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	06/18/2026

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

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to follow their policy and procedure (P&P) for maintenance service when a sink faucet in room [ROOM NUMBER] was unattached to the sink and without accessible to hot water. This failure resulted in residents and staff to perform handwashing in room [ROOM NUMBER] and had the potential for increased risk of infection for patients and staff. Findings: During an observation on June 15, 2026, at 10:30 AM, in room [ROOM NUMBER] , the sink faucet was observed to not be fully secured to the sink. A further observation revealed the sink was without hot water. During an interview on June 15, 2026, at 10:33 AM, with Housekeeping Manager (HM), the HM stated, the sink faucet is not supposed to be unattached to the sink and there should be access to hot water. The HM further stated she was unaware of the issue in room [ROOM NUMBER] During an interview on June 15, 2026, at 10:54 AM, with Maintenance Director ([NAME]), [NAME] stated, the sink faucet should be attached to the sink and there should be access to hot water. The [NAME] further stated, the staff were expected to document maintenance issues in the maintenance logs, but did not. During a review of Maintenance Repair Log, dated June 2026, the Maintenance Repair Log did not indicate a note describing the faucet not fully secured to the sink and without accessible hot water in room [ROOM NUMBER]. During a concurrent interview and record review on June 15, 2026, at 11:25 AM, with the [NAME], the facility's policy and procedure (P&P) titled, Maintenance service, dated December 2009, was reviewed. The P&P indicated, .2. Functions of maintenance personnel include but are not limited to: d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. The [NAME] stated he was unaware of the problem, and it is important for the faucet to work properly for staff and residents so they can have water access. The [NAME] stated the hot water was not working because it had been turned off. The [NAME] further stated, the P&P was not followed by staff. During a concurrent interview and record review on June 17, 2026, at 12:35 PM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Maintenance service, dated December 2009 was reviewed. The P&P indicated, .2. Functions of maintenance personnel include but are not limited to: d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. The DON confirmed the policy was not followed. The DON further stated, it is important for plumbing fixtures to be in good working order, so staff, residents, and visitors have access to water and can wash their hands.

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 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure nursing staff implemented appropriate interventions for one (1) of 29 sampled residents (Resident 17) when, nursing staff did not document the restraint (an item used to stop a patient from removing medical equipment or hurting themselves) repositioning every two hours or initiate a restraint care plan as indicated in the facility's policy and procedure (P&P). This failure had the potential to result in resident care needs not being met, inappropriate use of restraints, and failure to identify complications associated with the use of restraints which could jeopardize the health and safety for for Resident 17 Findings:During a review of Resident 17's admission Record (contains demographic and medical information), the admission Record indicated Resident 17 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage (Brain injury caused when the brain gets no oxygen for too long, killing brain cells), generalized muscle weakness (condition where muscles lose strength and can't move as well as they normally should), and gastrostomy (surgical procedure creating a small opening through the belly into the stomach for feeding or drainage). During an observation on June 15, 2026, at 8:34 AM, in Resident 17's room, Resident 17 was lying in bed, with bilateral (both sides) hand mitten restraints (soft, padded glove designed to prevent a patient from grasping, picking at medical devices or wounds, while still allowing arm movement). During a concurrent observation and interview on June 15, 2026, at 3:28 PM, with Licensed Vocational Nurse 1 (LVN 1), Resident 17 had bilateral hand mitten restraints. LVN 1 confirmed Resident 17 had bilateral hand mitten restraints in place. LVN 1 stated, she was unsure if there was an active order for restraints for Resident 17. During a review of Patient 17's Order Summary, (document that shows all active orders) dated June 3, 2026, the Order Summary indicated, [Brand name] Padded easy view protective mitt [mitten] x [times] 2. During an interview on June 16, 2026, at 4:25 PM, with LVN 2, LVN 2 stated that when residents are placed on restraints, the nursing staff are required to initiate the restraint care plan. LVN 2 stated, this process