

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 12/11/2025
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)		
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to ensure dietary staff were able to safely and effectively carry out the functions of food and nutrition services when one dietary staff did not perform testing of the sanitizing solution in accordance with the manufacturer instructions. This failure had the potential to result in kitchen equipment used for food preparation and service being maintained outside required chemical parameters, increasing the risk for cross-contamination. Findings: On December 10, 2025, at 8:09 a.m., a concurrent observation and interview were conducted with the Dietary Aide (DA). The DA was asked to demonstrate the sanitation testing process using the Quaternary (sanitation solution) test paper. The DA obtained a test strip from the test paper distribution container, dipped the strip into the sanitizing solution, and counted aloud to 15 seconds, stating we need to count for a total of 15 seconds according to our process. After counting to 15, the DA removed the test strip and compared it to the color chart located on the front of the container. The DA stated the acceptable range should be between 200 and 400 ppm (parts per million - a unit of measure) to ensure effectiveness. A review of the sanitation strip container labeled [brand name] Quat test paper indicated the test strip should be immersed in the sanitizing solution for 10 seconds and immediately compared to the color chart. On December 11, 2025, at 2:45 p.m., an interview was conducted with the Registered Dietitian (RD). The RD stated the quaternary test paper was used to test the concentration of the quaternary sanitizing solution for dishwashing. The RD stated the test strips should be immersed in the solution for 10 seconds in accordance with manufacturer instructions. The RD stated, they should be following the manufacturers guidelines. A review of the [Brand Name] (QT-40) Quat Test Paper instructions, indicated, .Dip the strip into the sanitizing solution for 10 seconds, then instantly compare the resulting color with the enclosed color chart which matches concentrations of 0-500 ppm (parts per million). A review of the Food Code 2022: section 4-501.114 Manual and Mechanical Warewashing Equipment, Chemical Sanitization - Temperature, pH, Concentration, and Hardness indicated, .with respect to chemical sanitization, section 4-501.114 addresses the proper use conditions for the sanitizing solution. quaternary ammonium compounds. if these parameters are not as specified in the Code or on the EPA registered label, then the provision is violated. in accordance with the EPA-registered label use instructions for food contact surface sanitizers. A quaternary ammonium compound solution shall: (1) Have a minimum temperature of 24oC (75oF), P. (2) Have a concentration as specified under S 7-204.11 and as indicated by the manufacturer's use directions included in the labeling, P and. (3) Be used only in water with 500 MG/L hardness or less or in water having a hardness no greater than specified by the EPA-registered label use instructions.		

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to treat residents with dignity and respect for three of three residents reviewed for dignity (Residents 6, 123, and 124) when:1. Resident 123 did not receive her meal at the same time as her roommate. 2. Resident 6's Foley catheter drainage bag was left uncovered and exposed; and3. A staff entered Resident 124's room without knocking. These failures had the potential to negatively affect the resident's dignity, comfort, and psychosocial well-being.Findings: 1. On December 8, 2025, at 12:55 p.m., Resident 123 was observed exiting her room and asking when her lunch would be arriving. Resident 123 stated that her roommate was already eating her lunch and that she was hungry. During a concurrent observation, Resident 123's roommate was observed with her meal tray approximately halfway consumed. On December 8, 2025, at 1:12 p.m., an interview was conducted with Certified Nursing Assistant 2 (CNA 2). CNA 2 stated she had just served Resident 123's meal tray. She further stated Resident 123 should have received the meal at the same time as her roommate. CNA 2 stated it was not right Resident 123 was waiting for her food. On December 8, 2025, at 1:18 p.m., an interview was conducted with the Licensed Vocational Nurse 2 (LVN 2). LVN 2 stated the expectation is to make sure residents in the same room receive and eat their meals at the same time in order to respect resident dignity. On December 11, 2025, at 2:25 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated, the staff are expected to verify meal trays and served them in order so that residents in the same room are served and eating at the same time. The DON stated, it should not occur that one resident is eating while the other resident has not yet received a meal. A review of the facility's policy and procedure titled, Assisting the Resident with In-Room Meals no date, indicated, .the purpose of this procedure is to provide appropriate assistance for residents who choose to receive meals in their rooms.be sure that everyone is served. 