STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055581	A. Building B. Wing	06/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Jurupa Hills Post Acute	6401 33rd Street. Riverside, CA 92509

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** 46509 Based on interview and record review the facility failed to ensure one of seven sampled residents (Resident D) received treatment and care in accordance with professional standards of practice, when the new physician orders from a consulting physician ' s office were not initiated as soon as the resident came back to the facility. This failure has the potential to result in worsening of Resident D ' s autoimmune disease (when the body ' s immune system attacks itself). Findings: On June 20, 2024, at 8:35 a.m., an unannounced visit to the facility was conducted to investigate issues on quality care. On June 20, 2024, at 9:00 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the Social Services Department or case management was responsible in arranging appointments for the residents in the facility, and if transportation is needed, they would take care of that as well. The DON stated a resident is allowed to attend an appointment without a staff member if the resident is alert, appropriate, and independent, we encourage the family to attend these appointments with the resident when possible. The DON stated, upon return from an appointment a resident may return with the physician ' s orders and progress notes, the physician ' s orders are reviewed and entered by the charge nurse or RN (Registered Nurse) supervisor, verified with the resident ' s primary physician, to ensure there are appropriate with the resident ' s plan of care. The DON stated, when no orders are sent back with the resident, the licensed nurses, would follow up with the office to verify if there were any orders, and the medical records staff may follow up for required documents. On June 20, 2024, at 4:15 p.m., a telephone interview was conducted with Resident D ' s family member. The family member stated Resident D has a rare skin disease and sees a specialist for it, Resident D was sent to the facility for 24-hour care and rehabilitation needs. The family member stated the facility did not follow up with Resident D ' s provider after the appointment on June 6, 2024, and was trying to get the orders to the facility to start Resident D ' s new medications, the nursing staff were not helpful. The family member concluded Resident D ' s medical care was delayed. (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: 055581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 33rd Street. Riverside, CA 92509	

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On June 21,2024, at 2:10 p.m., an interview was conducted with Licensed Vocational Nurse Two (LVN 2). LVN 2 stated she was the charge nurse for Resident D the day the resident was sent out for her consulting physician appointment. LVN 2 stated when residents are sent out for an appointment, the facility would send them with an appointment packet, which included a face sheet, medication list, labs, a blank progress note, and a telephone order sheet for new physician ' s orders. LVN 2 stated most residents come back with the paperwork, and sometimes different papers from the consulting office. LVN 2 stated she did ask Resident D the morning after her appointment if she had any paperwork, she stated no, then spoke with the Resident D ' s family member about the orders. LVN 2 stated normally the nurses would call and follow up with the consulting physician offce for the paperwork and let the primary provider know what happened at the consultation, and verify any orders received. LVN 2 stated she did try to call the office for orders twice and Resident D ' s family member also tried to contact the office. LVN 2 stated she did let the next shift know Resident D ' s family member was trying to get the orders from the consulting office. LVN 2 stated she has not received the orders before she left on Friday, June 7, 2024 (One day after the resident went to the appointment). LVN 2 stated Resident D has an autoimmune disease and developed painful lesions on her body and is receiving treatment for them. LVN 2 stated Resident D went to the consultant appointment to be re-evaluated. LVN 2 stated, Resident D ' s new orders were not started until June10, 2024 (Four days after the resident's appointment), this could potentially cause harm to the resident, since there was a delay in treatment with the medications and she did not have continuity of care. On June 21,2024, at 3:40 p.m., during an interview with the Registered Nurse (RN), the RN stated the missing paperwork for Resident D was not a regular situation, and they should inform the MD (medical doctor), and if the MD stated it was okay to wait until Monday, then the nurses do. The RN stated there was a delay in the new medications and there should be a progress notes