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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interviews, and facility policy, the facility failed to ensure that three residents (Residents #4, #50, and #60) medications were administered per physician's orders of three residents sampled. The universe was 113. The deficient practice could result in unnecessary use of opioids. Findings include: Regarding Resident #4 Resident #4 was admitted to the facility on [DATE] with diagnoses that included nontraumatic subdural hemorrhage, unspecified, extradural and subdural abscess, and cognitive communication deficit. Review of the baseline care plan initiated on February 12, 2026 revealed a focus indicating Resident #4 was prescribed an opioid medication with interventions that included to administer the opioid medication as prescribed. Further review of the care plan revealed a focus indicating acute/chronic pain related to the head and abdominal areas. Interventions included to follow the pain scale and to medicate as ordered, monitor and record pain characteristics such as quality, severity, anatomical location, onset, duration, and aggravating/relieving factors.Review of the 5-day minimum data set (MDS) dated [DATE] revealed Resident #4 had a brief interview for mental status (BIMS) score of 0 indicating the resident had a severe cognitive impairment. Review of the MDS revealed Resident #4 required moderate to maximum assistance with personal hygiene and activities of daily living (ADLs). Further review of the MDS revealed the resident was on a PRN (as needed) opioid medication with a pain scale score of ten at the time of assessment. Review of a physician's order revealed an order for oxycodone hydrochloride (HCl) (opioid) five milligrams (MG) with a start date of February 20, 2026, to administer one tablet by mouth every six hours as needed for a pain scale rating of four through ten. Review of the medication administration record (MAR) for February 2026 revealed the following days in which oxycodone HCl five MG was administered with the corresponding numeric pain level. February 21, 2026 at 8:28 a.m., reported pain scale of one February 21, 2026 at 4:09 p.m., reported pain scale of oneFebruary 26, 2026 at 8:35 a.m., reported pain scale of zero February 26, 2026 at 3:23 p.m., reported pain scale of oneFebruary 27, 2026 at 9:37 a.m., reported pain scale of oneFebruary 28, 2026 at 8:03 a.m., reported pain scale of oneFebruary 28, 2026 at 3:03 p.m., reported pain scale of one Review of the medication administration record (MAR) for March 2026 revealed the following days in which oxycodone HCl five MG was administered with the corresponding numeric pain level. March 5, 2026 at 8:09 a.m., reported pain scale of zeroMarch 5, 2026 at 2:09 p.m., reported pain scale of oneMarch 6, 2026 at 7:46 a.m., reported pain scale of oneMarch 6, 2026 at 4:48 p.m., reported pain scale of oneMarch 7, 2026 at 9:01 a.m., reported pain scale of oneMarch 7, 2026 at 6:16 p.m., reported pain scale of oneRegarding Resident #50 Resident #50 was re-admitted to the facility on [DATE] with diagnoses that included lymphedema, muscle weakness (generalized), and hereditary and idiopathic neuropathy, unspecified. Review of the baseline care plan initiated on July 30, 2025 revealed a focus indicating Resident #50 was prescribed an opioid medication related to complaints of pain in the right thigh and knee. Interventions included to administer opioid medications. Review of the quarterly Minimum Data Set, dated [DATE] revealed Resident #50 had a BIMS score of 14, indicating the resident was cognitively intact. Review of the MDS revealed Resident #50 was dependent on staff for all personal cares and activities of daily living (ADLs). Further review of the MDS revealed the resident to be on scheduled (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

