STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055135	A. Building B. Wing	07/01/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Healthcare Center	2123 Verdugo Blvd. Montrose, CA 91020

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (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: 055135	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/01/2025

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure one of three sampled residents (Resident 1), had a comprehensive, person-centered care plan created for known behaviors related to the diagnosis of dementia.During the investigation, Resident 1 had known behaviors that included noncompliance with safety interventions, such as the resident's inability to consistently remember to use the call light and repeated attempts to get out of bed or chair without seeking staff assistance. Despite a documented history of three prior falls, Resident 1's care plans lacked individualized interventions and measurable goals to effectively manage Resident 1's behaviors. This failure has further potential to result in a decline in the resident' physical and psychosocial well- being due to the lack of individualized and effective care.Findings:During a review of Resident 1's admission Record (AR), the AR indicated the facility initially admitted the resident on 11/26/2025, with a diagnosis of dementia (a decline in mental ability such as memory, and problem solving, making it hard to perform everyday task and activities.During a review of Resident 1's care plan titled Non - Compliance with Care - I am at risk for health conditions not being treated or managed because I refuse to use call light to ask for assistance and remove my tab alarm, dated 3/1/2024, the care plan goal included to comply with the facility's policy and protocols and physician's orders. The care plan Interventions included documenting of resident's noncompliance as needed and to respect her right to refuse.During a review of Resident 1's Minimum Set Data (MDS- a federally mandated resident assessment tool) dated 5/28/2025, the MDS indicated Resident 1 is not cognitively intact (has difficulty with short-term memory, attention, or decision - making). The MDS indicated Resident 1 also required the use of a walker and wheelchair for mobility and requires steadying with contact guard assistance as resident completes activities such as transfer to toilet or chair to bed activities.During a review of Resident 1's History and Physical (H&P), dated 6/24/2025, the H&P indicated Resident 1 had the capacity to understand and make decisions.During a review of Resident 1's Medication Administration Record (MAR) for the month of June 2025, the MAR indicated Resident 1 received Tramadol HCL (an opioid analgesic - used for moderate to severe pain) oral Tablet 50mg on the following dates:- - 6/14/2025 at 11:30AM for Pain of 9 out of 10 on pain scale- -6/19/2025 at 05:30AM for Pain of 7 out of 10 on pain scale- -6/19/2025 at 3:50PM for Pain of 8 out of 10 on pain scale- -6 /20/2025 at 1:38PM for Pain of 8 out of 10 on pain scale- -6/21/2025 at 11:05 PM for Pain of 6 out of 10 on pain scale- -6/22/2025 at 10:30PM for Pain of 6 out of 10 on pain scale- -6/23/2025 at 12:15 PM for Pain of 9 out of 10 on pain scale- -6/29/2025 at 9:21PM for Pain of 6 out of 10 on pain scaleDuring a review of Resident 1's Fall Risk assessment dated 2/28/ 2025, the record indicated Resident 1 had a fall risk score of 24. The record indicated a score higher than 18 is considered High Risk and a care plan will be developed to reduce falls and injuries. There were no further care plan revised or developed for Resident 1's high fall risk assessed on 2/28/2025. During a review of Resident 1's Radiology Results Report, dated 6/14/2025, the report indicated the reason for X-ray was unspecified pain. Radiology findings indicated Resident 1 had a right superior and inferior pubic rami fracture with mild displacement(a right sided fracture of the pelvis with broken pieces of bone slightly shifted out of place).During a review of Resident 1's General Acute Care Hospital record (GACH 1) titled Emergency Department Final Report dated 6/14/2025, the GACH 1 record indicated Resident 1 was admitted for a witnessed fall. The GACH 1 record indicated Resident 1 did not have nay head trauma or loss of consciousness, but complaining of severe right hip pain. The GACH 1 record indicated an X-ray done was performed and Resident 1 was positive for right and lower pubic fracture.During an interview on 7/1/2025 at 10:08 AM, Family Member (FM1), stated Resident 1 cannot walk by herself and requires assistance with transfers from bed to wheelchair and using the restroom. FM 1 stated Resident 1 has dementia with periods of confusion. FM1 stated Resident 1 has had previous falls while trying to use the restroom.During an interview on 7/1/2025 at 11:15 AM, with Licensed Vocational Nurse (LVN1), LVN 1 stated Resident 1 has behaviors such as getting up by herself and not asking for assistance. During an interview on 7/1/2025 at 11:32 AM, with Certified Nursing assistant (CNA1), CNA 1 stated Resident 1 was her regular assignment. CNA 1 stated Resident 1 tries to get up by self frequently to use the restroom and required one to two person assistance depending on how the resident was feeling. CNA1 stated Resident 1 is a high risk for falls.During an interview on 7/1/2025 at 1:49 PM with LVN1, LVN 1 stated Resident 1 sometimes has the capacity for understanding. LVN 1 stated due to a diagnosis of dementia, the resident has periods of forgetfulness, which adds to noncompliance with using the call light or requesting assistance. LVN 1 stated that despite ongoing reminders and education, the resident is unable to