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	04/08/2026

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 Eliquis (blood thinner medication) was resumed 48 hours post (after) procedure, as ordered by the physician, for one of seven residents reviewed (Resident 1).This failure had the potential to increase the resident's risk of developing blood clots and placed the resident at risk for further complications. Findings:On March 17, 2026, at 12:45 p.m., an unannounced visit was conducted at the facility to investigate a complaint involving quality of care. On March 17, 2026, at 4:29 p.m., an observation with a concurrent interview was conducted with Resident 1. Resident 1 was observed in bed, alert, and calm. Resident 1 stated she had a procedure to replace her suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower belly directly into the bladder to drain urine) on March 11, 2026. Resident 1 stated her Eliquis was supposed to be resumed 48 hours after her procedure on March 14, 2026. Resident 1 stated the licensed nurse (LN) did not administer her Eliquis as ordered by the physician on March 14, 2026, until she reminded the LN.On March 17, 2026, Resident 1's medical record was reviewed. Resident 1 was admitted to the facility on [DATE], with diagnoses which included atrial fibrillation (a fast, irregular heart rhythm, increasing risks of stroke and blood clots).A review of Resident 1's care plan, dated June 4, 2024, indicated, .potential for bleeding or abnormal bruising.r/t (related to) .use of Eliquis.r/t diagnosis Afib (Atrial fibrillation) .will minimize ASE (Adverse Side Effect) .from medication.Medication as ordered.A review of Resident 1's Minimum Data Set (MDS - a resident assessment tool), dated February 14, 2026, indicated Resident 1 had a BIMS (Brief Interview of Mental Status - a cognitive assessment tool) score of 15 (cognitively intact - able to understand and make decisions). A review of Resident 1's medical records indicated the following physician orders:- Eliquis Oral Tablet 5 milligrams (mg - unit of measurement), (Apixaban) Give 5 mg by mouth two times a day for atrial fibrillation, date ordered June 4, 2024; - Appointment for suprapubic catheter placement on March 11, 2026, at 8 a.m., date ordered February 16, 2026;- Eliquis 5 mg hold from March 9, 2026, to March 12, 2026, date ordered on February 16, 2026;- Eliquis 5 mg hold from March 12, 2026, for two days (March 14, 2026, at 8:59 a.m.) post procedure, date ordered March 12, 2026;A review of Resident 1's Medication Administration Record (MAR), dated March 2026, indicated,-Eliquis was held on March 9, 2026, 6 am dose, to March 14, 2026, at 6 a.m. dose;-Eliquis 5 mg was administered on March 14, 2026 at 10:22 a.m.A review of Resident 1's written physician order, dated March 12, 2026, at 11 a.m., indicated, .Resume Eliquis sat (Saturday) AM (morning).A review of Resident 1's Nurse's Notes, dated March 14, 2026, at 11 a.m., indicated, .resident stated her Eliquis.was supposed to be held for 48 hours.and restarted today.undersigned after research discovered order written by NP (Nurse Practitioner).to resume Eliquis Saturday.medication given to resident by charge nurse.On March 18, 2026, at 11:15 a.m., a concurrent interview and record review were conducted with the Assistant Director of Nursing (ADON) and Director of Nursing (DON). The ADON stated the facility's process when a resident returns from a follow up appointment or procedure was to review the after-visit summary then verify any orders or instructions with the appointment physician. The ADON stated the LN would then verify the new orders with the attending physician and enter orders in the resident's electronic medical record (EMR). The ADON verified Resident 1's (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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Jurupa Hills Post Acute	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	physician order to resume Eliquis 5 mg on March 14, 2026, was not followed as ordered by the physician. The ADON stated the LN should have administered Resident 1's Eliquis at 6:00 a.m., on March 14, 2026.A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated, .medications are administered .in accordance .with prescriber orders .medications are administered within one (1) hour .of their prescribed time .