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	and PRN pain medications, including opioids, with a pain scale rating of five out of ten at the time of the assessment. Review of a physician order revealed an order for oxycodone HCl ten MG, with a start date of August 15, 2025, to administer one tablet by mouth every four hours as needed for a pain scale rating of five through ten. Review of the MAR for February 2026 revealed the following days in which oxycodone HCl ten MG was administered with the corresponding numeric pain level. February 5 2026 at 8:56 a.m., reported pain scale of zeroFebruary 5, 2026 at 12:58 p.m., reported pain scale of oneFebruary 6, 2026 at 8:27 a.m., reported pain scale of one February 7, 2026 at 8:37 a.m., reported pain scale of one February 7, 2026 at 6:25 p.m., reported pain scale of two February 13, 2026 at 9:33 a.m., reported pain scale of twoFebruary 13, 2026 at 5:30 p.m., reported pain scale of oneFebruary 14, 2026 at 11:36 a.m., reported pain scale of one February 19, 2026 at 8:22 a.m., reported pain scale of zeroFebruary 19, 2026 at 5:15 p.m., reported pain scale of oneFebruary 20, 2026 at 4:58 pm., reported pain scale of one February 21, 2026 at 9:02 a.m., reported pain scale of one February 21, 2026 at 2:47 p.m., reported pain scale of one February 26, 2026 at 9:33 a.m., reported pain scale of zero February 26, 2026 at 5:20 p.m., reported pain scale of one February 27, 2026 at 8:58 a.m., reported pain scale of one Review of the MAR for March 2026 revealed the following days in which oxycodone HCl ten MG was administered with the corresponding numeric pain level. March 5, 2026 at 7:51 a.m., reported pain scale of twoMarch 7, 2026 at 9:13 a.m., reported pain scale of zero Regarding Resident #90Resident #90 was admitted to the facility on [DATE] with diagnoses that included a fracture of an unspecified part of neck of left femur, subsequent encounter for closed fracture with routine healing, encephalopathy unspecified, and muscle weakness (generalized). Review of the comprehensive care plan initiated on January 1, 2026 revealed a focus indicating Resident #90 to be prescribed an opioid medication for pain with interventions that included to administer opioid medications as prescribed. Further review of the care plan revealed a focus of acute/chronic pain with interventions that included following the pain scale to medicate as ordered and complete a pain assessment every shift. Review of the 5-day MDS dated [DATE] revealed Resident #90 had a BIMS score of 3, indicating a severe cognitive impairment. Review of the MDS revealed Resident #90 required maximum assistance and/or was fully dependent on staff with personal cares and ADLs. Review of the MDS revealed Resident #90 to have received as needed pain medications with a pain scale rating of eight out of ten. Further review of the MDS revealed Resident #90 to have received opioid medications. Review of a physician's order revealed an order for oxycodone HCl five MG, with a start date of January 1, 2026, to administer one tablet by mouth every six hours as needed for a pain scale rating of four through six. Review of a physician's order revealed an order for oxycodone HCl five milligrams, start date of January 1, 2026, to administer two tablets by mouth every six hours as needed for a pain scale rating of seven through ten. Review of the MAR for February 2026 revealed the following days in which one oxycodone HCl five milligram tablet for a pain scale rating of four through six, was administered with the corresponding numeric pain level. February 7, 2026 at 4:26 p.m., reported pain scale of three February 21, 2026 at 7:56 a.m., reported pain scale of one February 27, 2026 at 7:55 a.m., reported pain scale of oneFebruary 28, 2026 at 7:45 a.m., reported pain scale of one Review of the MAR for February 2026 revealed the following days in which two oxycodone HCl five MG tablets for a pain scale rating of seven through ten, were administered with the corresponding numeric pain level.February 5, 2026 at 6:54 p.m., reported pain scale of zeroFebruary 6, 2026 at 6:45 a.m., reported pain scale of zeroFebruary 7, 2026 at 7:46 a.m., reported pain scale of one February 13, 2026 at 10:25 a.m., reported pain scale of one February 14, 2026 at 8:51 a.m., reported pain scale of one February 19, 2026 at 8:39 a.m., reported pain scale of zeroFebruary 19, 2026 at 2:39 p.m., reported pain scale of one February 26, 2026 at 7:43 a.m., reported pain scale of zeroReview of the MAR for March 2026 revealed the following days in which one oxycodone HCl five MG tablet for a pain scale rating of four through six, was administered with the corresponding numeric pain level. March 5, 2026 at 9:36 a.m., reported pain scale of one Review of the MAR for March 2026 revealed the following days in which two oxycodone HCl five MG tablets for a pain scale rating of seven through ten, were administered (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	with the corresponding numeric pain level.March 6, 2026 at 10:56 a.m., reported pain scale of one March 7, 2026 at 7:15 a.m., reported pain scale of one An interview was conducted on March 12, 2026 at 9:13 a.m. with a licensed practical nurse (LPN/Staff #109). Staff #109 stated to monitor pain, staff use facial expressions, pain scale rating, and behaviors to assess a resident's pain level. Staff #109 stated staff can only administer as needed pain medications when a resident asks for it and the pain type is within the ordered parameters. Staff #109 stated nursing staff must document the numeric pain scale rating when administering medications. Staff #109 further stated the risks associated with not administering opioid medications as ordered could lead to addiction and over-sedation. An interview was conducted on March 12, 2026 at 12:53 p.m. with a LPN (Staff #182). Staff #182 stated she would always ask the resident to rate their pain and if the resident is nonverbal assess the pain based on the resident's behaviors. Staff #182 stated she would administer as needed pain medications when the resident is showing signs and symptoms of pain or if they are asking for the pain medication and it is within the provider's set parameters. Staff #182 stated staff will try to avoid administering pain medications by utilizing non-pharmalogical interventions such as repositioning. Staff #182 further stated that the risks of not administering pain medications as ordered or not assessing pain correctly could lead to an opioid addiction and could escalate to the level of neglect. An observation of Resident #4's MAR for March 2026 with Staff #182 was made on March 12, 2026 at 1:02 p.m. Staff #182 stated that upon initial review, it appeared the nurse who administered oxycodone HCl 5 mg did not follow the ordered parameters. Staff #182 further stated that the nurse may have documented the administration incorrectly; however, she was unable to make that determination based on the information available.An interview was conducted on March 12, 2026 at 1:37 p.m. with the Director of Nursing (DON/Staff #144). Staff #144 stated the expectation for nurses when administering high-risk medications such as narcotics is to ensure there is a valid physician's order, follow all ordered parameters, and document per facility policy. Staff #144 stated nurses assess residents' pain using a standard pain scale of one through ten and administer lighter pain medications, such as tylenol, for lower pain ratings (generally 1-3), and stronger medications, including narcotics, for higher pain ratings (generally 6-10), though ranges may vary based on physician orders and patient response. Staff #144 stated that nurses are required to remove the medication from the blister pack, document the medication in the MAR and narcotic sign-out sheet, record that the resident took the medication, document the pain scale rating at the time of administration, and include any non-pharmacological interventions (NPIs) provided. Staff #144 also noted that nurses must follow parameters when determining whether to administer or hold a medication and may notify the physician if a dosage adjustment is needed. Staff #144 further stated that risks associated with improper administration include giving medication when it is not needed, however, scheduled medications do not really have any risks.An observation of Resident #4's MAR for March 2026 with Staff #144 was made on March 12, 2026 at 1:52 p.m. Staff #114 confirmed oxycodone HCl five MG was given outside of parameters, however, indicated the staff administering the medication must have documented incorrectly. Upon review, Staff #144 stated that the documentation and administration of medications for Resident #4 did not meet expectations and that medications should not be administered outside of parameters and that nurses are required to document correctly. Staff #144 indicated that additional staff training may be necessary.Review of the Oral Medication Administration policy last reviewed September 2024 revealed the facility will accurately prepare, administer, and document oral medications.

