

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 056315	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/19/2026
NAME OF PROVIDER OR SUPPLIER Citrus Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9025 Colorado Avenue Riverside, CA 92503	

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 0580</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure that a significant change in condition, an unwitnessed fall with development of a black eye, was immediately reported to the physician and responsible party for one of four residents reviewed for falls (Resident 1). This failure had the potential to place the resident at risk for delayed medical evaluation and treatment of injuries related to the fall. Findings: On February 10, 2026, at 2:40 p.m., an interview with Resident 1's responsible party (RP) was conducted. The RP stated that a family visited Resident 1 on January 24, 2026, at around 3:00 p.m., and noticed that Resident 1 had a black eye and never received a call from the facility regarding an incident. On February 11, 2026, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis which included muscle weakness and dementia (decline in cognitive function). A review of Resident 1's Progress Notes, indicated, .effective date 1/23/2026.LATE ENTRY.situation: The Change in Condition/s reported on this CIC Evaluation are/were: Other change in condition.found resident sitting up position in bathroom floor with both hands holding on to toilet, no apparent injury noted skin intact did no c/o pain on assessment, vital signs wnl (within normal limit), A/O (alert and oriented) at usual baseline . resident stated she slipped and did not hit her head. Further record review of Resident 1's progress note indicated there was no documented evidence that the responsible party was notified immediately following the incident, and the physician was not notified until January 25, 2026, two days after the fall. On February 11, 2026, at 2:41 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN 1). LVN 1 stated, he was the assigned nurse for Resident 1 on January 24, 2026, the day the RP called the facility to ask about the black eye and had not been informed. LVN 1 stated, he did not observe a black eye and was not aware of a change in condition from the previous shift. On February 11, 2026, at 4:10 p.m., an interview was conducted with Certified Nursing Assistant (CNA 1). CNA 1 stated, she worked the evening when Resident 1 was found on the bathroom floor. CNA 1 stated she was not aware that the incident needed to be documented under a New Alert so it would be visible to other staff. On February 11, 2026, at 4:26 p.m., an interview was conducted with LVN 2. LVN 2 stated she forgot to report the incident that occurred to Resident 1 on the evening of January 23, 2026, to the Registered Nurse, the physician, the family and did not initiate a Change of Condition (COC). LVN 2 further stated reporting and initiating a COC was the expected practice. On February 11, 2026, at 4:47 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, the fall incident involving Resident 1 was a change in condition, and staff were expected to assess, monitor, initiate a care plan, updated the care plan as needed, and notify the physician and responsible party immediately. The DON further stated a COC should be initiated immediately to ensure timely interventions. A review of the facility policy and procedure, titled, Change in condition: Notification of, dated August 25, 2021, indicated, .a facility must immediately inform the resident, consult with the Resident's physician and/or NP, and notify, consistent with his/her authority, Resident Representative where there is: an accident involving the resident.a significant change in Resident's physical, mental or psychosocial status.a need to alter treatment significantly.</p>

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident?s preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure timely and ongoing assessment, monitoring, and care-plan revision following a change in condition (unwitnessed fall) for one of four residents reviewed for falls (Resident1). This failure resulted in delayed recognition of injury (black eye) and had the potential to compromise the resident's physical and psychosocial well-being. Findings: On February 11, 2026, Resident 1's record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnosis which included muscle weakness and dementia (decline in cognitive function). A review of Resident 1's medical records revealed that on January 23, 2026, on the p.m. shift, Resident 1 experienced an unwitnessed fall. A review of Resident 1's Progress Notes, indicated, .effective date 1/23/2026.LATE ENTRY.situation: The Change in Condition/s reported on this CIC Evaluation are/were: Other change in condition.found resident sitting up position in bathroom floor with both hands holding on to toilet, no apparent injury noted skin intact did no c/o (complaint of) pain on assessment, vital signs wnl (within normal limit), A/O (alert and oriented) at usual baseline responsible verbally resident stated she slipped and did not hit her head. Further review of the progress notes indicated there was no documented evidence or staff awareness that an ongoing assessment for delayed injuries and monitoring were conducted on January 23, 2026, and January 24, 2026, following the unwitnessed fall. In addition, there was no documented evidence that the resident's care plan was reviewed or revised to address the fall and to implement interventions to prevent further incidents. On February 11, 2026, at 2:41 p.m., a concurrent interview and record review was conducted with Licensed Vocational Nurse (LVN 1). LVN 1 stated that he was the assigned nurse for Resident 1 on January 24, 2026, the day the RP called the facility asking why Resident 1 had a black eye and had not been informed. LVN 1 stated, he did not receive any report that Resident 1 had a change of condition (COC) due to a fall. LVN 1 stated once a resident had a COC, the licensed nurse would assess the resident for the next 72 hours. LVN 1 further stated, the COC was not created until January 26, 2026, two days after the fall and Resident 1 did not have ongoing monitoring and assessment until January 25, 2026. On February 11, 2026, at 5:27 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated that the incident which occurred with Resident 1 was a COC, and when there is a COC, staff are required to assess, monitor, initiate or revise the care plan. The DON stated, since the COC was not done for Resident 1, there was no ongoing assessment and monitoring and no revision of the care plan. The DON further stated a COC should be initiated immediately to ensure timely interventions.</p>		