

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0690</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure licensed nursing staff accurately and consistently monitored and documented fluid intake and output (intake refers to the total amount of fluids a person consumes, while output refers to the total amount of fluids the body eliminates) for one of one resident reviewed for urinary catheters (Resident 100), when Resident 100's intake and output record had blanks (no data recorded), documentation was not in the correct milliliter (ml - unit of measure) format, and there was no policy and procedure regarding monitoring and documenting intake and output as specified in Resident 100's care plan (an individualized plan for the medical care of a resident). These failures resulted in inconsistencies in the monitoring and documentation of Resident 100's intake and output which had the potential for Resident 100's medical record to inaccurately portray his fluid balance, and functional urinary status. Findings: During a review of Resident 100's admission Record (contains medical and demographic information), the admission Record, indicated Resident 100 was admitted on [DATE], with diagnoses which included benign prostatic hyperplasia with lower urinary tract symptoms (the non-cancerous enlargement of the prostate gland, causing a range of urinary problems), hereditary and idiopathic neuropathy (hereditary neuropathy is a group of genetic disorders causing peripheral nerve damage, while idiopathic neuropathy refers to nerve damage with an unknown cause), and secondary malignant neoplasm of the brain (cancer that has started somewhere else in the body has spread to the brain). During a concurrent observation and interview on July 29, 2025, at 10:00 AM, with Resident 100, Resident 100 was observed lying in bed. Resident 100 stated he recently had an indwelling urinary catheter placed because he was not able to urinate on his own. During a review of Resident 100's physician's orders, dated July 22, 2025, indicated, Record intake & [and] output every shift x14 [for fourteen] days. Reassess continuation of intake & output after 14 days. During a review of Resident 100's physician's orders, dated July 23, 2025, the order indicated Resident 100 had an indwelling foley catheter (a thin, flexible tube inserted into the bladder to drain urine). During a concurrent interview and record review on July 31, 2025, at 9:51 AM, with the Director Of Nursing (DON), Resident 100's Monitor Record (document used by licensed nursing staff to record intake and output), dated July 1, 2025, through July 31, 2025, was reviewed. The Monitor Record, indicated the following: -For Friday, July 25, 2025, during the 7:00 AM - 3:00 PM nursing shift, and Tuesday, July 29, 2025, during the 3:00 PM - 11:00 PM nursing shift, there were blanks where Resident 100's intake and output was supposed to be documented. -For thirteen (13) of 26 documented shifts, output was documented as x1 (one time) or x2 (two times) and was not in milliliter (volume) format. -For 10 of 26 documented shifts, output was documented as milliliters volume. The DON acknowledged Resident 100's intake and output Monitor Record, for the month of July 2025 had blanks where intake and output was not documented by staff and stated licensed nurses should have documented the resident's intake and output on the days where there were blanks but stated they did not. Additionally, the DON stated output should have been recorded in milliliter volume instead of the number of times the resident urinated and stated the documentation was incorrect. The DON stated the certified nursing assistants (CNA) also recorded the amount of urine output they drained from the catheter bag but stated she was not sure if the CNA documented values were in addition to the values recorded by the licensed nurses. The DON stated the documentation for intake and output seemed to be inconsistent. During a review of Resident 100's care plan titled, The resident has indwelling catheter: neurogenic bladder [a condition where the nerves that control bladder function are damaged or impaired] . dated July 23, 2025, the care plan indicated, the resident has indwelling catheter: neurogenic bladder. Monitor and document intake and output as per facility policy. During an interview on July 31, 2025, at 2:05 PM, with the DON, when asked for the facility's policy and procedure (P&P) regarding monitoring and documenting of intake and output as specified in Resident 100's care plan. The DON stated she was not sure if the facility had a P&P regarding monitoring and documenting intake and output and stated the Nurse Consultant (NC) would know. During a concurrent interview and record review on July 31, 2025, at 2:06 PM, with the NC, Resident 100's care plan titled, The resident has indwelling catheter: neurogenic bladder . dated July 23, 2025, was reviewed. The NC acknowledged the care plan indicated Monitor and document intake and output as per facility policy. The NC stated the facility did not have a P&P regarding monitoring and documenting intake and output as specified in Resident 100's care plan and that she had looked but was unable to find one. During a review of the facility's P&P titled, Documentation in Medical Record, dated</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0692</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide enough food/fluids to maintain a resident's health.