STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555093	A. Building B. Wing	05/19/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Citrus Post-Acute	1929 N. Fairview Street Santa Ana, CA 92706

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the care plans were revised and the interventions were followed for two of three sampled residents (Residents 1 and 2). * The facility failed to revise Resident 1's care plan to reflect the refusals and/or non-compliance of the bowel regimens when the resident was not having regular bowel movements. * The facility failed to implement Resident 2's care plan interventions for pain. These failures posed the risk of the residents not receiving appropriate, consistent, and individualized care.Findings: Review of the facility's P&P titled Care Plans, Comprehensive Person Centered revised 3/2022 showed the following:- the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;-the residents are informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences;-assessments of residents are ongoing and care plans are revised as information about the residents and resident's conditions change;-the resident has a right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies; and-care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relation between the resident's problem areas and their causes, and relevant clinical decision making. 1. Closed medical record review for Resident 1 was initiated on 5/13/26. Resident 1 was readmitted to the facility on [DATE], and transferred to the acute care facility on 1/26/26. Review of Resident 1's Care Plan Report dated 11/12/25, showed the following care plans:- risk for constipation related to decreased mobility, diminished appetite, medication side effect, poor fiber intake, and poor fluid intake. The care plan interventions included to assess for any signs and symptoms of constipation every shift, increase fiber and fluid intake, encourage physical activities as tolerated, monitor and report to physician as needed for signs and symptoms of complications related to constipation, offer prune juice if desired, and provide laxatives, suppositories and enemas only as needed; and- Resident 1 was on pain medication therapy (hydrocodone-acetaminophen, narcotic pain medication). The interventions included monitoring for constipation. Review of Resident 1's Order Summary Report dated 12/22/25, showed the following physicians orders:- hydrocodone-acetaminophen oral tablet 7.5-325 mg, one tablet by mouth every six hours as needed for severe pain (7-10, on the pain scale of 0 to 10 with 0 = no pain and 10 = worst);- Dulcolax (laxative) suppository 10 mg, insert one suppository rectally every 24 hours as needed for bowel management if the milk of magnesia (laxative) was ineffective;- Fleet Enema (laxative) rectal enema 7-19 grams/118 ml (Sodium Phosphates), insert one applicator rectally every 24 hours as needed for bowel management if the Dulcolax suppository was ineffective;- Milk of Magnesia oral suspension 400 mg/ml (Magnesium Hydroxide), give 30 ml by mouth every 24 hours as needed for bowel management; and- Polyethylene Glycol (laxative) 3350 Powder (Polyethylene Glycol 3350 (Bulk), give 17 grams by mouth as needed for constipation mix powder with four to eight ounces of water prior to administration. Review of Resident 1's Documentation Survey Report Bowel Movements dated from 1/17/26 to 1/24/26, (continued on next page)

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	showed the bowel movements per shift was coded as 1, indicating none. Review of Resident 1's Nurses Note dated 1/17/26, showed the resident refused any bowel regimen, stating she had a medium sized loose stool post dialysis on 1/16/25. Review of Resident 1's Nurses Notes dated 1/19/26, showed Resident 1 stated her last bowel movement was on 1/16/26, at around 1700 hours. A stool softener/laxative was offered but the resident declined. Review of Resident 1's Nurses Note dated 1/23/26, showed offered as needed stool softener/laxative, resident declined, attempts three times and explained risk and benefits, resident refused. On 5/19/26 at 1245 hours, an interview and concurrent medical record review for Resident 1 was conducted with the DON. When asked what the process was if a resident was refusing care, the DON stated the process would be to notify the physician, document, and update the care plan for non-compliance. The DON verified Resident 1 had multiple episodes for refusals of bowel regimen, and the care plan was not revised to reflect the refusals. 