

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 08/08/2025
NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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. (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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility did not ensure that new medical orders were implemented in a timely manner after an orthopedic (specialty focusing on musculoskeletal system) consultation for one of one resident (Resident 2) reviewed. This failure caused a delay in treatment and services for Resident 2. Findings:On August 6, 2025, at 9:50 a.m., Resident 2 was interviewed. Resident 2 stated that his right arm was broken. Resident 2 stated that he needed to have an order from the Medical Doctor (MD) to start therapy exercises on his right arm. Resident 2 further stated that he has not had any physical therapy (PT) on his right arm since he was admitted to the facility.On August 6, 2025, at 9:45 a.m., Resident 2's medical record was reviewed. Resident 2 was admitted on [DATE], with a primary diagnosis of unspecified displaced fracture of surgical neck of right humerus (fractured upper arm bone).A review of Resident 2's, History and Physical, dated June 7, 2025, indicated Resident 2 had the capacity to understand and make decisions.A review of Resident 2's, Order Summary Report, as of August 6, 2025, indicated Resident 2 had a follow up orthopedic consult on July 30, 2025, at 11 a.m. In addition, Resident 2 had a physician's order, dated June 8, 2025, to have an arm sling to right arm to immobilize and support the arm in a comfortable position to reduce movement at the fracture site of humeral (upper arm bone).Resident 2 did not have a current active order for therapy exercises on his right arm.A review of Resident 2's, Progress Notes, dated July 30, 2025, indicated Resident 2 went out for orthopedic appointment at approximately 10 a.m. and returned to the facility at approximately 1 p.m. the same day. There was no documentation of evidence that the facility had followed up with the orthopedic doctor for new orders or recommendations that had been given for Resident 2 when he went out for his appointment with the orthopedic doctor on July 30, 2025.On August 6, 2025, at 11:05 a.m., Occupational Therapist Assistant (OTA) 1 was interviewed. OTA 1 stated Resident 2's arm had a sling, so she did arm exercises to his left arm only. OTA 1 further stated Resident 2 was admitted with a broken right arm and he should be reassessed if he needed an exercise therapy to his right arm.On August 6, 2025, at 3:30 p.m. an interview was conducted with Social Service Assistant (SSA) 1. SSA 1 stated Resident 2 had an orthopedic appointment on July 30, 2025, but there was no documentation pertaining to the visit. The SSA 1 further stated if there was no documentation of the visit, it could lead to complications and cause delays in the care or attention that Resident 2 needed. On August 7, 2025, at 2:49 p.m., an interview with a concurrent record review was conducted with SSA 1. A review of Resident 2's, Referral Letter, dated and signed by the Medical Doctor (MD) on August 7, 2025, indicated, .Reason for Referral.physical therapy for elbow and wrist 12 session.Start Date.07/31/2025.In a concurrent interview, SSA 1 stated the Physical Therapy (PT) orders (referring to the Referral Letter) from the orthopedic consultation on July 30, 2025, for the right arm were received on August 7, 2025. SSA 1 stated when a resident was sent out for an appointment, they were supposed to come back with an AVS (After Visit Summary). SSA 1 stated Resident 2 did not have an AVS when he came back from his appointment on July 30, 2025.On August 7, 2025, at 4:30 p.m., an interview with a concurrent record review was conducted with the Director of Nursing (DON). The DON stated the following:- The facility staff expects an AVS when a resident returns from an appointment and the social services and nursing were expected to follow up on the results from the consultation; - Resident 2 went out for a follow up appointment with the orthopedic doctor on July 30, 2025. The SSD did not document anything about the following up on the orthopedic doctor recommendation for Resident 2 up until August 6, 2025;- The orthopedic doctor's new orders for exercises to the right arm was ordered on July 31, 2025, and there was a seven-day delay in implementing this new order; and- The lack of follow-up on new recommendations from the doctor resulted in a delay in services for the resident and it was not acceptable.A review of Resident 2's (name of orthopedic office) consultation notes, dated July 30, 2025, indicated, .Chief Complaint.Right shoulder.Impression.IMPACTED RIGHT PROXIMAL HUMERAL NECK FRACTURE.Treatment.Referral To: Physical Therapist.Reason: physical therapy for elbow and wrist 12 sessions.Follow up.2 Weeks (Reason: repeat x-rays elbow and wrist.The facility was not able to provide their policy and procedure on following up new orders or recommendations from a consulting doctor for residents who went out for a specialty doctor appointment.</p>		