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the Order Summary Diet Order (a list of provider orders) was followed for one of three residents (Resident 21) reviewed for dining observations when Resident 21 did not receive his physician ordered Boost VHC (nutritional supplement, very high calories) with meals for lunch on July 29, 2025 and for breakfast on July 30, 2025. These failures had the potential to have contributed to Resident 21's weight loss. Findings: During a review of Resident 21's admission Record (contains medical and demographic information), it indicated Resident 21 was admitted to the facility on [DATE], with the diagnoses which included Myocardial infraction (heart attack), Dementia (a progressive state of decline in mental abilities) and immunodeficiency(a condition where the body's immune system is weakened, making it less able to fight off infections and diseases). During a review of Residents 21's Order Summary Diet Order, dated July 18, 2025, the Order Summary Diet Order indicated, receive boost VHC TID (three time a day) with meals . During a review of Resident 21's weight record, the weight record indicated Resident 21's weight on March 28, 2025 was 118 pounds, and 102 pounds on July 8, 2025 (Resident 21 lost 16 pounds from March 28, 2025, to July 8, 2025). During a review of Resident 21's IDT (Interdisciplinary Team) Progress Notes, dated July 16, 2025, indicated .weight loss of 13 pounds in one month and a 15-pound weight loss in three months due to poor meal intake range of 10%-70% average per week. Registered Dietitian recommended appetite simulant. add Boost VHC TID with meals. During a lunch observation on July 29, 2025, at 12:42 PM in Resident 21's room, Resident 21 was sitting at the edge of the bed with a lunch tray on his side table. No Boost VHC was observed on the tray, and none was provided after Resident 21 finished eating. During a breakfast observation on July 30, 2025, at 7:30 AM, in Resident 21's room, Resident 21 was sitting at the end of the bed with a breakfast tray on his side table. No Boost VHC was observed on the tray, and none was provided after Resident 21 finished eating. During a concurrent observation, interview, and record review on July 30, 2025, at 8:06 AM with a Licensed Vocational Nurse 4 (LVN 4) in Resident 21's room, Resident 21's meal tray did not have Boost VHC. LVN 4 reviewed Resident 21's Order Summary Diet Order and stated the order was not followed and should have been. During a phone interview on July 30, 2025, at 1:22 PM with the Registered Dietician (RD), the RD stated Resident 21 currently has a Boost VHC ordered TID and should be given with meals. During a concurrent interview and record review on July 30, 2025, at 1:43 PM with the Director of Nursing (DON), the Order Summary Diet Order dated July 18, 2025, was reviewed. The Order Summary Diet Order indicated, Boost VHC TID with meals. Subsequently, the DON reviewed Resident 21's medical record from July 18, 2025 to July 29, 2025. The DON stated there was no documentation for Resident 21's Boost VHC intake. During a concurrent interview and record review on July 30, 2025, at 2:09 PM, with the DON, the facility's policy and procedure (P&P) titled, Nutritional and Dietary Supplements, dated December 2022 was reviewed. The P&P indicated, . 2. The facility will provide nutritional and dietary supplements to each resident, consistent with the resident's assessed needs. The DON stated the P&P was not followed for Resident 21.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain accurate records of controlled medications (medications that are controlled by the government because it may be abused or cause addiction) for one of three sampled medication carts (South Cart) with narcotics when Resident 100's Controlled Drug Receipt/Record/Disposition Form (CDR - document used to record the administration or destruction of a controlled drug for tracking purposes) was found to be inaccurate.This failure had the potential to place the facility at risk for drug diversion (illegal distribution of controlled drugs for any illicit use) of controlled medications by staff .Findings:During a review of Resident 100's clinical records, the admission Record, indicated Resident 100 was admitted on [DATE], with diagnoses which included, pressure ulcers stage 4 (Full-thickness skin and tissue loss with exposed muscle, tendon, ligament, cartilage, or bone), Type two diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), spinal stenosis (a condition where the spinal canal narrows, putting pressure on the spinal cord and/or the nerves), and neuropathy (damage to or disease affecting the nerves, outside the brain and spinal cord).During a review of Resident 100's Order Summary, dated July21, 2025, indicated, Pregabalin (medication used to treat neuropathic pain) oral capsule 25 mg (miligrams-a unit of measurement), give 1 capsule by mouth two times a day for Neuropathy.During a concurrent observation, interview, and record review on July 31, 2025, at 9:00 AM, with a Licensed Vocational Nurse 4 (LVN 4), at South Unit Station Cart, the South Unit Station Cart CDR was inspected. Resident 100's Pregabalin 25 mg CDR indicated 13 tablets were administered (one tablet was unaccounted for). Resident 100's Pregabalin 25 milligram pill bubble packet (a card that packages doses of medications within plastic bubbles organized by day and time of the day) indicated it contained 28 quantities. LVN 4 counted the contents of the bubble pack and stated there were 14 remaining tablets, and 14 tablets had been administered to Resident 100. During a follow up interview on July 31, 2025, at 9:10 AM, with LVN 4, LVN 4 stated one pill was given to Resident 100, and she forgot to document it on the CDR but did document it in the EMR. She further stated the expectation is when a controlled medication is given it should be documented in the CDR and the EMR and the contents of the bubble pack should match its CDR to prevent drug diversion.During a concurrent interview and record review, on July 31, 2025, at 12:24 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Controlled Substances Administration & Accountability, dated June 2023, was reviewed. The P&P indicated, .1. General Protocols. f. In all cases, the dose noted on the usage form or entered into the automated dispensing system must match the dose recorded on the medication administration record, controlled drug record, or other facility specified form and placed in the patient's medical record. h. The controlled drug (or other specified form) serves the dual purpose of recording both narcotic disposition and patient administration. i. The Controlled Drug Record is a permanent medical record document and in conjunction with the MAR is the source for documenting any patient specific narcotic dispensed from the pharmacy.4. Obtaining/Removing/Destroying Medications.a. The entire amount of controlled substances obtained or dispensed is accounted for. The DON stated the licensed nurse is expected to document dispensed narcotics in Resident's MAR and CDR to prevent potential drug diversion.The DON further stated the facility's policy was not followed.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure medical supplies were labeled and stored in accordance with currently accepted professional principles when an intravenous (giving medications through the vein) (IV) cart (a mobile cart used to store and transport medications and other supplies to patients) was found with expired supplies. These failures had the potential for the supplies to be less effective and compromised health and safety for the highly vulnerable population of 85 Residents in the facility. Findings: During a concurrent observation and interview on [DATE], at 12:23 PM, with the Director of Nursing (DON), the intravenous (IV) cart (a mobile storage unit designated to hold and transport medical supplies for intravenous medication and other treatment) was inspected. The following items were found expired and available for use: 1. Six alcohol swabs (small, disposable pads or wipes that are saturated with isopropyl alcohol) were found with the following expiration dates: three with an expiration date of [DATE] (484 days expired) and three with an expiration date of March, 2025 (119 days expired). 2. Two povidone-iodine swab sticks (two swab sticks per pack- an antiseptic prep used on the skin to decrease risk of infection) were found with an expiration date of [DATE] (861 days expired). 3. Eight Chloraprep triple swab sticks (sterile skin antiseptic swab stick) were found with the following expiration dates: one with an expiration date of [DATE] (908 days expired), five with an expiration date of [DATE] (849 days expired), one with an expiration date of [DATE] (605 days expired), and one with an expiration date of [DATE] (574 days expired). 4. Five luer lock tip caps (tip used to keep material in a syringe or IV when not in use and prevent contamination) were found with an expiration date of [DATE] (88 days expired). 5. 24 red end caps (end caps used to keep material in a syringe or IV, when not in use, protected and to prevent contamination) were found with an expiration date of [DATE] (23 days expired). The DON acknowledged the items in the IV cart were expired and should have been discarded. The DON further stated the license staff are responsible for checking expiration date in the IV cart every shift. During an interview on [DATE], at 4:10 PM with the DON, the DON stated that the facility does not have a policy for supply storage and management.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	

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)
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to adequately protect and safeguard the healthcare identifiable information for two out of 25 sampled residents (Resident 7 and 89) when on July 30, 2025, the laptop screen of the Electronic Medical Record (EMR) (electronic form of record keeping) used by Licensed Vocational Nurse 3 (LVN 3) were:1. Left open, unsecured and unattended from 05:44 AM to 5:47 AM, for a total of 3 minutes in the North hallway for Resident 7.2. Left open, unsecured and unattended from 6:08 AM AM to 6:12 AM, for a total of 4 minutes in the North hallway for Resident 89. This failure resulted in the exposure of health-related identifiable information for Residents 7 and 89 when records were left unsecured and unattended in a location easily accessible to residents, visitors, and other unauthorized individuals, which led to a breach of resident confidentiality, violations of resident's privacy, potential loss of sensitive personal information.Findings:1. During an observation on July 30, 2025, at 5:44 AM, LVN 3 was in the North hallway preparing the morning medications for Resident 7. LVN 3 frequently referred to the Electronic Medical Records (EMR) displayed on a laptop situated on top of the medication cart. After performing hand hygiene and locking the medication cart, LVN 3 entered Resident 7's room leaving the EMR laptop screen containing Resident 7's medical information open, unsecured, and unattended. During an observation on July 30, 2025, at 5:47 AM, LVN 3 exited the Resident 7's room. Upon stepping back into the hallway, LVN 3 realized that the EMR laptop screen was open and unsecured. LVN 3 immediately stated that she usually turns off or hides screens containing private information because she understands the importance of protecting patient confidentiality and knows that leaving the screen open constitutes a Health Insurance Portability and Accountability Act (HIPPA is a U.S. federal law enacted in 1996 and primarily aims to protect sensitive patient health information from being disclosed without the patient's consent or knowledge) violation confirming she should have not left the EMP laptop screening open, unsecured, and unattended. A review of the Resident 7's Face Sheet (document containing demographic information) indicated Resident 7 was admitted to the facility on [DATE], with diagnoses which include this dysphasia (difficulty swallowing), chronic obstructive pulmonary disease (lung diseases that block airflow, making it difficult to breathe), hypertension (high blood pressure).A review of Resident 7's History and Physical (H&P) dated April 2, 2025, indicated Resident 7 does not have the capacity to understand and make decisions.2. During an observation on July 30, 2025 at 6:08 AM, LVN 3 was stationed on the North hallway. Further observation, LVN 3 unlocked the laptop screen situated on top of the medication cart to check Resident 89's physician orders. LVN 3 left the North hallway, leaving the laptop screen unlocked, unsecured, and unattended, with Resident 89's medical information visible to anyone passing by. LVN 3 returned to the medication cart at 6:12 AM, explaining that she had gone to the nursing station to wash her hands. LVN 3 confirmed the laptop screen remained open and acknowledged that she had forgotten to lock it and secure it again. A review of the Resident 89's Face Sheet indicated Resident 89 was admitted to the facility on [DATE], with diagnoses which include chronic obstructive pulmonary disease (lung diseases that block airflow, making it difficult to breathe), heart failure (a condition where the heart muscle cannot pump blood effectively enough to meet the body's needs), diabetes mellitus (a disease that occurs when your blood sugar is too high).A review of the resident 89's History and Physical (H&P) dated May 21, 2025, indicated Resident 89 does not have the capacity to understand and make decisions.During an interview with LVN 4 on July 31, 2025, at 10:22 AM, LVN 4 was asked how staff protect electronic medical records from unauthorized viewing. LVN 4 explained she uses a lock button feature that hides the screen when not in use and states she locks the screen every time she turns away or steps away from the laptop. LVN 4 further emphasized the importance of adhering to stringent security protocols to safeguard sensitive patient information. LVN 4 highlighted that consistently utilizing the lock button feature significantly reduces the risk of unauthorized access to electronic medical records. LVN 4 underlined that this practice is in accordance with HIPPA regulations which requires strict measures to protect patient data.During an interview with Registered Nurse 1 (RN 1) on July 31, 2025, at 10:33 AM, RN 1 was asked how staff protect electronic medical records from unauthorized viewing. RN 1 explained her approach to safeguarding electronic medical records (EMR) by completely turning off and logging out of computers when stepping away, rather than just relying on privacy screens. She emphasized this practice is especially important when using mobile computers for medication administration During a concurrent interview and record review on July 31, 2025</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure safe infection control practices and sanitary environment were followed when: a. Resident 101's oxygen nasal cannula tubing (device used to deliver oxygen into the nose via a tube) was found unlabeled and undated. b. Resident 84's oxygen tubing (is a small flexible plastic tube that connects to an oxygen source) [like machine or tank] was not labeled and dated per facility's policy and procedure (P&P). c. A facility's janitor ([DATE]) removed multiple pillows from several trash containers and placed them on a handrail at the facility's rear entrance/exit next to the laundry room. These failures had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasite) to 85 medically compromised residents and staff in the facility. Findings:</p> <p>a. During a review of Resident 101's admission Record (contains medical and demographic information), the &ldquo;admission Record&rdquo; indicated Resident 101 was admitted to the facility on [DATE] with the diagnoses which included chronic respiratory failure with hypercapnia (lungs are unable to exchange oxygen leading to too much carbon dioxide in the blood), Cardiomegaly (enlarged heart), and Myocardial Infraction (heart attack).