STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	035193	A. Building B. Wing	03/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Heights Respiratory and Rehabilitation	3130 East Broadway Road Mesa, AZ 85204

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: 11F607 -TFFTE that the abuse policy was implemented following allegations of abuse for 11 residents.Based on clinical record review, staff interviews, review of facility documentation, policies and procedures, and the State Agency (SA) database, the facility failed to implement its policy regarding conducting thorough investigations of abuse and neglect allegations and protecting residents from further abuse for 11 out of 67 sampled residents. This deficient practice had the potential to result in continued abuse and/or neglect that was not prevented.Findings Included:Resident #148Review of the SA records revealed that Resident #148 reported that a nurse aide at the facility was involved with loss of personal property on August 23, 2024. It was reported that the facility conducted an internal investigation immediately following the incident. A request for the facility's investigation report was made on March 11, 2026, at 9:20 a.m.; however, the facility indicated it was not in possession of the requested records.Further attempts to access Resident #148's clinical records in the electronic health record (EHR) system were unsuccessful during the survey. Upon request for EHR access on March 11, 2026, at 9:00 a.m., the facility stated that Resident #148 had never resided at Citrus Heights. However, according to the S.A MDS assessment, the resident had been admitted to the facility on [DATE].Resident #149Review of SA records revealed that on May 24, 2024, a complaint was reported regarding the misappropriation of property involving Resident #149. The report indicated that the resident's payee had exhausted the resident's account, resulting in an inability to pay for living expenses at the facility.Resident #149 had been admitted on [DATE], with diagnoses including dementia with behavioral disturbances, bipolar disorder, anxiety disorder, depression, difficulty walking, generalized muscle weakness, and other comorbid conditions. The resident had been discharged on February 24, 2024.A review of Resident #149's clinical records in the EHR revealed significant discrepancies. No care plan was in place for May 2024, and no nursing progress notes corresponding to the dates of the alleged incident were available. Additional documentation, including task records, was also absent. A request made on March 11, 2026, at 9:00 a.m. for the care plan, nursing progress notes, and any supporting documentation related to the alleged incident was unsuccessful. The facility stated it was not in possession of these documents.Resident #124 and Resident #97A resident-to-resident altercation between Resident #124 and Resident #97 was documented in the SA records on March 26, 2024. It was alleged that on March 19, 2024, Resident #124 had been eating lunch in the dining room when Resident #97 approached and struck Resident #124's hand. Staff reported that the residents were separated and that a facility investigation had been conducted.Resident #97 had been admitted on [DATE], with diagnoses including dementia, psychotic disturbances, mood and anxiety disorders, generalized muscle weakness, major depressive disorder, and other comorbid conditions. The resident remained in the facility at the time of the survey. The earliest nursing progress notes available in the EHR were dated March 5, 2025. A request made on March 11, 2026, at 9:20 a.m. for the facility's five-day report and related nursing documentation was unsuccessful, and the facility stated it was not in possession of such records.Resident #124 was not identified in the facility's EHR system. A request for a face sheet on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility reported it (continued on next page)

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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was not in possession of such documentation. Additionally, a request for the facility's five-day investigation report related to this incident was unsuccessful, with the facility again stating it was not in possession of the records.Resident #151 and Resident #43Review of SA records revealed that the facility reported a resident-to-resident altercation between Resident #151 and Resident #43 on November 13, 2023. Staff reported that they observed Resident #43 strike Resident #151 on the left shoulder with an open hand.Resident #43 had initially been admitted in February 2020 and was readmitted on [DATE], with diagnoses including schizoaffective disorder, traumatic brain injury with depressive features, generalized anxiety disorder, major depressive disorder, bipolar disorder, and other comorbid conditions.Resident #151 had been admitted on [DATE], with diagnoses including a history of traumatic brain injury, anxiety disorder, depression, and other comorbid conditions. Both residents remained in the facility at the time of the survey.A review of records revealed no nursing progress notes corresponding to the timeframe of the incident. Nursing progress notes for Resident #151 began on February 24, 2025, and for Resident #43 began on March 1, 2025. A request for the facility's five-day investigation report on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility stated it was not in possession of such records.Resident #26Review of SA records revealed that the facility reported an alleged misappropriation of financial resources involving Resident #26 on July 7, 2023. The facility reported that an investigation had been conducted regarding this allegation.Resident #26 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension without heart failure, a history of transient ischemic attack and cerebral infarction without residual deficits, adjustment disorder, and other comorbid conditions. The resident remained in the facility at the time of the survey.A review of the medical record indicated that no care plan was in place for 2023, and nursing progress notes were only available beginning March 1, 2025. An initial request was made on March 11, 2026, at 11:10 a.m. for progress notes, a care plan, and a five-day investigation report covering June through August 2023. A second request was made at 3:10 p.m. on the same date. The facility stated it was not in possession of these documents.Resident #22Resident #22 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including