STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056185	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menifee Lakes Post Acute	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)
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** 41422 Based on interview and record review, the facility failed to ensure an allegation of abuse was reported within two hours to the California Department of Public Health (CDPH), for one of four residents, (Resident 1). This failure had the potential to place Resident 1 at risk for further abuse or harm. Findings: A review of Resident 1's medical records indicated he was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (irregular heartbeat), diabetes mellitus (abnormal blood sugar levels), with diabetic neuropathy (a type of nerve damage that can occur in people with diabetes), and anxiety disorder (a chronic condition characterized by an excessive and persistent sense of apprehension). A review of Resident 1's History and Physical dated February 10, 2025, indicated he had the capacity to make decisions. A review of Resident 1's Progress Notes dated February 8, 2025, at 3:39 a.m., indicated .Resident (Resident 1) aggressive towards staff. When writer came to respond to call light resident verbalized request for immediate needs for side rails in very rude and loud: '(explicit word)' .tried to hit writer with fist. Writer immediately left pt. (patient) room and assigned resident to other SN. Pt (Resident 1) reported to local Police about being abused . A review of Resident 1's eINTERACT Change in Condition Evaluation dated February 8, 2025, at 4:02 p.m., indicated .The change in condition, symptoms or signs I am calling about is/are . allegation of physical abuse .This started on: morning . allegation of physical abuse by staff . 1.Were the change in condition and notifications reported to primary care clinician .yes .2/8/25 13:00 .Recommendation of primary clinician(s) . monitor anticipate needs . (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
	056185	A. Building B. Wing	02/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Menifee Lakes Post Acute	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)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On February 21, 2025, at 12:58 p.m., a telephone interview was conducted with Registered Nurse (RN 1). RN 1 stated on February 8, 2025, at approximately 12 a.m., he responded to Resident 1's call light. RN 1 stated that Resident 1 was aggressive and using inappropriate language toward staff. RN 1 stated that Resident 1's call light had fallen to the floor, and after picking it up and placing it back on Resident 1's bed, Resident 1 attempted to punch him. RN 1 further stated, during his lunch break at 3 a.m., the police were called by Resident 1, who claimed he was being abused by the staff. RN 1 stated that allegations of abuse should be reported to the administrator within 24 hours. On February 21, 2025, at 1:54 p.m., an interview was conducted with the Licensed Vocational Nurse (LVN). The LVN stated that when there is an allegation of abuse, staff should notify the administrator within two hours. On February 21, 2025, at 2:05 p.m., an interview was conducted with RN 2. RN 2 stated that if a resident calls the police and makes an allegation of abuse, the incident should be reported to the facility administrator, the Ombudsman, the resident's physician, and the state survey agency within two hours. On February 21, 2025, at 2:36 pm., an interview was conducted with the Director of Nursing, (DON). The DON stated that Resident 1 had called the police to report that RN 1 had abused him by squeezing his leg. The DON further stated that all allegations of abuse should be reported to the state survey agency immediately. On March 6, 2025, at 3:51 p.m., an interview was conducted with the Administrator (Adm). The Adm stated, on February 8, 2025, at around 1 p.m., Resident 1 reported an allegation of physical abuse that had occurred around 12 to 2 a.m. on the same day, involving RN 1. The Adm stated, licensed nurses became aware of the allegation of physical abuse when the police arrived at around 3 a.m. on February 8. 2025. The Adm stated, he reported Resident 1's allegation of abuse to CDPH, and the local state agency immediately on February 8, 2025 (approximately 10 hours after the allegation was made). The Adm stated he placed the RN on suspension pending the investigation. The Adm stated, the licensed nurses should have reported the allegation of abuse within two hours after the allegation was made. A record review of the facility's policy and procedure titled Abuse, Neglect and Exploitation revised December 19, 2022, indicated .Reporting/Response . 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g., law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury .