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	03/27/2025

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to ensure an assessment and evaluation for self-administration (taking medication or substance by oneself, rather than by a healthcare professional) of medication albuterol inhaler (used to prevent and treat wheezing, difficulty breathing, chest tightness, and coughing caused by lung disease such as asthma) was completed, for one of 27 residents reviewed (Resident 180). In addition, the facility failed to ensure the medication was stored safely and securely. This failure increased the potential for unsafe self-administration and duplication of administered medication for Resident 180, and potential for visitors, and other residents to have access to the medication at bedside. Findings: On March 25, 2025, at 4:30 p.m a concurrent observation and interview was conducted with Resident 180. Resident 180 was observed awake, alert, sitting up on his bed and was able to verbalize his needs. Resident 180 was observed to reach into his pant's pocket and removed an albuterol inhaler. Resident 180 stated he had asthma, and had used the albuterol inhaler for a long time, paid his own prescription, and got it from his own doctor. Resident 180 stated he wanted to have the albuterol inhaler handy in case he had an asthma attack. Resident 180 was observed talking in fast tone, raising his voice, jitters with sudden movements scratching his left arm, and placed the inhaler back into his pant's pocket. Resident 180 did not want to talk about his albuterol inhaler. A review of Resident 180's Admission Record, indicated Resident 180 was admitted to the facility on [DATE], with diagnoses which included asthma and cellulitis (a bacterial skin infection). Resident 180 was alert, and oriented to time, place, person, and situation. A review of Resident 180's Medication Administration Record (MAR), dated March 26, 2025, included a physician's order, dated March 13, 2025, which indicated, Albuterol Sulfate Inhalation Aerosol Solution, 2 puffs inhale orally two times a day for asthma. A review of Resident 180's Self -Administration Of Medication Observation, dated March 13, 2025, indicated Resident 180 did not want to self-administer medication, electronically signed by the Registered Nurse (RN) when Resident 180 was admitted to the facility. (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 26, 2025, at 11:51 a.m., a concurrent observation and interview was conducted with Resident 180. Resident 180 was observed sitting upright on his bed. The medication albuterol inhaler was observed on top of Resident 180's bedside table. In a concurrent interview with Resident 180, he stated the nurse gave the albuterol inhaler for him to keep. On March 26, 2025, at 12:15 p.m. a concurrent interview and review of Resident 180's MAR was conducted with Licensed Vocational Nurse (LVN) 1. LVN 1 confirmed Resident 180 had an order for the albuterol inhaler. LVN 1 stated he administered the albuterol inhaler to Resident 180 at 9 a.m. LVN 1 stated he was not aware the albuterol inhaler was at the bedside. On March 26, 2025, at 2:20 p.m., a concurrent interview and record review was conducted with the MDS (Minimum Data Set - an assessment tool) Coordinator. The MDS Coordinator stated the facility's document titled,Self- Administration Of Medication Observation, dated March 13, 2025, indicated Resident 180 did not want to self-administer his medication. The MDS stated Resident 180 should not be administering his own albuterol inhaler. On March 26, 2025, at 3:35 p.m., an interview was conducted with the Registered Nurse Supervisor (RNS). The RNS stated she was not aware Resident 180 had the albuterol inhaler with him. The RNS stated when Resident 180 was admitted on [DATE], she conducted his assessment and completed the self-administration of medication form for Resident 180. However,the RNS stated there was no albuterol inhaler with Resident 180 at the time he was admitted to the facility. On March 26, 2025, at 4:05 p.m., the Director of Nursing (DON) was interviewed. The DON stated Resident 180 should not have self-administered his albuterol inhaler without the licensed staff assessment and physician's order. A review of the facility's policy and procedure titled, Self-Administration of Medications, dated February 2021, indicated, .Resident have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so .Self-administered medications are stored in a safe and secure place,which is not accessible by other residents .Any medications found at the bedside that are not authorized for self-administration are turned over to the nurse in charge for return to the family or responsible party .