involved assessing the resident, and documenting the resident repositioning every two hours while the restraints remains in place. LVN 2 stated, the care plan is important to ensure restraints are removed when they are no longer required and guide the nursing staff in plan of care. LVN 2 added, the importance of assessing and documenting on a resident with restraints every two hours is to monitor the skin integrity and to identify any change in condition. During an interview on June 16, 2026, at 4:36 PM, with the Director of Nursing (DON), the DON stated the nursing staff was expected to initiate a restraint care plan and document the resident's restraint assessment and repositioning. During a concurrent interview and record review on June 16, 2026, at 4:38 PM, with the DON, the facility's P&P titled, Use of Restraints, dated April 2017 was reviewed. The P&P indicated, . examples of devices that are/may be considered physical restrains include . hand mitts.12. The following safety guidelines shall be implemented and documented while a resident is in restraints. d. The opportunity for motion and exercise is provided for a period of not less than ten (10) minutes during each two (2) hours in which restraints are employed. E. Restrained residents must be repositioned at least every two (2) hours on all shifts. 19. Documentation regarding the use of restraints shall include.f. observation, range of motion and repositioning flow sheets.17. Care plans for resident in restraints will reflect interventions that address not only the immediate medical symptom (s), but the underlying problems that may be causing the symptom(s)18. Care plans shall also include the measures taken to systematically reduce or eliminate the need for restrains use. The DON stated the policy was not followed as she was unable to provide documentation for a restraint care plan or assessment and repositioning of restraints every two hours. The DON further stated, it was important for the nursing staff to document the care plan, reposition and assessment to prevent skin breakdown.

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F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the Preadmission Screening and Resident Review (PASRR- federal requirement ensuring that anyone with a serious mental illness, intellectual disability, or a related condition isn't placed in a nursing home without proper assessment and support) was completed for one (1) of 29 residents (Resident 14) when the facility did not complete a required PASRR level 1 screening (a quick check to spot potential mental illness or intellectual disability when someone is about to enter a nursing home) after Resident 14 remained in the facility for more than 30 days under exempted hospital discharge status (EHDS- allows an individual to enter a nursing facility without full PASRR, if a physician certifies before discharge that the resident is likely to need less than 30 days of skilled nursing care). This failure had the potential to delay the identification of mental health needs, the determination of whether a PASRR Level II evaluation (detailed follow-up when the Level I screening flags a concern that involves professionals assessing the individual's mental health, support needs, and whether a nursing home is the most suitable option) was necessary, and the development of appropriate placement and care plans for Resident 14Findings: During a review of Resident 14's admission Record (a document with resident demographics, brief medical history, and emergency contacts), the admission Record indicated, Resident 14 was admitted on [DATE] with diagnoses that included diabetes (DM- High blood sugar), chronic obstructive pulmonary disease (COPD-a long term lung condition that makes it hard to breathe because the airways are damaged and narrowed), and major depressive disorder (MDD- a serious mood disorder marked by persistent feelings of sadness or loss of interest, significantly impairing daily life through thoughts, emotions, behaviors, and physical health). During a concurrent interview and record review on June 16, 2026, at 2:11 PM, with the Minimum Data Set Coordinator (MDSC), Resident 14's PASRR Level I screening dated September 28, 2025, and Notice of Exempted Hospital Discharge dated October 27, 2025, were reviewed. The PASRR Level I screening indicated, .18. does the individual meet the criteria for an exempted hospital discharge? The answer was marked .yes.resolution: exempted hospital discharge. During a review of the Notice of Exempted Hospital Discharge, the Notice of Exempted Hospital Discharge indicated, .Your Level I Screening indicates that a Level II Mental Health Evaluation is not required.Reason: Exempted Hospital Discharge.if the individual remains int he NF [Nursing facility] longer than 30 days, the facility must resubmit a new Level 1 screening as a resident review on the 31s day. The MDSC stated, the facility is responsible for submitting a new PASRR level 1 if the residents remains in the facility for longer than 30 days. The MDSC stated for Resident 14 it was missing and was not completed until June 16, 2026. During an interview on June 17, 2026, at 1:21 PM, with the Administrator (Admin), the Admin stated, the MDSC is responsible for completing the PASRR. The Admin, further stated the facility did not have a policy and procedure (P&P) outlining the steps to follow when a resident remains in the facility longer than 30 days under an EHDS. During an interview on June 18, 2026, at 11:45 AM, with the Director of Nursing (DON), the DON stated the expectation for the PASRR Level I is to be reviewed, and corrected as needed to ensure residents receive the services they require.