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	08/07/2025

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 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. (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Based on observation, interview, and record review, the facility failed to ensure professional standards for food safety were upheld when:1. Several kitchen staff did not wear hairnets properly; and2. The Dishwasher did not change gloves after touching dirty kitchenware and before touching the clean and sanitized large SS pans coming from the dishwashing machine. In addition, during the dishwashing process, multiple kitchenware which had crusted food residue on them, were rinsed above and beside beverage cups and glasses.This failure had the potential to cause food-borne illness in a highly susceptible population of residents who could consume food.Findings:On June 30, 2025, at 3:05 p.m., an unannounced visit was conducted at the facility to investigate complaints regarding dietary services and infection control.On July 1, 2025, at 10:50 a.m., a concurrent kitchen observation was conducted with the Dietary Supervisor (DS). The following were observed:1. The Dietary Supervisor, Dietary Aide (DA) 1, and DA 2 were wearing hairnets that did not fully contain or cover the hair at the top and sides of their heads, as well as the nape of their necks. Hair was observed escaping the hairnets.In a concurrent interview, the DS stated she expected the kitchen staff's hair should be tucked in the hairnets, and that hairspray was suggested during training to make sure that hair stayed in place while using the hairnets.A review of the facility's undated policy and procedure titled, DRESS CODE, from Healthcare Menus Direct, LLC 20123, indicated, Hat for hair, if hair is short, which completely covers the hair.Hair net for hair, if hair is long (over the ears or longer).2a. During the dishwashing process, the DA 3, who was the dishwasher, was observed rinsing various dirty kitchenware and dishware with his gloved hand at the dirty side of the dishwashing station. The dishwashing machine to his left finished a washing cycle and 2 large stainless pans emerged from the farther side of the dishwashing machine towards the clean side of the dishwashing station. DA 3 proceeded to touch the clean and sanitized stainless steel pans without removing his dirty gloves and changing into clean ones.In a concurrent interview, DA 3 confirmed he touched the clean and sanitized kitchenware with his dirty gloves, and stated he should have changed his gloves.The DS, who witnessed the event and was concurrently interviewed, stated DA 3 should have removed his dirty gloves, washed his hands and donned new gloves before touching or handing the cleaned and sanitized stainless steel pans to avoid cross-contamination.2b. During the dishwashing process, DA 3 was observed rinsing multiple kitchenware which had crusted food residue on them using the sprayer, above and beside beverage cups and glasses which were placed upside down on the compartment glass racks/trays.In a concurrent interview, the DS stated she expected kitchen staff to scrape off the food debris from kitchenware used during the meal preparation process and soak them prior to trayline (food assembly process), and before the dishwasher came in, to make the dishwashing process easier and more efficient. In addition, the DS stated she expected the DA 3 to wash the kitchenware used for meal preparation first before washing the beverage cups and other dishware that came in from the patient care areas, to ensure dishware were not soiled with food debris from the meal preparation process.A review of the facility's undated policy and procedure titled, Dishwashing, from Healthcare Menus Direct, LLC 20123, did not indicate the procedure for transitioning from dirty to clean or clean to dirty tasks.