

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

Printed: 08/27/2026
Form Approved OMB
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 06/23/2026
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 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 an allegation of physical abuse was reported to the State agency immediately, but not later than two hours after the allegation was made, for one of two residents reviewed for abuse (Resident 1). This failure had the potential to delay investigation of the allegation and implementation of measures necessary to ensure resident safety and prevent further abuse. Findings: On May 21, 2026, at 1:05 p.m., the California Department of Public Health received an online complaint reporting an allegation of abuse involving residents at the facility. On June 1, 2026, at 11:57 a.m., an unannounced visit was conducted to investigate an allegation abuse. A review of Resident 1's record indicated the resident was admitted to the facility on [DATE], with diagnoses which included anxiety disorder (having worried thoughts). A review of Resident 1's Minimum Data Set (an assessment tool) dated August 14, 2025, indicated a Brief Interview for Mental Status (a cognitive assessment) score of 15 indicating the resident was cognitively intact. A review of Resident 1's Change of Condition dated November 18, 2025, indicated, .accusing the chairbound residents that they kicked her. Further review of Resident 1's record indicated there was no documented evidence the allegation of physical abuse was reported to the State Agency or that an abuse investigation was initiated. On June 2, 2026, at 10:35 a.m., a concurrent interview and record review was conducted with the Licensed Vocational Nurse (LVN). The LVN stated on November 18, 2025, Resident 1 reported to her that she was kicked by other residents in the facility. The LVN stated she reported the incident to the Director of Nursing (DON) and was unsure whether the allegation had been reported to CDPH. The LVN stated the facility process was for the allegation of abuse to be reported immediately to the DON and Administrator. The LVN stated the DON would complete the abuse report form and notify CDPH. On June 2, 2026, at 11:20 a.m., a concurrent interview and record review was conducted with the Registered Nurse (RN). The RN stated Resident 1's report of being hit was an allegation of physical abuse and any allegation of abuse should be reported to the state agency by the licensed nurse, if the DON was not available within two hours. The RN stated the Director of Nursing (DON) and the Administrator should be informed of allegations of abuse so that protective measures could be implemented and an investigation could be initiated. On June 3, 2026, at 8:49 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated any allegation of abuse, including verbal and physical, should be reported to the state agency within two hours by the licensed nurse. The DON stated the allegation of physical abuse on November 18, 2025, was not reported to the state agency, and it should have been reported within two hours in accordance with the facility policy. A review of the facility policy and procedure titled, Abuse Investigation and Reporting, dated July 2017, indicated, .All alleged violations involving abuse will be reported to the State licensing/certification agency will be reported immediately, but not later than Two (2) hours if the alleged violation involves abuse.		

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
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** Based on interview and record review, the facility failed to develop and implement a comprehensive, person-centered care plan to address a resident's behavioral symptoms for one of two residents reviewed (Resident 1).This failure had the potential to result in staff lacking appropriate guidance and interventions to consistently address the resident's behavioral symptoms and monitor the effectiveness of interventions. Findings:A review of Resident 1's record indicated the resident was admitted to the facility on [DATE], with diagnoses which included anxiety disorder (having worried thoughts).A review of Resident 1's Minimum Data Set (an assessment tool) dated August 14, 2025, indicated a Brief Interview for Mental Status (a cognitive assessment) score of 15 (cognitively intact).A review of Resident 1's Change of Condition dated November 18, 2025, indicated, .False accusations. Resident noted screaming in the hallways, accusing the chairbound residents that they kicked her, verbally aggressive towards the staffs and the residents.Further review of Resident 1's record indicated no documented evidence that a care plan was developed or implemented to address Resident 1's behavioral symptoms, including false accusations, yelling, and verbal aggression.On June 1, 2026, at 4 p.m., a concurrent interview and record review was conducted with the Registered Nurse (RN). The RN stated the licensed nurse was responsible for completing the change of condition and initiating the care plan related to the change. The RN stated there was no care plan initiated to address Resident 1's behavioral symptoms on November 18, 2025. The RN stated a care plan should have been initiated to provide staff with appropriate interventions and to evaluate the effectiveness of those interventions. On June 3, 2026, at 8:49 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the licensed nurse who identified the change of condition should have initiated a care plan to address Resident 1's behavioral symptoms. The DON stated that a care plan addressing those behaviors had not been initiated and should have been. The DON stated it was important to initiate a care plan to inform staff of the treatment plan and interventions. A review of the facility policy and procedure titled, Care Plans, Comprehensive Person-Centered, dated March 2022, indicated, .comprehensive, person-centered care plan is developed within seven (7) days of.Significant Change in Status.interdisciplinary team reviews and updates the care plan.when there has been a significant change in the resident's condition.		