traumatic brain injury, legal blindness, colostomy status, post-traumatic seizures, major depressive disorder, and schizoaffective disorder. The resident remained in the facility at the time of the survey.Further review of SA records revealed that Resident #22 reported to a state surveyor that he had been attacked by another resident on or about February 28, 2023. The allegation also included that the alleged perpetrator had exhibited aggressive behavior toward other residents during that time.A review of records indicated that the Minimum Data Set (MDS) and care plan corresponding to the timeframe of the allegation were not available. The earliest MDS on record was dated March 6, 2023, and the earliest care plan was dated February 22, 2025. Requests made on March 11, 2026, at 11:10 a.m. and again at 3:10 p.m. for progress notes and care plans covering December 2022 through January 2023 were unsuccessful. The facility stated it was not in possession of these documents.Resident #157 and Resident #144A complaint was reported alleging that Resident #157 stated that his roommate, Resident #144, had engaged in inappropriate sexual contact on the night of January 15, 2023.A review of the EHR revealed no documentation for Resident #144. Upon request on March 11, 2026, at 9:00 a.m., the facility stated that Resident #144 had never resided at Citrus Heights.Resident #157 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension, neurogenic bladder, paraplegia, depression, psychotic disorder, and other comorbid conditions. No MDS or care plan dated on or prior to January 15, 2023, was available. The resident had been discharged on November 10, 2025. The earliest care plan in the EHR was dated February 24, 2025, and nursing progress notes were not available prior to March 1, 2025.Resident #155On May 25, 2023, it was reported that Resident #155 attempted to access benefits through a nursing home insurance catalog and discovered that only fifty cents remained in the account. The resident alleged that the benefits had been misused.A review of the facility's EHR system did not identify any records for this resident. A request for clinical records (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	on March 11, 2026, at 9:00 a.m. was unsuccessful. The facility stated it was not in possession of such information, particularly for residents or incidents occurring prior to March 1, 2025.An interview with the facility's Administrator (Staff #11), conducted on March 12, 2026, at 12:37 p.m., revealed that the facility did not have access to medical records for residents prior to the change of ownership on March 1, 2025. Staff #11 further stated that the facility did not have access to five-day investigation reports or self-reported incidents, either in the EHR or in paper form, from the previous owner. Staff #11 stated that the risks associated with not having access to medical records included lack of resident history and an incomplete understanding of residents' needs.An interview with the Medical Records Supervisor (Staff #104), conducted on March 12, 2026, at 11:03 a.m., indicated that resident medical records, incident reports, and five-day investigation reports should be retained for ten years following discharge. Staff #104 stated that no paper records existed for residents prior to the change of ownership on March 1, 2025, and acknowledged that the absence of such records posed risks, including legal and regulatory consequences.A review of the policy titled Abuse: Prevention of and Prohibition Against, last reviewed in September 2024, indicated that each resident had the right to be free from abuse, neglect, misappropriation of property, and exploitation. The policy stated that staff with knowledge of an actual or potential violation were required to report the information to the Administrator immediately and that the facility must identify and document abuse, neglect, exploitation, and misappropriation of resident property. The policy further indicated that indicators could include assessments, occurrences, patterns, and trends, such as resident-to-resident altercations, whether willful or accidental, with or without injury. The policy also stated that the facility was to respond immediately to protect alleged victims and preserve the integrity of the investigation, including examination of the alleged victim for signs of injury through physical and/or psychosocial assessment as indicated.

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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 Note: The nursing home is disputing this citation.	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** Number of residents sampled:Number of residents cited: 11F609 - TFFTE that allegations of abuse were reported to the State Agency for 11 residents.Based on interviews, review of clinical records, and review of facility policies and procedures, the facility failed to ensure that allegations of abuse were reported to the state agency for 11 out of 67 sampled residents. The deficient practice could have led to allegations of abuse not being investigated thoroughly and in a timely manner.Findings Included:Resident #148 Resident #148 was involved in an altercation with a nurse aide at the facility regarding the loss of personal property on August 23, 2024. It was reported that the facility conducted an internal investigation immediately following the incident. A request for the facility's investigation report was made on March 11, 2026, at 9:20 a.m.; however, the facility indicated that it was not in possession of the requested records. Further attempts to access Resident #148's clinical records in the electronic health record (EHR) system were unsuccessful during the survey. The facility stated that Resident #148 had never resided at Citrus Heights, based on a request made on March 11, 2026, at 9:00 a.m. for EHR access.Resident #149 The resident had been admitted to the facility on [DATE], with diagnoses including dementia with behavioral disturbances, bipolar disorder, anxiety disorder, depression, difficulty walking, generalized muscle weakness, and other comorbid conditions. Resident #149 had been discharged on February 24, 2024. On May 24, 2024, a complaint was reported regarding the misappropriation of property involving Resident #149. The report indicated that Resident #149's payee had exhausted the resident's account, resulting in an inability to pay for living expenses at the facility.A review of Resident #149's clinical records in the EHR revealed significant