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39920 Based on observation, interview, and record review, the facility failed to accommodate the needs, for one of two residents reviewed (Resident 56), when Resident 56 was not provided appropriate bed for the resident's height. This failure resulted in Resident 56 not to have his preference to use a bed tall enough to accommodate his height and had discomfort when lying in bed. Findings: On March 23, 2025, at 4:18 p.m., a concurrent observation and interview was conducted with Resident 56. Resident 56 was observed in bed, awake and alert. Resident 56 was observed with a bed footrest made out of cardboard from a carton box. In a concurrent interview, Resident 56 stated he was about 6'7 - 6'8 tall (79 to 80 inches), and his current bed was too small. Resident 56 stated he asked a few months ago for a tall bed to accommodate his height, but it was not provided to him. On March 26, 2025, at 9:26 a.m., a concurrent observation and interview was conducted with Resident 56. Resident 56 was observed again, lying in bed, with the same cardboard at the foot of the bed. Resident 56 was observed keeping his feet on each side of the bed's footrest. In a concurrent interview, Resident 56 stated otherwise his feet would reach the foot of the bed and he had to bend his legs while lying in bed. Resident 56 stated because the bed was a regular bed and he was tall guy, it was very uncomfortable for him while lying in bed. Resident 56 stated he told staff about the short bed a few months ago. Resident 56 stated the maintenance supervisor put the cardboard at the foot of bed a few months ago. On March 26, 2025, at 9:34 a.m., a concurrent observation and interview was conducted with Certified Nursing Assistant (CNA) 1. CNA 1 stated she took care of Resident 56 and was familiar with him. CNA 1 observed the bed with the cardboard and stated, he needs a longer bed. CNA 1 confirmed Resident 56 kept his feet on each side of footrest, and if he fully extended his legs, he would hit the footrest and had to bend his knees. On March 26, 2025, at 9:44 a.m., a concurrent observation and interview was conducted with the Maintenance Director (MD) and the Central Supplies Director (CSD). The MD confirmed he was the one who put the cardboard box at the foot of the bed at the request of the resident. The MD confirmed the cardboard box was a make-shift set-up that should not be there. The CSD stated the current bed had a small extension at the head of the bed and a small extension at foot of bed. The CSD stated the extensions were still not enough, and Resident 56 needed a bed that would accommodate his height. On March 26, 2025, at 9:47 a.m., a concurrent observation and interview was conducted with the Assistant Director of Nursing (ADON). The ADON stated the cardboard footrest should not be at the foot of the bed, in place of the footrest. The ADON confirmed Resident 56 kept his feet on each side of the footrest and stated he needed a bed tall enough to accommodate his height. (continued on next page)

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 56's record was reviewed. Resident 56 was admitted to the facility on [DATE], with diagnoses which included cervical disc degeneration (a condition where the intervertebral discs in the neck [cervical spine] deteriorate over time), inclusion body myositis (a rare condition that causes muscle weakness and damage), polyneuropathy (peripheral nerves become damaged, creating problems with sensation, coordination, or other body functions), and difficulty in walking. A review of Resident 56's Weights and Vitals Summary, indicated Resident 56 was 80 inches tall (6 feet and 8 inches). A review of Resident 56's care plan, dated April 3, 2024, indicated, .Resident has actual for ADL (Activities of Daily Living)/mobility decline and requires assistance related to weakness, impaired mobility, Cervical disc degeneration .Will have needs anticipated and met by staff .Will have no complications of immobility .At risk for pain or discomfort due to .general body weakness with lack of coordination .Inclusion body myositis . Polyneuropathy .cervical disc degeneration .lower extremity with episodes of sliding out at the edge of the bed uncontrolled .position for comfort . A review of the facility's policy and procedure titled, Accommodation of Needs, revised March 2021, indicated, .The resident's individual needs and preferences are accommodated to the extent possible . including the need for adaptive devices and modifications to the physical environment .To accommodate individual needs and preferences, adaptations may be made to the physical environment, including the resident's bedroom .Examples of such adaptations may include .providing a variety of types .sizes (height and depth) .of furniture in rooms .