written on Resident D over the weekend, until the new orders were started, and no one wrote notes about the resident ' s care. On June 25, 2024, at 11:00 a.m., an interview was conducted with the Medical Records (MR) staff, the MR staff stated normally a resident would come back from a doctor ' s appointment with orders or progress notes, the Licensed Nurse (LN) would receive and would enter the orders into the system, and the medical records staff would receive, scan, and upload the records to the documents tab. The MR staff stated, for Resident D, the facility received the documents on June 7, 2024, and uploaded the orders and progress notes to Resident D ' s medical record by 4:00 p.m., the nursing staff should be able to view them and verify all information. A review of Resident D ' s medical record was conducted on June 25, 2024, at 12:50 p.m. Resident D was admitted to the facility on [DATE], with diagnoses which included pemphigus vulgaris (a rare skin disease in which blisters develop). Resident D ' s documents from the consulting office were reviewed, the documents were dated June 6, 2024, with a fax verification date of June 7, 2024. Resident D ' s care plans were reviewed, dated June 2, 2024, indicated .Skin: Resident has skin impairment and is at risk for delayed healing and infection related to: generalized open blisters/Lesions to body area . Interventions .administer medications as ordered .administer treatments as ordered and monitor for effectiveness .Dermatology consult . A review of the dermatology totes, dated 06/06/2024, at 3:30 p.m., indicated .blisters all over body .continue prednisone 75mg daily .increase Cellcept .Bactrim DS .obtain DEXA Scan .Bactrim .start 6/7/24 .Cellcept . increase medication from 500mg .to 1000mg .start 6/6/24 . (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the Order Summary Report indicated the following: -Monitor healed blisters to body generalized areas, every shift, ordered 06/02/2024. -Monitor pain every shift, ordered 06/01/2024. -Bactrim DS tab 800-160mg, give one tab every Mon, Wed, Fri for Pemphigus Vulgaris, ordered 06/10/2024. -CellCept tab give 1500mg BID for immunosuppressant as tolerated, ordered 06/10/2024. Further review of the resident's records indicated the medications ordered during the dermatology consult on June 6, 2024, was not provided to the resident until June 10, 2024. A review of the facility ' s policy titled Administering Medications, dated April 2019, indicated .Medications are administered in a safe and timely manner .medications are administered in accordance with prescribed orders, including any time frame .medication administration times are determined by resident need .

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(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 - 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** 46509 Based on observation, interview, and record review, the facility failed to provide adequate supervision while smoking, to one of three sampled residents (Resident C). In addition, the facility failed to ensure smoking paraphernalia was not kept in possession of the residents in accordance with the facility policy and procedure. These failures resulted in Resident C to cause physical harm to Resident A and Resident B. Resident C hit Resident B in the face; and Resident C burnt Resident A's arm with a lit cigarette while at the smoking patio, on June 9, 2024, resulting in Resident A to sustain a cigarette burn on the right arm. Findings: On June 20, 2024, at 8:35 a.m., an unannounced visit to the facility was conducted to investigate a safety concern. On June 20, 2024, at 10:50 a.m., during a concurrent observation and interview conducted with Resident A, Resident A was in his wheelchair, next to his bed, with a blanket covering his lower extremities. Resident A stated he was outside on June 9, 2024, and one of the residents burned him with a cigarette on his right arm. Resident A held out his right forearm (section of the arm from the elbow to the wrist), a circle was noted to his skin, whitish in color with pink edges surrounding the area, the approximate size of a cigarette. Resident A stated, he went to the back patio to get a soda from the vending machine, and Resident C was out on the patio. Resident A stated he said Hi to Resident C, and as he was placing a dollar into the vending machine for a soda, Resident C came over to him, and touched a lit cigarette to his right forearm, and burned him. Resident A stated, he told the charge nurse what happened, and Registered Nurse 1 (RN 1) looked at his arm, took a picture, and did not treat the burn site. On June 20, 2024, at 11:05 a.m., an observation and concurrent interview were conducted with Certified Nursing Assistant 1 (CNA 1). CNA 1 was observed on the back patio with approximately eight residents, most residents were smoking, none of the residents smoking wore a smoking apron (an assistive device used to