STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Grove Post Acute	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed for two of two residents reviewed for change in condition (Residents 1 and 2), to consistently monitor and assess residents following a significant change in condition. These failures had the potential for changes in a resident's condition to go unrecognized, which could delay recognition of worsening neurological status, recurrent elopement behaviors, or other complications requiring timely nursing or physician intervention. Findings: 1. A review of Resident 1's record indicated Resident 1 was admitted on [DATE], with diagnoses which included cerebral infarction (brain tissue injury). A review of Resident 1's Change of Condition dated May 25, 2026, indicated, .increased confusion, elopement risk. A review of Resident 1's Progress Notes for 72-hour monitoring was reviewed. The following entries were missing: -May 26, 2026, morning shift -May 27, 2026, night shift -May 28, 2026, morning shift -May 28, 2026, evening shift On June 17, 2026, at 11:20 a.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor 1 (RNS 1). RNS 1 stated licensed nurses were expected to document what was monitored each shift, including the resident's condition and any changes observed. RNS 1 stated the documentation served as evidence that monitoring was performed and allows staff to identify changes in the resident's condition, communicate with the physician when necessary, and ensure appropriate follow-up care. RNS 1 acknowledged there was missing documentation for Resident 1's 72-hour monitoring and stated licensed nurses should have documented the resident's condition and what was monitored each shift. RNS 1 stated the documentation was necessary to determine whether the resident's condition was improving or worsening, communicate changes to the physician or responsible party when needed, and ensure appropriate follow-up care. RNS 1 acknowledged that because documentation was missing, there was no proof the required monitoring had been completed during those shifts. On June 17, 2026, at 11:43 a.m., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated 72-hour monitoring should include the resident's behavior, condition, and interventions, and should be documented by the licensed nurse every shift. The ADON stated the documentation was important to identify changes in the resident's condition, determine whether additional interventions were needed, determine how to proceed with the resident's change of condition, evaluate whether monitoring should be extended beyond 72 hours, and determine whether the care plan required re-evaluation based on the effectiveness of the intervention. The ADON acknowledged, Resident 1's 72-hour monitoring had missing entries and without documentation, the facility was unable to determine the resident's condition during the missing shifts or what had been monitored. 2. A review of Resident 2's record indicated Resident 2 was admitted on [DATE], with diagnoses which included metabolic encephalopathy (brain dysfunction causing altered mental status). A review of Resident 2's Change of Condition dated May 31, 2026, indicated, .RESIDENT WAS FOUND IN FRONT PARKING LOT OF FACILITY. A review of Resident 2's Progress Notes for 72-hour monitoring was reviewed. The following entries were missing: -June 1, 2026, morning shift -June 2, 2026, morning shift On June 17, 2026, at 10:10 a.m., a concurrent interview and record review were conducted with the Licensed Vocational Nurse 1 (LVN 1). The LVN 1 stated when a resident experiences a change of condition, the (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Grove Post Acute	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)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	licensed nurse is responsible for assessing the resident, reviewing medications related to the change in condition, notifying the physician and responsible party, updating the care plan, documenting the resident's condition and interventions each shift for 72 hours, and communicating the change of condition to the oncoming nurse. LVN 1 stated the documentation should reflect what was monitored or observed regarding the resident's status, the interventions implemented, and the resident's progress each shift. LVN 1 acknowledged there were missing entries for Resident 2's 72-hour monitoring. LVN 1 stated it was important to document the resident's condition each shift to determine whether the resident was improving, identify any additional issues that needed to be addressed, and evaluate the effectiveness of the interventions implemented. LVN 1 stated the documentation also helped determine whether the resident's needs could continue to be managed by the facility. On June 17, 2026, at 11:43 a.m., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated 72-hour monitoring should include the resident's behavior, condition, and interventions, and should be documented by the licensed nurse every shift. The ADON stated the documentation was important to identify changes in the resident's condition, determine