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 29623 Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain cleanliness and proper hygiene of resident's fingernails, for one of 27 residents reviewed (Resident 115). This failure had the potential to negatively impact the physiological and psychological well-being of Resident 115. In addition this failure had the potential to result in cross contamination of bacteria underneath the dirty fingernails to Resident 115's food during meals. Findings: On March 23, 2025, at 11:04 a.m., Resident 115 was observed sitting at the edge of the bed alert, oriented, and able to verbalize his needs. Resident 115 was observed with blackish materials underneath all his long fingernails. Resident 115 stated it had been a month since his nails were cleaned. Resident 115 stated he would not mind if staff would clean his nails. On March 23, 2025, at 12:06 p.m., Certified Nursing Assistant (CNA) 3 was interviewed. CNA 3 stated she took care of Resident 115 on March 22, 2025, today, and two weeks ago. CNA 3 stated she did not notice Resident 115's fingernails were dirty. CNA 3 stated the dirty fingernails could be a source of bacteria if not cleaned. On March 23, 2025, at 12:15 p.m., a concurrent observation of Resident 115 and interview with the Infection Preventionist (IP) was conducted. The IP stated Resident 115's fingernails were dirty. The IP stated the CNAs were responsible of providing skin, and nail care daily. The IP stated the dirty fingernails could be a source of infection. On March 23, 2025, at 4:06 p.m., the Director of Nursing (DON) and the Assistant Director of Nursing (ADON) were interviewed. The DON stated the CNAs were responsible in giving daily hygiene to the residents including the cleaning of resident's fingernails. A review of Resident 115's record indicated, Resident 115 was admitted to the facility on [DATE], with diagnoses which included peripheral arterial disease (a circulatory condition in which narrowed blood vessels reduce blood flow to the limbs). A review of Resident 115's care plan, initiated on January 9, 2025, indicated, .Activities of daily living (ADL)/Mobility: Resident had actual risk for ADL/Mobility decline and requires assistance .Goal .Will have needs anticipated and met by staff . A review of the facility's policy and procedure titled, Activities of Daily Living (ADL) , dated March 2018, indicated, .Residents will be provided with care, treatment and services as appropriate to maintain or improve their ability to carry out activities of daily living .Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming, and personal .hygiene .

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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** 44173 Based on interview and record review, the facility failed to ensure care and treatment according to the professional standards of practice and physician's order was provided, for one of 24 residents (Resident 105) when Insulin Lispro (a type of insulin medication) was administered to Resident 105 when the blood sugar level was below below the hold parameter). This failure had the potential for Resident 105 to experience hypoglycemia (a condition in which the body's blood sugar level goes below the standard range). Findings: On March 23, 2025, at 12:54 p.m., during a concurrent observation and interview with Resident 105, Resident 105 was observed lying in bed, awake and alert. Resident 105 stated a nurse gave him insulin when his blood sugar was low. Resident 105 stated he was half asleep when his blood sugar was taken and when he was given the insulin, he did not feel good and knew his blood sugar was low. Resident 105 stated he asked the nurse to check his blood sugar, and it was 32. Resident 105 stated the incident happened a month ago, during the day shift. On March 25, 2025, Resident 105's record was reviewed. Resident 105 was admitted to the facility on [DATE], with diagnoses which included diabetes mellitus (DM - a disorder characterized by poor blood sugar control). A review of Resident 105's history and physical, dated March 6, 2025, indicated Resident 105's decision making capacity was intact. A review of Resident 105's Minimum Data Set (MDS - a federally mandated resident assessment tool), dated March 3, 2025, indicated Resident 105 had a BIMS (Brief Interview for Mental Status - an assessment tool used by facilities to screen and identify memory, orientation, and judgement status of the resident) score of 15 (cognitively intact). A review of Resident 105's Order Summary Report, included a physician's order, dated February 18, 2025, which indicated, .HumaLOG Solution 100 UNIT/ML (a unit of measurement) (Insulin Lispro (Human) Inject 3 (three) unit (sic) subcutaneously (under the skin) before meals for diabetes HOLD if BS Blood sugar) < (less than) 90 . A review of Resident 105's Medication Administration Record (MAR), for the month of February 2025, indicated, Resident 105 received 3 (three) units of Insulin Lispro subcutaneously for BS of 89 which was below the hold parameter of 90, on February 21, 2025, at 6:30 a.m. On March 26, 2025, at 2:43 p.m., in a concurrent interview and record review with the Director of Nursing (DON), she stated Resident 105's blood sugar was 89 on February 21, 2025, at 6:30 a.m. The DON stated Resident 105 received 3 (three) units of Insulin Lispro subcutaneously for a blood sugar of 89, which was below the parameter of 90. The DON stated the Licensed Vocational Nurse (LVN) should have held the insulin and should have documented the reason for not giving the insulin. The DON stated the LVN did not follow the physician's order. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility's policy and procedure titled, Administering Medications, revised April 2019, indicated, .Medications are administered in a safe .manner .and as prescribed .Medications are administered in accordance with prescriber orders .