2. On December 9, 2025, at 11:07 a.m., an observation was conducted in Resident 6's room. Resident 6 had a FC bag hanging below the bed, uncovered and exposed to other residents and visitors. On December 9, 2025, at 11:18 a.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA1). CNA 1 confirmed Resident 6's FC bag was not covered with a dignity bag. She stated the FC bag should be covered for privacy and dignity. On December 11, 2025, at 2:23 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated all FC bags should be covered for dignity with a dignity bag (a cover used to conceal a urinary catheter drainage (Foley) bag from public view). A review of the facility's policy and procedure titled, Quality of Life- Dignity no date, indicated, .each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, feeling of self-worth and self-esteem.residents are treated with dignity and respect at all times.staff are expected to promote dignity and assist residents, for example: (continued on next page)		

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	.helping the resident to keep urinary catheter bags covered. 3. A review of Resident 124's admission record indicated Resident 124 was admitted to the facility on [DATE], with diagnoses which included altered mental status (confusion). On December 9, 2025, at 8:36 a.m., LVN 1 was observed entering Resident 124's room without knocking prior to entry. During a concurrent interview with LVN 1, LVN 1 stated he did not knock before entering the resident's room. LVN 1 stated he should have knocked prior to entry. LVN 1 further stated that knocking is a courtesy used to announce entry and to respect resident's privacy and dignity. On December 11, 2025, at 9:49 a.m., the DON was interviewed. The DON stated the staff should knock before entering the resident's room to respect their privacy and dignity. A review of facility policy and procedure titled Quality of Life- Dignity, undated, indicated .Residents are treated with dignity and respect at all times. Residents Private spaces and property are respected at all times. Staff are expected to knock and request permission before entering residents' room.		

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interview and record review, the facility failed to provide a written notice of bed hold (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) to the resident or resident representative (RP) at the time of transfer to an acute care hospital for one of three residents reviewed for closed records (Resident 3). This failure had the potential for residents and/or their RPs not being fully informed of bed-hold rights or the right to return to the facility following hospitalization which could lead to an inappropriate discharge. Findings:A review of Resident 3's admission Record indicated Resident 3 was admitted to the facility July 7, 2022, with diagnoses which included depression (mood disorder).A review of the Nurse Progress Note dated December 6, 2025, at 8:44a.m., indicated, .Resident departed facility at approx (approximately) 0840 (8:40 a.m.) .Resident was sent to (name of hospital) for further evaluation .Resident alert and verbally responsive at time of departure . A review of the facility document titled Bed Hold -Informed Consent-Confirmation of Transfer and Bed hold Provision- Transferred to (blank) Name of Person Notified (blank) .24 Hour Notification (blank). There was no documented evidence the facility provided written notification of bed hold to Resident 3 at the time of transfer on December 6, 2025. On December 10, 2025, at 1:06 p.m., a concurrent interview and record review were conducted with Licensed Vocational Nurse (LVN) 4. LVN 4 stated she did not notify the resident about the bed-hold policy at the time of transfer. LVN 4 stated she should have completed the bed-hold notification form and should not have been left blank.On December 11, 2025, at 9: 49 a.m., a concurrent interview and record review were conducted with the Director of Nursing (DON). The DON stated, the licensed nurses are expected to complete the bed-hold notification form at admission and again at the time of transfer to ensure residents bed hold rights are honored and to prevent inappropriate discharge. A review of facility policy and procedure titled Bed-Holds and Returns, undated indicated .All residents/representatives are provided written information regarding the facility and state bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave) Residents regardless of payer source, are provided notice about these policies at least twice.1. well in advance of any transfer (admission); and 2. at the time of transfer.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to follow facility's policy and procedures for two of five residents reviewed (Residents 1 and 51) when:1. Staff did not properly identify a resident (Resident 51) and ensure the correct breakfast was served.This failure had the potential to result in adverse reactions due to receiving an incorrect diet and to cause emotional distress. 