

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055565	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  09/23/2025
NAME OF PROVIDER OR SUPPLIER  Waterman Canyon Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE  1850 N. Waterman Ave. San Bernardino, CA 92404	

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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge.</p> <p>(continued on next page)</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 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, and record review , the facility failed to permit the return of one of four sampled residents (Resident 1) following the clearance provided by a psychiatrist for transfer back to the facility from hospitalization . This failure resulted in Resident 1's delayed transfer to a skilled nursing facility (SNF- a place for people recovering from a hospital stay to get medical care and rehabilitation.) possibly resulted in disruption of care, which may lead to emotional distress.A review of Resident 1's admission Record (a document containing clinical and demographic information data) indicated Resident 1 was initially admitted to the facility on [DATE] , with a diagnosis that included acute kidney failure ( kidneys suddenly stops working properly), liver dieses ( a condition that stops the liver from working properly), and peripheral vascular disease ( blood vessels outside the heart and brain narrowed, restricting blood flow).During an interview on September 23, 2025, at 12:34 PM, the Director of Nursing (DON) confirmed that Resident 1 has been transferred to the hospital and is currently not in the facility.During a concurrent observation and record review, September 23, 2025, at 12:38 PM, it was observed Resident 1 was not present at the facility and noted that his name was not included in the current list of residents at the facility.During a review of the facility progress notes, dated September 4, 2025, it was recorded that at 10:30 AM, Resident 1 displayed aggressive behavior toward other residents and staff. A 911 call was made, and law enforcement arrived at the facility. A 5150 psychiatric evaluation was subsequently ordered, resulting in the transfer of Resident 1 to the hospital at 3:02 PM, on September 4, 2025.During a review of an Order Summary, dated September 4, 2025, at 1:34 PM, the order indicated for a 7-day hold, covering the period from September 4, 2025, to September 11, 2025.During a review of Emergency Department, notes dated September 4, 2025, it was noted that Resident 1 arrived at ER via EMS on September 4, 2025, at 3:24 PM. It was indicated that Resident 1 requires admission to Medical/Surgical floor, and a psychiatric evaluation was required for safety and further management.During a review of Resident 1's hospital psychiatry consult dated September 5, 2025, the note stated, .Disposition back to [NAME] Canyon; patient [Resident 1] is declining any thoughts of self-harm or harm to others. Patient [Resident 1] is not endorsing auditory visual hallucinations; patient is not endorsing delusional thought process.During a review of Resident 1's Social Worker (SW) note dated September 6, 2025, the note stated, .SW received a call from CMA reporting [name of a staff] from [NAME] Canyon Post is reporting the patient is unable to return. @1048~This writer called [NAME] w/[NAME] Canyon Post reporting the patient is unable to DC back due to being picked up by PD on 9/4/2025 and being placed on a 5150 hold and being aggressive with another resident. The patient [Resident 1] has been a resident at [NAME] Canyon Post for 3 years.During a review of the Discharge Planning Progress Note, dated September 9, 2025,it has been noted that the anticipated discharge date for Resident 1 is scheduled for September 10, 2025. The discharge plan entails transfer to SNF. Additionally, the search for placement has been expanded to Riverside and San [NAME] county. The note stated, . Previous SNF not taking patient [Resident 1] back. Also, the note mentioned, .leadership talking with [NAME] and ombudsman being called. During an interview on September 23, 2025, at 3:00 PM with the DON, the director emphasized that not accepting the resident would violate their policy. But, accepting him would potentially endanger the safety of other residents, as he had potential to assault them. The DON stated, I didn't take him back, this is the first time we didn't follow our policy. During a concurrent interview and record review on September 23, 2025, at 3:10 PM, with the DON, the facility's policy and procedure (P&amp;P) titled, Bed-Holds and Returns, dated October 2022 was reviewed. The P&amp;P indicated, .Following a hospitalization, residents whom staff are concerned about permitting to return due to their clinical/behavioral condition at the time of transfer are evaluated based on their current condition, not their condition when originally transferred. During a subsequent interview and record review on September 23, 2025, at 3:10 PM, with the DON, the facility's P&amp;P titled Transfer or Discharge Notices, dated March 2025, was reviewed. The P&amp;P indicated, . If discharge is initiated by the facility after an emergency transfer to the hospital, the reason for discharge is based on the resident's status at the time the resident seeks return to the facility (not at the time the resident was transferred to acute care). When the DON was asked if the facility's P&amp;Ps were followed, the DON did not provide a direct answer.During a telephone interview on October 21, 2025, at 10:57 AM with the Marketing Coordinator (Coordinator) , she confirmed that the facility did not evaluate the resident at the hospital to determine if he was okay to return. she stated, Normally we do, but in this case, we did not. She</p>		