protect a resident from burning themselves), the smoking aprons were hanging on the corner of the building. CNA 1 stated, when the residents are done with their cigarettes, the butts should be placed in the safety receptacle, pointing to a large stand, with a hole to drop in the used tobacco products. A resident was observed throwing a smoldering (burning slowly with smoke but no flame) cigarette in the grass, and another resident went over and stepped on the cigarette to extinguish it. CNA 1 stated if she sees any cigarettes in the grass area, she will pick them up and throw them in the safety receptacles. CNA 1 stated the residents were allowed to keep their own cigarettes and lighters with them, smoking aprons are only used when a resident need one. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On June 20, 2024, at 11:15 a.m. during an interview with Resident F, he stated he was Resident A ' s roommate. He stated when Resident C burned Resident A with a cigarette, Resident A told him what happened. Resident F stated Resident A showed him the burn mark on his right arm. Resident F stated, there was no staff outside on the smoking patio on June 9, 2024. He stated there was never a staff outside to supervise the residents while smoking. On June 20, 2024, at 11:22 a.m., an interview was conducted with Resident F. Resident F stated he was at the patio the day Resident C attacked the two male residents. Resident F stated Resident C came out to the patio, in her sandals, a hospital gown, and a sheet wrapped around her, and was notably upset about something, Resident C walked over to the metal trash can, and kicked it real hard, and made a dent in it (pointed to the metal trash can, noted a small dent). Resident F stated, Resident B had walked over to the soda machine to get their drinks, because his (Resident B) legs work, and the rest of them were in wheelchairs. Resident F stated as Resident B walked up to the soda machine, Resident C was standing in front of it, and as Resident B stated excuse me to Resident C, she punched Resident B in the face with her left hand. Resident F chuckled and stated Resident C ' s hospital gown was falling off and she was trying to hold onto the sheet, Resident C exposed herself a few times, Resident C was definitely having a bad day. Resident F stated, they were allowed to keep their cigarettes and a plastic lighter. On June 20, 2024, at 11:30 a.m., an interview was conducted with Resident B, at the smoking patio. Resident B stated he was trying to get sodas out of the machine for some of the residents, and he noticed Resident C and Resident A were both by the soda machine when he walked up to it. He stated he was kneeling down to read the labels on the machine, and when he stood up Resident C hit him in the face, on his left side. Resident B stated no staff comes to watch them, and he stated staff only come out in the patio if they are looking for a resident. On June 20, 2024, at 3:50 p.m. Resident C ' s medical record was reviewed. Resident C was admitted to the facility initially on December 8, 2023, and readmitted on [DATE], with diagnoses which included COPD (Chronic Obstructive Pulmonary Disease-a group of lung diseases that block airflow and make it difficult to breathe) and bipolar disorder (associated with mood swings ranging from depressive lows to manic highs). A review of Resident C ' s smoking observation assessment, dated June 3, 2024, indicated adaptive equipment needed: Supervision, May smoke with supervision, patient will have supervision during smoke break for safety. A review of Resident C ' s care plan, dated June 4, 2024, indicated Resident C has potential for injury related to smoking with episodes of non-compliance to smoking rules, smoking schedule, smoking supervision, smoking materials to be given and retained by staff. The care plan indicated interventions which included cigarette and lighter will be stored in Nurse ' s station. A review of Resident C ' s nurse ' s note, dated June 9, 2024, indicated the following: - at 12:56 p.m., .Notified [family] .resident has been refusing medication .encouraged resident to take medications but resident refusing . (continued on next page)

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Jurupa Hills Post Acute	6401 33rd Street. Riverside, CA 92509

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F 0689

Level of Harm - Actual harm

Residents Affected - Few

- at 12:59 p.m., .Resident noted to be verbal aggressive towards staff. Resident refused all morning and noon medication. I tried to explain what each medication is for and as well r/b (risks and benefits) of not taking medication and still refused. Resident was [sic] flicked a lit cigarette to staff. RN (Registered Nurse) supervisor spoke with resident as well as [family] was made aware and s/w (spoke with) resident and she still refused to take medication and still noted with verbal aggression. Dr [name] is made aware .