2. Staff did not change the resident's nasal cannula (a medical device used to deliver supplemental oxygen) on a weekly basis.This failure had the potential to result in cross-contamination and increased risk of infection. 1. On December 10, 2025, at 8:05 a.m. an interview was conducted with Resident 51. Resident 51 stated the breakfast tray that was initially served had another resident's name on the meal ticket and was not intended for him. Resident 51 stated, They didn't even know it was for someone else!A review of Resident 51's admission Record dated December 10, 2025, indicated an admission date of June 11, 2025, with diagnoses including dementia (forgetfulness).A review of Resident 51's History and Physical dated June 12, 2025, indicated resident had the capacity to make decisions.A review of Resident 51's Physician Orders dated July 2, 2025, indicated, .Regular diet Regular texture, Thin consistency.A review of Resident 91's Physician Orders dated October 17, 2025, indicated, .Regular, No Added Salt diet minced & moist texture, Thin consistency, with 1200ml (milliliter - a unit of measure) fluid restriction.On December 10, 2025, at 8:06 a.m., an interview was conducted with Certified Nurse Assistant (CNA) 3. CNA 3 stated she was a bit distracted and did not correctly identify Resident 51's full name using the meal ticket when serving the breakfast tray. CNA 3 stated she should have identified Resident 51 using his full name, rather than only the first two letters of his first name, to ensure the correct tray was served to the correct resident. CNA 3 stated, proper identification was important to prevent emotional distress, such as refusal of a meal and adverse reactions such as choking. CNA 3 stated the breakfast tray served to Resident 51 was intended for Resident 91, who had a different diet order. On December 10, 2025, at 4:18 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the CNA should have verified the resident's full name against the meal ticket prior to serving the breakfast tray to ensure the correct diet was provided. The ADON stated this was important to prevent adverse effects, such as aspiration related to incorrect food texture or hyperglycemia (high blood sugar) in diabetic residents.On December 11, 2025, at 8:36 a.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated the CNA should have identified the resident using the full name prior to serving the breakfast tray to ensure the correct diet was served to the correct resident. The DSD further stated this was important to prevent any adverse reactions including choking due to incorrect food texture, affecting disease course, and allergic reactions.A review of the facility's policy and procedure titled, Tray Identification, undated, indicated, .before serving the residents .Nursing staff will verify the name of the resident using resident identifier such as door name, wrist band, and or PCC photo .2. On December 9, 2025, at 9:34 a.m., an observation was conducted in Resident 1's room. Resident 1 was observed receiving oxygen via nasal cannula at 2 liters per minute (L/min). The nasal cannula was not labeled with a date, indicating when it was last changed. In a concurrent interview with Resident 1, she stated she uses oxygen continuously. A review of Resident 1's admission Record dated December 10, 2025, indicated the resident was admitted on [DATE], with diagnoses including chronic obstructive pulmonary disease (lung disease which causes breathing difficulties).A review of Resident 1's Physician Orders dated November 11, 2025, indicated an order for oxygen at 2 L/min continuously via nasal cannula. On December 10, 2025, at 11:25 a.m., a concurrent observation and interview were conducted with LVN 2 in Resident 1's room. LVN 2 stated the nasal cannula tubing was observed with the number 11 written in black permanent marker at the concentrator point. LVN 2 stated the nasal cannula was dated for November and had not been changed weekly in accordance with facility standards of practice. LVN 2 stated (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen tubing should be changed every seven days and labeled with the date it was changed. LVN 2 further stated not changing the nasal cannula weekly could place the resident at risk for cross-contamination. On December 10, 2025, at 4:08 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated oxygen tubing should be changed weekly on Wednesdays and as needed. The ADON stated the licensed nurse should have changed Resident 1's nasal cannula in accordance with facility practice. The ADON further stated failure to change the nasal cannula weekly could place the resident at risk for cross-contamination. A review of the facility's document titled, Competency Skills Oxygen Administration undated, indicated, .Label Oxygen tubing with date and to be changed every 7 days/PRN (as necessary).		

