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	01/14/2026

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** Based on observation, interview, and record review, the facility failed to ensure, for one of four residents reviewed for quality of care (Resident 5):1. A physician's order to schedule a follow up orthopedic (branch of surgery concerned with conditions involving the musculoskeletal system) appointment, related to left shoulder rotator cuff tear (RCT - injury to the group of muscles and tendons that stabilize the shoulder causing pain, weakness, and limited arm movement) was done.This failure resulted to the delay treatment and services, putting Resident 5 at high risk for complications from the left shoulder rotator cuff tear; and2a. An assessment was conducted and documented prior to obtaining an order to increase dose in Gabapentin (medication used to relieve nerve pain) on November 11, 2025. This failure placed the resident at risk for complications due to lack of assessment to meet the resident's appropriate needs; and2b. An assessment was conducted prior to obtaining an order for neurology referral for Resident 5 on December 12, 2025.These failures had the potential to place Resident 5 at risk for complications if needs were not appropriately met due to insufficient information on required resident's health care needs.Findings:On January 14, 2026, at 8:15 a.m., an unannounced visit was conducted at the facility to investigate a complaint on quality of care.1.On January 14, 2026, at 8:30 a.m., an observation with a concurrent interview was conducted with Resident 5. Resident 5 was observed in bed, alert, and conversant. Resident 5 stated he had limited movement and some pain in the left shoulder due to an RTC sustained prior to his admission to the facility. Resident 5 stated he had been at the facility for 90 days and he had been requesting to see an orthopedic doctor related to his RCT but it was not being done.On January 14, 2026, Resident 5's medical record was reviewed. Resident 5 was admitted to the facility on [DATE], with diagnoses including rotator cuff tear of left shoulder and strain of muscles and tendons of the rotator cuff of left shoulder.A review of the acute hospital document, dated October 9, 2025, indicated, .Hospital course.The patient complained of left shoulder pain and overall weakness.ortho (orthopedic) was consulted and recommended outpatient follow-up.Patient had MRI (Magnetic Resonance Imaging - non invasive scan that used strong magnets, radio waves, and computer to create detailed pictures of body's internal structure, bones, and organs) of shoulder and was found to have RCT.Discharge Instructions.Follow-up Appointments.PLEASE FOLLOW UP WITH YOUR PCP (Primary Care Physician).(Name of PCP).Specialty: orthopaedic Surgery.Consult follow up timeframe: In 2-3 weeks.A review of the physician's order, dated October 10. 2025, indicated, .May have following: Consulting Provider 1: (name of physician).Specialty: Orthopaedic Surgery.Follow up Timeframe: In 2-3 weeks. Resident 5's physician order did not indicate the reason for the follow up appointment with the orthopedic doctor.A review of the care plan dated October 10, 2025, indicated, .Musculoskeletal Disorder: Resident is a risk for pain, joint stiffness, and/or spontaneous/pathological fracture related to.Rotator cuff tear of left shoulder. The care plan did not indicate Resident 5's physician's order to see an orthopedic doctor in two to three weeks.In addition, there was no (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	documented evidence that an appointment was scheduled for Resident 5 to see an orthopedic doctor in two to three weeks from the time it was ordered on October 10, 2025.On January 14, 2026, at 10:05 a.m., an interview with a concurrent record review was conducted with Registered Nurse (RN) 1. RN 1 stated Resident 5 had an admission order for an orthopedic follow-up within two to three weeks from October 10, 2025, but there was no record of the appointment being scheduled in that timeframe. RN 1 stated Resident 5's physician order to see an orthopedic doctor did not specify the reason for the follow-up appointment, and the order was not included in the care plan. RN 1 stated Resident 5's appointment to see the orthopedic doctor was not scheduled until February 2026.On November 14, 2025, at 11:23 a.m., an interview was conducted with the Director of Nursing (DON). The DON stated the following:- Resident 5's physician's order, dated on October 10, 2025, for an orthopedic consult was not done as ordered;- The staff were expected to call and set up an appointment within 72 hours after the order was made. The DON stated no one from the facility made the call;-The licensed nurse should have indicated the reason for the orthopedic consult in the physician's order and added the order in the care plan. The DON stated this was not done; and- Resident 5 not seeing the orthopedic doctor in two to three weeks as ordered by the physician on October 10, 2025, resulted in the delay of treatment care and services to Resident 5.A review of the facility's policy and procedure titled, Referrals, Social Services, dated December 2008, indicated, .Social services personnel shall coordinate most resident referrals with outside agencies.Referrals for medical services must be based on physician evaluation of resident need and a related physician order.Social services will collaborate with the nursing staff or other pertinent discipline to arrange for services that have been ordered by the physician.A review of the facility's policy and procedure titled, Care Plans, Comprehensive Person- Centered, dated March 2022, indicated, .A comprehensive person-centered care plan that inlcuded measurable objectives and timetables to meet the resident's physical, psychosocial and functional needs is developed and implemented for each resident.The comprehensive, person-centered care plan.describes the services that are to be furnished to attain or maintain the resident's highest practicable, physical, mental, and psychosocial well-being.which professional services are responsible for each element of care.Assessments of residents are ongoing and care plans are revised as information about the residents and resident's condition change.2a. On January 14, 2026, at 8:15 a.m., an unannounced visit was conducted at the facility to investigate a complaint on quality of care.On January 14, 2025, Resident 5's record was reviewed. Resident 5 was admitted to the facility on [DATE], with diagnoses including neuropathy (nerve damage that can cause symptoms like pain, numbness, or muscle weakness).Resident 5 had an admission physician's order, dated October 10, 2025, to give Gabapentin 100 milligrams (mg - unit of measurement) three times a day orally for neuropathy (Order discontinued November 10, 2025).A review of the physician's order, dated October 10, 2025, indicated to monitor Resident 5's pain level every shift.A review of the physician's order, dated November 10, 2025, indicated to give Resident 5 Gabapentin 300 mg orally three times a day for neuropathy.A review of the Pain Level Summary, dated October 27, 2025, to November 10, 2025, indicated Resident 5's pain level every shift was at 0.There was no documented evidence of an assessment conducted by the licensed nurse prior to obtaining an order to increase the dose of Gabapentin from 100 mg three times a day to 300 mg three times a day on November 10, 2025. In addition, the licensed nurse did not document the rationale for the increased dose of Gabapentin.On January 14, 2026, at 11:20 a.m., an interview with a concurrent record review was conducted with Registered Nurse (RN) 1. RN 1 stated the following:- Resident 5 had a current order for Gabapentin 300 mg orally to be given three times a day for neuropathy (Order Date November 10, 2025);- Licensed Vocational Nurse (LVN) 1 carried out the order on November 10, (continued on next page)

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