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure appropriate catheter care was provided and documented for one (1) of 29 sampled residents (Resident 8) with an indwelling urinary catheter (foley- a tube inserted into the bladder to continuously drain urine) when staff did not document routine cleansing of the foley catheter as required by the facility's policy and procedure (P&P). This failure had the potential to increase the risk for catheter-associated urinary tract infection (CAUTI- a urinary tract infection caused by or associated with urinary catheter), skin irritation, and other catheter-related complications for Resident 8.Findings: During a review of Resident 8's admission Record (contains demographic and medical information), the admission Record indicated Resident 8 was admitted to the facility on [DATE], with diagnoses which included kidney transplant (received a donated kidney to replace a failed kidney), neuromuscular dysfunction of bladder (loss of normal bladder control cause by nerve or muscle dysfunction), generalized muscle weakness (condition where muscles lose strength and can't move as well as they normally should), and gastrostomy (surgical procedure creating a small opening through the belly into the stomach for feeding or drainage) status. During a review of resident 8's Order Summary dated June 13, 2026, through June 18, 2026, the Order Summary indicated, Catheter: Indwelling foley catheter.for neurogenic bladder [loss of bladder control caused by nerve damage]: check placement and patency Q (every) daily. During a review of the Care Plan dated June 18, 2026, the Care Plan indicated, Focus: Resident has indwelling foley catheter for dx [diagnosis]: neurogenic bladder .interventions: foley catheter care with soap and water every shift date. During an interview on June 18, 2026, at 2:56 PM, with Certified Nurse Assistant 1 (CNA 1), CNA 1 stated, the treatment nurse is typically in charge of cleaning and documenting the foley care provided. CNA 1 stated that the CNAs will clean the catheter when it has feces over it with soap and water. CNA 1 stated it is important to clean the catheter to avoid infections. During an interview on June 18, 2026, at 2:57 PM, with Licensed Vocational Nurse 3 (LVN 3), LVN 3 stated, both the CNA's and LVN's will clean the catheter. LVN 3 stated it is important to clean the catheter and document to prevent infections and to ensure someone is completing the task. During an interview on June 18, 2026, at 3:05 PM, with the Treatment Nurse (TN), the TN stated, sometimes the TN will have an order to clean the foley catheter. The TN added that if she does have an order, she will ensure it is completed her end. During an interview on June 18, 2026, at 3:13 PM, with the Infection Preventionist (IP), the IP stated the expectation is for the nursing staff to clean the foley catheter with soap and water every shift. The IP added it is important for it to be completed and documented to prevent CAUTI's. The IP stated Resident 8 did not have an order to have the catheter cleaned but should have. During a concurrent interview and record review on June 18, 2026, at 3:15 PM, with the Director of Nursing (DON), the Nursing Notes dated June 12, 2026, through June 18, 2026, and Treatment Administration Record (TAR-a record of non medication treatments provided to a resident) dated June 2026 were reviewed. The Nursing Notes and TAR did not indicate the nursing staff was cleaning the catheter. The DON stated there was no documentation the foley catheter was being cleaned by the nursing staff. The DON added the expectation is the nursing staff to clean and documented the foley catheter care. During a follow-up concurrent interview and record review on June 18, 2026, at 3:16 PM with the DON, the facility's P&P titled, Catheter Care, Urinary dated August 2022 was reviewed. The P&P indicated, The purpose of this procedure is to prevent urinary catheter-associated complications, including urinary tract infections.perineal care 1. Use soap and water.for routine daily hygiene. 15. Use a clean washcloth with warm water and soap (or clean bathing wipe to cleanse and rinse the catheter from insertion site to approximately four inches outward. Documentation.the following information should be recorded in the resident's medical record.1. The date and time that catheter care was given. 