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to implement interventions to address aggressive behavior towards other residents were provided, for one of seven sampled residents (Resident 4), when Resident 4 continued to have aggressive behavior towards other residents placed in the room with Resident 4. In addition, the facility continued in assigning a roommate to Resident 4, even after a trigger for the resident's aggressive behavior had been identified.This failure resulted in foreseeable risk of harm, escalation of behaviors and decline in the resident's psychosocial well-being. Findings:On March 17, 2026, Resident 4's medical record was reviewed. Resident 4 was admitted to the facility on [DATE], with diagnoses which included Alzheimer's disease (a progressive brain disease that destroys memory and thinking skills), dementia (loss of brain function impacting memory, thinking, and daily tasks), and psychosis (when a person has trouble telling the difference between what's real and what's not).A review of Resident 4's Psychologist Progress Note: CHE Behavioral Health, dated April 4, 2025, indicated, .SSD (Social Services Director) reported the patient .expressing a desire to physically harm .his roommate .history of present illness .the patient continued .to express that his roommate .does not belong in his room .he wants to kill him .for stealing his space .difficult to redirect .does not understand that .he is not at home .due to cognitive impairment .A review of Resident 4's Psychiatry Progress Note, dated December 5, 2025, indicated, .patient recently attacked his roommate .wanting to kick him out of room .each time a new resident is placed in his room .will need psychotropic (medications that change how the brain works, affecting mood, thoughts and behavior) med (medication) adjustment .or patient may hurt himself .or others .A review of Resident 4's History & Physical, dated December 11, 2025, indicated, .started to have episodes of altered mental status.with episodes of aggression and verbally abusive behavior.was sent out to the emergency department.for further evaluation.of these behavioral changes.representing a change from his baseline.functioning at the facility.assessment and plan.monitor for worsening behaviors.does not have the capacity to understand and make decisions. A review of Resident 4's care plan, dated January 24, 2025, indicated, .Altered Behavior Pattern: Resident is at risk for behavioral symptoms (i.e. striking out, grabbing others, combative, verbally, or physically abusive.).Interventions.Document and record behavioral episodes.Manage environmental factors to optimize comfort.Observe and document changes in behavior, including frequency of occurrence and potential triggers.Observe whether the behavior endangers the resident and/or others. (Intervene if necessary; removing others from the surrounding area.Reduce stimulation.A review of Resident 4's care plan, dated December 1, 2025, indicated, .Resident involved in altercation.Aggression towards peer: resident (B) was holding a butter knife against resident's (A) chest.Both residents separated immediately and placed on monitoring for emotional and psychosocial distress.Further review of Resident 4's care plans showed no new interventions for aggressive behavior beyond separating the residents.A review of Resident 4's Psychiatry Progress Note, dated December 19, 2025, indicated, .patient seen for an urgent psychiatry re-evaluation.patient seen pacing back and forth.talking to himself in Spanish.attempted to speak to patient.patient used curse words.patient does not like having a roommate.becomes aggressive.attacks staff or resident that is placed in his room.patient is angry.with disorganized thoughts and speech.behavior: agitated.speech: pressured yelling.mood: irritable.plan: continue Ativan 0.5 mg po (by mouth) q6h (every 6 hours) prn (as needed) for anxiety m/b anxiousness with inability to relax.monitor and report.any changes in behaviors/mood to Psychiatry for urgent evaluation.A review of Resident 4's Psychiatry Progress Note, dated January 9, 2026, indicated, .patient seen standing at the doorway of his room .per translator .cursing in Spanish .with other erratic speech .not allowing staff in his room .to setup for new resident to move in .will need psychotropic med adjustment .or patient may hurt himself .or others .A review of Resident 4's (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Minimum Data Set (MDS - a resident assessment tool), dated January 21, 2026, indicated Resident 4 had a BIMS (Brief Interview of Mental Status-a cognitive assessment tool) score of 3 (severe cognitive impairment). A review of Resident 4's Progress Notes, indicated the following: -March 12, 2026, at 8:20 p.m., .Anger issue towards having a room mate noted at 17:35 (5:35 p.m.) today while LVN (Licensed Vocational Nurse) passing medication. Pt (patient was given education regarding having a room mate. Pt refused to follow instruction.-March 14, 2026, at 11:29 p.m., .Resident displayed multiple out burst (sic) unable to calm self down.resident is not easily redirected.Roommates room changed d/t (due to) incompatibility.-March 15, 2026, at 11:40 p.m., .Resident displayed multiple out burst unable to calm self down.Resident is noted cursing staff and roommate and requires staff to defuse (sic) situation by leaving until resident is calm.