discrepancies. There was no care plan in place for May 2024, and no nursing progress notes corresponding to the alleged dates were available. Additional documentation, including task records, was also absent. A request was made on March 11, 2026, at 9:00 a.m. for the care plan, nursing progress notes, or any other documents related to the time of the alleged incident; however, the request was unsuccessful. The facility stated that it was not in possession of these documents.Resident #124 and Resident #97 A resident-to-resident altercation between Resident #124 and Resident #97 was reported on March 26, 2024. It was alleged that on March 19, 2024, Resident #124 was eating lunch in the dining room when Resident #97 approached and struck Resident #124's hand. Staff separated the residents and conducted a facility investigation.Resident #97 had been admitted to the facility on [DATE], with diagnoses including dementia, psychotic disturbances, mood and anxiety disorders, generalized muscle weakness, major depressive disorder, and other comorbid conditions. At the time of the survey, Resident #97 remained at the facility. The earliest nursing progress notes found in the EHR were dated March 5, 2025. A request made on March 11, 2026, at 9:20 a.m. for the facility's 5-day report and related nursing progress notes was unsuccessful. The facility stated that it was not in possession of such records.Resident #124 was not identified in the facility's EHR system. A request for a face sheet on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility reported that it was not in possession of such documentation. Additionally, a request for the facility's five-day investigation report related to Resident #124 was unsuccessful, with the facility again stating that it was not in possession of the records.Resident #151 and Resident #43 Review of State Agency (SA) records revealed the facility reported an alleged resident to resident altercation between Residents #43 and #151 on November 13, 2023. Staff reported observing one resident strike the other on the left shoulder with a hand.Resident #43 had initially been admitted in February 2020 and was readmitted on [DATE], with diagnoses including schizoaffective disorder, traumatic brain injury with depressive features, generalized anxiety disorder, major depressive disorder, bipolar disorder, and other comorbid conditions.Resident #151 had been admitted on [DATE], with diagnoses including a history of traumatic brain injury, anxiety disorder, depression, and other comorbid conditions. At the time of the (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	survey, both residents remained at the facility.A review of records revealed no nursing progress notes corresponding to the timeframe of the incident. Nursing progress notes for Resident #151 began on February 24, 2025, and for Resident #43 began on March 1, 2025. A request for the facility's investigation report on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility stated that it was not in possession of such records.Resident #26 Review of SA records, revealed the facility reported an alleged misappropriation of financial resources for one resident (Resident #26) on July 7, 2023. The facility conducted an investigation regarding this allegation.Resident #26 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension without heart failure, a history of transient ischemic attack and cerebral infarction without residual deficits, adjustment disorder, and other comorbid conditions. At the time of the survey, the resident remained at the facility.A review of the medical record indicated that no care plan was in place for 2023, and nursing progress notes were only available beginning March 1, 2025. An initial request was made on March 11, 2026, at 11:10 a.m. for progress notes, a care plan, and a five-day report covering June through August 2023. A second request was made at 3:10 p.m. on the same date. The facility responded that it was not in possession of these documents.Resident #22 Resident #22 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including traumatic brain injury, legal blindness, colostomy status, post-traumatic seizures, major depressive disorder, and schizoaffective disorder. At the time of the survey, the resident remained at the facility.Review of SA records, revealed that Resident #22 reported to a state surveyor that he had been attacked by another resident on or about February 28, 2023. The allegation also included that the alleged perpetrator had exhibited aggressive behavior toward other residents during that time.A review of records indicated that the minimum data set (MDS) and care plan corresponding to the dates of the allegation were not available. The earliest MDS on record was dated March 6, 2023, and the earliest care plan was dated February 22, 2025. Requests were made on March 11, 2026, at 11:10 a.m. and again at 3:10 p.m. for progress notes and care plans covering December 2022 through January 2023. The facility stated that it was not in possession of these documents.Resident #157 and Resident #144 A complaint was reported alleging that Resident #157 stated that his roommate, Resident #144, had fondled his genitals on the night of January 15, 2023. Upon review of the EHR, no documentation was found for Resident #144. A request made on March 11, 2026, at 9:00 a.m. for records indicated that Resident #144 had never resided at Citrus Heights.Resident #157 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension, neurogenic bladder, paraplegia, depression, psychotic disorder, and other comorbid conditions. No MDS or care plan dated on or prior to January 15, 2023, was found. Resident #157 was discharged on November 10, 2025. The earliest care plan in the EHR was dated February 24, 2025, and nursing progress notes were not available prior to March 1, 2025.Resident #155 On May 25, 2023, it was reported that Resident #155 attempted to use his benefits through his nursing home insurance catalog and discovered that only fifty cents remained in his account. The resident alleged that his benefits had been misused.A review of the facility's EHR system did not locate any records for this resident. A request for clinical records on March 11, 2026, at 9:00 a.m. was unsuccessful. The facility stated that it was not in possession of such information, particularly if the resident or incident had occurred prior to March 1, 2025.An interview with Medical Records Supervisor, Staff #104 was conducted on March 12, 2026, at 11:03 a.m. Staff #104 stated