences during room changes. Resident 1 ' s preferences of a quiet room was not assessed, and his care plan was not revised to ensure his needs were met. On May 14, 2025, at 9:30 a.m., the ADM and DON were notified an extended survey would be conducted due to the substandard quality of care issues. On May 14, 2025, at 5:25 p.m., the ADM and DON presented an acceptable IJ removal plan. On May 14, 2025, at 6:03 p.m., the immediate jeopardy was removed in the presence of the ADM and the DON, upon verification of the implementation of the IJ removal plan. Findings: On May 9, 2025, Resident 2 ' s admission record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), impulse disorder (a mental health condition) and hospice care services (specialized end-of-life care). (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 2's History and Physical, dated April 9, 2023, indicated Resident 2 does not have the capacity to understand and make decisions. A review of Resident 2's Minimum data Set (MDS-an assessment tool), dated March 25, 2025, indicated a Brief Interview for Mental Status (BIMS - a tool used to identify the cognitive condition of a resident) score of 3 (severe cognitive impairment). A review of Resident 2's IDT (Interdisciplinary Team) Note, dated May 8, 2025, indicated, at 2 a.m. on 5/8/2025, a Certified Nursing Assistant (CNA) visited Resident 2 in his room and found him with blood stain on his face and both hands. The document further indicated it was reported immediately to the charge nurse and 911 was called. The police department, hospice services, physicians, the California Department of Public Health (CDPH), long term care Ombudsman (resident advocate) and the family were notified, and Resident 2 was transferred to the hospital for further treatment. A review of Resident 2's Nurse ' s Note, documented by Licensed Vocational Nurse (LVN) 1, on May 8, 2025, at 3:22 a.m., indicated that on May 8, 2025, at 2 a.m., a CNA went to the nursing station and reported there was a blood bath in Resident 2 ' s room. The document further indicated, the staff found Resident 2 in bed lying on his right side, awake, and was responsive to touch and noted to have lacerations to both sides of his face, hands, and arms. There was blood noted on Resident 2 ' s pillow and on the ceiling and wall away from his immediate bed area. The document further indicated, staff called 911 and the incident was reported to the local police department. At approximately 2:15 a.m., police arrived and assessed the residents and questioned the suspected abuser in bed A (Resident 1). At 2:25 a.m., the paramedics arrived and took Resident 2 to a local hospital. Staff made police and paramedics aware that Resident 2 was on hospice care. A review of Resident 2's Social Service Notes, dated May 8, 2025, at 9:55 a.m., indicated, .resident (Resident 2) was transfer to (initials of hospital) due to altercation with roomate (sic) overnight . A review of Resident 2's Care Plan, dated June 10, 2022, indicated, .Problem with behavior related to socially inappropriate/disruptive behavior manifested by constant shouting .Goal: Will have 0-1 episode of constant crying daily x3 months .Interventions: observe and assess for possible cause of shouting and intervene immediately .report to MD if with uncontrollable shouting . A review of Resident 2 ' s Emergency Department Note - Physician, dated May 8, 2025 at 5:36 a.m., indicated, .exam reveals extensive complex laceration ranging from right forehead across the bridge of the nose to the left eyelid .nose is unstable .bilateral (both) eyes are swollen shut .when opened there is severe chemosis (eye swelling) .ecchymosis (bruising) to the chest .small laceration to the upper gum .patient has extensive facial fracturing .has an inferior (below) blowout fracture on the right .with muscle protrusion (sticking out) .rib fractures .and fracture of L1 (lumbar area - lower part of back) vertebra . On May 9, 2025, Resident 1' s admission record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and a history of being a registered sex-offender on parole (an individual convicted of a sex crime required to register with law enforcement and released from prison under parole supervision) and wore an ankle bracelet (a device used to track the location and movements of an individual under the supervision of the criminal justice system) for monitoring. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of Resident 1's History and Physical, dated January 15, 2025, indicated Resident 1 has the capacity to make needs known but not able to make medical decisions. A review of Resident 1's MDS, dated [DATE], indicated a BIMS score of 3 (severe cognitive impairment). A review of Resident 1's IDT Note, dated May 8, 2025, indicated at around 2 a.m., a report of an unwitnessed interaction occurred in Resident 1 ' s room. Resident 1 was found on his bed, covered with the sheet and refused to be assessed and interviewed. There was blood stain noted on the wall and ceiling in the room, and both Residents 1 and 2 were lying on their beds. The document further indicated the two residents (Residents 1 and 2) had no prior history and Resident 1 had no prior history of aggressive behaviors towards Resident 1. During interview with the law enforcer, Resident 1 admitted hitting Resident 2 because he made too much noise. Resident 1 was taken into custody by the local police department. A review of Resident 1's eINTERACT Change of Condition, dated May 8, 2025, indicated, at around 2 a.m., a CNA reported a blood bath in Resident 1 ' s room. Resident 1 was lying face down in bed with sheet covering his entire body, and he refused to be interviewed and assessed by LVN. Staff called 911 and police. The document further indicated Resident 1 was interviewed, and he stated he (Resident 2) makes too much noise, and I hit him. The document further indicated Resident 1 was observed to have blood on his hands and body and was escorted by the police. A review of Resident 1's Care Plan, dated December 12, 2024, indicated, .Resident is at risk for physical and verbal aggression r/t Dementia, and is a registered sex offender on parole, wears an ankle bracelet .Goal: Will have no evidence of behavior problems by review date .Interventions: monitor behavior episodes and attempt to determine underlying cause .consider location, time of day, persons involved, and situations . document behavior and potential causes . Further review of Resident 1 ' s records indicated that he had room changes, since admission, on the following dates: - 1/24/25 - moved from 14A to 19A - 1/26/35 - moved from 19A to 31A - 2/13/25 - moved from 31A to 19A - 3/1/25 - moved from 19A to 14B - 3/19/25 - moved from 14A to 25A - 5/5/25 - moved from 25A to 34B - 5/7/25 - moved from 34B to 31B - 5/8/25 - moved from 31B to 30A (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	On May 9, 2025, at 2:11 p.m., Resident 3 was interviewed. Resident 3 stated three days ago, Resident 1 was his roommate and then was transferred to another room. Resident 3 stated, Resident 1 yelled at him regarding his music and got out of bed as if he was going to come at me. Resident 3 stated, Resident 1 stood at him and with clenched fist. Resident 3 stated, the Licensed Vocational Nurse (LVN) 2 overheard and intervened. On May 9, 2025, at 3:05 p.m., LVN 2 was interviewed. LVN 2 stated Residents 1 and 3 used to be roommates before. LVN 2 stated he recalled Resident 1 complained about Resident 3 ' s loud television and radio and he had to intervene because Resident 1 became upset at Resident 3. LVN further stated, he notified the Director of Nursing (DON) and Resident 1was moved to a different room due to the roommate's (Resident 3) noise. On May 9, 2025, at 4:32 p.m., Certified Nursing Assistant (CNA) 1 was interviewed. CNA 1 stated Resident 1 recently had been upset about his ankle bracelet and would refuse to charge it. CNA 1 stated she was instructed to report any changes in Resident 1 ' s behavior to the charge nurses. CNA 1 stated, she knew Resident 1 and he did not like noise. CNA 1 further stated, it was a terrible idea to place him in the same room with Resident 2 who constantly moaned and yelled. On May 12, 2025, at 3:22 p.m., a concurrent interview and records review of Resident 1 ' s room change forms was conducted with the Case Manager. The CM stated nursing staff would let her know if there was a room change request, and she would complete a room change form for the residents. The CM stated nursing would assess for compatibility, and she would only write the resident ' s names on the form and indicate the old and new room numbers for each resident. The CM stated she did not know the reasons of why Resident 1 had those room changes. The CM stated there were no assessments or reason of the move documented on the forms. The CM further stated it would help to have them written on the forms to help track the room changes and avoid any problems with incompatibilities. On May 13, 2025, at 10:09 a.