A review of Resident C ' s SBAR (type of communication stands for Situation, Background, Assessment, and Recommendation) Summary for Providers, dated June 9, 2024, 3:52 p.m. indicated .fell ow resident c/o (complain of) that [Resident C] slapped him 2 X in the face and another c/o being burnt with cigarette on his hand in the arm she was hallucinating (a false sense something is real), threatening student nurse .Physical aggression .verbal aggression .other behavioral symptoms, worse delusions (a false belief of reality, occurs in mental conditions), hallucinations noted .

On June 21, 2024, at 11:15 a.m., an interview was conducted with the Director of Staff Development (DSD). The DSD stated they all keep an eye on residents who are smokers. She stated most of them are independent and are able to freely smoke. The DSD stated if there is a smoker who is not independent, that smoker will be supervised by a staff member to ensure their safety, it is important to ensure no resident goes outside to smoke with oxygen on. The DSD stated Resident C would talk with herself, would wear a gown and a sheet, and had her purse with her. The DSD stated, Resident C kept her cigarettes and lighter, in her purse, if Resident C did flick ash or a cigarette at an employee or visitor, she should have had her cigarettes and lighter taken away, Resident C may not be willing to give up those items, when that occurs, the staff have to call the Sheriff.

On June 21, 2024, at 12:20 p.m., an interview was conducted with the Activities Director (AD). The (AD) stated between the DSD and activities department, they work together to ensure residents on the smoking patio, have supervision. The AD stated, on Sunday, June 9, 2024, the activity assistant was at the facility from 8:00 a.m.to 4:30 p.m. The AD was told about the incident with Resident C the following day, but the activity assistant was not outside when it occurred and did not witness the incident. The AD stated Resident A and Resident B stated they were fine, felt safe, were not having any distress, Resident A had small red area to his arm but stated it did not hurt. The AD stated there is no formal schedule regarding who would monitor the residents on the patio while smoking, most staff know to watch. The AD stated the activity assistants were trained if they see anyone yelling, they need to intervene quickly, before the situation escalates, step in to remove the resident from the area, and report it immediately. The AD concluded if proper intervention had occurred, the harm to Resident A and Resident B could have been prevented.

On June 21, 2024, at 1:25 p.m., a telephone interview was conducted with Licensed Vocational Nurse 1 (LVN 1). LVN 1 stated, she was the charge nurse for Resident C on June 9, 2024, the day the incident occurred. LVN 1 stated it was reported to her that Resident C had flicked a lit cigarette at a student in the front of the facility. LVN 1 stated Resident C was in front of the facility building smoking a cigarette and flicked a lit cigarette at one of the students the day of the incident. LVN 1 stated the residents were not allowed to smoke on the front patio.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On June 25, 2024, at 10:30 a.m., an interview was conducted with the DSD Assistant. The DSD Assistant stated she was working at the reception desk on the day shift, on June 9, 2024. The DSD Assistant stated she could see Resident C smoking out front; she seemed a little agitated and went to visit Resident C but kept her distance, Resident C had already yelled at the DSD Assistant and was told to leave her alone, and though the DSD Assistant knew Resident C was not to smoke out front she did not want to agitate her more. The DSD Assistant stated there were staff and students out front, and she saw Resident C, flicked a cigarette at the staff and students, but when she asked the resident about it, the resident stated she was offering a cigarette to them. On June 25, 2024, at 3:35 p.m., Resident B ' s medical record was reviewed. Resident B was admitted to the facility on [DATE], with diagnoses which included spondylosis with radiculopathy (weakness in the bones of the spine). Resident B ' s smoking observation/assessment, dated May 15, 2024, indicated .Resident denies smoking or use of all tobacco products (assessment completed) . Resident B had another smoking observation/assessment, dated