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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and policy review, the facility failed to ensure food items in the kitchen and the nourishment refrigerator were labeled, dated, and stored correctly. The deficient practice could result in possible food-borne illnesses. Findings include: An initial kitchen observation was conducted on March 10, 2026 at 8:10 a.m. with the Dietary Supervisor (Staff #88). At this time an observation of the refrigerator and freezer units was conducted with Staff #88, the following was observed;Six piping bags filled with whipped cream, one of which was opened with no visible dates which was located in the refrigerator. A partially closed cardboard box which held bacon strips in a clear plastic bag, open and exposed to air which was located in the refrigerator. A partially closed cardboard box which contained a clear plastic bag of frozen burger patties, open and exposed to air, which was located in the freezer.An interview was conducted on March 11, 2026 at 8:21 a.m. with Staff #88. Staff #88 stated that the whipped cream should be dated and labeled. Staff #88 stated that they always store their bacon like that and have never had a problem with it. Staff #88 stated that the risks of incorrectly storing food could make people sick,An observation of the nourishment refrigerator on Station 1 - the behavioral unit, was conducted on March 10, 2026 at 8:25 a.m. with Staff #88. The following was observed;Trader Joe's buffalo chicken dip with no room number or datesSmall container of Fritos bean dip with no room number or datesBlack tupperware container with white rice with no room number or datesRe-used sliced peaches jar of which was filled with soup with no room number or datesHillshire farms roasted turkey breast deli meat container filled with bologna slices with no room number or datesBrown crusted and sticky substance on the floor outside of the refrigeratorWhite sticky substance on the shelving inside the refrigeratorSmall brown food crumbs inside the freezer An interview was conducted on March 11, 2026 at 8:33 a.m. with Staff #88. Staff #88 stated that what was observed in the nourishment refrigerator on the behavioral unit was not acceptable practice and there should be labels on those items. Staff #88 stated that one of the kitchen staff is expected to come in and clean out the fridges and make sure the foods are not expired. Staff #88 further stated that she did not have an answer as to why there are appropriate labels. An observation of the nourishment refrigerator on Station 4, was conducted on March 10, 2026 at 8:49 a.m. with the Dietary Director (Staff #27). The following was observed;Two lunch totes with no names, labels, or datesGlass tupperware container with a pink lid containing food that was unidentifiable Redbull energy drink with no names, labels, or datesAn interview was conducted on March 11, 2026 at 8:49 a.m. with Staff #27. Staff #27 stated that he was unsure of whose lunchboxes they were and that they may be staff lunch boxes. Staff #27 stated that staff should be storing their lunches in the break room and the nourishment refrigerator is for resident food only. Staff #27 stated residents are able to give food items to the certified nursing assistants (CNAs) and the CNAs are responsible for labeling the food correctly. Staff #27 stated the risks of storing staff food with resident food could result in cross-contamination. Staff #27 further stated that not discarding expired food items could result in food-borne illnesses. An interview was conducted on March 11, 2026 at 2:22 p.m. with the Administrator (Staff #11), a resource Registered Dietician (Staff #171), and Staff #88. Staff #88 stated staff are expected to have a received date, opened date, and a discard date on all food items. Staff #88 further stated there is a sheet taped outside of the fridge that includes specific dates for certain food items if staff need a reference and indicated that staff are shown this when orienting. Staff #11 stated the Dietary Director is expected to follow their policy regarding food safety. Review of the Policy and Procedure manual for Food Storage, last revised March 2025, revealed all foods should be covered, labeled, dated, and monitored to assure that foods will be consumed by their use by dates. Review of the Resident and Personal Food Storage Policy, last revised January 2025, revealed food brought by family members or friends will be handled according to food handling guidelines. Further review of the policy revealed food storage areas should be clean at all times.