that residents' medical records should be retained at the facility for ten years after discharge. Staff #104 further stated that incident reports and 5-day investigations were retained for ten years. Additionally, Staff #104 stated that there were no paper records for residents who had been at the facility prior to the change of ownership date on March 1, 2025. Staff #104 reiterated that the risks of not having residents' medical records included legal and state findings.An interview with the facility's Administrator, Staff #11 was conducted on March 12, 2026, at 12:37 p.m. Staff #11 stated that there were no medical records or access to medical records for residents prior to the date of the change of ownership on March 1, 2025. Staff #11 also stated that the facility had no access to (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	any 5-day investigations or self-reports, either in the electronic health record system or as paper copies, from the former owner. Staff #11 stated that the risks of not accessing medical records included lack of patient history and lack of a clear understanding of residents' needs.A review of the policy titled Record Retention Schedule, revised in March 2025, indicated that resident health records were to be retained for 10 years from the date of the most recent discharge. The same policy indicated that all facility investigations were to be retained for 5 years. Additionally, a review of the facility's policy titled Abuse: Prevention of and Prohibition Against, revised in September 2024, indicated that each resident had the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. The policy further indicated that all allegations of abuse, neglect, misappropriation of resident property, or exploitation were to be reported immediately to the Administrator and appropriate state and federal agencies in accordance with applicable timeframes and regulations.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Number of residents sampled: Number of residents cited: 11F610 - TFFTE allegations of abuse were investigated for 11 residents.Based on clinical record review, facility documentation, State Agency (SA) database review, staff interviews, and facility policies and procedures, the facility failed to ensure that 11 allegations of abuse and neglect out of 67 sampled residents were thoroughly investigated in accordance with established policy. The facility's failure to conduct and maintain complete investigations had the potential to result in allegations of abuse and neglect not being fully evaluated, thereby increasing the risk that abuse and/or neglect could occur and remain unaddressed within the facility.Findings Included:Resident #148Review of SA records revealed that Resident #148 allegedly accused a nurse aide at the facility of loss of personal property on August 23, 2024. Facility staff reported that an internal investigation had been conducted immediately following the incident. A request for the facility's five-day investigation report was made on March 11, 2026, at 9:20 a.m.; however, the facility indicated it was not in possession of the requested documentation.Further attempts to access Resident #148's clinical records in the electronic health record (EHR) system were unsuccessful during the survey process. Upon request for EHR access on March 11, 2026, at 9:00 a.m., the facility stated that Resident #148 had never resided at Citrus Heights. However, according to the SA Minimum Data Set (MDS) assessment, the resident had been admitted to the facility on [DATE].Resident #149Resident #149 had been admitted on [DATE], with diagnoses including dementia with behavioral disturbances, bipolar disorder, anxiety disorder, depression, difficulty walking, generalized muscle weakness, and other comorbid conditions. The resident had been discharged on February 24, 2024.On May 24, 2024, a complaint was reported regarding the alleged misappropriation of property involving Resident #149. The report indicated that the resident's payee had exhausted the resident's financial account, resulting in an inability to pay for ongoing living expenses at the facility.A review of Resident #149's clinical records in the EHR revealed significant gaps and inconsistencies. No care plan was in place for May 2024, and no nursing progress notes corresponding to the timeframe of the alleged incident were available. Additional documentation, including task records, was also absent. A request made on March 11, 2026, at 9:00 a.m. for care plans, nursing progress notes, and supporting documentation related to the allegation was unsuccessful. The facility stated it was not in possession of the requested records. The lack of documentation limited the ability to determine whether the allegation had been appropriately investigated.Resident #124 and Resident #97A resident-to-resident altercation between Resident #124 and Resident #97 had been reported on March 26, 2024. It was alleged that on March 19, 2024, Resident #124 had been eating lunch in the dining room when Resident #97 approached and struck Resident #124's hand. Staff reported the residents were separated and that a facility investigation had been conducted.Resident #97 had been admitted on [DATE], with diagnoses including dementia, psychotic disturbances, mood and anxiety disorders, generalized muscle weakness, major depressive disorder, and other comorbid conditions, and remained in the facility at the time of the survey. The earliest nursing progress notes available in the EHR were dated March 5, 2025. A request made on March 11, 2026, at 9:20 a.m. for the facility's five-day investigation report and corresponding nursing documentation was unsuccessful, and the facility stated it was not in possession of such records.Resident #124 was not identified within the facility's EHR system. A request for a face sheet on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility reported it was not in possession of any documentation for this resident. Additionally, a request for the facility's five-day investigation report related to this incident was unsuccessful. The absence of records for both residents prevented verification that a thorough investigation had been completed.Resident #151 and Resident #43Review of SA records revealed that the facility reported a resident-to-resident altercation between Resident #151 and Resident #43 on November 13, 2023. Staff reported observing Resident #43 strike Resident (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	#151 on the left shoulder with a hand.Resident #43 