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51080 Based on observation, interview, and record review, the facility failed to ensure a resident who is fed by enteral means (directly to the gastrointestinal system or stomach) receives the appropriate care to prevent complications of enteral feeding when, one of one resident reviewed for tube feeding (Resident 122), was positioned with the head of the bed (HOB) not elevated 30-45 degrees while receiving tube feeding (nutrition provided through a tube inserted into the stomach). This failure had the potential for Resident 122 to experience complications from tube feeding, such as aspiration (when food or liquid or other materials enters the airway and lungs instead of being swallowed) , nausea, vomiting, or abdominal pain. Findings: On March 24, 2025, at 8:57 a.m., Resident 122 was observed laying flat on the bed and was receiving tube feeding nutrition. On March 25, 2025, at 9:11 a.m., during a concurrent observation of Resident 122 and interview with Licensed Vocational Nurse (LVN) 3, Resident 122 was observed lying on bed with the head of bed (HOB) flat, and the tube feeding was running. In a concurrent interview with LVN 3, she stated Resident 122's head of bed was too low and should be elevated at least 45 degrees. On March 27, 2025, at 9:50 a.m. an interview with the Director of Nursing (DON) was conducted. The DON stated Resident 122's HOB during tube feeding and 30 minutes after should be elevated at 30 - 45 degrees. A review Resident 122's Admission Record, indicated, Resident 122 was admitted to the facility on [DATE], with diagnoses which included dysphagia (condition that affects your ability to swallow) following cerebral infarction (stroke). A review of Resident 122's care plan, dated February 8, 2025, indicated, .Risk for aspiration as resident on tube feeding .Patient will have no aspiration and complication from feeding tube .Keep HOB elevated during feedings . A review Resident 122's Order Summary Report, included the following physician orders: - .HOB elevated to tolerance or 30 degrees during and 30 mins (minutes) after feeding, date ordered February 9, 2025; and - .every shift Formula Jevity 1.2 via G tube (gastrostomy tube, type of tube feeding method) method of administration via epump (electronic pump for delivering the feeding formula) .@ (at) rate of 65cc (milliliter -unit of measurement)/hr (hour) x (times) 20 hours or until dose met. Start at 2pm (p.m.), stop at 10am (a.m.) or until dose met . (continued on next page)

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F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A facility policy titled, Enteral Nutrition, dated November 2018, stated .The provider will consider the need for supplemental orders, including .Head of bed elevation .Risk of aspiration is assessed by the nurse and provider and addressed .Improper positioning of the resident during feeding .

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39920 Based on observation, interview, and record review, the facility failed to provide respiratory care and treatment, for one of two residents reviewed for oxygen administration (Resident 101), when the physician's order for oxygen administration was not followed. This failure had the potential to result in ineffective oxygen therapy, respiratory distress, and decline in the resident's health condition. Findings: On March 23, 2025, at 3:53 p.m., Resident 101 was observed in bed with oxygen (O2) via nasal cannula (NC - a tube used to deliver oxygen through the nose). Resident 101's oxygen administration was observed at 3.5 liters per minute (LPM). On March 26, 2025, at 10:50 a.m., Resident 101 was observed in bed with O2 via NC at 4 LPM. On March 26, 2025, at 10:52 a.m., a concurrent observation of Resident 101, interview, and record review was conducted with Licensed Vocational Nurse (LVN) 3. LVN 3 confirmed Resident 101 was receiving 4 LPM of oxygen. LVN 3 verified Resident 101's physician order for oxygen should be at 2 LPM. LVN 3 stated the physician's order for oxygen was not followed. On March 26, 2025, at 11:03 a.m., a concurrent interview and record review was conducted with the Assistant Director of Nursing (ADON). The ADON confirmed the O2 order should be at 2 LPM, as per physician's order. The ADON stated the physician's order was not followed. A review of Resident 101's Admission Record, indicated Resident 101 was admitted to the facility on [DATE], with diagnoses which included heart failure (a condition when the heart does not pump enough blood), chronic pulmonary edema (fluid accumulates in the lungs over an extended period, leading to difficulty breathing), acute respiratory failure with hypoxia (low oxygen in the blood), pleural effusion (buildup of excess fluid in the pleural space, the area between the lungs and chest wall, which can make it harder to breathe), pneumonia (an infection/inflammation in the lungs), and anemia (a condition where the body does not have enough healthy red blood cells that carry oxygen). A review of Resident 101's physician's order, dated January 6, 2025, indicated, .O2 @ (at) 2 LPM via nasal cannula . A review of the facility's policy and procedure titled, Oxygen Administration, revised October 2010, indicated, . The purpose of this procedure is to provide guidelines for safe oxygen administration .Verify that there is a physician's order for this procedure. Review the physician's orders or facility protocol for oxygen administration .

