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	03/13/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on observation, interview, and record review, the facility failed to ensure the physician was notified of a significant change in condition for one of two residents reviewed (Resident 1), when staff did not notify the physician after the resident alleged that staff handled her roughly. This failure had the potential to result in a delay in medical and psychosocial evaluation and to place the resident at risk for unmet medical and psychosocial needs.Findings: On March 13, 2026, at 10:10 a.m., an interview was conducted with Resident 1's Family Member (FM). The FM stated, during the night of February 25, 2026, Resident 1 reported that a Certified Nursing Assistant (CNA 1) slammed her left arm onto the bed while trying to wake her for brief change. The FM stated Resident 1 expressed she did not feel safe following the incident and wanted to leave the facility. A review of Resident 1's admission Record dated March 13, 2026, indicated an admission date of September 17, 2025, with diagnoses which included contracture of the left elbow, wrist, and hand (tightening of the muscles, tendons, or tissues that restrict normal joint movement). A review of Resident 1's History and Physical dated September 18, 2025, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's medical record indicated no documented evidence that the physician was notified following the allegation of abuse on February 25, 2026. On March 13, 2026, at 2:32 p.m., an interview was conducted with the Registered Nurse Supervisor (RNS). The RNS stated, on the morning of February 25, 2026, she was made aware of an incident between Resident 1 and CNA 1 when Resident 1 reported that CNA 1 was rough with her during perineal care (cleaning of the genital and anal areas). The RNS stated this alleged incident was considered a change of condition and the physician should have been notified. On March 13, 2026, at 4:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, staff are expected to notify the physician of significant changes in condition, including allegations of abuse to ensure timely interventions. The DON stated the licensed nurse should have reported the change in condition to Resident 1's physician. A review of the facility policy and procedure titled, Notification of Changes, dated December 19, 2022, indicated, .facility must inform the resident, consult with the resident's physician.when there is a change requiring such notification.Significant change in the resident's physical, mental, or psychosocial condition.

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 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. Based on interview and record review the facility failed to ensure an allegation of abuse was reported immediately, but not later than two hours after the allegation was made for one of two residents reviewed for abuse (Resident 1) when the Registered Nurse Supervisor (RNS) did not report an allegation after becoming aware of the incident. This failure resulted in a delay initiating an investigation and implementing protective measures, placing Resident 1 at risk for potential ongoing abuse. Findings: On March 13, 2026, at 10:10 a.m., an interview was conducted with Resident 1's family member (FM). The FM stated during the night of February 25, 2026, she (Resident 1) reported to him a certified nursing assistant (CNA1) slammed her left arm on the bed while trying to wake her for a brief change. The FM stated Resident 1 expressed that she did not feel safe following the incident and wanted to leave the facility. A review of Resident 1's admission Record dated March 13, 2026, indicated an admission date of September 17, 2025, with diagnoses which included contracture of the left elbow, wrist, and hand (tightening of the muscles, tendons, or tissues that restrict normal joint movement). A review of Resident 1's History and Physical dated September 18, 2025, indicated Resident 1 had the capacity to understand and make decisions. Further review of Resident 1's record indicated there was no documented evidence in the electronic medical record that the allegation was reported to the DON, Administrator, State Agency within two hours after the allegation was made. On March 13, 2026, at 2:32 p.m., an interview with the Registered Nurse Supervisor (RNS) was conducted. The RNS further stated on the morning of February 25, 2026, she was made aware of an incident between Resident 1 and CNA 1 when Resident 1 reported CNA 1 was rough with her during perineal care (cleaning of the genital and anal areas). The RNS stated this incident was considered an allegation of abuse and should have been reported to the DON immediately and to the State Agency. The RNS stated it was the expectation from the staff that allegation of abuse should be reported to the DON. The RNS stated she did not report the incident to the DON and to State Agency. The RNS stated timely reporting is important to ensure appropriate monitoring, assessment, and intervention for the resident. On March 13, 2026, at 4:45 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated staff expectation was to report any allegations of abuse to the DON and administrator within two hours. The DON stated Resident 1's allegation against CNA 1 was considered an allegation of abuse and it should have been reported to the State Agency. The DON stated the reporting is necessary to ensure timely notification of appropriate parties, completion of an assessment, monitoring of the resident, and initiation of an investigation. A review of the facility policy titled, Abuse, Neglect, and Exploitation, dated December 19, 2022 indicated, .to ensure all residents are protected from physical and psychosocial harm, as well as additional abuse, during and after the investigation.Reporting of all alleged violations to the Administrator, state agency.and to all other required agencies.Immediately, but not later than 2 hours after the allegation is made.