2. The name and title of the individual giving (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the catheter care. 3. All assessment data obtained when giving catheter care.7. How the resident tolerated the procedure. The DON stated she was unable to provide documentation of the staff cleaning the foley and the policy was not followed and should have been. The DON added that it is important for the nursing staff to follow the policy to prevent the residents from getting an infection.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility failed to ensure adequate nutritional interventions and monitoring for 2 (two) of 29 sampled residents (Resident 17 and 104) when: 1. For Resident 17, the facility failed to communicate Registered Dietitian's recommendations to the physician after the Resident 17 experienced weight loss, including recommendations for weekly weights and modification of the tube^feeding regimen, resulting in no updated medical orders. 2. For Resident 104, the facility failed to ensure weekly weights were obtained as ordered by the physician. These failures resulted in delayed identification and treatment of nutritional concerns, contributed to continued weight loss, inadequate nutritional intake, and decline in overall health status for Residents 17 and 104. Findings: 1. During a review of Resident 17's admission Record (contains demographic and medical information), the admission Record indicated Resident 17 was admitted to the facility on [DATE], with diagnoses that included anoxic brain damage (Brain injury caused when the brain gets no oxygen for too long, killing brain cells), generalized muscle weakness (condition where muscles lose strength and can't move as well as they normally should), and with a gastrostomy (surgical procedure creating a small opening through the belly into the stomach for feeding or drainage). During an observation on June 15, 2026, at 8:35 AM, in Resident 17's room, Resident 17 sitting upright, and receiving [name of tube feeding] 1.2 cal [calories- units of energy provided by good and drinks] at 65 milliliters (ml-unit of measurement)/ hour (hr). A review of Resident 17's Section C [cognitive (the ability to understand) pattern] of the Minimum Data Set (MDS- A detailed checklist nursing facilities use to determine a resident's ability of moving around, memory, and medical problems) indicated, .C1000 cognitive skills for daily decision making. severely impaired. A review of Resident 17's Weights Summary dated May 4, 2026, through June 4, 2026, were reviewed as follows: May 4, 2026: 141.2 pounds (lbs. unit of measurement) June 4, 2026: 130.9 lbs. (loss of 10.3 lbs., -7.3% in one month) During an interview on June 17, 2026, at 8:35 AM, with the Registered Dietician (RD), the RD stated residents with significant weight loss are the ones who have lost 2% or more in one week, 5% or more in one month, 7.5% or more in three months, and 10% or more in six months. The RD further stated these residents are followed by the dietician on a weekly basis until the weight is stable. The RD stated if during her assessment an intervention is required, she documents recommendation on the Nutritional Recommendations by Registered Dietician provides a copy of the recommendations to each nursing station and emails it to the Director of Nurse (DON), the Administrator (admin), and medical records. The RD stated the registered nurse (RN) was expected to get the Nutritional Recommendation by Registered Dietician and call the doctor (MD) to get the orders changed or the rationale for denying the recommendation. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on June 17, 2026, at 8:38 AM, with the RD, Resident 17's Nutrition/Dietary Note dated June 8, 2026, and Order Summary (document that shows all active orders) dated May 29, 2026, through June 17, 2026, were reviewed. The Nutrition/Dietary Note indicated, .Res [resident] will benefit from gradual wt [weight] gain r/t [related to] BMI [Body mass Index- estimates whether a person's weight is healthy, less than 18.5 is underweight, 18.5-24.9 normal, 25-29.9 overweight, 30+ is overweight] of 18.8.significant wt [weight] loss x3 and x1 month . Possible wt [weight] loss d/t [due to] on TF [tube feeding] and wounds. RD will rec [recommend] to switch feeding to [name of tube feeding 1.5] to run at 55 ml/hr x 20 hrs (.1650 kcal.) to provide additional kcals and promote gradual wt gain.plan: switch to [name of tube feeding 1.5] to run at 55 ml/hr x 20 hrs (.1650 kcal).ADD on weekly weights x4 weeks. The Order Summary indicated, Enteral feed. [name of tube feeding 1.2] at. 65 ml [milliliter-unit of measurement] / hr [hour] x [times] 20 hrs.via PEG to provide a total of. 1560 kcal [kilocalorie- energy in food] . monitor every shift. The RD verified and confirmed that her recommendations were not implemented as an order, and Resident 17 had a significant weight loss. The RD stated, she currently had Resident 17 as part of her monthly