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 46393 Based on interview and record review, the facility failed to request a medication regimen review (MRR) following changes in condition (worsening of an existing problem or the emergence of new signs or symptoms, such as falls), and failed to ensure the consultant pharmacist (CP) identified potential medications contributing to falls and make recommendations to the facility for reduction or discontinuation of the medications during the monthly MRRs for one out of five sampled residents (Resident 35). This failure had the potential for medications not being optimized for best possible health outcome, and unnecessary or prolonged use of medications which could lead to medication adverse effects (such as falls) for the resident. Findings: A review of Resident 35's Admission Record, indicated Resident 35 was admitted to the facility on [DATE], with diagnoses including contracture (a permanent shortening or tightening of muscles that restricts movement) of right upper arm muscle, spastic (uncontrolled muscle movements) hemiplegia (weakness on one side of the body) cerebral palsy (disorder that affects movement and posture of the body), dementia, major depressive disorder, anxiety, and psychosis. A review of Resident 35's Minimum Data Set (MDS, a care area assessment and screening tool), dated June 18, 2024, indicated the following: - Resident 35 had Brief Interview of Mental Status (BIMS - a tool to assess cognitive function of an individual) score of 9 (moderate cognitive impairment); - No exhibition of hallucinations/delusions and no physical/verbal behavioral symptoms, required substantial/maximal assistance for mobility (helper does more than half the effort, lifts or holds trunk or limbs); and - Had no active psychiatric/mood disorder diagnoses, and had not received antipsychotic/antidepressant medications. A review of Resident 35's MDS, dated [DATE], indicated the following: - Resident 35 had BIMS score of 9; - No exhibition of hallucinations/delusions and no physical/verbal behavioral symptoms; - Required supervision or touching assistance for mobility (helper provides verbal cues and/or touching/steadying and/or contact guard assistance as resident completes activity); - Had active psychiatric/mood disorder diagnoses, and had received antidepressant/anticonvulsant medications. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 35's Order Summary Report, dated March 26, 2025, indicated the following physician's orders: - Prozac (brand name for fluoxetine, used for depression, which has sedating effects) 10 mg (milligrams, unit of measurement) one capsule by mouth one time a day for depression m/b (manifested by) crying/angry outbursts, started September 23, 2024; and - Valproic Acid (an anticonvulsant used for seizures or as a mood stabilizer, which has sedating effects) oral solution 250 mg per 5 ml (milliliter, unit of measurement) 5 ml (250 mg) two times a day for dementia m/b mood swings, started September 23, 2024. A further review of Resident 35's Order Summery Report, dated March 26, 2025, indicated on November 20, 2024, the provider increased the dose of Valproic Acid to 250 mg three times a day for dementia m/b mood swings; and two weeks later, on December 4, 2024, the provider ordered a new medication, Risperdal (brand name for risperidone, an antipsychotic medication for bipolar disorder and schizophrenia, which has sedating effects) 0.5 mg one tablet by mouth twice a day for psychosis m/b delusions. A review of the Change of Condition Evaluation, dated December 8, 2024, at 10:12 a.m., indicated, [Resident 35] was found on the floor of her room. When [Resident 35] was asked what happened [Resident 35] stated that she attempted to transfer herself onto her wheelchair. A further review of Resident 35's clinical records titled, Change in Condition Evaluation, indicated she sustained four additional unwitnessed falls on the following dates: - On December 29, 2024; - On January 13, 2025; - On January 24, 2025; and - On February 15, 2025. Additionally, a review of the nurse's progress notes dated January 13, 2025, at 9:15 p.m., indicated Resident 35 was transferred from the facility to the hospital on January 13, 2025, at 4:45 p.m. for evaluation after the fall. A review of the nurse's progress notes, dated January 13, 2025, at 10:23 p.m., indicated Resident 35 returned to the facility from the hospital on January 13, 2025, with a right knee abrasion (a scrape or rubbing away of the skin's surface). A review of the Prescribing Information (PI, detailed description of a drug's uses, dosage range, side effects, drug-drug interactions, and contraindications that is available to clinicians) for Prozac (fluoxetine) tablets, dated August 2023, retrieved from DailyMed (The contents of DailyMed is provided and updated daily by the U.S. Food and Drug Administration) indicated, Warnings and Precautions .Potential for Cognitive (the mental processes involved in thinking, learning, understanding, and remembering) and Motor Impairment: Has potential to impair judgment, thinking, and motor skills .Adverse Reactions .somnolence (drowsiness) .Drug Interactions .CNS (Central Nervous System) Acting Drugs: Caution should be used when taken in combination with other centrally acting drugs . (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Jurupa Hills Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 6401 33rd Street. Riverside, CA 92509	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of PI for Risperdal (risperidone) tablets, dated June 2010, retrieved from DailyMed, indicated, Warnings and Precautions .Potential for cognitive and motor impairment .Adverse Reactions .somnolence . fatigue .dizziness .Drug Interactions .Fluoxetine increase plasma concentrations (amount of drug in the blood) of risperidone . A review of PI for Valproic Acid oral solution, dated January 2025, retrieved from DailyMed, indicated, Somnolence in the elderly can occur. Valproic acid dosage should be increased slowly . On March 26, 2025, the facility document titled Pharmacist Medication Regimen Reviews, for the months of December 2024, January 2025, and February 2025, indicated there were no recommendations from the Consultant Pharmacist (CP) for consideration of changes to Prozac, valproic acid, and/or Risperdal as they had the potential to increase the risk of sedations/falls. On March 26, 2025, at 2:11 p.m., during an observation of activities in the dining room, Resident 35 was sitting in a wheelchair at the table with other residents, talking to the staff, and laughing. On March 26, 2025, at 2:15 p.m., during an interview with Licensed Vocational Nurse (LVN) 4, LVN 4 stated she had cared for Resident 35 for a few months. LVN 4 stated the resident was a fall risk, used a wheelchair, and could not walk or transfer without assistance. LVN 4 stated she was aware Resident 35 had fallen in the past and stated she had not witnessed the falls. On March 26, 2025, at 2:20 p.m., during an interview with the Social Services Director (SSD), the SSD stated she participated in Resident 35's Interdisciplinary Team (IDT) quarterly meetings related to behavior management since January 2024 (over one year). The SSD stated Resident 35 used a wheelchair. The SSD stated she was aware the resident had sustained falls at the facility but was unsure regarding the number of falls. On March 26, 2025, at 2:32 p.m., during an interview with the Director of Nursing (DON), the DON stated the CP provided the facility a monthly report called medication regimen review (MRR) regarding medication related irregularities including potential adverse drug reactions or potential drug interactions. The DON stated, in addition to the scheduled monthly MRR, if a resident had a fall, the facility could have requested an additional medication review to see if any medications could have contributed to the fall. On March 26, 2025, at 2:48 p.m., during a group interview and record review with the DON and the Assistant Director of Nursing (ADON), Resident 35's clinical record was reviewed, including Resident 35's psychotropic/antipsychotic medications (Prozac, Valproic Acid, and Risperdal) and Change of Condition Evaluation notes for the five (5) falls dated December 8, 2024, December 29, 2024, January 13, 2025, January 24, 2025, and February 15, 2025. The DON and ADON stated the CP was not notified after resident 35 sustained falls on the above dates when asked whether the facility requested the pharmacist to review Resident 35's medication regimen to see if the falls could have been attributed to any of Resident 35's medications. The DON and the ADON stated the CP should have been notified and a medication review should have been requested after Resident 35 fell multiple times. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On March 26, 2025, at 4:45 p.m., during an interview with the DON, the DON acknowledged the CP's MRRs for Resident 35, dated December 2024, January 2025, and February 2025 did not identify the combination of medications (Prozac, Valproic Acid, and Risperdal) having the potential to increase the risk of sedation/falls or recommend dose adjustments or further evaluation of the above medications. The DON stated the pharmacist should have identified and reported during the monthly MRRs for Resident 35. A review of the facility's policy and procedure titled, Medication Regimen Review and Reporting, dated May 2019, indicated, .The Consultant Pharmacist Reviews the medication regimen of each resident at least monthly .The goal of the MRR is to promote positive outcomes while minimizing adverse consequences and potential risks associated with medication .The MRR involves a thorough review of the resident's medical record to prevent, identify, report and resolve medication related problems .and other irregularities, for example .potentially significant medication-related adverse consequences or actual signs and symptoms that could represent consequences .An acute change of condition may prompt a request for a MRR. The staff member who identifies the change of condition follows reporting procedures to notify the physician. The physician may request a MRR be conducted within a specific timeframe (e.g. [example] within 24 hours) .