June 14, 2024, which indicated .Resident is smoker .adaptive equipment needed: supervision .may smoke with supervision .Resident has potential for injury related to smoking . Resident safety and hygiene will be maintained q (every) shift through review date . Resident B ' s progress notes were reviewed, dated June 9, 2024, at 3:27 p.m., indicated, .change in condition .Resident reported being slapped on the face by another resident .no orders from MD (medical doctor) . Resident B ' s nurse ' s note, dated June 9, 2024, at 8:15 p.m., indicated, .resident came to nurses' station, reported that he was at soda machine when a female approached him and slapped him twice in the face, he seemed alarmed . Resident B ' s nurse ' s note, dated June 10,2024, at 9:00 a.m., indicated, .resident came into office .what part of his face did he get slapped by the other resident .'this one (touching his left side of his face) ' .he said he was by the vending machine helping another patient when resident walked toward him and slapped him on his face . Resident B ' s care plan dated June 14, 2024, indicated, .resident has potential for injury related to smoking with episodes of non-compliant to 1. smoking rules 2. Smoking schedule 3. Smoking supervision 4. Smoking materials to be given and retain by staff . Interventions .cigarettes and lighter will be stored in the nurse ' s station . On June 25, 2024, at 4 p.m., Resident A ' s medical record was reviewed. Resident A was admitted to the facility on [DATE], with diagnoses which included paraplegia (Paralysis that affects the lower portion of the body) and cerebral palsy (an abnormal development in parts of the brain that control movement). Resident A ' s SBAR, dated June 9, 2024, at 4:00 p.m., indicated, .change in condition .Resident reported to charge nurse getting a cigarette burn to R (right) arm by another resident when getting a soda from vending machine .monitor site . (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Resident A ' s activities note, dated June 10, 2024, at 8:48 a.m., indicated, .Resident is doing fine and commented that he was surprised about the way the other resident acted . and Resident A ' s Interdisciplinary team (IDT) note, at 3:00 p.m., indicated, .Resident reported an allegation that another resident burned his right forearm with cigarette on 06/09/2024 (June 9, 2024) while outside by the smoking area using the vendo [sic] machine .said he is fine and it ' s not a big thing . A review of the facility ' s Smoking Policy/Procedure, dated June 8, 2018, that is read and signed by all residents identified as smokers indicated, .A designated smoking area outside the building is available .No lighting materials (e.g. matches, lighters), tobacco products, or smoking devices will be allowed to be kept in the possession of the residents .residents who desire to smoke will be assessed for their ability to do so safely. The Interdisciplinary Team will assess residents by using the Smoking Assessment form and a review of the resident ' s clinical record .the resident will be offered to smoke .under staff supervision .no lighting materials .tobacco products, or smoking devices will be allowed to be kept in the possession of the resident either on their person or in their room .The frequency of smoking for residents under staff supervision will be: 8:00 am, 11:00 am, 1:30 pm, 4:00 pm, 7:00 pm these times will be no more than twenty (20) minute increments .all smoking materials will be retained by staff . A review of the facility ' s policy titled Smoking Policy-Residents, dated October 2023, indicated, .This facility has established and maintains safe resident smoking practices .smoking is only permitted in designated resident smoking areas .resident smoking status is elevated upon admission .ability to smoke safely with or without supervision .A resident ' s ability to smoke safely is re-evaluated quarterly, upon a significant change (physical or cognitive) .any smoking related privileges, restrictions, and concerns .need for close monitoring . are noted in the care plan .any resident with smoking privileges requiring monitoring shall have the direct supervision of a staff member .or volunteer worker at all times while smoking .Residents without independent smoking privileges may not have or keep any smoking items, including cigarettes, tobacco, etc., except under direct supervision .

