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	05/29/2026

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one (1) of three (3) sampled residents (Resident 1) received continuous oxygen therapy that was titrated (adjusting the dose, amount, or flow rate of a medication or treatment based on the resident's condition) to ensure the resident's oxygen saturation (is how much oxygen your blood is carrying indicating whether your body is getting enough oxygen to your organs and tissues , normal oxygen saturation ranges from 95% - 100%) is above 95% in accordance with the physician's orders. This deficient practice had the potential to result in inadequate oxygenation, shortness of breath, respiratory distress, and a decline in the resident's overall respiratory status. During a review of Resident 1's admission Record indicated the resident was admitted to the facility on [DATE] with diagnoses that included malignant neoplasm of prostate (prostate cancer - a cancerous tumor that develops in part of the male reproductive system), encounter for palliative care (medical care focused on relieving pain, symptoms, and stress caused by a serious illness), and cerebral infarction (a stroke caused by a blockage in the blood vessel that supplies blood to the brain). During a review of Resident 1's History and Physical (H&P) dated 5/10/2026, it indicated the resident does not have the capacity to understand and make decisions. During a review of Resident 1's Order Summary dated 5/13/ 2026, indicated to administer oxygen at 2 liters/ minute (min) with nasal canula (a tube used to deliver oxygen through the nose), and to titrate up to 5 liters/ min for oxygen saturation less than 95%. During a review of Resident 1's Medication Administration Record (MAR) for month of May, 2026 indicated to monitor oxygen saturation every shift. Oxygen saturation: 5/14/26 Evening Shift : 93%5/14/26 Night Shift: 92%5/15/26 Day Shift: 92%5/15/26 Evening Shift: 94%5/15/26 Night Shift : 93%5/16/26 Day Shift : 94%5/16/26 Night Shift: 93%5/17/26 Day Shift: 93%5/17/26 Evening Shift: 92%5/17/26 Night Shift: 90%5/18/26 Day Shift: 92% During an interview on 5/29/2026 at 10:00AM with Licensed Vocation Nurse (LVN1), LVN1 stated Resident 1 had orders for oxygen, however we (licensed nurses) did not titrate. LVN 1 stated that LVN 1 believes Resident 1 was on 2 liters/ min of oxygen. During a concurrent interview and record review on 5/29/2026 at 12:05 PM with Registered Nurse (RN1), Resident 1' s Physicians Orders Summary dated 5/13/2026, was reviewed. The Physicians order Summary indicated to administer oxygen at 2 liters/ min with nasal canula, and to titrate up to 5 liters/ min for oxygen saturation less than 95%. RN 1 stated no documentation was recorded on Resident 1's medical record to indicate how many liters per/min the resident was being administered, further stating, the oxygen should have been titrated as ordered. RN 1 stated, we should keep titrating to reach 95 % of oxygen saturation as ordered. RN 1 also stated if Resident 1 O2 saturation the licensed nurse should notify the physician and document. During a concurrent interview and record review on 5/29/2026 at 12:40 PM with Director of Nursing (DON), Resident 1's Licensed Nurses Notes dated 5/13/2026 to 5/18/2026 were reviewed. The notes indicated, on 5/13/2026 to 5/14/2026, and 5/17/2026 to 5/18/2026, the resident was receiving 2 liters of oxygen and there was no documented evidence of oxygen titration, monitoring, or clinical justification supporting oxygen flow rate administered was found. The DON stated oxygen (02) titration and monitoring should be documented in the nursing charting (licensed nurses notes) and, if performed each shift. The DON stated staff should document the resident's (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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	oxygen administration if how many liters/ min was administered and titration, including rational for adjustments. The DON stated if titration was not done it had the potential to result in inadequate respiratory monitoring, respiratory discomfort, and did not ensure the residents' comfort and respiratory stability. During concurrent interview and record review on 5/29/2026 at 12:40 PM with the DON, Resident 1's physician order summary dated 5/13/2026 was reviewed. The DON stated the physician order was to titrate up to 5 liters/ minute based on residents' respiratory status to maintain the resident oxygen saturation at 95% or above. The DON stated no documentation was found indicating assessment of the resident's oxygen needs was done on the dates when the resident's oxygen saturation was below 95% or that oxygen therapy was being titrated in accordance with ordered parameters. During a review of the facility's policy and procedure the P&P indicated in preparation of administration of oxygen verification of the physician's order is reviewed, along with resident's care plan to assess for any special needs of the resident. The P&P indicated staff were required to document the oxygen flow rate (liters/ min), route of administration, assessment findings, and resident response following oxygen setup or adjustment. It also indicated, documentation will be recorded in the resident's medical record to include the date and time that of procedure performed, the rate of oxygen flow, route, and rationale, the frequency and duration of the treatment, the reason for as needed administration and how the resident tolerated the procedure.