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	05/07/2026

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure residents are free from verbal abuse from staff, for one of four residents reviewed (Resident 3).This failure had the potential for Resident 3 to experience emotional and psychosocial distress related to verbal abuse from staff.Findings:On March 30, 2026, at 12:15 p.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse.On April 3, 2026, at 3 p.m., during an interview with Resident 3, the resident stated Certified Nursing Assistant (CNA) 1 provided care to her a week ago during the NOC (11 p.m. to 7 a.m.) shift. Resident 3 stated CNA 1 threw the wipes at her groin and looked at her disgusted and CNA 1 told her, Looks like the diaper does not fit, you are too fat, and left the room. Resident 3 further stated CNA 1 talked to CNAs 2 and 3 outside her door and called the resident the fat bitch and the CNAs started laughing. Resident 3 stated she told the social services staff and filed a complaint the next day. Resident 3 stated CNA 1 was not suspended and continued to work and would smirk at her when CNA 1 saw her.A review of Resident 3's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which indicated morbid obesity (a serious, chronic disease defined by extreme excess body fat that poses severe health risks).A review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated January 7, 2026, indicated the resident has a BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact).A review of facility document Grievance Report, dated March 30, 2026, indicated Resident 3 complained about CNA 1 left her during care due to brief not fitting and had an attitude. The grievance report included the Director of Staff Development (DSD) response that CNA 1 was texted on March 30, 2026, at 10:44 a.m., to work on communication skills in a professional manner. The document did not indicate the Administrator or designee conducted further investigation on what was the attitude of CNA 1 towards Resident 3. On April 3, 2026, at 3:45 p.m., the Social Services Assistant (SSA) was interviewed. The SSA stated that he did not receive any complaint from Resident 3 regarding the statement made by CNA1 about her. The SSA stated calling a resident a derogatory (comments, attitudes, or actions that are insulting, disrespectful, or intended to lower the reputation and value of a person or thing) statement is a form of verbal abuse and the expectation would be to start an investigation and remove the staff member from caring for the resident.On April 6, 2026, at 11 a.m., the Social Services Director (SSD) was interviewed. The SSD stated Resident 3 came to her office on March 30, 2026, and complained about a CNA had been in her room, changed her brief, CNA became frustrated when he could not adjust the brief to his liking, on March 29, 2026. The SSD stated she did not ask further questions and had the impression CNA 1 left Resident 3 without completing the care and could be considered neglected. The SSD stated she referred the issue to the Director of Staff Development (DSD) to follow up. The SSD stated the staff members are not allowed to speak with the resident in an inappropriate manner, that is unprofessional, and further investigation should be carried out.On April 6, 2026, at 11:30 a.m., the DSD was interviewed. The DSD stated CNA 1 was not the assigned to care for Resident 3. The DSD stated CNA 1 answered Resident 3's call light and completed the task. The DSD stated the staff member should not talk to the resident with (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	inappropriate remarks, and it is a form of verbal abuse, and neglect if the task was not completed.On April 6, 2026, at 12:20 p.m., CNA 2 was interviewed. CNA 2 stated she worked with CNA 1 on March 29, 2026. CNA 2 stated CNA 1 went to answer Resident 3's call light and when CNA 1 came out of the resident's room and commented that he does not like fat people, that the resident was complaining about the brief did not fit her right, and joked about the resident being fat and called Resident 3 a fat bitch out in the hallway. CNA 2 stated the DSD called her earlier today and asked if she was helping CNA 1 the night before and she responded to the DSD that she was not in the resident's room during provision of care. A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 2001, indicated, .All reports of resident abuse.neglect, exploitation .are reported to local, state and federal agencies.and thoroughly investigated by facility management. Finding of all investigations are documented and reported.if resident abuse, neglect.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.The administrator or the individual making the allegation immediately reports his or her suspicion to.the state licensing/certification agency responsible for surveying/licensing the facility.immediately.within two hours of an allegation involving abuse or result in serious bodily injury.Upon receiving any allegations of abuse.the administrator is responsible for determining what actions (if any) are needed for the protection of residents.All allegations are thoroughly investigated.Any employee who has been accused of resident abuse is placed on leave with resident contact until the investigation is complete.The individual conducting the investigation.interviews the person(s) reporting the incident.interviews any witnesses to the incident.interviews the resident.staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the facility's policy on abuse was implemented on conducting a thorough investigation when Resident 3 alleged she heard a Certified Nursing Assistant (CNA) made derogatory statements about her to other staff. This failure had the potential for a delay in the investigation of Resident 3's abuse allegation and could subject the resident and other residents for further abuse by the CNA. Findings:On March 30, 2026, at 12:15 p.