had initially been admitted in February 2020 and was readmitted on [DATE], with diagnoses including schizoaffective disorder, traumatic brain injury with depressive features, generalized anxiety disorder, major depressive disorder, bipolar disorder, and other comorbid conditions.Resident #151 had been admitted on [DATE], with diagnoses including a history of traumatic brain injury, anxiety disorder, depression, and other comorbid conditions. Both residents remained in the facility at the time of the survey.A review of clinical records revealed no nursing progress notes corresponding to the timeframe of the incident. Nursing documentation for Resident #151 began on February 24, 2025, and for Resident #43 began on March 1, 2025. A request for the facility's investigation report on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility stated it was not in possession of such records. The lack of contemporaneous documentation and investigation records prevented confirmation of an appropriate investigative process.Resident #26Review of SA records revealed that the facility reported an alleged misappropriation of financial resources involving Resident #26 on July 7, 2023. The facility indicated that an investigation had been conducted.Resident #26 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension without heart failure, history of transient ischemic attack and cerebral infarction without residual deficits, adjustment disorder, and other comorbid conditions. The resident remained in the facility at the time of the survey.A review of the medical record indicated that no care plan was in place for 2023, and nursing progress notes were only available beginning March 1, 2025. Requests made on March 11, 2026, at 11:10 a.m. and again at 3:10 p.m. for progress notes, care plans, and a five-day investigation report covering June through August 2023 were unsuccessful. The facility stated it was not in possession of these documents. The absence of records prevented validation of the facility's investigative actions.Resident #22Resident #22 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including traumatic brain injury, legal blindness, colostomy status, post-traumatic seizures, major depressive disorder, and schizoaffective disorder. The resident remained in the facility at the time of the survey.Review of SA records revealed that the resident reported to a state surveyor that he had been physically attacked by another resident on or about February 28, 2023, and that the alleged perpetrator had demonstrated aggressive behaviors toward other residents during that period.A review of records revealed that the MDS and care plans corresponding to the timeframe of the allegation were not available. The earliest MDS was dated March 6, 2023, and the earliest care plan was dated February 22, 2025. Requests made on March 11, 2026, at 11:10 a.m. and 3:10 p.m. for relevant documentation were unsuccessful. The facility stated it was not in possession of the requested records, limiting the ability to determine whether the allegation had been appropriately investigated and addressed.Resident #157 and Resident #144A complaint had been reported alleging that Resident #157 stated that his roommate, Resident #144, engaged in inappropriate sexual contact on the night of January 15, 2023.A review of the EHR revealed no documentation for Resident #144. Upon request on March 11, 2026, at 9:00 a.m., the facility stated that Resident #144 had never resided at Citrus Heights.Resident #157 had initially been admitted on [DATE], and was readmitted on [DATE], with diagnoses including hypertension, neurogenic bladder, paraplegia, depression, psychotic disorder, and other comorbid conditions. No MDS or care plan dated on or prior to January 15, 2023, was available. The resident had been discharged on November 10, 2025. The earliest care plan in the EHR was dated February 24, 2025, and nursing progress notes were not available prior to March 1, 2025. The absence of documentation prevented verification of the facility's response and investigation of the allegation.Resident #155On May 25, 2023, it was reported that Resident #155 attempted to access benefits through a nursing home insurance catalog and discovered that only fifty cents remained in the account. The resident alleged that the benefits had been misused.A review of the facility's EHR system did not identify any records for this resident. A request for clinical documentation on March 11, 2026, at 9:00 a.m. was unsuccessful. The facility stated it was not in possession of such information, particularly for residents or incidents occurring prior to March 1, (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	2025. The absence of records prevented verification of investigative actions taken by the facility.An interview with the facility's Administrator (Staff #11), conducted on March 12, 2026, at 12:37 p.m., revealed that the facility did not have access to medical records for residents prior to the change of ownership on March 1, 2025. Staff #11 further stated that the facility did not have access to five-day investigation reports or self-reported incidents, either electronically or in paper form, from the previous owner. Staff #11 indicated that the inability to access historical records resulted in a lack of resident history and an incomplete understanding of residents' needs.An interview with the Medical Records Supervisor (Staff #104), conducted on March 12, 2026, at 11:03 a.m., indicated that resident medical records, incident reports, and five-day investigation reports should be retained for ten years following discharge. Staff #104 stated that no paper records existed for residents prior to the change of ownership on March 1, 2025, and acknowledged that the absence of such records posed risks, including regulatory noncompliance and potential legal consequences.A review of the policy titled Abuse: Prevention of and Prohibition Against, last reviewed in September 2024, indicated that all allegations of abuse, neglect, misappropriation of resident property, and exploitation were required to be promptly reported and thoroughly investigated by the Administrator or designee. The policy outlined that investigations were to include interviews with the reporter, the resident, witnesses, and the alleged perpetrator, as well as a comprehensive review of all circumstances related to the allegation. The policy further required that all phases of the investigation be documented and maintained in accordance with confidentiality requirements.