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain cleanliness and proper hygiene when staff failed to clean and trim the resident's fingernails, leaving them long and discolored for one of three residents reviewed (Resident 6). This failure had the potential for Resident 6 at risk for infection and injury due to the unhygienic condition of the resident's fingernails. Findings: A review of Resident 6's medical records indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (decline in mental ability) and diabetes (high blood sugar). On December 9, 2025, at 11:08 a.m., an observation was conducted of Resident 6. Resident 6 was observed sitting on his bed, awake, with fingernails that were long and yellowish in color. On December 9, 2025, at 11:18 a.m., a concurrent observation and interview were conducted with Certified Nursing Assistant (CNA 1) regarding Resident 6's fingernails. CNA 1 stated Resident 6's fingernails were long and yellow and stated the fingernails should have been cleaned and trimmed to prevent the risk for infection. On December 10, 2025, at 3:07 p.m., an interview was conducted with Licensed Vocational Nurse 2 (LVN 2). LVN 2 stated that it was the responsibility of the LVN and CNAs to check residents' fingernails and further stated that trimming fingernails was important to prevent residents from scratching themselves, which could result in infection. On December 11, 2025, at 10:07 a.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated CNAs were expected to check residents' fingernails daily and ensure they were not long or dirty. The DSD stated CNA's or the LVN's should have maintained Resident 6's fingernails by offering to clean or file them to prevent the resident from scratching himself, which could result in injury or infection. The DSD further stated there was no documentation explaining why Resident 6's fingernails were kept long. On December 11, 2025, at 2:23 p.m., an interview was conducted with the Director of Nursing (DON). The DON stated CNAs were responsible for providing daily hygiene care to residents including cleaning fingernails. The DON stated Resident 6 should have been offered nail care daily to prevent scratching, which could result in infection. A review of Resident 6's document titled, Section GG- Functional Activities, dated, November 28, 2025, indicated, .Personal hygiene: The ability to maintain personal hygiene, including comping hair, shaving, applying makeup, washing/drying face and hands (excludes baths, showers, and oral hygiene) .score: 01 (Dependent- helper does all the effort. Resident does none of the effort to complete the activity .A review of Resident 6's document titled, Care plan report, dated November 10, 2025, indicated .The resident has an ADL Self Care Performance Deficit r/t Dementia, Limited Mobility, Limited ROM, Musculoskeletal impairment .Interventions .Personal Hygiene/ Oral care: The resident requires (1) staff participation with personal hygiene and oral care. A review of the policy and procedure titled, Fingernails/Toenails, Care of undated, indicated, .the purpose of this procedure is to clean the nail bed, to keep nails trimmed and to prevent infections. nail care includes daily cleaning and regular trimming.		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide pharmaceutical services to meet the needs of one of seven sampled residents (Resident 49) when one medication was documented as administered on December 7, 2025, could not be accounted for as being available for administration as the medication was not received by the facility until December 9, 2025. This deficient practice had the potential for Resident 49's health and well-being to be negatively impacted due to unintended consequences, including decreased medication effectiveness and the potential for adverse reactions (an unwanted effect caused by the administration of a drug). Findings: On December 8, 2025, at 3:38 p.m., Resident 49 stated he had not received his medication Nuedexta (a prescription medication used to treat pseudobulbar affect [PBA - a condition that causes a person to have sudden, uncontrollable episodes of laughing or crying that do not match how they actually feel]) to help control his cognitive abilities in which he stated they stopped it because they said the insurance didn't cover it and I need it. I don't know if that is true, I have not had it for over one week. I ordered it but they still haven't given it to me and I need it. On December 9, 2025, a review of Resident 49's admission record indicated, the resident was admitted on [DATE], with diagnosis which included, anxiety disorder (persistent excessive worry which is out of proportion to the situation). The Minimum Data Set (MDS - an assessment tool), dated October 1, 2025, indicated a Brief Interview of Mental Status (a screening tool for cognition) score of 13 (cognitively intact). A review of the Order Summary Report, dated December 1, 2025, indicated Resident 49 had a physician's order for Nuedexta Oral Capsule 20-10 mg, to give 1 capsule by mouth two times a day for PBA (pseudobulbar affect - a condition that causes a person to have sudden, uncontrollable episodes of laughing or crying that do not match how they actually feel) emotional outbursts. A review of the Medication Administration Records (MAR) for November and December 2025, indicated Resident 49 did not receive Nuedexta as ordered on: December 4, 5, 6, and 7 (9 a.m. dose) December 8 and 9 (9 a.m. dose). Further review of the MAR for November and December 2025, indicated Nuedexta was documented as administered on: December 2 and 3 December 7 (9 p.m. dose) December 9 (9 p.m. dose); and December 10 and 11. A review of the Nurse's Progress Notes, dated December 4, 2025, at 9:13 a.m., indicated, .Nuedexta oral tablet.has not arrived from pharmacy. A review of the The Change in Condition dated December 4, 2025, at 9:33 a.m., indicated, .resident missed a scheduled dose of nudexta from the morning medication pass due to it not being delivered from pharmacy. Resident was assessed following the missed dose. No acute distress noted. Vital signs within baseline. Physician has been notified as per facility protocol. A review of Resident 49's Nurse's Progress Notes, indicated: -Dated December 4, 2025, at 8:30 p.m., .Nuedexta Oral Capsule.will give med when available, f/u (follow up) with pharmacist still pending authorization. -Dated December 5, 2025, at 11:05 