whether additional interventions were needed, determine how to proceed with the resident's change of condition, evaluate whether monitoring should be extended beyond 72 hours, and determine whether the care plan required re-evaluation based on the effectiveness of the intervention. The ADON acknowledged, Resident 2's 72-hour monitoring had missing entries and without documentation, the facility was unable to determine the resident's condition during the missing shifts or what had been monitored. A review of the facility form titled, Competency Skills: Change In Condition, undated, indicated, .Complete comprehensive assessment/evaluation and documentation to include responses to nursing care/intervention provided.Resident will be monitored for change of condition with follow up documentation done every shift for 72 hours or as indicated.Best practice: Re-evaluate the resident as a follow-up after initial evaluation/assessment had been done and document in PCC progress notes the outcome of re-evaluation to provide a proof that the resident is followed up and monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Grove Post Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision and implement appropriate interventions to prevent the elopement of one of three residents reviewed for accidents (Resident 2) after the resident had been identified as being at risk for leaving the facility without notice. This failure resulted in Resident 2 leaving the facility without staff knowledge on June 20, 2026, and had the potential to place Resident 2 at risk for serious harm.Findings: A review of Resident 2's record indicated Resident 2 was admitted on [DATE], with diagnoses which included metabolic encephalopathy (brain dysfunction causing altered mental status). A review of Resident 2's Minimum Data Set (an assessment tool) dated May 25, 2026, indicated a Brief Interview for Mental Status (a cognitive assessment) score of 10 reflecting moderate cognitive impairment. A review of Resident 2's progress notes dated May 28, 2026, indicated .Informed by staff of noting resident exiting front door of facility. Resident stepped outside of front door and staff immediately intervened and were able to redirect resident safely inside of facility .staff notified and aware of resident at risk for elopement .Face sheet left at front desk receptionist to be aware of resident . A review of Resident 2's Leave of Absence Without Notice (LAWN) Evaluation Form dated May 28, 2026, indicated, .IDT (interdisciplinary Team) CONSIDERATIONS .BIMS score .10 .Has diagnosis/es that may impair cognition .Yes .safety awareness a concern .yes .wanders in and out of the facility .Yes .IDT DETERMINATION .IST has determined that the resident is at risk for Leave of Absence Without Notice based on the above consideration . A review of Resident 2's Care Plan dated May 29, 2026, indicated, .Focus.at risk for exit-seeking behavior.found outside facility.Goal.will remain safe within facility grounds.Interventions.Monitor for signs of exit seeking behavior. A review of Resident 2's Change of Condition indicated the following: -Dated May 31, 2026, .RESIDENT WAS FOUND IN THE PARKING LOT OF FACILITY .RESIDENT ATTEMPTED TO LEAVE THE FACILITY .RESIDENT VERBALIZED 'RESIDENT WANTING TO GO OUTSIDE' . -Dated June 20, 2026, indicated, .elopement.Around 2pm CNA (Certified Nursing Assistant) reported that they were unable to find res (resident).Patient was found and brought back to the facility. Further review of Resident 2's record indicated there was no documented monitoring log of Resident 2's whereabouts despite the resident's identified elopement risk. In addition, following Resident 2's prior exit-seeking incidents, the facility did not revise the care plan or implement additional interventions, such as a WanderGuard, before the June 20, 2026, elopement. On June 17, 2026, at 11:20 a.m., a concurrent interview and record review was conducted with Registered Nurse Supervisor 1 (RNS 1). RNS 1 stated residents identified as being at risk for elopement should have frequent documented monitoring of their whereabouts. RNS 1 stated Resident 2 did not have a monitoring log and stated it should have been implemented to track the resident's location and ensure safety. On June 17, 2026, at 11:43 a.m., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON stated staff were expected to perform and document visual checks every 15 minutes to one hour, depending on the resident's condition. The ADON confirmed Resident 2 should have had a documented monitoring log. On June 25, 2026, at 9:25 a.m., an interview was conducted with Resident 2. Resident 2 stated she walked out the front door to take a walk down the street. Resident 2 stated no one was present and the front door alarm did not activate. On June 25, 2026, at 10:30 a.m., an interview was conducted with the Certified Nursing Assistant (CNA). The CNA stated she was assigned to Resident 2 on the day of the incident on June 20, 2026. The CNA stated she knew Resident 2 had a history of attempting to leave the facility and routinely checked on her approximately