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	05/07/2026

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a safe and homelike environment for one of four residents reviewed (Resident 1), when the resident's dentures and clothing were not maintained, safeguarded, and accounted for. This failure resulted in Resident 1's dentures and clothing not being available upon transfer to the hospital and had the potential to result in unmet nutritional needs, weight loss, and psychosocial distress. Findings:Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in mental cognition).A review of Resident 1's Resident's Clothing and Possessions dated September 3, 2025, indicated Resident 1 had one upper denture and one lower denture. The document was signed by the Social Service Director (SSD) and Social Service Assistant (SSA).On March 27, 2026, at 12:31 p.m., an interview was conducted with Certified Nurse Assistant 1 (CNA). CNA 1 stated Resident 1 had upper dentures. CNA 1 stated Resident 1 was not wearing her dentures when she was transferred out of the facility and should have left the facility with her dentures to prevent issues with eating. On March 27, 2026, at 3:15 p.m., an interview was conducted with the Registered Nurse Supervisor (RNS). The RNS stated Resident 1 was transferred to the hospital on February 21, 2026, without her dentures. The RNS stated Resident 1 should have left the facility with her dentures to prevent issues such as inability to eat, weight loss, and psychosocial distress. On March 30, 2026, at 10:58 a.m., a concurrent interview and record review was conducted with the SSD. The SSD stated the facility was notified of Resident 1's missing dentures on March 4, 2026, by Resident 1's conservator. The SSD stated the Resident's Clothing and Possessions indicated upper and lower dentures. The SSD stated Resident 1's dentures should have been accounted for and placed in safe keeping to prevent psychosocial distress and eating difficulties.Om March 30, 2026, at 12:56 p.m., a concurrent interview and record review was conducted with Director of Nursing (DON). The DON stated Resident 1's dentures were missing and there was no documentation Resident 1 left the facility with her dentures and clothing items. The DON stated belongings should have been kept safe to prevent psychosocial distress and potential dietary modifications.Further review of Resident 1's record indicated no documented evidence the facility tracked, secured, or ensured the transfer of Resident 1's dentures and clothing at the time of transfer to the hospital. A review of the facility policy and procedure titled, Resident Personal Belongings, dated December 19, 2022, indicated, .It is the policy of this facility to protect.and assure the personal belongings and/or possessions are rightfully returned to the resident, or to the resident's representative in the event of the resident's.discharge from the facility.Following the discharge.all personal clothing and items.are to be given to the designated resident representative.

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
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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure post fall 72-hour monitoring (consistent monitoring of residents, each shift, for any changes from their baseline condition) was completed and documented for three of three residents reviewed for falls.This failure had the potential to delay identification of post-fall complications, changes in neurological status, pain, injury or decline in condition, resulting in delayed physician notification and implementation of necessary interventions.Findings:Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in mental cognition).A review of Resident 1's Interdisciplinary Care Conference dated February 2, 2026, indicated Resident 1 sustained a witnessed fall on February 1, 2026.A review of Resident 1's Progress Notes indicated there was no documented evidence licensed nurses completed and documented post-fall 72-hour monitoring assessments each shift to monitor for changes from baseline following the falls.Resident 2's record was reviewed. Resident 2 was admitted to the facility on [DATE], with diagnoses which included abnormalities of gait and mobility.A review of Resident 2's Interdisciplinary Care Conference dated February 10, 2026, indicated Resident 1 sustained an unwitnessed fall on February 9, 2026.A review of Resident 2's Progress Notes indicated there was no documented evidence licensed nurses completed and documented post-fall 72-hour monitoring assessments each shift to monitor for changes from baseline following the falls.Resident 3's record was reviewed. Resident 3 was admitted to the facility on [DATE], with diagnoses which included dementia (decline in mental cognition).A review of Resident 3's Interdisciplinary Care Conference dated March 6, 2026, indicated Resident 3 sustained an unwitnessed fall on March 6, 2026.A review of Resident 3's Progress Notes indicated there was no documented evidence licensed nurses completed and documented post-fall 72-hour monitoring assessments each shift to monitor for changes from baseline following the falls.On March 30, 2026, at 2:55 p.m., an interview was conducted with Licensed Vocational Nurse 1 (LVN). LVN 1 stated falls were considered a change of condition and residents should have been monitored following the falls for any changes from baseline.On March 30, 2026, at 4:20 p.m., a concurrent interview and record review of Residents 1, 2, and 3 were conducted with the Director of Nursing (DON). The DON stated that a fall is considered a change of condition, and according to the facility's practice, licensed nurses should have documented 72ˆhour monitoring for each shift. The DON stated the importance of monitoring and documenting each shift was to identify any potential changes in a resident's condition from their baseline and to ensure the physician was notified, for appropriate interventions to be implemented.A review of the facility policy and procedure titled, Notification of Changes, dated December 19, 2022, indicated, .ensure the facility.consults the resident's physician.when there is a change requiring notification.significant change in the resident's physical, mental, or psychosocial condition.clinical complications.