a.m., .missed dose Nuedexta. Per resident verbatim the other medication won't work if there is no Nuedexta. Nuedexta is pending due to insurance non-coverage-requiring authorization. -Dated December 5, 2025, at 3:21 p.m. indicated, .spoke with (name of pharmacy representative) .Nuedexta order will be processed and sent to facility arriving by December 8, 2025. -Dated December 5, 2025, at 8:49 p.m. indicated, .Nuedexta Oral Capsule.will give med when available. -Dated December 6, 2025, at 8:41 a.m., indicated, .Nuedexta Oral Capsule.awaiting delivery. -Dated December 6, 2025, at 10:13 p.m. indicated, .missed dose of medication Nudexta.continue to monitor needs and safety. -Dated December 7, 2025, at 8:22 a.m. indicated, .Nuedexta Oral Capsule.awaiting delivery from resident pharmacy via mail. -Dated December 8, 2025 at 9:10 a.m., indicated, .Nuedexta Oral Capsule.awaiting delivery. -Dated December 8, 2025, at 8:29 p.m., indicated, .Nuedexta Oral Capsule.medication not available. Resident made aware and verbalized understanding. -Dated December 9, 2025, at 8:56 a.m., indicated, .Nuedexta Oral Capsule.pending pharmacy delivery. Further review of Resident 49's progress notes indicated there (continued on next page)		

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was no documentation that the medication was available prior to December 9, 2025. A review of the care plan, Missed dose of medication of Nuedexta, indicated, .interventions.monitor resident for any changes in condition or potential adverse effects.reinforce medication schedule with staff and ensure next scheduled dose is administered as ordered. On December 11, 2025, at 1:42 p.m. a concurrent interview and MAR review was conducted with Licensed Vocational Nurse (LVN) 6. LVN 6 stated, the medication was not available from December 5 to 8, 2025. LVN 6 stated if there is a check mark during that time that means it was marked as given. LVN 6 stated she could not locate the medication as being available on the morning of December 8, 2025, and that she did not receive a report from the nurse who had given the medication that it was available. On December 11, 2025, at 1:52 p.m., a concurrent observation, interview, and record review were conducted with LVN 6 and the DON. LVN 6 stated she was able to obtain the tracking verification regarding the delivery of the medication that was received on December 9, 2025, at 1:15 p.m. The DON stated that the process for receiving medications by mail was that the nurse should note the time of delivery, mark the bottle of the medication with the open date and administer the medication on the next scheduled time. The DON stated a dose of Nuedexta was held for the 9 a.m. administration time on December 7, 2025, and that it was given at 9 p.m. by the evening nurse. The DON stated, the medication was held again on December 8, 2025, for the 9 a.m. and 9 p.m. doses. The DON stated it appeared that the medication was given. The DON observed a bottle of Nuedexta with an open date of December 9, 2025. The DON stated the orders from the pharmacy via mail would be processed by the receiving nurse and that a confirmation of the receipt of the medication should be verified. The DON stated the open date should reflect when the medication was first administered. The DON stated the medication appeared to be administered on the evening of December 7, 2025, and was noted to not be available until the afternoon of December 9, 2025. The DON stated they could not identify a bottle or bubble pack with the medication prior to receiving it on December 9, 2025. A review of the facility policy and procedure titled Administering Medications undated, indicated, .Medications are administered in accordance with prescriber orders, including any required time frame.the expiration/beyond use date on the medication label is checked prior to administering. When opening a multi-dose container, the date opened is recorded on the container.		

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 12/11/2025
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.			
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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the physician reviewed and addressed the Consultant Pharmacist (CP) recommendations during the monthly Medication Regimen Review (MRR), for one of five residents reviewed for unnecessary medications (Resident 13) when Resident 13's recommended gradual dose reduction of buspirone (antianxiety medication) was not addressed by the physician. This failure had the potential to result in continued unnecessary psychotropic medication use. Findings: A review of Resident 13's admission Record indicated the resident was admitted to the facility on [DATE], with diagnoses which included dementia (forgetfulness) and bipolar disorder (mental illness). A review of Resident 13's History and Physical Examination dated July 31, 2025, indicated the resident had fluctuating decision making capacity. A review of Resident 13's CP recommendation to the attending Physician dated October 2025, indicated Resident 13 was receiving buspirone (anti- anxiety) 20 mg three times daily and included a recommendation to consider, if clinically appropriate, initiating a gradual dose reduction (GDR) with the eventual goal of discontinuation. Further review of Resident 13's record indicated no documentation that the physician reviewed, accepted, or rejected the CP recommendation. On December 11, 2025, at 1:40 p.m., a concurrent interview and record review were conducted with the Director of Nursing (DON) and ADON. The ADON stated the CP recommendation was received via email on November 10, 2025, The DON stated there was no documented evidence the recommendation was communicated to the physician upon receipt. A review of the facility policy and procedure titled Medication Regimen Reviews, undated indicated, .Medication regimen reviews are done upon admission (or as close to admission as possible) and at least monthly thereafter, or more frequently if indicated .the goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication .the MRR involves a thorough review of the resident's medical record .The attending physician documents in the medical record that the irregularity has been reviewed and what (if any) action was taken to address it .copies of medication regimen review reports, including physician responses, are maintained as part of the permanent medical record .		