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51063 Based on observation, interview, and record review, the facility failed to ensure infection control practices were implemented when: 1. For Residents 57 and 48, the nursing staff failed to properly clean and disinfect the shared blood pressure (BP-pressure of blood in blood vessels) cuffs and stethoscope according to the disposable wipe manufacturer's specified contact time (the time the resident equipment was to be in contact with the disposable wipes to kill micro-organisms), for two of four residents observed during medication administration observation; and 2. For Resident 65, Certified Nursing Assistant (CNA) 2 failed to use the disposable gown while providing high contact resident care activities, for one of 51 residents requiring Enhanced Barrier Precautions (EBP - an infection prevention practices using gowns and gloves during high-contact resident care activities to reduce the spread of multidrug-resistant organism). This failure had the potential for vulnerable residents to be exposed to cross-contamination and development of infections. Findings: 1. On March 24, 2025, at 9:01 a.m., during a medication pass observation, Licensed Vocational Nurse (LVN) 1 was observed wiping the shared automatic wrist BP cuff with a Micro-Kill One disposable wipe. LVN 1 stated he needed to wait for one minute for the BP cuff to dry. After one minute, LVN 1 applied the automatic BP cuff to Resident 57's left wrist. After obtaining Resident 57's BP reading, LVN 1 removed the automatic BP cuff from Resident 57's left wrist. LVN 1 did not disinfect the shared automatic wrist blood pressure cuff according to the manufacturer's specified contact time. On March 24, 2025, at 9:40 a.m., during a medication pass observation, LVN 4 was observed using a shared manual BP cuff and stethoscope to measure Resident 48's BP. LVN 4 was observed wiping the shared manual BP cuff and stethoscope with a Micro-Kill Bleach disposable wipe and stated, It takes three (3) minutes for the disinfectant to dry. LVN 4 did not disinfect the shared manual blood pressure cuff and stethoscope according to the manufacturer's specified contact time. On March 24, 2025, at 11:21 a.m., during an interview with the Infection Preventionist (IP), the IP stated the expectation was for nursing staff to disinfect all shared resident care equipment, such as blood pressure cuffs and stethoscopes, before and after use. The IP stated nursing staff should have looked on the disposable wipe container for the manufacturer's instructions regarding how long to let it sit. The IP stated the manufacturer instructions for Micro-Kill Bleach wipes indicated the shared resident care equipment needed to sit for three (3) minutes and the Micro-Kill One wipes needed one (1) minute. When asked to define needs to sit, the IP stated it meant the shared resident care equipment needed to air dry for one (1) or three (3) minutes depending on the manufacturer's instructions. (continued on next page)