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure medications were administered and stored according to policy for one resident (#36), out of 23 sampled. The universe was 113. The deficient practice could result in overdose, negative medication interactions and other residents having unrestricted access to medications.Findings include:Resident #36 was admitted on [DATE] with diagnosis including major depressive disorder, single episode, anxiety disorder, neuromuscular dysfunction of the bladder, dependence on respirator (ventilator) status, morbid obesity, obstructive sleep apnea, polyneuropathy, chronic diastolic congestive heart failure, chronic respiratory failure with hypoxia and bradycardia.A review of the quarterly MDS (minimum data set) dated December 18, 2025 revealed a BIMS (brief interview of mental status score) of 15, indicating that the resident was cognitively intact. A review of the physician order revealed no evidence of an order for the resident to self-administer medications.A review of the care plan revealed no evidence that the resident was authorized to self-administer medications.A review of the EHR (electronic health record) revealed no evidence that resident was assessed for medication self-administration.An observation was conducted on March 10, 2026 at 11:14 AM in the resident's room. A bottle of Zinc 50 mg was observed on the resident's bedside table. The bottle had both the resident's name and room number written on it. Additionally, a bag of Halls, cherry flavored menthol cough drops was also observed on the resident's bedside table. The resident stated that had both since admission.An interview was conducted on March 10, 2026 at 11:30 AM with staff #52, CNA (Certified Nursing Assistant.) Staff #52 stated that a medication is anything prescribed by a doctor to help alleviate pain or make the resident feel better. Staff #52 further stated OTC's (over the counter), including vitamins, could also be considered medications. Staff #52 stated that residents can't have medication at their bedside unless they have an order in place for medication self-administration. She stated that no one on the current unit, where resident #36 was residing, was authorized to self-administer medications. Staff #52 stated that cough drops would be a medication as well as zinc, if taken orally. Staff #52 stated that she checks for medications at bedside each time she enters a resident's room. Staff #52 stated that the risks for medications at bedside would be few, contingent on how long the medications have been there. Staff #52 entered the resident's room looked at the zinc and halls and stated that these should not have been there, but would ask the nurse on duty to confirm.An interview was conducted on March 10, 2026 at 11:38 AM with staff #15, RN (Registered Nurse). Staff #15 stated that a medication can include things used to care for a resident. She stated that a medication can be prescribed of over the count and that medications can come in pill form, but they can also be topicals, inhaled or injected. Staff #52 stated that both zinc and cough drops would be considered medications and would require an order to self-administer. Staff #52 stated that if a medication is identified at bedside, it is removed and she would then inform the unity manager. She further stated that she checks for medications at bedside, each time she enters the room. She stated the risk for unauthorized medications at bedside could include residents taking medication without staff's knowledge. Staff #15 checked the EHR for resident #36 and stated that there was no evidence of an order for zinc taken orally and that there was no evidence of an order for the cough drops either.An interview was conducted on March 11, 2026 at 11:24 AM with staff #112, RN/ Unit Manager. Staff 112 stated that residents can't have medications at bedside unless they have been assessed and an order is in place for the medication as well as the ability to self-administer the medication. Staff #112 stated that the risk for medications at bedside could include a resident taking too many.An interview was conducted on March 12, 2026 at 9:31 AM with staff #144, DON (Director of Nursing). Staff #144 stated that if a resident wanted to (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	self-administer medication, they would let the staff know and an assessment would be conducted and if deemed to be able to self-administer medication then a lock box would be provided and it would also be care planned for the resident. Staff #144 stated that zinc was definitely a medication but stated that she wasn't sure about the cough drops and that it would depend on their ingredients. Staff #144 stated that the risk for having medications at bedside included not taking the medication as ordered and a potential with interaction with other medications.A review of the facility policy titled Self Administration of Medications with a review date of March 2025 revealed that upon admission all residents are informed of the right to self-amdinister medications and that if a resident desires to participate in self-administration, the IDT (interdisciplinary team) would assess and periodically re-evaluate the resident. The policy further revealed that if the resident is a candidate to self-administer medications, it would be documented in the 'chart'. The steps outlined in the policy included an initial review, IDT determination and then re-evaluation based on changes in the resident's status. The policy also noted that the storage and location of drug administration would comply with state and federal requirements for medication storage. Finally, the policy revealed that an appropriate notation of the determinations would be placed in the residents care plan.