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review the facility failed to ensure a timely assessment and monitoring of a resident following an allegation of abuse for one of two residents reviewed for abuse (Resident 1), when Resident 1 was not assessed for pain and emotional distress after the resident reported that a staff member slammed her arm during care. This failure resulted in a delay in identifying potential injury and unmet needs, placing Resident 1 at risk for untreated pain and undetected physical and psychosocial harm. Findings:On March 13, 2026, at 10:10 a.m., an interview with Resident 1 was conducted. Resident 1 stated during the night of February 25, 2026, Certified Nurse Assistant (CNA) 1 slammed her left arm on the bed while trying to wake her up for a brief change. A review of Resident 1's admission Record dated March 13, 2026, indicated an admission date of September 17, 2025, with a diagnosis which included contracture of the left elbow, wrist, and hand (tightening of the muscles, tendons, or tissues that restrict normal joint movement). A review of Resident 1's History and Physical dated September 18, 2025, indicated Resident 1 had the capacity to understand and make decisions. A review of Resident 1's record indicated there was no documented evidence that Resident 1 was assessed following the incident for injury, pain, or emotional distress. In addition, there was no documented evidence of monitoring or interventions initiated following the reported incident. On March 13, 2026, at 2:32 p.m., an interview was conducted with the Registered Nurse Supervisor (RNS). The RNS stated during the morning of February 25, 2026, she was made aware of an incident that had occurred between Resident 1 and CNA 1. The RNS stated the resident reported that CNA 1 was rough during care. The RNS stated this incident was considered a change of condition. The RNS stated, the resident should have been assessed and monitored. The RNS stated no assessment, or monitoring was completed for Resident 1. The RNS stated it was important to complete a change of condition and notify the physician to have interventions in place to manage and adequately monitor Resident 1 for injuries, pain, and emotional distress. On March 13, 2026, at 4:45 p.m., during an interview and concurrent record review with the Director of Nursing (DON), the DON stated the licensed nurses were expected to complete a change of condition when a concern is identified with a resident, notify the physician, and perform an assessment and monitoring. The DON stated a change of condition was not completed for Resident 1 for the above alleged incident and should have been. The DON stated it was important to complete a change of condition to identify the concern, notify the physician, assess the resident, and provide monitoring for pain and distress. A review of the facility policy and procedure titled, Notification of Changes, dated December 19, 2022, indicated, .facility must inform the resident, consult with the resident's physician.when there is a change requiring such notification.Significant change in the resident's physical, mental, or psychosocial condition.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Observe each nurse aide's job performance and give regular training. Based on interview and record review, the facility failed to maintain current personnel records for three of three personnel files reviewed (CNAs 1, 2, and 3) when annual performance evaluations were not completed. This failure resulted in not inability to assess staff performance, identify areas needing improvement, and ensure competency in providing resident care. Findings:On March 13, 2026, a review of personnel files for the following CNAs revealed no documented evidence of annual performance evaluations: -CNA 1 was hired on August 16, 2022 -CNA 2 was hired on August 30, 2023 -CNA 3 was hired on February 28, 2024 On March 13, 2026, at 2:55 p.m., a concurrent interview and record review were conducted with the Director of Staff Development (DSD). The DSD stated it was their responsibility to complete performance evaluations for CNAs. The DSD stated there was no documented evidence that annual performance evaluations had been completed for CNA 1, 2, and 3. The DSD stated completing annual performance evaluations is important to ensure staff competency in providing resident care. On March 13, 2026, at 4:45 p.m. an interview was conducted with the Director of Nursing (DON). The DON stated, the DSD is responsible for completing annual performance evaluations for CNAs. The DON stated there were no annual performance evaluations had been completed for CNA 1, 2, and 3 and it should have been completed. The DON stated annual evaluations are necessary to ensure staff are competent in providing appropriate care and meeting residents' needs. A review of the facility policy titled, Evaluation Process, dated December 19, 2022, indicated, .to review the work performance of employees with a formal written evaluation annually. Factors that will be considered.job performance, achieving preset goals, attendance records, adherence to workplace policies.