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated room change process included identifying the reasons for the move and assessing for compatibility. RN 1 stated staff were conducting assessments, but not documenting the assessments or the reason for the room change in the residents ' records. RN 1 stated staff should have identified that Resident 1 did not like noise and should not have been placed with Resident 2 who constantly moaned and yelled. RN 1 further stated, staff should have documented the assessments and reason for moving Resident 1 to a new room to make staff aware of any incompatibilities and avoid any arguments or harm. On May 13, 2025, at 10:20 a.m., a concurrent interview and record review of Resident 1 ' s room changes since admission were conducted with the DON. The DON stated there were no documented evidence room preference and assessments conducted for Resident 1. The DON further stated, there were no documentation of the reasons for moving Resident 1 into a new room on his records and on the room change forms for all the room changes that had occurred for Resident 1. The DON further stated staff should have been documenting them to track compatibility and identify any issues between Resident 1 and other residents; and to avoid an altercation or injury. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A review of facility policy and procedures titled Room Change, revised 2021, indicated, .changes in room or roommate assignment are made when the facility deems it necessary or when the resident requests the change .resident preferences are taken into account when such changes are considered .the patients involved with room change will be assessed by facility staff for compatibility and appropriateness .final approval for room changes will be approved by DON, if DON is not available, MDS or RN Supervisor will provide final approval .documentation or a room change is recorded in the resident ' s medical records . inquiries concerning room changes should be referred to the administrator . A review of facility policy and procedures titled Resident-to-Resident Altercations, revised September 2022, indicated, .all altercations, including those that may represent resident-to-resident abuse, are investigated and reported to the nursing supervisor, the director of nursing services and to the administrator .facility staff monitor residents for aggressive/inappropriate behaviors towards other residents, family members, visitors, or to the staff .behaviors that may provoke a reaction by residents or others include .physically aggressive behavior, such as hitting, kicking, grabbing .pushing/shoving .threatening gestures .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a report with sufficient information to describe the alleged physical abuse that occurred between two residents (Residents 1 and 2) was provided to the State Agency (SA) and Long Term Care (LTC) Ombudsman (a resident advocate) on May 8, 2025. This failure had the potential for the SA and other officials to receive misleading informations which could negatively affect the investigation compromising the safety of the residents at the facility. Findings: On May 9, 2025, Resident 2 ' s admission record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), impulse disorder (a mental health condition) and hospice care services (specialized end-of-life care). A review of Resident 2's History and Physical, dated April 9, 2023, indicated Resident 2 does not have the capacity to understand and make decisions. A review of Resident 2's IDT (Interdisciplinary Team) Note, dated May 8, 2025, indicated, at 2 a.m. on 5/8/2025, a Certified Nursing Assistant (CNA) visited Resident 2 in his room and found him with blood stain on his face and both hands. The document further indicated it was reported immediately to the charge nurse and 911 was called. The police department, hospice services, physicians, the California Department of Public Health (CDPH), long term care Ombudsman (resident advocate) and the family were notified, and Resident 2 was transferred to the hospital for further treatment. A review of Resident 2's Nurse ' s Note, documented by Licensed Vocational Nurse (LVN) 1, on May 8, 2025, at 3:22 a.m., indicated that on May 8, 2025, at 2 a.m., a CNA went to the nursing station and reported there was a blood bath in Resident 2 ' s room. The document further indicated, the staff found Resident 2 in bed lying on his right side, awake, and was responsive to touch and noted to have lacerations to both sides of his face, hands, and arms. There was blood noted on Resident 2 ' s pillow and on the ceiling and wall away from his immediate bed area. The document further indicated, staff called 911 and the incident was reported to the local police department. At approximately 2:15 a.m., police arrived and assessed the residents and questioned the suspected abuser in bed A (Resident 1). At 2:25 a.m., the paramedics arrived and took Resident 2 to a local hospital. Staff made police and paramedics aware that Resident 2 was on hospice care. On May 9, 2025, Resident 1' s records was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and a history of being a registered sex-offender on parole (an individual convicted of a sex crime required to register with law enforcement and released from prison under parole supervision) and wore an ankle bracelet (a device used to track the location and movements of an individual under the supervision of the criminal justice system) for monitoring. A review of Resident 1's History and Physical, dated January 15, 2025, indicated Resident 1 has the capacity to make needs known but not able to make medical decisions. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 1's IDT Note, dated May 8, 2025, indicated at around 2 a.m., a report of an unwitnessed interaction occurred in Resident 1 ' s room. Resident 1 was found on his bed, covered with the sheet and refused to be assessed and interviewed. There was blood stain noted on the wall and ceiling in the room, and both Residents 1 and 2 were lying on their beds. The document further indicated the two residents (Residents 1 and 2) had no prior history and Resident 1 had no prior history of aggressive behaviors towards Resident 1. During interview with the law enforcer, Resident 1 admitted hitting Resident 2 because he made too much noise. Resident 1 was taken into custody by the local police department. A review of Resident 1's eINTERACT Change of Condition, dated May 8, 2025, indicated, at around 2 a.m., a CNA reported a blood bath in Resident 1 ' s room. Resident 1 was lying face down in bed with sheet covering his entire body, and he refused to be interviewed and assessed by LVN. Staff called 911 and police. The document further indicated Resident 1 was interviewed, and he stated he (Resident 2) makes too much noise, and I hit him. The document further indicated Resident 1 was observed to have blood on his hands and body and was escorted by the police. A review of the faxed (facsimile - telephonic transmission of scanned-in printed material) transmittal document titled SOC 341 form, dated May 8, 2025, did not indicate pertinent details on the alleged physical abuse involving two residents (Resident 1 and 2). On May 12, 2025, at 2:05 p.m., an interview was conducted with Registered Nurse (RN) 1. RN 1 stated when reporting an incident, a brief description of the event, time, date, names of residents involved should be included on the SOC 341 form. RN 1 stated after the incident between Residents 1 and 2 on May 8, 2025, she was asked to fax the form to SA and the Ombudsman. RN 1 stated she did not complete the form and did not realize it only said allegation on it. RN 1 stated she should have checked it for accuracy before faxing it. RN 1 further stated when reporting an incident, the form should have included important details to ensure the agencies being reported to were made aware of the safety of residents and could advocate for them. On May 13, 2025, at 1:02 p.m., a concurrent interview and record review of the SOC 341 faxed by the facility to the Ombudsman, was conducted with the Administrator (ADM). The ADM stated for reporting any incident, the expectation was for staff to complete the SOC 341 form with the important information so that local agencies and Ombudsman would be made aware of the details of the incident being reported. The ADM stated the staff should not have only put allegation on the form and should have included more information so that agencies were aware of the incident and the Ombudsman could offer assistance and advocate for the residents involved and the other residents in the facility. A review of facility policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, revised September 2022, indicated, .all reports of resident abuse are reported to local, state and federal agencies and thoroughly investigated by facility management .verbal/written notices to agencies are submitted via .fax, e-mail, or by telephone .notices include, as appropriate .the resident ' s name, the resident ' s room number, the type of abuse that is alleged, the date and time the alleged incident occurred, the names of all persons involved in the alleged incident, and what immediate action was taken by the facility .the investigator notifies the ombudsman that an abuse investigation is being conducted .the ombudsman is notified of the results of the investigation as well as any other corrective measures taken .