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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. 46509 Based on observation, interview, and record review the facility failed to ensure one of seven sampled residents (Resident E) was assessed properly for bladder and bowel control. This failure had the potential for Resident E to not be identified, assessed, and provided appropriate treatment and services to achieve as much bladder and bowel function as possible. Findings: On June 25, 2024, at 9:30 a.m., an unannounced visit to the facility was conducted to investigate a complaint for quality of care. Resident E's medical record was reviewed on June 25, 2024, at 10:50 a.m. Resident E was admitted tot the facility on May 22, 2024, with diagnoses which included heart failure. Resident E's Nursing-Bowel and Bladder Observation/Assessment, dated May 22, 2024, indicated new admission, resident has bladder incontinence-yes, resident has bowel incontinence-yes, type of toileting program-check and change every 2 hours. Resident E's Minimum Data Set (MDS-a clinical assessment of a resident), on admission, dated June 4, 2024, indicated in Section H Bladder and Bowel, resident is always continent for urinary and bowel continence (ability to control). On June 25, 2024, at 11:15 a.m., an interview was conducted with Resident E. Resident E stated she would sit in a soiled diaper, for one to two hours and would call for a staff member to change her. Resident E stated, her bottom is clearing up, but has redness in her groin and peri-area from sitting in urine-soaked diapers. Resident E has been wearing a diaper since her admission to the facility, and only gets out of her bed to shower. On June 27, 2024, at 10:00 a.m., an interview was conducted via telephone with the MDS coordinator. The MDS coordinator stated she was able to review Resident E's MDS on admission, and there was a data entry on the facility's part, and it has now been modified to reflect Resident E's bladder and bowel status as always incontinent. The MDS stated they will continue to check on the resident every 2 hours and change her if soiled, assess her skin, monitor for skin breakdown, and reviewed preference with resident about her choice to continue to wear diapers.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe, appropriate pain management for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46509 Based on interview, and record review, the facility failed to ensure two of seven sampled residents' (Resident D and Resident E) pain were managed consistent with professional standards of practice, and the residents' comprehensive person-centered care plans, when the residents did not receive pain medications in accordance with the physician orders. This failure has the potential to negatively affect the health status of Residents D and E. Findings: On June 20, 2024, at 8:35 a.m., an unannounced visit to the facility was conducted to investigate quality of care issues. On June 20, 2024, at 4:50 p.m., an interview was conducted with Resident D. Resident D stated she was having pain, her lesions on her arms were painful, and her tongue hurts, because her mouth was sore it was difficult for her to eat her food. A review of Resident D's medical record indicated the resident was admitted to the facility on [DATE], with diagnoses which included pemphigus vulgaris (a rare skin disease in which blisters develop). A review of Resident D's order summary report dated June 1, 2024, indicated the following: -Tylenol tab 325 mg, give 2 tabs every 6 hours as needed for pain. -Norco (an opioid) tablet 5-325 mg one tab every 6 hours as needed for moderate pain (4-6). -Norco tablet 10-325 mg one tab every 6 hours as needed for severe pain (7-10). A review of Resident D's Medication Administration Record (MAR), dated June 2024, indicated the following: -Norco tab 5-325 mg, one tab every 6 hours as needed for moderate pain (4-6); and -Norco tablet 10-325 mg, one tab every 6 hours as needed for severe pain (7-10). Further review of the MAR indicated the following: -On 06/02/2024, at 12:23 a.m., a Norco 10 mg tab was given for a pain level of 8, at 09:21 a.m., a 10 mg tab was given for a pain level of 8, at 5:24 p.m., a 5 mg Norco tab was given for a pain of 7, and at 9:25 p.m., (4 hours later) a 10 mg tab was given for a pain level of 8. -On 06/04/2024, at 5:30 a.m. a 10 mg tablet was given for a pain level of 7, and at 10:50 p.m. a 5 mg tablet was given for a pain level of 8. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 33rd Street. Riverside, CA 92509	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	-On 06/07/2024, at 10:17 a.m., a 10 mg tablet was given for pain level of 9, and at 9:19 p.m. a 5 mg tablet was given for a pain level of 9. -On 06/08/2024, at 9:25 a.m. a 10 mg tablet was given for a pain level of 8, and at 9:54 p.m., a 10 mg tablet was given for a pain level of 6. -On 06/09/2024, at 9:59 p.m., a 5 mg tablet was given for pain level of 7. -On 06/10/2024, at 5:15 a.m., a 10 mg tablet was given for a pain level of 8, at 11:47 a.m., a 10 mg tablet was given for a pain level of 8, and at 9:59 p.m., a 5 mg tablet was given for a pain level of 7. -On 06/11/2024, at 8:01 p.m., a 10 mg tablet was given for a pain level of 6, and at 11:41 p.m. (3 hrs. 40 min later), a 5 mg tablet was given for a pain level of 6. -On 06/12/2024, at 8:52 a.m., a 10 mg tablet was given for a pain level of 6, at 5:30 p.m., a 5 mg tablet was given for a pain level of 6, and at 9:32 p.m. (4 hrs. 2 min later) a 10 mg tablet was given for a pain level of 8. -On 06/14/2024, at 4:47 p.m., a 5 mg tablet was given for pain level of 7. -On 06/15/2024, at 9:05 p.m., a 5 mg tablet was given for a pain level of 7. -On 06/16/2024, at 6:10 a.m., a 10 mg tablet was given for a pain level of 8, at 8:46 p.m., a 5 mg tablet was given for pain level of 7, at 11:20 p.m. (2 hrs. 34 min later) a 10 mg tablet was given for a pain level of 7. -On 06/17/2024, at 5:10 a.m., a 5 mg tablet was given for a pain level of 7, at 1:59 p.m., a 10 mg tablet was given for pain level of 8, at 8:50 p.m., a 5 mg tablet was given for a pain level of 8. -On 06/18/2024, at 9:01 p.m., a 10 mg tablet was given for a pain level of 8, at 11:58 p.m. (2 hrs. 57 min later) a 5 mg tablet was given for pain level of 8. -06/20/2024, at 5:02 a.m., a 5 mg tablet was given for a pain level of 7. -On 06/22/2024, at 2:40 a.m., a 5 mg tablet was given for a pain level of 8, at 5:04 a.m. (2 hours 22 min later) a 10 mg tablet was given for a pain level of 7, at 11:12 a.m., a 10 mg tablet was given for a pain level of 8, at 8:22 p.m., a 5 mg tablet was given for a pain level of 7. -on 06/23/2024, at 12:26 a.m. (4 hours 4 minutes later) a 10 mg tablet was given for pain level of 8, at 5:05 a.m. (4 hours 39 min later), a 5 mg tablet was given for a pain level of 7, at 11:24 a.m., a 10 mg tablet was given for a pain level of 8, at 9:25 p.m., a 10 mg tablet was given for a pain level of 7. Resident D received 51 doses of a prescribed pain medication in a 25-day period, dated June 1- June 25, 2024, 24 of those doses were given not in accordance with the physician orders. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 055581	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/25/2024
NAME OF PROVIDER OR SUPPLIER: Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE: 6401 33rd Street. Riverside, CA 92509	

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident D' s care plan, dated June 3, 2024, indicated .Pain: at risk for pain or discomfort due to general body, dx (diagnosis) Pemphigus vulgaris .Interventions .administer medication as ordered .Assess pain every shift and as indicated .notify physician if resident experiences unmanageable or intolerable pain . pain consult as ordered . On June 25, 2024, at 11:15 a.m., an interview was conducted with Resident E. Resident E stated she is concerned she is not getting her medications on time, especially her muscle relaxant and pain medication, she is having a difficult time with sleep because of her pain. Resident E stated her medication times vary based on who is passing them out, some shifts are better than others, but the medications she receives for pain management have not been given on time and she is having pain. She stated when she was home, she received her Tramadol twice a day, but now she may only receive one every couple of days, as well as her muscle relaxant, she has a history of pain, and the facility is not managing her pain well. Resident E concluded she would like her medications given at certain times to not have so much pain in her knee. Resident E's medical record was reviewed. Resident E was admitted to the facility on [DATE], with diagnoses which included heart failure. Resident E's order summary report indicated the following: -Acetaminophen (a medicine to