every 20 minutes to one hour and those were not documented. The CNA stated after assisting other residents, she discovered Resident 2 was missing, notified the licensed nurse, and a Code Pink (the facility's missing resident/elopement response) was initiated. On June 25, 2026, at 10:54 a.m., an interview was conducted with the Licensed Vocational (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Grove Post Acute	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)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Nurse 2 (LVN 2). LVN 2 stated Resident 2 had a history of exit-seeking behaviors. LVN 2 stated interventions before the elopement consisted of visual checks for wandering behaviors. LVN 2 stated there was no documented monitoring and Resident 2 did not have a WanderGuard in place. LVN 2 stated following the elopement, Resident 2 was placed near the nurse's station, a physician was notified, a WanderGuard was applied, hourly monitoring was initiated, and the care plan was updated. On June 25, 2026, at 11:19 a.m., an interview was conducted with Registered Nurse Supervisor 2 (RNS 2). RNS 2 stated staff performed visual checks, and these were not documented. RNS 2 stated the front entrance alarm did not sound because it was daytime and that the receptionist did not observe Resident 2 leave. RNS 2 stated after the incident, a WanderGuard was implemented. On June 25, 2026, at 12:01 p.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated she was informed Resident 2 could not be found and Resident 2 was found down the street sitting on the grass at a church. The DSD stated Resident 2 was alert with confusion. On June 25, 2026, at 3:55 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated residents as being at risk for elopement should have their whereabouts monitored by CNAs and licensed nurses. The DON stated after Resident 2's first exit-seeking incident, interventions included monitoring for exit-seeking behaviors and updating the care plan. The DON stated after the second exit seeking incident on May 31, 2026, no additional interventions were implemented. The DON acknowledged a WanderGuard should have been considered after Resident 2's incidents because it alerts staff when a resident attempts to leave the facility. The DON further stated hourly documented monitoring should have been implemented to verify the resident's whereabouts and demonstrate monitoring was performed. A review of the facility policy and procedures titled, Tab Alarms, Bed Alarms, Wanderguard System, dated December 12, 2024, indicated, .Wanderguard would be used for residents at risk for elopement. A review of the facility policy and procedures titled, Wandering and Elopements, dated March 2019, indicated, .The facility will identify residents who are at risk of unsafe wandering and strive to prevent harm.care plan will include strategies and interventions to maintain the resident's safety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056315	A. Building B. Wing	06/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Grove Post Acute	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)
F 0908 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep all essential equipment working safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure the front door exit alarm was maintained in proper operating condition. This failure had the potential to delay staff awareness of residents exiting the facility and place residents at risk for elopement. Findings: On June 16, 2026, at 3:05 p.m., a concurrent observation and interview were conducted with the Maintenance Supervisor (MS) at the facility's front entrance located in the lobby. The MS activated the front door alarm. When the front door was opened, the alarm did not produce an audible sound. The MS stated the front door alarm should have sounded loudly when the door was opened to alert staff that someone was exiting the building and to help ensure resident safety. The MS stated he did not know the front door alarm was not functioning. The MS further stated the alarm should have been working and acknowledged it was important because it alerts staff when someone attempts to leave the facility. A review of the facility's maintenance report titled Doors Mag Lock, dated May 28, 2026, indicated all door alarms had passes inspection. However, when the front door alarm was tested on [DATE], it failed to produce an audible alarm when tested. In addition, the facility was unable to provide evidence that the malfunctioning front door alarm had been identified and repaired prior to June 16, 2026. On June 17, 2026, at 11:43 a.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the alarmed door should be working. The ADON stated it was important for the alarmed doors to be working to ensure resident safety and alert staff if someone is accessing the alarmed door. A review of the facility policy and procedure titled, Exit Door Alarm Testing and Inspection, undated, indicated, .Exit door alarm systems shall be maintained in good working order.to ensure the safety and security of residents, staff, and visitors.