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, review of clinical record, and review of facility policy and procedure, the facility failed to ensure the presence of complete and readily accessible medical records for 17 out of 23 residents sampled residents (#22, #26, #43, #124, #125, #136 #137, #138, #143, #144, #146, #148, #149, #151, #154, #155, #157). The deficient practice could lead to a lack of historical data for the residents impacting their care. Findings included: On review of the residents' records in the facility's electronic health system, significant discrepancies were identified, as resident records dated prior to March 1, 2025, were not available. Requests for documentation were made on March 11, 2026, at 9:00 a.m., 9:20 a.m., and 11:10 a.m.; however, these requests for care plans, nursing progress notes, and five-day reports were unsuccessful. The facility stated that it was not in possession of documents dated prior to March 1, 2025. However, according to the State Authority (S.A.) Minimum Data Set (MDS), the residents listed below had been admitted to the facility on the following dates: Resident #148 A request for the facility's investigation report was made on March 11, 2026, at 9:20 a.m.; however, the facility indicated that it was not in possession of the requested records. Further attempts to access Resident #148's clinical records in the electronic health record (EHR) system were unsuccessful during the survey. However,according to the S.A MDS assessment, the resident had been admitted to the facility on [DATE]. Resident #149 A review of Resident #149's clinical records in the EHR revealed significant discrepancies. No care plan was available for May 2024, and no nursing progress notes corresponding to the alleged dates were found. Additional documentation, including task records, was also absent. A request was made on March 11, 2026, at 9:00 a.m. for the care plan and nursing progress notes related to the time of the alleged incident; however, the request was unsuccessful. The facility stated that it was not in possession of these documents. However, according to the S.A MDS assessment, the resident had been admitted to the facility on [DATE]. Resident #124 and Resident #97 A resident-to-resident altercation between Resident #124 and Resident #97 was reported on March 26, 2024. The earliest care plan available for Resident #97 was dated March 1, 2025, and the earliest nursing progress notes in the EHR were dated March 5, 2025. A request was made on March 11, 2026, at 9:20 a.m. for care plans and nursing progress notes corresponding to the time of the allegation; however, the request was unsuccessful. The facility stated that it was not in possession of such records. Resident #124 was not identified in the facility's EHR system. A request for a face sheet on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility reported that it was not in possession of such documentation. Additionally, a request for the facility's five-day investigation report was unsuccessful, with the facility again stating that it was not in possession of the records. No clinical records for Resident #124 were found in the EHR, and no care plan for Resident #97 corresponding to the date of the allegation was available. However, according to the S.A. MDS assessment, Resident #124 had been admitted to the facility on [DATE], and Resident #97 had been admitted on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Resident #151 and Resident #43 A resident-to-resident altercation between Resident #151 and Resident #43 was reported on November 13, 2023. A review of records revealed no nursing progress notes corresponding to the timeframe of the incident. Nursing progress notes for Resident #151 began on February 24, 2025, and for Resident #43 began on March 1, 2025. A request for the facility's investigation report on March 11, 2026, at 9:20 a.m. was unsuccessful, and the facility stated that it was not in possession of such records. At the time of the survey, both residents remained at the facility. However, the S.A. MDS assessment stated, Resident #151 had been admitted on [DATE], and Resident #43 had been admitted on [DATE]. Resident #26 An investigation into a complaint involving the alleged misappropriation of Resident #26's financial resources were reported on July 7, 2023. A review of the medical record indicated that no care plan had been in place for 2023, and nursing progress notes were only available beginning March 1, 2025. An initial request was made on March 11, 2026, at 11:10 a.m. for progress notes, a care plan, and a five-day report covering June through August 2023. A second request was made at 3:10 p.m. on the same date; however, the facility responded that it was not in possession of these documents. According to the S.A. MDS assessment, the resident had been admitted to the facility on [DATE]. Resident #154 A fall incident involving Resident #154 was reported on May 30, 2023. Upon review of the facility's EHR system, the resident's name was not found. A request for clinical records on March 11, 2026, at 9:00 a.m. was unsuccessful. The facility stated that it was not in possession of such information, particularly for incidents occurring prior to March 1, 2025. According to the S.A. MDS assessment, the resident had been admitted to the facility on [DATE]. Resident #22 It was alleged that the resident reported to a state surveyor that he had been attacked by another resident on or about February 28, 2023. A review of records indicated that the MDS and care plan corresponding to the dates of the allegation were not available. The earliest MDS on record was dated March 6, 2023, and the earliest care plan was dated February 22, 2025. Requests were made on March 11, 2026, at 11:10 a.m. and again at 3:10 p.m. for progress notes and care plans covering December 2022 through January 2023; however, the facility stated that it was not in possession of these documents. According to the S.A. MDS assessment, the resident had been admitted to the facility on [DATE]. Resident #157 and Resident #144 A resident-to-resident altercation was reported on January 15, 2023. Upon review of the EHR, no documentation was found for Resident #144. A request made on March 11, 2026, at 9:00 a.m. indicated that Resident #144 had never resided at the facility. No MDS or care plan dated on or prior to January 15, 2023, was found. The earliest care plan in the EHR was dated February 24, 2025, and nursing progress notes were not available prior to March 1, 2025. However, the S.A. MDS assessment, Resident #157 had been admitted on [DATE], and Resident #144 had been admitted on [DATE]. Resident #155 An allegation that the resident's benefit funds had been misused was reported on May 25, 2023. A review of the facility's EHR system did not locate any records for this resident. A request for clinical records on March 11, 2026, at 9:00 a.m. was unsuccessful. The facility stated that it was not in possession of such information, particularly for incidents occurring prior to March 1, 2025. According to the S.A. MDS assessment, the resident had been admitted to the facility on [DATE]. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Findings include: A record request was submitted for grievance logs on March 10, 2026 at 3:00 PM for the years of 2023, 2024 and 2025. The facility responded with a written statement from staff #11, Administrator, noting that the grievance logs for 2023 and 2024 were not in the facility's possession and that the logs for January 2025 and February 2025 were also not in their possession. A secondary record request was submitted to the facility on March 11, 2026 at 9:00 AM for medical records for residents #137, #136, #138, #146, #143, #144 and #125. Staff #11 responded with a written statement that none of the residents noted, resided at Citrus Heights. Documentation regarding the following residents (#137, #136, #138, #146, #143, #144, #125) was obtained through iQIES (Internet Quality Improvement and Evaluation System) for data submitted to CMS (Centers for Medicare and Medicaid Services) specific for resident submissions at this facility. iQIES is a web-based system that collects and analyzes patient assessment data such as the MDS (minimum data set) submitted by skilled nursing facilities and was specific for residents residing at this facility. -Regarding Resident #137 Review of the electronic health records (EHR) revealed no evidence of resident #137. Resident #137 was admitted on [DATE] with diagnosis including schizophrenia. A review of the discharge MDS (minimum data set) with a discharge date of February 20, 2024 revealed no documented BIMS (brief interview of mental status score). -Regarding Resident #136 Review of the EHR revealed no evidence of resident #136. Resident #136 was admitted on [DATE] with diagnosis including atrial fibrillation, hypertension, hyperlipidemia, thyroid disorder, arthritis, anxiety disorder and Parkinson's disease. A review of the comprehensive MDS with an assessment reference date of February 16, 2024 revealed a BIMS score of 15, indicating that the resident was cognitively intact. -Regarding Resident #138 Review of the EHR revealed no evidence of resident #138. Resident #138 was initially admitted on [DATE] with diagnosis including anemia, diabetes mellites, hyperlipidemia, non-Alzheimer's dementia, depression, psychotic disorder, schizophrenia, asthma and respiratory failure. A review of the quarterly MDS with an assessment reference date of October 5, 2023 revealed a BIMS score of 12, indicating moderate cognitive impairment. -Regarding Resident #146 (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	Review of the EHR revealed no evidence of resident #146. Resident #146 was readmitted on [DATE] with diagnosis including peripheral vascular disease, diabetes mellitus, malnutrition, and anxiety disorder. A review of the quarterly MDS with an assessment reference date of March 21, 2023 revealed a BIMS score of 15, indicating that the resident was cognitively intact. -Regarding Resident #143 Review of the EHR revealed no evidence of resident #143. Resident #143 was initially admitted on [DATE] with diagnosis including peripheral vascular disease, diabetes mellitus, anxiety disorder and psychotic disorder. A review of the quarterly MDS with an assessment reference date of April 25, 2023 revealed a BIMS score of 13 indicating that the resident was cognitively intact. -Regarding Resident #144 Review of the EHR revealed no evidence of resident #144. Resident #144 was readmitted on [DATE] with diagnosis including coronary artery disease, heart failure, hypertension, orthostatic hypotension, renal insufficiency, neurogenic bladder, diabetes mellitus and hyperlipidemia. A review of the quarterly MDS with an assessment reference date of April 13, 2023 revealed a BIMS score of 7 indicating severe cognitive impairment. -Regarding Resident #125 Review of the EHR revealed no evidence of resident #125. Resident #125 was admitted on [DATE] with diagnosis including anemia, coronary artery disease, heart failure, hypertension, peripheral vascular disease and renal insufficiency. A review of the quarterly MDS with an assessment reference date of November 15, 2021 revealed a BIMS score of 15 indicating that the resident was cognitively intact. An interview was conducted on March 12, 2026 at 11:03 PM with staff #104, Medical Records Supervisor. Staff #104 stated that there were no medical records available for residents that were admitted and discharged prior to March 1, 2025. She further stated that some records for current residents in the facility, that were admitted prior to March 1, 2025, may also not be available. She stated that the expectation for medical record retention, to include facility generated incident reports as well as the 5-day investigative reports, is to keep the records for 10 years. She further stated that there were no paper copies available of either the incident reports or 5-day investigations for any alleged incidents. Staff #104 further stated that she no idea what the previous owners of the facility had done with the paper records and that the facility is unable to reach them as they relocated to another country. Staff #104 stated that she did not start her current role as medical records (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some Note: The nursing home is disputing this citation.	supervisor until August of 2025 and that she was not part of the transition process during the change of ownership. Staff #104 stated that going forward she would maintain records for a 10-year time frame and then archive them. She stated that the risk for not maintaining and being able to access resident records, incident reports and 5-day investigations could include legal ramifications and potential findings during a state survey. An interview was conducted on March 12, 2026 at 12:37 PM with staff #11, Administrator. The Administrator stated that an ownership transfer of the facility took place on March 1, 2025. Staff #11 stated that when he became the Administrator of this facility on March 1, 2025 and walked into the building he had 'zero' access and no physical records. Staff #11 stated in addition to medical records not being available for those residents that were admitted and discharged prior to the change of the ownership date, the incident reports as well as 5-day investigations prior to March 1, 2025 were also not available. He stated that the expectation was to maintain resident medical records for 10-years. He stated that upon transfer of ownership, the expectation would have been to have access to all resident records within the 10-year time frame. Staff #11 stated that going forward, all records would be retained according to facility policy. Staff #11 stated that the risk for not maintaining the records or having access to the records could include a lack of resident history and a lack of a clear picture of what the resident's needs are. A review of the facility's policy titled Documentation and Charting with a revision date of October 2025 revealed that it is the facilities policy to provide a complete account of the resident's care, treatment, response to care, signs, symptoms, as well as the progress of the resident's care. A review of the policy titled Record Retention Schedule with a revision date of November 2024 revaled that resident medical records need to be retained for 10 years and that all investigations need to be retained for 5 years.