-March 16, 2026, at 2:05 p.m., .Resident's daughter, (name of family member), arrived at approximately 1:00 p.m. to drop off food for the resident. During her visit, she observed the resident displaying antagonistic behavior toward his roommate. The roommate later approached staff requesting a room change due to ongoing incompatibility. According to the roommate, the resident had been behaving in a hostile manner, including repeatedly opening the roommate's privacy curtain, turning the lights on and off, and moving the roommate's personal belongings. Staff intervened and redirected the resident to prevent further escalation. Due to continued behavior and the roommate's request, the roommate was relocated to another room.;-March 16, 2026, at 3:10 p.m., .patient noted exhibiting antagonizing behavior toward roommate creative (sic) disruptive environment by standing over patient, turning on and off lights, not allowing privacy for patient, staff attempted verbal redirection and escalation, however patient continued behavior toward roommate despite interventions. Due to ongoing behaviors and inability to redirect, MD (physician) was notified and decision made to transfer to (name of general acute care hospital) for psych (psychiatric) eval (evaluation).resident continued using profanity towards staff and transportation staff, unable to be redirected.Further review of Resident 4's record indicated there was no documented evidence the facility addressed the resident's behavior of anger outbursts and antagonizing behavior towards roommates and continued to place a roommate with Resident 4. On March 17, 2026, at 3:40 p.m., a concurrent observation and interview was conducted with Resident 2. Resident 2 was observed inside his room watching television. In a concurrent interview, Resident 2 stated he was admitted to the facility on [DATE], and was roomed with Resident 4. Resident 2 stated Resident 4 was disruptive and was using profanity towards him when he was admitted to the room on March 15, 2026. Resident 2 stated Resident 4 touched his feet while he was laying in bed, was walking around the room while looking at him, was waving his finger, opening and closing the privacy curtain, turning the lights on and off. Resident 2 stated he felt scared at that time but felt safe now that Resident 4 was sent to the hospital.On March 19, 2026, at 1:01 p.m., an interview was conducted with LVN (Licensed Vocational Nurse) 1. LVN 1 stated Resident 4 always had issues with his roommates after his wife passed away. LVN 1 stated Resident 4 would complain that he didn't want a roommate in his room. LVN 1 stated Resident 4's behavior issues were only when he had a roommate. LVN 1 stated if Resident 4 had his own room it would have been a calmer environment for the resident.On March 20, 2026, at 12:26 p.m., a group interview was conducted with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). The DON stated Resident 4 has behavior of anger outbursts towards any roommate placed with Resident 4. The DON stated the facility did not implement interventions to prevent Resident 4's triggered behavior of anger outburst towards roommates as they could not provide a private room for the resident. The DON stated the staff should have monitored Resident 4 frequently and should have provided one on one monitoring to ensure residents' safety if a roommate was to be placed with Resident 4.A review of the facility's policy and procedure titled, Behavioral Health Services, revised February 2019, indicated, .the facility will provide .residents will receive .behavioral health services .as needed to attain or maintain .the highest practicable .physical, mental and psychosocial well-being .in accordance with the comprehensive assessment .plan of care .behavioral health services .are provided to residents .as (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed as part of the interdisciplinary, person-centered approach to care .staff must promote dignity .autonomy .privacy .safety .as appropriate for each resident .staff training regarding behavioral health services includes .recognizing changes in behavior .implementing care plan interventions that are relevant to the resident's diagnosis and appropriate to his or her needs .monitoring care plan interventions and reporting changes in condition .A review of the facility's policy and procedure titled, Behavioral Assessment, Intervention and Monitoring, revised February 2025, indicated, .resident will have minimal complications associated with the management of .altered or impaired behavior .new onset or changes in behavior .are evaluated and documented .regardless of the degree of risk to the resident or others .the interdisciplinary team (IDT - a group of healthcare professionals) thoroughly evaluates new or changing behavioral symptoms .to identify causes and address any modifiable factors .that may have contributed to the resident's change in condition .including .environmental factors .alteration in routine .sleep disturbances .noise .the IDT evaluates behavioral symptoms in residents to determine the degree of severity, distress, and potential safety risk to the resident .develops a plan of care accordingly .safety strategies are implemented immediately .if necessary to protect the resident and others from harm .the care plan includes .a description of the behavioral symptoms .targeted and individualized interventions for the behavioral and/or psychosocial symptoms .the rationale for the interventions and approaches .specific and measurable goals for targeted behaviors .how staff will monitor the effectiveness of the interventions .non-pharmacologic approaches are used to the extent possible .to avoid or reduce the use of psychotropic medications to manage behavioral symptoms .the IDT monitors for and documents any new, worsening, or improved symptoms in the resident's behavior, mood, and function .Interventions are adjusted based on the impact on behavior and other symptoms .