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and review of facility policy and procedures, the facility failed to ensure that appropriate infection prevention and control practices were followed regarding hand hygiene, and the use of proper personal protective equipment (PPE) when entering and cleaning a contact isolation room for 1(resident #84) of 2 sampled residents. The universe was 113. The deficient practice could result in the spread of infection. Findings include:- Regarding hand hygiene:An observation was conducted on March 11, 2026, at 12:56 PM, of a certified nursing assistant (CNA /Staff #95) as she passed out lunch trays to residents in the dining room of the locked unit. Staff #95 was observed moving a basket of laundry from a dining table, then redirected a resident by placing a hand on their shoulder. Immediately after, the CAN grabbed a lunch tray and delivered it to a resident. Staff #95 did not perform hand hygiene between contact with the resident and contact with the food tray. During an observation of the locked unit on March 11, 2026, at 1:02 PM, it was noticed that there were no hand sanitizer dispensers on the hallway walls, in resident rooms, or at the nurse's station. An interview was conducted on March 11, 2026, at 1:06 PM, with staff #95. Staff #95 stated she does not usually work on this unit and was not used to there not being accessible hand sanitizer. She further stated that another staff member had reminded her to perform hand hygiene. She stated that the expectation is that hand hygiene is performed so that residents do not get sick. An interview was conducted on March 11, 2026, at 1:09 PM, with a CNA (staff #47). Staff #47 confirmed there were no hand sanitizer dispensers in the unit, as this posed a risk to the resident population on the unit. He further stated that each staff member is equipped with their own personal hand sanitizer bottle for use. Staff #47 produced a bottle of hand sanitizer from his scrub pocket as evidence of this practice. Staff # 47 stated that hand hygiene should be performed between resident care, and further stated that this included passing trays to residents. An interview was conducted on March 12, 2026, at 2:24 PM with the Assistant Director of Nursing/Infection Preventionist (ADON /IP/Staff #49). Staff #49 stated that she conducts daily staff observations to verify that staff perform hand hygiene and follow other infection control practices. Staff #49 explained that staff are educated during orientation by the IP, and other department leaders are educated during daily meetings who in turn educate their employees on infection control protocols and procedures. Staff #49 said that CNAs with seniority would normally act as resources to newer staff members in terms of expectations regarding hand hygiene and other infection control practices.- Regarding the use of personal protective equipment (PPE) in a contact isolation room:Resident # 84 was admitted on [DATE], with diagnoses that included enterocolitis due to clostridium difficile (C. diff), dependence on renal dialysis, and acute respiratory failure with hypoxia. A physician order dated February 27, 2026 prescribed contact for C. diff. Per the order, all therapies, treatment, cares, and meals are in a single occupancy room every shift.A review of a physician order dated March 9, 2026 prescribed strict contact isolation precautions related to clostridium difficile. The order indicated the use of a gown and gloved. The order directed to wash with soap and water before leaving the room. An observation was conducted on March 12, 2026, at 11:48 AM of resident #84's room being cleaned. There was no signage outside of the room annotating the occupant's transmission-based precaution status. Further, there was no signage indicating which resident was the occupant of the room. A housekeeper (staff #100) was observed cleaning the floor and removing trash from the room. Staff #100 wore gloves, but no other PPE. An interview was conducted on March 12, 2026, at 11:49 AM with staff #100. Staff #100 stated that resident #84 was transferred to another room, but did not know when. The housekeeper was cleaning the room since she was informed that a new admission was being assigned to the room later in the day. Staff #100 stated there was no signage posted outside of the room before she entered. However, she indicated that she was aware that the room had been a transmission-based precaution room the day prior. The housekeeper stated that bleach is used to clean contact precaution rooms. Staff #100 noted that (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	signage posted outside the room designated the type of transmission-based precautions to be followed. Staff #100 repeatedly stated that there was no sign posted, but that she used bleach to clean the room, and pointed to a chair she had sprayed with a bleach mixture. Staff #100 stated that she should wear a gown when cleaning a contact precaution room. When asked about the risk to a resident if infection control practices were not followed, staff #100 refused to answer. An interview was conducted on March 12, 2026, at 1:52 PM with the housekeeping supervisor (staff #16). Staff #16 stated that when cleaning isolation rooms, staff should wear the PPE indicated on the signage outside the door, which included gowns, shoe coverings, and/or masks. She was unaware how this is communicated to housekeeping staff if nursing staff remove signs without informing housekeeping staff. Staff # 16 said that a list of rooms and required precautions are communicated between her and the Infection Preventionist (IP). Staff #16 stated