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse and quality of care issues.On April 3, 2026, at 3 p.m., during an interview with Resident 3, the resident stated Certified Nursing Assistant (CNA) 1 provided care to her a week ago during the NOC (11 p.m. to 7 a.m.) shift. Resident 3 stated CNA 1 threw the wipes at her groin and looked at her disgusted and CNA 1 told her, Looks like the diaper does not fit, you are too fat, and left the room. Resident 3 further stated CNA 1 talked to CNAs 2 and 3 outside her door and called the resident the fat bitch and the CNAs started laughing. Resident 3 stated she told the social services staff and filed a complaint the next day. Resident 3 stated CNA 1 was not suspended and continued to work and would smirk at her when CNA 1 saw her.A review of Resident 3's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which indicated morbid obesity (a serious, chronic disease defined by extreme excess body fat that poses severe health risks).A review of Resident 3's Minimum Data Set (MDS - a resident assessment tool), dated January 7, 2026, indicated the resident has a BIMS (Brief Interview of Mental Status) score of 15 (cognitively intact).A review of facility document Grievance Report, dated March 30, 2026, indicated Resident 3 complained about CNA 1 left her during care due to brief not fitting and had an attitude. The grievance report included the Director of Staff Development (DSD) response that CNA 1 was texted on March 30, 2026, at 10:44 a.m., to work on communication skills in a professional manner. The document did not indicate the Administrator or designee conducted further investigation on what was the attitude of CNA 1 towards Resident 3. On April 3, 2026, at 3:45 p.m., the Social Services Assistant (SSA) was interviewed. The SSA stated that he did not receive any complaint from Resident 3 regarding the statement made by CNA1 about her. The SSA stated calling a resident a derogatory (comments, attitudes, or actions that are insulting, disrespectful, or intended to lower the reputation and value of a person or thing) statement is a form of verbal abuse and the expectation would be to start an investigation and remove the staff member from caring for the resident.On April 6, 2026, at 11 a.m., the Social Services Director (SSD) was interviewed. The SSD stated Resident 3 came to her office on March 30, 2026, and complained about a CNA had been in her room, changed her brief, CNA became frustrated when he could not adjust the brief to his liking, on March 29, 2026. The SSD stated she did not ask further questions and had the impression CNA 1 left Resident 3 without completing the care and could be considered neglected. The SSD stated she referred the issue to the Director of Staff Development (DSD) to follow up. The SSD stated the staff members are not allowed to speak with the resident in an inappropriate manner, that is unprofessional, and further investigation should be carried out.On April 6, 2026, at 11:30 a.m., the DSD was interviewed. The DSD stated CNA 1 was not the assigned to care for Resident 3. The DSD stated CNA 1 answered Resident 3's call light and completed the task. The DSD stated the staff member should not talk to the resident with inappropriate remarks, and it is a form of verbal abuse, and neglect if the task was not completed.On April 6, 2026, at 12:20 p.m., CNA 2 was interviewed. CNA 2 stated she worked with CNA 1 on March 29, 2026. CNA 2 stated CNA 1 went to answer Resident 3's call light and when CNA 1 came out of the resident's room and commented that he does not like fat people, that the resident was complaining about the brief did not fit her right, and joked about the resident being fat and called Resident 3 a fat bitch out in the hallway. CNA 2 stated the DSD called her earlier today and asked if she was helping CNA 1 the night before and she responded to the DSD that she was not in the resident's room during provision of care. On April 6, 2026, at 12:50 p.m., (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	during a concurrent interview and review of Resident 3's grievance form with the Administrator (ADM), the ADM stated the grievance placed by Resident 3 should have been investigated thoroughly.A review of the facility's policy and procedure titled, Abuse, Neglect, Exploitation or Misappropriation - Reporting and Investigating, dated 2001, indicated, .All reports of resident abuse.neglect, exploitation .are reported to local, state and federal agencies.and thoroughly investigated by facility management. Finding of all investigations are documented and reported.if resident abuse, neglect.is suspected, the suspicion must be reported immediately to the administrator and to other officials according to state law.The administrator or the individual making the allegation immediately reports his or her suspicion to.the state licensing/certification agency responsible for surveying/licensing the facility.immediately.within two hours of an allegation involving abuse or result in serious bodily injury.Upon receiving any allegations of abuse.the administrator is responsible for determining what actions (if any) are needed for the protection of residents.All allegations are thoroughly investigated.Any employee who has been accused of resident abuse is placed on leave with resident contact until the investigation is complete.The individual conducting the investigation.interviews the person(s) reporting the incident.interviews any witnesses to the incident.interviews the resident.staff members (on all shifts) who have had contact with the resident during the period of the alleged incident.If the investigation reveals that the allegation(s) of abuse are founded, the employee(s) is terminated.