assessment but should have been following Resident 17 on a weekly basis to prevent further weight loss. During an interview on June 18, 2026, at 8:08 AM with Registered Nurse 1 (RN 1), RN 1 stated the RN of the shift was responsible for checking the Nutritional Recommendations by Registered Dietician located in the nursing station and calling the MD to get new orders. RN 1 stated the orders should be reflected within 24 hours of the RD's recommendations. RN 1 stated when orders are not updated per RD's recommendations a nurse's note with the documentation of the discussion with the MD is placed in the resident's record. RN 1 stated it is important to notify the physician of the RD's recommendation to prevent further weight loss. During a follow up interview on June 18, 2026, at 9:16 AM with the RD, the RD stated the reason for changing the tube feeding for Resident 17 was to increase the caloric intake for Resident 17. The RD further stated the difference in calories between the tube feeding Resident 17 has been receiving and the tube feeding that was recommended on June 8, 2026, is approximately 90 calories per day (In 9 days it is approximately 810 calories). During a concurrent interview and record review on June 18, 2026, at 8:55 AM with Director of Nurses (DON), Resident 17's Nutritional Recommendations by Registered Dietician dated June 8, 2026, and Care plan dated June 8, 2026, were reviewed. The Nutritional Recommendations by Registered Dietician indicated, switch to [name of tube feeding 1.5] to run at 55 ml/hr x 20 hrs (.1650 kcal) .ADD on weekly weights x4 weeks. The DON stated the orders were implemented on June 17, 2026 (9 days after the recommendation was given). The Care plan indicated, Focus.Resident is at nutritional risk.goal.:GTF [Gastrostomy feeding] [name of tube feeding 1.5] The DON stated there were no nursing notes or documentation of the MD being notified of the RD recommendations and there should have been. The DON stated it is important to follow the care plan to know the residents' nutritional needs and ensure the facility is providing it. During a follow-up concurrent interview and record review on June 18, 2026, at 9:00 AM with the DON, the facility's policy and procedures (P&P) titled, Weight Assessment and Intervention, dated March 2022 and Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol dated September 2017 were reviewed. The Weight Assessment and Intervention P&P indicated, Resident weights are monitored for undesirable weight loss.the threshold for significant unplanned and undesired weight loss will be based on the following criteria.a. 1 month- 5% weight loss is significant; greater than 5% is severe.undesirable weight change is evaluated by the treatment team.care planning for weight loss or (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	impaired nutrition is a multidisciplinary effort and includes the physician, nursing staff, the dietitian, the consultant pharmacist and the resident's legal surrogate. Individualized care plans shall address to the extent possible. b. goals and benchmarks for improvements, and c. time frames and parameters for monitoring and reassessment . The Nutrition (Impaired)/Unplanned Weight Loss-Clinical Protocol P&P indicated, .4.the staff will report to the physician significant.loses or any abrupt or persistent change.the physician will review for.weight loss before ordering interventions.the physician with the help of the multidisciplinary team, will identify conditions.that may be causing.weight loss. the staff and physician will identify pertinent interventions based on identified causes and overall resident condition.10. The physician will authorize appropriate interventions, as indicated.1. The physician and staff will monitor nutritional status, an individual's response to interventions. The DON stated the P&Ps were not followed as the recommendations were never escalated to the physician. The DON stated that it is important to follow the P&P to prevent continued weight loss. 2. During a review of Resident 104's admission Record (contains demographic and clinical data), the admission Record indicated Resident 104 was admitted to the facility on [DATE], with diagnoses which included acute ischemic heart disease (heart isn't getting enough blood and oxygen due to blood vessels that feed it are blocked or narrowed), depression (health condition that affects mood, energy, sleep, appetite, and daily functioning), and epilepsy (brain condition that causes repeated seizures due to sudden bursts of abnormal electrical activity in the brain). During a review of Resident 104's Order Summary Report (written instructions from a doctor or authorized provider that tell the staff exactly what care a patient needs), dated April 9, 2026, the Order Summary Report stated Weight monitoring weekly X 4 weeks then monthly if stable every day shift every 31 day(s). During a review of Resident 104's Weights and Vitals Summary (weight trends and basic health measurements that show how