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0657 Level of Harm - Actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to review and revise the care plan (a document that outlines a patient's current health status, diagnoses, treatment goals, and interventions) to address the potential risk for physical agression related to the resident's preference for a quiet environment for one of two sampled residents (Resident 1). This failure resulted in Resident 1 being placed in a room with a resident (Resident 2), who exhibits behaviors of moaning and yelling, which subsequently resulted in Resident 1 assaulting Resident 2, with Resident 2 sustaining lacerations, extensive facial fractures, rib fractures and vertebra fracture. Resident 2 was transferred to the general acute care hospital (GACH), where the resident expired. Findings: On [DATE], Resident 2 ' s admission record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss), impulse disorder (a mental health condition) and hospice care services (specialized end-of-life care). A review of Resident 2's History and Physical, dated [DATE], indicated Resident 2 does not have the capacity to understand and make decisions. A review of Resident 2's Minimum data Set (an assessment tool), dated [DATE], indicated a Brief Interview for Mental Status (BIMS - a tool used to identify the cognitive condition of a resident) score of 3 (severe cognitive impairment). A review of Resident 2's IDT (Interdisciplinary Team) Note, dated [DATE], indicated, at 2 a.m. on [DATE], a CNA visited Resident 2 in his room and found him with blood stain on his face and both hands. The document further indicated it was reported immediately to the charge nurse and 911 was called. The police department, hospice services, physicians, the California Department of Public Health (CDPH), long term care Ombudsman (resident advocate) and the family were notified, and Resident 2 was transferred to the hospital for further treatment. A review of Resident 2's Nurse ' s Note, documented by Licensed Vocational Nurse (LVN) 1, on [DATE], at 3:22 a.m., indicated that on [DATE], at 2:00 a.m., a Certified Nursing Assistant (CNA) went to the nursing station and reported there was a blood bath in Resident 2 ' s room. The document further indicated, the staff found Resident 2 in bed lying on his right side, awake, and was responsive to touch. There was blood noted on Resident 2 ' s pillow and on the ceiling and wall away from his immediate bed area. LVN 1 further documented, Resident 2 was observed to have lacerations to both sides of his face, hands, and arms. LVN 1 called 911 and Resident 2 was transferred to the hospital on [DATE], at around 2:25 a.m. LVN 1 further documented, police and paramedics were made aware that Resident 2 was on hospice care. LVN 1 indicated that physicians, family, facility Administrator (ADM) and DON (Director of Nursing) and reported the incident to the Ombudsman and CDPH were all notified of the incident. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0657 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 2's Social Service Notes, dated [DATE], at 9:55 a.m., indicated, . resident was transfer to (initials of hospital) due to altercation with roomate (sic) overnight A review of Resident 2's Care Plan, dated [DATE], indicated, .Problem with behavior related to socially inappropriate/disruptive behavior manifested by constant shouting .Goal: Will have 0-1 episode of constant crying daily x3 months .Interventions: observe and assess for possible cause of shouting and intervene immediately .report to MD if with uncontrollable shouting . On [DATE], Resident 1' s admission record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (memory loss) and a history of being a registered sex-offender on parole (an individual convicted of a sex crime required to register with law enforcement and released from prison under parole supervision) and wore an ankle bracelet (a device used to track the location and movements of an individual under the supervision of the criminal justice system) for monitoring. A review of Resident 1's Care Plan, initiated on [DATE], indicated, .Resident is at risk for physical and verbal aggression r/t Dementia, and is a registered sex offender on parole, wears an ankle bracelet .Goal: Will have no evidence of behavior problems by review date .Interventions: monitor behavior episodes and attempt to determine underlying cause .consider location, time of day, persons involved, and situations .document behavior and potential causes . A review of the care plan did not indicate that the facility reviewed and revise the care plan to address the individualized need of Resident 1, which was a quiet room. A review of Resident 1's History and Physical, dated [DATE], indicated Resident 1 has the capacity to make needs known but not able to make medical decisions. A review of Resident 1's MDS, dated [DATE], indicated a BIMS score of 3 (severe cognitive impairment). Further review of Resident 1 ' s records indicated that he had room changes, since admission, on the following dates: - [DATE] - moved from 14A to 19A - [DATE] - moved from 19A to 31A - [DATE] - moved from 31A to 19A - [DATE] - moved from 19A to 14B - [DATE] - moved from 14A to 25A - [DATE] - moved from 25A to 34B - [DATE] - moved from 34B to 31B - [DATE] - moved from 31B to 30A. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0657 Level of Harm - Actual harm Residents Affected - Few	A review of Resident 1's IDT Note, dated [DATE], indicated at around 2 a.m. a resident interaction had occurred in Resident 1 ' s room. There was blood stain noted on the wall and ceiling in the room, and both Residents 1 and 2 were lying on their beds. The document further indicated, from an interview with Resident 1 by the law enforcer, Resident 1 admitted hitting Resident 2 because he made too much noise. Resident 1 was then escorted by a law enforcer and was sent out under the custody of (name of police department). A review of Resident 1's eINTERACT Change of Condition, dated [DATE], indicated, at around 2 a.m., a CNA reported a blood bath in Resident 1 ' s room. Resident 1 was lying face down in bed with sheet covering his entire body, and he refused to be interviewed and assessed by LVN. The law enforcement and 911 were notified. The document further indicated Resident 1 admitted to the law enforcer that he hit Resident 2 because he made too much noise. Resident 1 was observed to have blood on his hands and body as he was being escorted by the law enforcer to be taken in custody. On [DATE], at 2:11 p.m., Resident 3 was interviewed. Resident 3 stated three days ago, Resident 1 was his roommate and then was transferred to another room. Resident 3 stated, Resident 1 yelled at him regarding his music and got out of bed as if he was going to come at me. Resident 3 stated, Resident 1 stood at him and with clenched fist. Resident 3 stated, the Licensed Vocational Nurse (LVN) 2 overheard and intervened. On [DATE], at 3:05 p.m., LVN 2 was interviewed. LVN 2 stated Residents 1 and 3 used to be roommates before. LVN 2 stated a few days ago, he recalled Resident 1 complain about Resident 3 ' s loud television and radio and he had to intervene because Resident 1 became upset at Resident 3. LVN 2 stated Resident 1 preferred a dark and quiet room and was moved to a different room that time. LVN 2 stated Resident 1 usually kept to himself and was on behavioral monitoring for refusing to charge his ankle monitor. LVN 2 stated he was not sure if he had a care plan about not liking noise. LVN 2 stated, he should have checked with the charge Registered Nurse (RN) 1 so that Resident 1 ' s preferences were addressed and could have prevented Resident 1 from hitting Resident 2. On [DATE], at 2:17 p.m., a concurrent interview and record review of Resident 1 ' s behavior monitoring was conducted with RN 1. RN 1 stated Resident 1 was usually quiet and kept to himself, she further stated, she recalled last month, Resident 1 complained about his ankle monitor and had multiple episodes of agitation. RN 1 stated they started to monitor his behaviors that time and had an order for Hydroxyzine (medication to help control anxiety) as needed. RN1 stated Resident 1 ' s care plan should have been revised to include assessing the resident during room changes and providing a quiet environment. RN 1 further stated, the interventions could have helped prevent Resident 1 from being triggered by Resident 2 ' s frequent talking and yelling behaviors. On [DATE], at 4:28 p.m., a concurrent interview and record review of Resident 1 ' s care plan was conducted with the DON. The DON stated Resident 1 had multiple room changes and she identified that he preferred a quiet room. The DON stated Resident 1 ' s care plan should have been revised to address his quiet room preferences, she further stated, she had been focused on moving him away from the noise instead of addressing his needs. The DON stated his care plan and interventions were updated, it could have prevented the incident and assault on Resident 2. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555319	A. Building B. Wing	05/14/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sunrise Post Acute	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 0657 Level of Harm - Actual harm Residents Affected - Few	A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, revised [DATE], indicated .a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident ' s physical, psychosocial and functional needs is developed and implemented for each resident .the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment .Care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relationship between the resident ' s problem areas and their causes, and relevant clinical decision making .When possible, interventions address the underlying source(s) of the problem area(s), not just symptoms or triggers . Assessments of residents are ongoing and care plans are revised as information about the residents and the residents ' conditions change .The interdisciplinary team reviews and updates the care plan .when there has been a significant change in the resident ' s condition .when the desired outcome is not met .