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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 medications were assessed/evaluated for continued use, for one of three residents reviewed (Resident 2), when propranolol (medication to treat high blood pressure) was held multiples times during the months of February, March, and April 2026.In addition, propranolol was administered to Resident 2 when the SBP (systolic blood pressure - the top number in a blood pressure reading which is the highest pressure in your arteries, measured in mmHg (millimeters of mercury) when the heart muscle contracts and pumps blood) < (less than) 110, according to the physician's order.These failures had the potential to place Resident 2 at risk for unnecessary medication and to experience adverse reactions of low blood pressure. Findings:On March 30, 2026, at 12:15 p.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse and quality of care issues.On April 3, 2026, at 1:25 p.m., Resident 2 was interviewed inside the resident's room. Resident 2 stated she rarely takes her propranol because she has low blood pressure.On April 3, 2026, a review of Resident 2's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included fibromyalgia (a chronic disorder characterized by widespread musculoskeletal pain, fatigue, sleep disturbances, and cognitive issues).A review of Resident 2's History and Physical, dated December 27, 2025, indicated the resident has the capacity to understand and make decisions.A review of Resident 2's Order Summary Report, included a physician's order, dated December 24, 2025, which indicated, .Propranolol HCl (hydrochloride) Oral Tablet 20 MG (milligram - unit of measurement).Give 1 (one) tablet by mouth in the morning for Hypertension (high blood pressure) Hold if SBP (systolic blood pressure - the top number in a blood pressure reading which is the highest pressure in your arteries, measured in mmHg (millimeters of mercury) when the heart muscle contracts and pumps blood) < (less than) 110 or HR < 60.A review of Resident 2's Medication Administration Record, for the months of February, March, and April 2026, indicated Propranolol was not administered to Resident 2 because SBP was below 110 on the number of times per month:-February 2026 = 21 out of 28 times per month;-March 2026 = 22 out of 31 times per month; and-April 2026 = seven times (April 1 to 7, 2026).A review of Resident 2's Medication Administration Record (MAR), for the months of February and March 2026, indicated Propranolol was administered to the resident when the SBP was below 110 on the following dates:-February 13, 2026; SBP = 108;-February 25, 206; SBP= 90;-March 2, 2026; SBP = 88;-March 10, 2026; SBP = 97; and-March 15, 2026; SBP = 100.On April 6, 2026, at 4:10 p.m., an interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the physician should be notified if the resident's medication was being held multiple times because it was outside parameter to evaluate the need of the medication. The ADON stated the licensed nurse should follow the physician's order to hold the medication if it is outside the vital signs parameter, to prevent having the resident's blood pressure going so low for resident safety.A review of the facility's policy and procedure titled, Administering Medication, dated April 2019, indicated, .Medications are administered in a safe and timely manner, and as prescribed.The following information is checked/verified for each resident prior to administering medications.Vital signs, if necessary.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** Based on observation, interview, and record review, the facility failed to ensure a safe environment was provided, for four of four residents, when the residents were smoking in an area not designated for smoking and without supervision, according to the facility's smoking contract.This failure has the potential to place the residents for smoking-related safety risks. Findings:On March 30, 2026, at 12:15 p.m., an unannounced visit was conducted at the facility to investigate an allegation of abuse and quality of care issues.On April 3, 2026, at 10:05 a.m., arrived at the facility and observed four residents sitting on their wheelchair in front of the facility off to the left in the parking area. The four residents were observed to be smoking. In a concurrent interview with the four residents, they stated they were not allowed to smoke outside in front of the facility.On April 3, 2026, at 10:20 a.m., during an interview with the Administrator (ADM), the ADM stated the back of the facility is the designated area for smoking and being supervised by the staff. The ADM stated the residents were not allowed to smoke in front of the facility, or other areas that were not designated for smoking. The ADM stated the residents were being evaluated if able to smoke independently and then to sign a contract. The ADM stated if the residents who do not follow the contract for smoking, they would lose their smoking privileges.On April 3, 2026, at 3:20 p.m., Resident 1 was interviewed. Resident 1 stated he was one of the four residents smoking in front of the facility. Resident 1 stated he usually does not smoke but was approached by the other residents and started smoking in front of the facility. Resident 1 stated he was aware they were not allowed to smoke out front but only the designated area.On April 3, 2026, Resident 1's record was reviewed. A review of Resident 1's admission Record, indicated the resident was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (abnormal blood sugar levels).A review of Resident 1's History and Physical, dated November 21, 2025, indicated the resident has the capacity to understand and make decisions.A review of the facility's policy and procedure titled, Smoking Contract, indicated, .This facility has established and maintains safe resident smoking practices.Prior to, and upon admission, residents are informed of the facility's smoking policy, including designated smoking areas, and the extent to which the facility can accommodate their smoking or non-smoking preferences.Smoking is only permitted in the designated resident smoking area located in the back patio next to room [ROOM NUMBER].