treat pain) tablet 500 mg (milligrams-a type of measurement) one tab every 6 hours as needed for mild pain (1-3), ordered May 22, 2024 -Tylenol tablet 325 mg, two tablets every 6 hours as needed for moderate pain (4-6), ordered May 22, 2024. -Tramadol (medication to treat pain-narcotic) tablet 50 mg, one tab every 12 hours as needed for severe pain (7-10), ordered June 14, 2024. Resident E's Medication Administration Record (MAR), dated June 2024, indicated the following: -Acetaminophen 500 mg tab one tab every 6 hours as needed for mild pain (1-3), was given on 06/20/2024, at 5:09 p.m., the medication was given for a pain level of 8. -Tramadol 50 mg tab, one tab every 12 hours as needed for Severe pain (7-10) was given 14 times from 06/03/2024 until 06/24/2024, three times for a pain level of 6. A review of Resident E's care plan, dated May 23, 2024, indicated .Pain: at risk for discomfort .Interventions . Administer medications as ordered .assess pain every shift and as indicated .pain consult ordered . On June 25, 2024, at 12:30 p.m., an interview was conducted with Resident D. Resident D stated, she is not sleeping well, and needs her medication for pain, she has nerve pain on the left side of her head, her pain doses are not managing her pain. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On June 25, 2024, at 2:30 p.m., a concurrent interview and record review were conducted with the Director of Nursing (DON). The DON stated we can adjust Resident D and Resident E's medication times to better accommodate their needs, and if the pain levels are not being controlled, are requesting pain medications several times a day, their medications need to be reevaluated. The DON stated a pain level number should always coincide with the medication the physician has ordered, if it does not, the order is not being followed correctly, and medications should be given in the time frame ordered, if the resident needs medication sooner, the physician should be called, and times should be reevaluated. The DON stated Resident D and Resident E may need a pain consult and a review by the interdisciplinary team to ensure their pain is being managed effectively. A review of the facility's policy titled Pain Assessment and Management , dated March 2020, indicated .to help the staff identify pain in the resident, and to develop interventions that are consistent with the resident's goals and needs .The pain management program is based on a facility-wide commitment to appropriate assessment and treatment of pain, based on professional standards of practice, the comprehensive care plan, and the resident's choices .pain management is a multidisciplinary care process .recognizing the presence of pain .developing and implementing approaches to pain management .monitoring for the effectiveness of interventions .significant worsening of chronic pain should be assessed every 30 to 60 minutes after the onset and reassess as indicated .for chronic pain the resident's pain and consequences of pain are assessed at least weekly .behavior signs of pain including .verbal expressions .evidence of depression, anxiety .ask the resident if they are experiencing pain .review the medication administration record to determine how often the individual requests and receives PRN pain medication, and to what extent the administered medications relieve the resident's pain .assess pain using a consistent approach .establish a treatment regimen .administering medications around the clock rather that PRN .implement the medication regimen as ordered .If pain has not been adequately controlled, the multidisciplinary team, including the physician, shall reconsider approaches and make adjustments as indicated .Report .prolonged, unrelieved pain despite care plan interventions . A review of the facility's policy titled Administering Medications , dated 04/2019, indicated .Medications are administered in a safe and timely manner .medications are administered in accordance with prescribed orders, including any time frame .medication administration times are determined by resident need and benefit, not staff convenience .honoring resident choices and preference .if a resident uses PRN medications frequently, the attending physician and Interdisciplinary Care Team with support from the Consultant pharmacist as needed, shall reevaluate the situation .consider whether a standing dose of medication is clinically indicated .