that the risks associated with not wearing the appropriate PPE while cleaning a contact isolation room include increased risk for contamination, and increased staff to resident transmission. An interview was conducted on March 12, 2026, at 2:24 PM with the Assistant Director of Nursing/IP (ADON/Staff #49). Staff #49 stated that she knew about the specific room in question regarding isolation rooms. Per the IP, the room had been deep cleaned the night prior by another nurse since housekeeping was not in the facility at that time. She was unsure of the time and pulled out her cellphone to confirm. Staff #49 said she believed the room was cleaned at approximately 9:00 PM based on text messages exchanged. The IP noted that she was unable to provide documentation confirming that the room was deep cleaned. Staff #49 stated that a deep clean entailed the use of the appropriate chemicals for certain organisms. The IP described a deep-cleaned room as ready for the next resident, free of trash on the floor, and cleaned by staff donning a gown. The facility policy titled IPCP (Infection Prevention and Control Program) Standard and Transmission-Based Precautions, reviewed March 2024, indicated that standard precautions were applied to the care of all residents, and included hand hygiene. Per the policy, contact precautions are used when a known infection can be spread by direct or indirect contact with a resident or their environment. Furthermore, contact precautions required a gown and gloves be worn during all physical interactions with a resident or their environment. PPE should be put on before entry to the room and should be taken off before exiting the room.Review of the facility policy titled, Infection Prevention and Control Program, reviewed August 2025, revealed that the facility must provide education and oversight to ensure hand hygiene is performed based on accepted standards. Further review revealed that staff were expected to conduct themselves and provide care to minimize the spread of infection. Review of the facility policy titled, Housekeeping Services, revised April 2025, revealed that the housekeeping supervisor is responsible for working with the infection preventionist to develop and maintain standards for cleaning. Further review revealed that housekeeping staff were expected to follow special procedures when handling infected or contaminated equipment and facility areas.

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and review of the clinical record and facility policy, the facility failed to ensure that one resident (resident #90)was provided a pneumococcal vaccination. The deficient practice could result in a higher likelihood of developing pneumonia. Findings include:Resident # 90 was admitted on [DATE], with diagnoses that included fracture of the left femur, encephalopathy, and a need for assistance with personal care. Review of the resident consent for influenza, pneumococcal, and COVID-19 vaccination, dated January 2, 2026, revealed that the resident verbally consented to receiving the pneumococcal vaccination. The consent was signed by 2 nurses, one of which was identified to be the Infection Preventionist (staff # 49). Resident #90 did not sign the consent and it was noted that verbal consent was provided on the form. A review of the Medicare 5-Day Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 3, which indicated severe cognitive impairment. Further review of the MDS revealed that the pneumococcal vaccination was not offered. A review of the physician's orders revealed no evidence of an order to administer the pneumococcal vaccination. A review of the Medication Administration Record and Treatment Administration Record (MAR/TAR) from January 1, 2026 through present revealed no evidence that the pneumococcal vaccination was administered during the resident's current admission. An interview was conducted on March 12, 2026, at 2:24PM with staff #49. Staff #49 confirmed that the consent to receive vaccinations indicated that Resident #90 had consented to receive the pneumococcal vaccination. When asked to look through the physician's orders for this resident, staff # 49 stated that she knew there would not be an order for the vaccination because she was the one who ordered the vaccinations and she had not been informed that resident # 90 needed a pneumococcal vaccination. Staff # 49 further stated that this was a nursing error. On March 12, 2026 at approximately 3:35 PM, staff # 49 approached this writer to provide a new consent for vaccinations from resident # 90. The consent provided was dated March 12, 2026, and indicated that the resident no longer wished to receive vaccinations. Staff # 49 stated that she followed up with the resident and when asked if he still wished to receive the pneumococcal vaccination, he stated no. Review of the consent revealed an illegible signature from the resident, and per documentation, one nurse - Staff # 49 - witnessed the signature from resident #90. The facility policy titled Informed Consent, revised July 2022, indicated that as soon as any consent is signed, physician's orders should be implemented.