

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  056185	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  07/16/2024
NAME OF PROVIDER OR SUPPLIER  Menifee Lakes Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  27600 Encanto Drive Sun City, CA 92586	

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)
<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41422</b></p> <p>Based on observation, interview, and record review, the facility failed to ensure one of seven residents (Resident 2), had a comfortable homelike environment when the curtain blinds, covering the resident's sliding door, were missing four slats and were not documented as needing repair in the maintenance repair log.</p> <p>This failure had the potential for Resident 2 to not feel like she was at home and has the potential to affect the efficiency of the blinds to block the sun's rays to keep the room cooler.</p> <p>Findings:</p> <p>On July 16, 2024, at 11:12a.m., an unannounced visit to the facility was conducted to investigate quality care issues.</p> <p>On July 16, 2024, at 12:56 p.m., an observation and concurrent interview was conducted with Resident 2, inside the resident's room. The resident had a sliding glass door, covered with curtain blinds. The curtain blinds was observed with four slats missing. Resident 2 stated, they knew about the blinds. Resident 2 was unable to state who or when the missing slats in the blinds were reported.</p> <p>A record review of Resident 2 ' s medical records indicated she was admitted on [DATE], with diagnoses of encounter for palliative care, (an interdisciplinary medical caregiving approach aimed at optimizing quality of life and mitigating suffering among people with serious, complex, and terminal illnesses), peripheral vascular disease, (PVD - is a slow and progressive circulation disorder), vascular dementia, (a decline in thinking skills caused by conditions that block or reduce blood flow to various regions of the brain), anxiety disorder, (a chronic condition characterized by an excessive and persistent sense of apprehension), major depressive disorder , (a mood disorder that causes a persistent feeling of sadness and loss of interest).</p> <p>Resident 2 ' s History and Physical dated August 1, 2023, at 11:29 p.m., indicated, Baseline dementia but otherwise pleasant and alert .</p> <p>On July 16, 2024, at 1:24 p.m., the Certified Nursing Assistant (CNA 1) was interviewed. CNA 1 stated that if they find missing curtain slats that need to be replaced, or other maintenance issues, they would document in the Maintenance Log which was kept at the Nurses station and would notify Maintenance services by phone. CNA 1 stated that the problem should be fixed within one day.</p> <p>(continued on next page)</p>

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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<p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On July 16, 2024, at 1:34 p.m., an interview was conducted with the Licensed Vocational Nurse (LVN). The LVN stated if they find missing curtain slats, they would call maintenance services by phone. The LVN denied that they have a maintenance log in the nurse ' s station.</p> <p>On July 16, 2024, at 1:59 p.m., an interview was conducted with CNA 2. CNA 2 stated that maintenance repairs should be documented in the maintenance book in the nurse ' s station.</p> <p>On July 16, 2024, at 2:20 p.m., a concurrent observation of Resident 2's room and interview was conducted with the Maintenance Director (MD). The MD verified there were missing curtain slats. The MD stated that the maintenance book is kept at the nurses ' station which he would check first thing every morning. The MD stated he would document when the problem is resolved in the maintenance repair log. The MD stated that he tries to resolve all issues within 24 hours.</p> <p>On July 16, 2024, at 3:54 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that all staff are responsible for documenting maintenance issues in the maintenance repair log.</p> <p>On July 16, 2024, at 4:07 p.m., a concurrent observation and interview was conducted with CNA 3. CNA 3 verified there were four missing blind slats inside Resident 2's room . CNA 3 stated that she did not notice the slats were missing and should have been reported in the maintenance book.</p> <p>A review of the Maintenance Repair Log indicated there was no documentation of room (number) ' s missing blind slats.</p>		