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	01/29/2026

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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure their Bed-Holds (holding or reserving a resident's bed while the resident is absent from the facility for therapeutic leave or hospitalization) and Returns policy and procedure was implemented for one of four sampled residents (Resident 1) when Resident 1's responsible party (Resident 1's daughter) was not provided any verbal or written information regarding Resident 1's right to exercise the bed hold provision (legal requirement, often lasting 7 days, that allows nursing home or skilled nursing facility (SNF) residents to reserve their specific bed while temporarily hospitalized) when he was transferred to the general acute care hospital (GACH) on January 4, 2026.This failure resulted in Resident 1 and Resident 1's representative not being able to exercise their right for the bed hold provision.Findings:A review of Resident's 1 admission Record (a document containing clinical and demographic information data) indicated Resident 1 was initially admitted to the facility on [DATE], with a diagnoses which included anxiety disorder (excessive and persistent fear, worry and apprehension), hematuria (presence of blood in the urine), and psychosis (mental state where a person loses touch with reality). Further review indicated Resident 1's responsible party was Resident 1's daughter.During a review of Resident 1's nurses' notes, dated January 4, 2026, it indicated At approximately 0445 (4:45 AM), CNA (Sitter) informed RN (Registered Nurse) and LVN (Licensed Vocational Nurse) that the resident had removed his catheter from his penis, CN (Charge Nurse) and RN came to the room to find resident still lying in bed, with blood coming from the penis profusely. RN asked the resident what happened and stated that he purposely pulled out his catheter because he wanted to be sent out. Sitter witnessed resident pull out his catheter . MD (Medical Doctor) notified. LVN called [Name of Ambulance Company], came around 0500 (5 AM). Patient left the facility at 0505AM (5:05 AM) accompanied by the [Name of Ambulance Company] personnel.During a review of Resident 1's Bed Hold Policy and Notification, it indicated Resident 1's daughter was notified via phone by the facility regarding Resident 1's right to hold a bed for 7 days on January 4, 2026, but Resident 1's daughter declined to exercise it. The form did not indicate what time the call occurred, and who the facility representative was. During a telephone interview on January 22, 2026, at 5:05 PM, with the Registered Nurse Supervisor (Supervisor), Supervisor stated she did not call Resident 1's daughter to notify her about Resident 1's bed hold.During a telephone interview on January 26, 2026, at 4:21 PM, with Licensed Vocational Nurse (LVN), LVN stated she called Resident 1's daughter and informed her about Resident 1's transfer to the GACH on January 4, 2026, but did not inform her about the bed hold.During a telephone interview with Resident 1's daughter on January 26, 2026, at 7:33 AM, Resident 1's daughter stated she still hasn't received any call or mail from the facility regarding Resident 1's exercise to the bed hold provision since Resident 1 was transferred to the GACH on January 4, 2026. (17 days ago)During a concurrent interview and record review on January 29, 2026, at 11:38 AM, with the Director of Nursing (DON) and (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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the Assistant Director of Nursing (ADON), the facility's policy and procedure (P&P) titled, Bed-Holds and Returns, dated March 2022 was reviewed. The P&P indicated, .1. All residents/representatives are provided written information regarding the facility bed-hold policies, which address holding or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave). Residents are provided written information about these policies at least twice: a. well in advance of any transfer (e.g., in the admission packet); and b. at the time of transfer (or, if the transfer was an emergency, within 24 bours). The DON stated the facility's P&P was not followed.