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NAME OF PROVIDER OR SUPPLIER Citrus Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9025 Colorado Avenue Riverside, CA 92503	
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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 observation, interview, and record review, the facility failed to implement required Enhanced Barrier Precautions (EBP-an infection control intervention to reduce transmission of multidrug-resistant organisms [MDRO- bacteria that have become resistant to multiple antibiotics), for one of ten residents reviewed (Resident 93) when Licensed Vocational Nurse (LVN 5) did not don required personal protective equipment (PPE - equipment, such as gloves and gown, used to protect against infection or illness) while providing direct bedside care to Resident 93, who was on enhanced barrier precaution.This failure had the potential to result in cross-contamination, increasing the risk for transmission of infection among a vulnerable resident population.Findings:On December 10, 2025, at 8:30 a.m., an EBP sign was observed posted outside Resident 93's room. LVN 5 was observed inside Resident 93's room without wearing a gown while administering oral medications, eye drops, and a breathing treatment. On December 10, 2025, at 9:30 a.m., an interview was conducted with LVN 5. LVN 5 stated Resident 93 was on Enhanced Barrier Precaution. LVN 5 further stated she did not wear PPE while administering oral medications, eye drops and the resident's breathing treatment.A review of Resident 93's medical record indicated the resident was admitted to the facility on [DATE], with diagnosis which included pressure ulcer of sacral region, stage 3 (deep open wound).On December 11, 2025, at 8:37 a.m., interview was conducted with the Infection Preventionist (IP). The IP stated all staff were expected to check posted precaution signage and wear appropriate PPE while providing resident care. The IP further stated LVN 5 should have worn a gown while providing bedside care to prevent the potential spread of infection. On December 11, 2025, at 2:23 p.m., an interview was conducted with the DON. The DON stated all staff were expected to wear required PPE when providing direct resident care in rooms designated for EBP. The DON further stated LVN 5 should have worn a gown to prevent cross-contamination. A review of Resident 93's Order Summary Report, dated July 23, 2025, indicated, .Infection precautions- Enhanced Barrier Precautions Q shift DX: wounds.A review of Resident 93's Care-plan, date November 12, 2025, indicated, .Patient at risk of MDRO infection due to wounds .focus: patient will not develop signs and symptoms of MDRO infection .interventions: Enhanced barrier precaution, use gloves and gowns when performing high contact activities: dressing, bathing, showering, transferring, providing hygiene, changing linens, changing briefs, or assisting with toileting, device care, or use of device, (e.g. central line, urinary catheter, feeding tube, tracheostomy, or ventilator) wound care (any skin opening requiring a dressing) . A review of the facility policy and procedure titled, Enhanced Barrier Precaution, dated February 21, 2025, indicated, .it is the policy of this facility to implement enhanced barrier precautions for the prevention of transmission of multidrug-resistant organisms.Enhanced barrier precaution (EBP) refer to an infection control intervention designed to reduce transmissions of multidrug-resistant organisms that employs targeted gown and gloves use during high contact resident care activities .		

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NAME OF PROVIDER OR SUPPLIER Citrus Grove Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 9025 Colorado Avenue Riverside, CA 92503	
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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure one bedroom (room [ROOM NUMBER]) did not accommodate more than four residents. This failure had the potential to affect the health and safety of the residents residing in this room. Findings: On December 8, 2025, at 9:43 a.m., during the initial tour of the facility, room [ROOM NUMBER] was observed to have five residents (Residents 13, 45, 47, 60, 113) assigned to the room. A record of the facility's room size was reviewed and indicated room [ROOM NUMBER] measured 440.94 square feet (sq ft) (length-in feet X width-in feet), 20 feet and 9 inches by 21 feet and 2 inches. The square footage allows 88.18 sq ft per resident. During the facility survey from December 8, 2025, to December 11, 2025, no adverse effects that would affect the quality of life of the residents were observed. Residents in room [ROOM NUMBER], who were interviewable, stated they were comfortable in the room and had no desire to change rooms. A continuation of room waiver is recommended.		