the body is working) dated December 5, 2025, through June 3, 2026, were reviewed as follows: December 5, 2025, Current weight: 128.4 Lbs. [pounds- unit of measurement] January 1, 2026, Current weight: 125.2 Lbs. February 5, 2026, Current weight: 120.6 Lbs. March 18, 2026, Current weight: 115.6 Lbs. April 2, 2026, Current weight :112.5 Lbs. May 4, 2026, Current weight:113.1 Lbs. June 3, 2026, Current weight 108.4 Lbs. During a concurrent interview and record review on June 18, 2026, at 8:30 AM, with the Director of Nursing (DON), Resident 104's Weights and Vitals Summary, were reviewed. The Weights and Vitals Summary did not have documented evidence indicating weights for Resident 104 have been monitored weekly from April 9, 2026, to June 18, 2026. The DON stated, weights should be documented in the electronic medical record in the Weights and Vitals Summary section. (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent interview and record review on June 18, 2026, at 2:20 PM, with the DON, the facility's policy and procedure (P&P) titled, Unplanned Weight Loss- Clinical Protocol, dated September 2012 was reviewed. The P&P indicated, .The physician and staff will monitor nutritional status, weight variance, an individual's response to interventions, and possible complications of such interventions. The DON acknowledged the policy was not followed. During a concurrent interview and record review on June 18, 2026, at 2:23 PM with the DON, the facility's policy and procedure (P&P) titled, Weight Assessment and Intervention, dated March 2022 was reviewed. The P&P indicated, .Residents are weighed upon admission and at intervals established by the interdisciplinary team. The DON acknowledged the policy was not followed and further stated it's important to monitor weights for residents and provide appropriate interventions for weight loss if necessary.

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	06/18/2026

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 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** Based on observation, interview, and record review, the facility failed to ensure one (1) of 29 sampled residents (Resident 29) received enteral feeding (method of delivering liquid nutrition directly into the gastrointestinal tract using a tube placed into the stomach or small intestine) as ordered by the the physician when the ordered daily total of 918 mL (milliliter-unit of measurement) was not administered. This failure had the potential to result in malnutrition, weight loss, and electrolyte imbalance for Resident 29.Findings: During a review of Resident 29's admission Record (contains demographic and medical information), the admission Record indicated Resident 29 was admitted to the facility on [DATE], with diagnoses which included metabolic encephalopathy (a temporary or permanent brain dysfunction caused by a chemical imbalance, illness, or organ failure elsewhere in the body, rather than a direct head injury), injury of left foot, and major depressive disorder (severe health condition where a persistent wave of sadness or emotional emptiness interferes with a person's ability to live his/her life). During a review of Resident 29's Order Summary Report, order dated September 21, 2025, the Order Summary Report indicated Patient 29 had an order to receive Enteral Feed Order every shift Enteral Feeding: [Brand name] Formula 1.2 to run at 51 mL/hr. (hour) x 18 hrs. (hours) or until dose is completed via GT [gastronomy tube] to provide total of 918 mL/day: 1102 kcal [a unit of energy measurement used in nutrition] Start: 2 pm. During an observation on June 15, 2026, at 9:38 AM, in Resident 29's room, Resident 29 was lying in bed and receiving enteral feedings. The enteral feed bottle [Brand name] formula was observed to be infusing and labeled with the date June 14, 2026, start time 1400 (2:00 PM). The formula in the bottle was measured below 1200 mL line. During a concurrent observation and interview on June 15, 2026, at 3:45 PM, with Licensed Vocational Nurse 5 (LVN 5) in Resident 29's room, LVN 5 verified the observed amount left in the enteral feeding bottle. LVN 5 stated Resident 29 received approximately 670 mL of formula over the period of one day, one hour, and 45 minutes (from June 14, 2026, at 2 PM to June 15, 2026, at 3:45 PM). LVN 5 further stated Resident 29 did not receive the ordered amount of 918 mL/day of enteral feeding formula. During a concurrent interview and record review on June 17, 2026, at 12:38 PM, with Director of Nursing (DON), the facility's Policy and Procedure (P&P) titled, Enteral Nutrition, dated November 2018 was reviewed. The P&P indicated, Policy Interpretation and Implementation.11. The nurse confirms that the orders of enteral nutrition are complete. Complete orders include . e. volume and rate of administration. The DON stated the P&P was not followed. The DON further stated it is important to follow the physician's enteral feeding order to help meet Resident 29's nutritional needs.

