

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555435	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/05/2026
NAME OF PROVIDER OR SUPPLIER The Canyons Post-Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain infection control practices for one of four sampled residents (Resident 1), who was on contact precaution isolation (measures applied when caring for patients with infections known or suspected to spread via touch or contact with contaminated item), when a Certified Nurse Assistant (CNA) failed to wear gloves while picking up the call light of Resident 1 from the floor. This failure had the potential to spread infectious disease (disease caused by bacteria, viruses, fungi or parasites) to Resident 1, other residents, and staff in the facility. Findings: 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 respiratory failure (a long-term condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), and Klebsiella Pneumoniae (a type of bacterium that can cause severe, hard-to-treat infections if it spreads to lungs or blood). During a review of Resident 1's physician's order, dated June 1, 2023, it indicated an isolation order for .Contact Precautions every shift for CRAB (Carbapenem-Resistant Acinetobacter Baumannii- a high-priority drug-resistant bacteria causing severe health care associated infection like pneumonia and blood stream infections), KPC (Klebsiella pneumoniae carbapenemase - an enzyme produced by some CRAB that breaks down last-resort antibiotics) infection, wear gown and gloves before entering room/caring for patient. Follow proper PPE donning and doffing procedures. Perform hand hygiene before putting on gloves and after removing them. During concurrent observation and interview on March 5, 2026, at 10:45 AM, with CNA 1, in Resident 1's room, the door signage indicated Resident 1 was placed on isolation for contact precautions. CNA 1 was observed picking up Resident 1's call light from the floor without wearing gloves. CNA 1 stated she forgot to wear gloves. She further stated that she is aware of the importance of wearing gloves to protect both herself and Resident 1. During an interview on March 5, 2026, at 12:39 PM, with the Assistant Director of Nursing (ADON), the ADON stated that it was unacceptable for CNA 1 to attend to Resident 1 without wearing gloves. She further stated that all staff are required to follow the established isolation protocols. During interview on March 5, 2026, at 12:44 PM, with the Director of Staff Development (DSD), the DSD stated that it was unacceptable for CNA 1 not to wear groves in a contact isolation room, as this poses a risk of cross-contamination (the unintentional transfer of harmful microorganisms like bacteria, virus). A review of the facility Policy and Procedure (P&P) titled, Isolation - Categories of Transmission-Based Precautions, dated October 2018, indicated, .4. Staff and visitors will wear gloves (clean, non-sterile) when entering the room. a. While caring for a resident, staff will change gloves after having contact with infective material (for example, fecal material and wound drainage). b. Gloves will be removed and hand hygiene performed before leaving the room. c. Staff will avoid touching potentially contaminated environmental surfaces or items in the resident's room after gloves are removed.</p>

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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<p>F 0919</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that a working call system is available in each resident's bathroom and bathing area.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the call light was within reach for two of four sampled residents (Residents 1 and 2), when Resident 1's call light was located on the floor, and Resident 2's call light was wrapped around the bed rail. In both instances, the call lights were out of reach of Resident 1 and Resident 2. These failures had the potential to delay Residents 1 and 2's ability to request assistance when needed, increasing the risk of unmet care needs, and possible injury. Findings: 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 respiratory failure (a long-term condition where the lungs cannot properly move oxygen into the blood or remove carbon dioxide), and Klebsiella Pneumoniae (a type of bacterium that can cause severe, hard-to-treat infections if it spreads to lungs or blood). During a concurrent observation and interview on March 5, 2026, at 10:45 AM, with a Certified Nursing Assistant (CNA 1), in Resident 1's room, Resident 1 was lying in bed, CNA 1 searched for Resident 1's call light and found it on the floor. CNA 1 stated the call light should be within the resident's reach. A review of Resident 2's face sheet indicated Resident 2 was admitted to the facility on [DATE], with diagnoses that included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) affecting right dominant side, tracheostomy status (a surgically created opening in the neck to assist with breathing). During a concurrent observation and interview on March 5, 2026, at 11:13 AM, with the Assistant Director of Nursing (ADON), in Resident 2's room, Resident 2 was lying in bed, ADON searched for Resident 2's call light and found it wrapped around the bed rail, which was not within Resident 2's reach. ADON stated the staff must have neglected to place it within reach after attending Resident 2, which is deemed unacceptable. A review of the facility's undated Policy and Procedures (P&P) titled, Answering the Call Light, undated, indicated, . 5. When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.</p>		