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F 0880

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

During the same interview, the IP reviewed the manufacturer's labeled instructions on the disposable wipe bottles and acknowledged nursing staff should have been instructed to keep the shared resident care equipment wet for one (1) minute when using the Micro-Kill One wipes or three (3) minutes when using the Micro-Kill Bleach wipes to achieve contact time when they wiped shared resident care equipment according to the manufacturer's instructions. The IP stated it was important to follow the manufacturer's instructions to prevent the spread of infection.

On March 24, 2025, at 4:17 p.m., during an interview with the Director of Nursing (DON), the DON stated the expectation was for nursing staff to disinfect shared resident care equipment according to the disposable wipe manufacturer's instructions. The DON stated the nursing staff needed to let the equipment stay wet according to the manufacturer's instructions. The DON stated it was important to follow the manufacturer's instructions to kill germs and prevent further spread of infection.

A review of the facility's policy and procedure titled, Assistive Devices and Equipment, dated January 2020, indicated, .equipment that is designated as reusable or shared is used by more than one resident .Durable medical equipment (DME) is cleaned and disinfected before being reused by another resident and decontaminated according to manufacturer's instructions .

A review of the manufacturer's instructions for contact time for the Micro-Kill One disposable wipes provided by the facility, the manufacturer's instructions indicated, .Contact time: Allow surface to remain wet for 1 full minute .

A review of the manufacturer's instructions for contact time for the Micro-Kill Bleach disposable wipes provided by the facility, the manufacturer's instructions indicated, .Contact time: Allow surface(s) to remain visibly wet for 30 seconds to kill the bacteria and viruses on the label .

29623

2. On March 23, 2025, at 12:22 p.m., Resident 65's room was observed with an EBP sign posted outside the door. Resident 65 was observed asleep with the dressing on his head, oxygen at two liters per minute through nasal cannula (a small thin plastic tube with a prong connected to the nose that delivers oxygen), and a urinary indwelling catheter (a thin flexible tube inserted into the bladder to drain urine).

A review of Resident 65's Admission Record, indicated Resident 65 was readmitted to the facility on [DATE], with diagnoses which included burns involving 20-29 % (percent) third degree of body surface, pressure ulcer of the head, and post colostomy (an opening in the abdominal wall to divert the stool from the colon directly to the outside of the body).

A review of Resident 65's Order Summary Report, included a physician's order, dated February 12, 2025, which indicated, .Enhanced barrier precautions during high contact resident care activities secondary to (Chronic Wound/Colostomy/Foley), every shift .

A review of Resident 65's care plan, dated June 14, 2024, indicated, .Enhanced Barrier Precautions: Resident requires enhanced barrier precautions during high-contact resident care activities .Interventions . Utilize .gown and gloves .as indicated .during high-contact resident care activities (e.g. dressing, bathing/showering, transferring, hygiene, linen changes, brief changes, toileting assistance, device care, wound care .

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Printed: 06/26/2025
Form Approved OMB
No. 0938-0391

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On March 24, 2025, at 11:46 a.m. Resident 65 was observed lying in bed with his eyes closed, with oxygen on at two liters per minute through nasal cannula, head wound dressing intact, and a urinary indwelling catheter. CNA 2 was observed providing care to Resident 65 without a disposable gown. On March 24, 2025, at 11:58 a.m., CNA 2 was interviewed. CNA 2 stated she was aware Resident 65 was on EBP, as indicated for Resident 65's wounds, colostomy, and urinary indwelling catheter. CNA 2 stated she forgot to wear the disposable gown before providing care for Resident 65. On March 24, 2025, at 12:06 a.m , the IP was interviewed in front of Resident 65's room. The IP stated Resident 65 was on EBP. The IP stated CNA 2 should have used the disposable gown during direct care of Resident 65, to prevent cross contamination between resident's care. A review of the facility's policy and procedure titled, Enhanced Barrier Precautions, dated March 2024, indicated, .Enhanced Barrier Precautions (EBPs) are utilized to reduce the transmission of multi-drug resistant organisms (MDROs) to residents .EBPs employ targeted gown and glove use in addition to standard precautions during high contact resident care activities .Gloves and gown are applied prior to performing the high contact resident care activity .EBPs are indicated .for residents with wounds and/or indwelling medical devices regardless of MDRO colonization .