2. Medical record review for Resident 2 was initiated on 5/13/26. Resident 2 was admitted to the facility on [DATE]. Review of Resident 2' s Care Plan Report dated 4/20/26, showed a care plan problem addressing the resident's risk for pain. The interventions included to indicate the nonpharmacological interventions attempted prior to administering the pain medication. Review of Resident 2's Order Summary Report dated 4/21/26, showed to administer Hydromorphone HCL (hydrochloride) (opioid pain medication) 4 mg tablet by mouth every six hours as needed for moderate (4-6) to severe (7-10) pain scale. Alternatives used prior to administering as needed (1) reposition (2) distraction (3) breathing techniques (4) gentle massage (5) relaxation technique (6) music and (7) other. Review of Resident 2's MAR showed the pain medication was administered and the non-pharmacological interventions were documented as NA (not applicable) on the following dates:- dated 5/1/26 at 1415 hours; PRN E (effective)- dated 5/2/26 at 0350 hours, and 1212 hours; PRN E- dated 5/3/26 at 0506 hours; PRN E- dated 5/4/26 at 1130 hours; PRN E- dated 5/7/26 at 0602 hours, and 1441 hours; PRN E- dated 5/8/26 at 0444 hours, and 1242 hours; and PRN E and- dated 5/9/26 at 1413 hours PRN E. On 5/13/26 at 1539 hours, an interview was conducted with Resident 2. Resident 2 stated he was constipated until 5/12/26, when he finally decided to do an enema. Resident 2 stated the pain medications made him constipated. On 5/19/26 at 1057 hours, an interview and concurrent medical record review for Resident 2 was conducted with the ADON. When asked what NA meant, the ADON stated not applicable. When asked if nonpharmacological interventions were conducted when documented NA prior to the PRN was shown to be administered, the ADON stated she did not see any documentation for nonpharmacological interventions. On 5/19/26 at 1245 hours, an interview and concurrent medical record review for Resident 2 was conducted with the DON. When asked what the process was when residents are on narcotic pain medication, the DON stated there was no specific process, however she was aware it could cause hard stool or constipation. The DON verified the non-pharmacological interventions for hydromorphone for Resident 2 were documented as NA and the medication were administered. The DON stated they should have documented which nonpharmacological interventions were attempted prior to the administration of the pain medication. On 5/19/26 at 1338 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON acknowledged the above findings.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to provide the appropriate care and services to prevent constipation for one of three sampled residents (Resident 1). * The facility failed to follow the physician's order for the bowel management when Resident 1 did not have a bowel movement for four days from 1/12/26 to 1/15/26. This failure had the potential for not providing the necessary care and services and posed a risk for adverse complications.Findings: Review of the facility's P&P titled Bowel (Lower Gastrointestinal Tract) Disorders revised 9/2017 showed the staff and physician will identify risk factors related to bowel dysfunction; for example, severe anxiety disorder, recent antibiotic use, or taking mediations that are used to treat, or that may cause or contribute to, gastrointestinal (referring collectively to the stomach) erosion (wearing away), bleeding, diarrhea, dysmotility (condition where muscles of digestive tract do not function normally), etc. Review of the facility's P&P titled Care Plans, Comprehensive Person Centered revised 3/2022 showed the following:- the care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment;-the residents are informed of his or her right to participate in his or her treatment, and provided advance notice of care planning conferences;-assessments of residents are ongoing and care plans are revised as information about the residents and resident's conditions change;-the resident has a right to refuse to participate in the development of his/her care plan and medical and nursing treatments. Such refusals are documented in the resident's clinical record in accordance with established policies; and-care plan interventions are chosen only after data gathering, proper sequencing of events, careful consideration of the relation between the resident's problem areas and their causes, and relevant clinical decision making. Closed medical record review for Resident 1 was initiated on 5/13/26. Resident 1 was readmitted to the facility on [DATE] and transferred to an acute care facility on 1/26/26. Review of Resident 1's Care Plan Report dated 11/12/25, showed the following care plans:- risk for constipation related to decreased mobility, diminished appetite, medication side effect, poor fiber intake, and poor fluid intake. The care plan interventions included to assess for any signs and symptoms of constipation every shift, increase fiber and fluid intake, encourage physical activities as tolerated, monitor and report to physician as needed for signs and symptoms of complications related to constipation, offer prune juice if desired, and provide laxatives, suppositories and enemas only as needed; and- Resident 1 was on pain medication therapy (hydrocodone-acetaminophen, narcotic pain medication). The interventions included monitoring for constipation. Review of Resident 1's Order Summary Report dated 12/22/25, showed the following physicians orders:- hydrocodone-acetaminophen oral tablet 7.5-325 mg, one tablet by mouth every six hours as needed for severe pain (7-10);- Dulcolax (laxative) suppository 10 mg, insert one suppository rectally every 24 hours as needed for bowel management if the milk of magnesia (laxative) was ineffective;- Fleet Enema (laxative) rectal enema 7-19 grams/118 ml (Sodium Phosphates), insert one applicator rectally every 24 hours as needed for bowel management if the Dulcolax suppository was ineffective;- Milk of Magnesia oral suspension 400 mg/ml (Magnesium Hydroxide), give 30 ml by mouth every 24 hours as needed for bowel management; and- Polyethylene Glycol (laxative) 3350 Powder (Polyethylene Glycol 3350 (Bulk), give 17 grams by mouth as needed for constipation mix powder with four to eight ounces of water prior to administration. Review of Resident 1's MAR for January 2026 showed Resident 1 was administered hydrocodone-acetaminophen from 1/12/26 to 1/15/26. Review of Resident 1's Documentation Survey Report Bowel Movements dated from 1/17/26-1/24/26, showed bowel movements per shift coded as 1, indicating none. Further review of Resident 1's medical record failed to show Resident 1 was offered or provided a bowel regimen for not having a bowel movement for four days (1/12/26 to 1/15/26). On 5/19/26 at 1245 hours, an interview and concurrent medical record review for Resident (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	1 was conducted with the DON. The DON verified there was no documentation showing Resident 1 was offered or provided a bowel management intervention for 1/12/26 to 1/15/26. On 5/19/26 at 1338 hours, an interview was conducted with the Administrator and the DON. The Administrator and the DON acknowledged the above findings.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, medical record review, and facility P&P review, the facility failed to ensure the resident's medical information was complete and accurate for one of three sampled residents (Resident 1). * The facility failed to ensure the turning and repositioning for Resident 1 was accurate. This failure had the potential to Resident 1 to receive inadequate care as the clinical information was not accurate.Findings: Review of the facility's P&P titled Charting and Documentation revised 7/2017 showed documentation in the medical record will be objective (not opinionated or speculative), complete, and accurate. Review of the facility's P&P titled Prevention of Pressure Injuries dated 4/2020 showed reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Teach the residents who can change positions independently the importance of repositioning. Provide support devices and assistance as needed. Remind and encourage residents to change positions. Closed medical record review for Resident 1 was initiated on 5/13/26. Resident 1 was readmitted to the facility on [DATE], and transferred to the acute care facility on 1/26/26. Review of Resident 1's Skin assessment dated [DATE], showed Resident 1 was readmitted to the facility with 12 wounds. Review of Resident 1's Order Summary Report showed a physician's order dated 1/2/26, to initiate dialysis schedule for Monday, Wednesday, and Friday at 1330 hours. Review of Resident 1's document titled SNF Wound Care dated 1/5/26, showed a wound practitioner's note for an evaluation and treatment for Resident 1's wounds. The document showed to change positions often to keep pressure off the wound, and spread body weight evenly with cushions, mattresses, pillows, foam wedges, or other pressure-relieving devices. Review of Resident 1's document titled Documentation Survey Report Turning and Repositioning very two hours and PRN for January 2026 showed the following:-dated 1/2/26 at 1321 hours, 1, indicating yes;-dated 1/7/26 at 1400 hours, 1, indicating yes;-dated 1/9/26 at 1326 hours, 1, indicating yes;-dated 1/12/26 at 1318 hours, 1, indicating yes;-dated 1/14/26 at 1326 hours, 1, indicating yes;-dated 1/16/26 at 1433 hours, 1, indicating yes;-dated 1/21/26 at 1312 hours, 1, indicating yes; and-dated 1/23/26 at 1445 hours, 1, indicating yes. On 5/19/26 at 1057 hours an interview and concurrent medical record review for Resident 1 was conducted with the ADON. The ADON stated Resident 1 would get picked up for dialysis on Mondays, Wednesdays, and Fridays at 1300 hours, and returned at 2000 hours. When asked if Resident 1 was repositioned when the resident was out for dialysis, the ADON stated no. On 5/19/26 at 1245 hours, an interview and concurrent medical record review for Resident 1 conducted with the DON. The DON verified the above findings. On 5/19/26 at 1338 hours, an interview was conducted with the Administrator and the DON. The Administrator and DON acknowledged the above findings.