</p> <p>During a review of Resident 101's Physician Order dated July 28, 2025, the &ldquo;Physician Order&rdquo; indicated, Change oxygen nasal cannula q [every] day shift, on Sunday and PRN [as needed].</p> <p>During an observation on July 28, 2025, at 3:21 PM, in Resident 101's room, Resident 101 was lying in bed, watching television. There was an oxygen nasal cannula tubing in use by Resident 101, attached to an oxygen concentrator (device that provides supplemental oxygen). The oxygen nasal cannula tubing was unlabeled and undated.</p> <p>During a concurrent observation and interview on July 28, 2025, at 3:27 PM, with a Licensed Vocational Nurse 2 (LVN 2), in Resident 101's room, LVN 2 inspected Resident 101's oxygen nasal cannula tubing. LVN 2 stated the oxygen nasal cannula tubing was not labeled and should have been labeled and dated.</p> <p>During a concurrent interview and record review on July 31, 2025, at 8:31 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Oxygen Administration, &rdquo; dated May 2024 was reviewed. The P&P indicated, . 4.b. Change the oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.</p> <p>The DON stated the P&P was not followed and should have been for infection control prevention.</p> <p>b. During a review of Resident 84's &ldquo;admission Record (contains demographic and medical information) the admission record indicated Resident 84 was admitted to the facility on [DATE], with the diagnoses of acute respiratory failure with hypoxia (not enough oxygen in the blood), heart failure, unspecified (heart not pumping enough blood), and hypertensive heart disease with heart failure (condition that forces the heart to work harder that it should).</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an observation on July 28, 2025, at 1:17 PM, Resident 84 with a nasal cannula tubing in place (oxygen through a nose) was sitting in a wheelchair in the south nursing station flipping through magazines. Resident 84's nasal cannula oxygen tubing was connected to a portable oxygen tank (oxygen storage) that was stored behind the wheelchair. There was no label and no date on the nasal cannula oxygen tubing.</p> <p>During an interview on July 28, 2025, at 1:20 PM with a Licensed Vocational Nurse 1 (LVN 1), LVN 1 stated the oxygen tubing was not labeled and is unsure when it was changed.</p> <p>During an interview on July 28, 2025, at 1:21 PM with Registered Nurse 1 (RN 1), RN 1 stated the oxygen tubing was not labeled and has no date.</p> <p>During a review of Resident 84's "Physician Order" dated March 24, 2025, the "Physician Order" indicated, "Oxygen via Nasal Canula at 2 liters per minute (L-liters-unit of measurement/min-minutes) may titrate (slowly increase or decrease over a period of time) O2 (Oxygen) to maintain SPO2 (levels of oxygen in the blood) greater or equal to 92% (95-100 is considered normal, with lower levels being acceptable for COPD), as needed for SOB (shortness of breath) r/t (related to), CHF (congestive heart failure);"</p> <p>During a concurrent interview and record review on July 31, 2025, at 8:31 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, "Oxygen Administration," dated May 2024 was reviewed. The P&P indicated, "4.b. Change the oxygen tubing and mask/cannula weekly and as needed if it becomes soiled or contaminated.</p> <p>The DON stated the P&P was not followed and should have been for infection control prevention.</p> <p>c. During an observation on July 29, 2025, at 2:28 PM, there were five pillows (without pillowcases) observed to be on the handrail at the rear entrance/exit of the facility near the laundry room. The pillows were tucked between the handrail and a wooden fence where multiple staff members were observed to be entering and exiting the building.</p> <p>During an observation on July 30, 2025, at 9:45 AM, the five pillows observed to be on the handrail near the entrance/exit of the facility were still on the handrail.</p> <p>During an interview on July 31, 2025, at 2:05 PM, with the Environmental Services Director (ESD), the ESD stated janitor 1 ([DATE]) placed the pillows on the handrail between the railing and the fence outside the exit/entrance door near the laundry room because the ([DATE]) thought the pillows needed to be washed and returned to residents. ESD stated the pillows actually were meant to be thrown away by the laundry staff and needed to be replaced. ESD stated [DATE] thought they were mistakenly placed in the trash so he ([DATE]) removed them from the trash and placed them on the handrail. ESD further stated the pillows should never have been removed from the trash and should have remained in the trash and been discarded with the trash.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	
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)		