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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. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure, for one of three residents (Resident 1):1. An environment free from accident hazards, when a resident (Resident 1) was able to gain access and ingest a packet of hydrocortisone (steroid ointment) without the staff knowledge. This failure resulted in the hydrocortisone packet getting lodged to the resident's throat causing the resident to choke while eating, which could subsequently obstruct the resident's airway leading to a loss of consciousness and death. Resident 1 was transferred to the general acute hospital (GACH), for evaluation and treatment; and2. The incident related to finding the hydrocortisone packet lodged in the resident's throat was thoroughly investigated. This failure placed the resident at risk of recurrence and further harm. Findings:On August 7, 2025, at 9:28 a.m., an observation was conducted with Resident 1. Resident 1 was observed sitting in a wheelchair in the dining room. Resident 1 was alert but not responding to interviews.On August 7, 2025, Resident 1's admission Record, indicated Resident 1 was admitted to the facility on [DATE], with diagnoses which included right side hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of body), and dementia (memory loss).A review of Resident 1's Progress Notes, dated July 30, 2025, indicated Resident 1 did not have the capacity to understand and make decisions.A review of Resident 1's Minimum Data Set (MDS - an assessment tool), dated May 11, 2025, indicated Resident 1 had a BIM (Brief Interview for Mental Status) Score of 3 (meant severe cognitive impairment). The MDS data further indicated Resident 1 was non-ambulatory and needed .substantial/maximal assistance. on eating and oral hygiene.A review of Resident 1's Care Plan Report, indicated the following:- On July 2, 2023, .Focus.Resident 1 at risk for aspiration (breathing in a foreign object) r/t (related to) difficulty in swallowing.Goal.Utilize aspiration precautions and swallow safely. The care plan indicated this Focus was resolved on August 26, 2024:- On August 7, 2025, Resident 1 had .history of putting uneatable items in mouth and choking.episode 7/2/2023 (July 2, 2023).episode 7/31/2025 (July 31, 2025). The care plan was initiated and created on August 7, 2025. Further review of Resident 1's care plan indicated there was no active care plan addressing aspiration or history of putting uneatable items in mouth before the episode on July 31, 2025. A review of Resident 1's, . Change in Condition Evaluation. dated July 31, 2025, at 10:18 a.m., indicated, .Signs & (and) Symptoms Identified.other change in condition.unknown substance lodged in throat.Functional Status Evaluation. Swallowing Difficulty.Describe the swallowing difficulty.Associated with new onset or progressive choking, aspiration.A review of Resident 1's, Progress Notes, dated July 31, 2025, indicated the Resident 1 was transferred to the GACH by the paramedics (a person trained to give emergency medical care to people who are injured or ill, typically in a setting outside of a hospital) on July 31, 2025, at 10:41 a.m. A review of Resident 1's GACH emergency room progress notes, dated July 31, 2025, indicated, .Patient Visit Information.You were seen today for.H/O (history of) swallowed foreign body.FOREIGN BODY REMOVAL FROM BACK OF THROAT.WE REMOVED A HYDROCORTISONE PACKET FROM THE BACK OF PATIENT'S THROAT.Foreign Object in Throat, Removed.Objects that are swallowed can get stuck in the throat.A stuck object can cause coughing, choking, pain when swallowing, or trouble swallowing.A review of Resident 1's GACH document titled, .HPI (history of present illness) - General Illness, dated July 31, 2025, at 11:22 a.m., indicated:- .Chief Complaint Swallowed a foreign body, possibly a packet of sugar. The patient has some kind of foreign body located in the posterior pharynx (cavity behind nose and mouth) it is unclear what it is at this time. Because the patient's dementia, he is unable to follow directions I am unable to remove it at this time without sedation (administer sedative drug to produce sleep or state of calm).Procedural Sedation Note.Once the patient was adequately sedated, I was able to open the patient's mouth and pulled out a small medication packet from the back of his throat. It was a packet of hydrocortisone.A review of Resident 1's Progress Notes, at the Skilled Nursing Facility (SNF), dated July 31, 2025, at 3:50 p.m., indicated Resident 1 returned to the facility from the GACH.A review of Resident 1's Order Summary Report, at the SNF, for the month of August 2025, indicated Resident 1 did not have a current order for a hydrocortisone treatment.Further review of Resident 1's record indicated there was no documented evidence of an investigation conducted to determine the cause of the incident resulting in finding a foreign object (hydrocortisone packet) in Resident 1's mouth on July 31, 2025. In addition, there was no documented evidence that the facility initiated or developed a care plan to address or prevent the incident from re-occurring since July 31 2025 On August 7 2025 at 10:36 a.m. I licensed Vocational Nurse (LVN) 1 was</p>		