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	06/18/2026

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

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to maintain effective infection control practices for one (1) of 29 sampled residents (Resident 60) when a humidifier bottle (a device that adds moisture to the air) attached to a tracheostomy (trach- a small tube placed into a surgically created opening in the neck to help a person breathe) oxygen delivery system was observed resting on the floor while in use. This failure resulted in improper handling and positioning of respiratory equipment, which had the potential to introduce germs (tiny organism that can cause an infection) into the humidification system and directly into Resident 60 airway (the breathing passage that carries air from nose and mouth to your lungs), increasing the risk for infections for Resident 60.Findings: During a review of Resident 60's admission Record (contains demographic and medical information), the admission Record indicated, Resident 60 was admitted to the facility on [DATE], with diagnoses which included respiratory failure with tracheostomy status (a serious breathing problem where the body cannot get enough oxygen in or remove carbon dioxide out needing a trach to assist them with breathing). A review of Resident 60's Order Summary dated January 29, 2026, through June 18, 2026, the order Summary indicated, Change humidifier.setup weekly on Tuesdays and as needed.tracheotomy mask (collar) at 2 liters [units of measurement] /minute every shift. During a concurrent observation and interview on June 15, 2026, at 11:35 AM with the Respiratory Therapist (RT 1) in Resident 60's room, the humidifier attached to the tracheostomy oxygen delivery system was observed resting on the floor while in use. RT 1 stated that the humidifier should never be on the floor because it can cause bacteria (tiny organism that can cause an infection). During a concurrent observation and interview on June 16, 2026, at 9:01 AM with the Licensed Vocational Nurse 2 (LVN 2) in Resident 60's room, the humidifier attached to the tracheostomy oxygen delivery system was observed resting on the floor while in use. LVN 2 stated that she was unsure why the humidifier was on the floor, but it should not be. LVN 2 stated, the humidifier should not be on the floor for infection control (prevent the spread of germs/bacteria). During an interview on June 17, 2026, at 2:00 PM with the Infection Preventionist (IP), the IP stated there was no reason for a humidifier to be on the floor. The IP further stated added it was important to keep off the floor because it could harbor bacteria. During an interview on June 18, 2026, at 11:30 AM with the Respiratory Therapist Lead (RTL), the RTL stated the expectation for the oxygen setup including the humidifier, was that everything was properly placed, secured and not touching the floor. RTL stated, it was important to keep the humidifier off the floor for infection control. During a concurrent interview and record review on June 18, 2026, at 11:41 AM with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Oxygen Administration via Artificial Airway dated June 2026, was reviewed. The P&P indicated .8.4 oxygen administration through an artificial airway shall be performed in a manner that promoted resident safety, comfort, infection prevention and maintenance of airway patency. The DON stated, the nursing staff and RTs are expected to ensure the oxygen equipment was set appropriately and the humidifier should not be on the floor. The DON stated, it was important to follow the P&P to prevent infections.