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>During an interview on July 31, 2025, at 2:40 PM, [DATE] stated the ESD had previously told him to be on the lookout for things in the trash that may not actually be trash but were in the trash bins. When asked about the pillows observed to be on the handrail near the rear entrance/exit of the facility. [DATE] stated he removed multiple pillows from trash bins which were part of the dirty linen and trash bin carts (a cart with wheels that has two bags, one bag is for dirty linen while the other bag is allocated for trash) located throughout the facility. [DATE] stated the dirty linen/trash bin carts which he retrieved the pillows from were from multiple different carts throughout the facility and stated the carts contained dirty linen and trash from resident rooms throughout the facility. [DATE] stated he thought the pillows were placed in the trash side of the cart by accident, so he removed them (the pillows) from the trash and placed them on the rail for processing by laundry staff.</p> <p>During an interview on July 31, 2025, at 2:46 PM, with the Infection Preventionist (IP), the IP stated the janitor should not have removed anything from the trash and the pillows he removed from the trash should not have been placed on the railing outside the laundry area. The IP further stated the pillows were already in the trash and disposed of and were dirty with "who knows what kind of bacteria or germs so once its in there it should be discarded."</p> <p>During an interview on July 31, 2025, at 3:20 PM, with the Director of Nursing (DON), the DON stated the trash should stay in the trash containers and pillows should not have been removed from trash receptacles and placed on the rail near the laundry because of infection control reasons.</p> <p>During a review of the facility's policy and procedure (P&P) titled, "Infection Prevention and Control Program," dated September 2, 2022, the P&P indicated, "This facility has established and maintains an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines;9. Equipment protocol: "c. Reusable items potentially contaminated with infectious materials shall be placed in a impervious clear plastic bag. Label bag as "CONTAMINATED" and place in the soiled utility room for pickup and processing;11. Linens: a. Laundry and direct care staff shall handle, store, process, and transport linens to prevent spread of infection;"</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055872	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2025
NAME OF PROVIDER OR SUPPLIER Citrus Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE 9440 Citrus Avenue Fontana, CA 92335	

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)
<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, interview, and record review, the facility failed to maintain a clean and sanitary environment for residents who reside in the facility when on July 29, 2025, the North hallway shower room was found to have black substance on the shower stalls. This failure had the potential to exposed the residents using this shower room to increased risks of developing allergies, skin irritation, and serious respiratory issues. Findings: During an observation on July 29, 2025, at 2:30 PM in the residents' shower room in North hallway, the three shower stalls were found to have a black substance on the shower stalls floors, walls, and where the wall meets the floor and the ceiling. The substance was also present on the wall joints, and on and between the tiles. During an interview on July 29, 2025, at 2:40 PM, Certified Nursing Assistant 1 (CNA 1) confirmed and stated that this shower room is used by all residents in North hallway. During a concurrent observation and interview with the Environmental Services Director of Maintenance (ESD) on July 29, 2025, at 2:58 PM, the ESD acknowledged the presence of a black substance on the shower stalls floors, walls, and where the wall meets the floor and the ceiling in the North Hallway shower room multiple shower stalls. The ESD stated this black substance might be a buildup from shampoo oils and soap scum. He mentioned a black crack where the ceiling meets the wall noting that this was the first time he had observed the ceiling issue since he started working at the facility in April 2025. During an observation and interview with the Director of Nursing (DON) on July 29, 2025, at 3:33 PM, the DON inspected the North Hallway shower room multiple shower stalls. She identified and confirmed the presence of black substances between the tiles, on tile surfaces, and observed black mold bleeding from the walls and ceilings. When ask about the suitability of the shower room for resident's use, the DON acknowledged that the showers were not suitable for residents in their current state. During a concurrent interview and record review on July 30, 2025, at 4:12 PM the facility's Policy and Procedure (P&P) titled, Routine bathroom cleaning, revised on December 19, 2022, was reviewed with the Administrator (Admin) and the ESD. The facility's P&P indicated, It is the policy of this facility to establish policies, procedures and guidelines to provide a clean and sanitary environment for residents, staff and visitors in order to prevent cross contamination and transmission of health care associated infection (HAI) . Procedure 1. (h) clean shower/tub faucets, walls and railing, scrubbing as required to remove soap scum. Inspect grout for mold, apply disinfectant to interior surfaces of shower/tub, including soap dish, faucets and shower head. Allow sufficient contact time for disinfectant according to manufacturer's recommendations. Rinse and wipe dry. Inspect shower curtain and replace as required . 4. Report areas of mold, cracked, leaking or damaged items in need of repair. The ADMIN and the ESD stated the facility's P&P were not followed.</p>