STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555435	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Canyons Post-Acute	1350 Reche Canyon Rd Colton, CA 92324

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. (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
	555435	A. Building B. Wing	12/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Canyons Post-Acute	1350 Reche Canyon Rd Colton, CA 92324

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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure that call light was within reach for two of four sample residents (Resident 1 and 2) reviewed, when Resident 1's call light was observed wrapped around the left bed rail with the cord hanging down towards the floor, while the bedside table was placed against the left bed rail, obstructing access to the call light. Resident 2's call light was observed clipped to the top portion of the bed with the cord oriented away from Resident 2, placing it out of Resident 2's reach.This failure had the potential to delay Resident 1 and 2's ability to request assistance when needed, increasing the risk of unmet care needs, and exacerbating the confusion of Resident 1 and 2, leading to possible Injury. During a review of Resident 1's face sheet (contains demographic and medical information) indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included chronic kidney disease stage 3B (moderate to severe kidney function loss), repeated falls. During a review of Resident 2's face sheet (contains demographic and medical information) indicated Resident 2 was originally admitted to the facility on [DATE], with diagnoses that included nondisplaced bimalleolar fracture (a broken ankle where both the inner and outer ankle bones are fractured but remain in their corrected alignment and position) of right lower leg, repeated falls. During a concurrent observation and interview on December 2, 2025, at 11:02 AM, with Resident 1, in resident 1's room, Resident 1 mentioned that he is unaware of the location of the call light and cannot recall the last time he experienced a fall within the facility. It was observed that the resident's call light was wrapped around the left bed rail, with the cord hanging down towards the floor, and the bedside table was placed against the left bed rail, obstructing access to the call light. During observation on December 2, 2025, at 11:03 AM, Resident 2, who shares a room with Resident 1, was found asleep in bed. It was observed that the call light designated for Resident 2 was attached to the upper section of the bed, with the cord oriented away from Resident 2, placing it out of Resident 2's reach. During a concurrent observation and interview on December 2, 2025, at 11:05 AM, in Resident 1 and 2's room with the Certified Nursing Assistant (CNA 1), CNA 1 reported that both Resident 1 and Resident 2 are capable of moving their hands to access the call light; however, when the CNA requested Resident 1 to reach for the call light, Resident 1 was unable to do so. Subsequently, the CNA roused Resident 2 and asked Resident 2 to reach for the call light, but Resident 2 also could not reach it. When inquired about the policy concerning the call light, the CNA indicated that the policy specifies that the call light should be within reach. During an interview on December 2, 2025, at 11:33AM with License Vocational Nurse (LVN 1), LVN 1 stated, the call light must be within reach. During a concurrent record review and interview on December 2, 2025, at 11:50 AM, with the Director of Nursing (DON) and the Assistant Director of Nursing (ADON). During this meeting, both DON and ADON reviewed the photograph depicting the placement of the call light for Residents 1 and 2. They confirmed that the call light was situated beyond the reach of both residents, which is unacceptable. The DON stated that it is the responsibility of the staff to ensure that the call light remains accessible after they have attended to the residents or participated in any activities. In this case, the established policy is not being followed. The DON further pointed out that resident confusion does not excuse the failure to keep the call light within reach. A concurrent interview and record review were conducted with both the DON and ADON. The call light policy was reviewed, which specifies, '5. When the resident is in bed or confined to a chair, ensure the call light is within easy reach of the resident.' Both DON and ADON affirmed that this is indeed their policy.