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	07/01/2026

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

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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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure informed consent for psychotropic medications were obtained and properly documented prior to administration for four of four sampled residents (Resident 1, Resident 2, Resident 3, and Resident 4) in accordance with the facility's Policy and Procedure (P&) titled Psychotropic Medication Use. This deficient practice resulted in the administration of psychotropic medications without documented evidence of residents informed decision-making and acknowledgement of the associated risks, benefits, and alternatives. Findings: 1. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE], with diagnoses that included dementia (a progressive state of decline in mental abilities), diabetes mellitus (DM, a disorder characterized by difficulty in blood sugar control and poor wound healing), and atherosclerotic heart disease (the clogging of arteries with sticky, fatty deposits called plaque narrowing the blood vessels and restricting vital blood flow). During a review of Resident 1's Psychotherapeutic Drug Informed Consent Form dated 4/15/2026, the Consent Form indicated quetiapine fumarate (a prescription medication classified as an atypical antipsychotic balancing specific chemical messengers in the brain) 12.5 milligrams (mg-a unit of measurement) in the morning and as needed (PRN) and 25 mg at bedtime for psychosis m/b rapid shift from calm to agitation. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included a facility staff's name, signature, and date the consent was provided. The Consent Form did not include the physician's signature or the date and did not include the representatives name, signature, or date. During a review of Resident 1's Physician's Order dated 4/15/2026 at 12:50 PM, the Physician's Order indicated for the resident to have quetiapine fumarate oral tablet 25 mg by mouth at bedtime for psychosis (a disconnection from reality) manifested by (m/b) rapid shift from calm to agitation. Informed consent was obtained by the physician from the RP. During a review of Resident 1's Physician's Order dated 4/15/2026 at 1:18 PM, the Physician's Order indicated for the resident to have quetiapine fumarate oral tablet, give 12.5 mg by mouth every 4 hours PRN for psychosis m/b rapid shift from calm to agitation. Informed consent was obtained by the physician from the RP. Give 12.5 mg by mouth one time a day for psychosis m/b rapid shift from calm to agitation. Informed consent was obtained by the physician from the RP. During a review of Resident 1's History and Physical (H&P) dated 4/15/2026 at 7:07 PM, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 4/21/2026, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, remember, and other cognitive skills that impacted their daily life. The MDS indicated the resident was on antipsychotic medications (medications that helped balance brain chemicals like dopamine [helped control mood, motivation and feelings of pleasure] and serotonin [carried signals between nerve cells] and calm severe mental health problems such as hallucinations (a false sensory experience that felt completely real but was happening on in the mind, not in the physical world), delusions (a strong, false belief that a person held onto tightly, even when faced with clear evidence (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

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	or logical proof that the belief was not true), and extreme mood swings). During a review of Resident 1's Medication Administration Record (MAR) dated 4/1/2026 to 4/30/2026, the MAR indicated the resident received quetiapine fumarate 12.5 mg oral tablet one time a day from 4/16/2026 to 4/30/2026 (a total of 15 doses) and quetiapine fumarate 25 mg oral tablet at bedtime from 4/15/2026 to 4/30/2026 (a total of 16 doses). During a review of Resident 1's Physician's Order dated 5/4/2026 at 4:03 PM, the Physician's Order indicated for the resident to have Trileptal (a prescription medication primarily used to prevent and control seizures [a sudden, uncontrolled burst of abnormal electrical activity in the brain] and sometimes prescribed off-label to use as a mood stabilizer [medication that acted like shock absorbers for emotions] for people with bipolar disorder [a mental health condition that caused extreme shifts in mood, energy, and activity levels]) oral tablet 300 mg, give one table by mouth two times a day for bipolar disorder m/b mood swings. Wear gloves when administering. During a review of Resident 1's MAR dated 5/1/2026 to 5/31/2026, the MAR indicated the resident received quetiapine fumarate 12.5 mg oral tablet one time a day from 5/1/2026 to 5/31/2026 (a total of 31 doses) and quetiapine fumarate 25 mg oral tablet at bedtime from 5/1/2026 to 5/31/2026 (a total of 31 doses). The MAR indicated the resident received Trileptal 300 mg oral tablet two times a day from 5 PM on 5/4/2026 to 5/31/2026 (a total of 55 doses). During a review of Resident 1's Psychotherapeutic Drug Informed Consent Form dated 6/17/2026, the Consent Form indicated quetiapine fumarate 12.5 mg, one time a day and PRN every four hours for psychosis m/ rapid shift from calm to agitation. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included a facility staff's name, signature, and date the consent was provided. The Consent Form did not include the physician's signature or the date and did not include the representatives name, signature, or date. During a review of Resident 1's Psychotherapeutic Drug Informed Consent Form dated 6/17/2026, the Consent Form indicated Trileptal 300 mg, oral, two times a day for bipolar disorder m/b mood swings. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included a facility staff's name, signature, and date the consent was provided. The Consent Form did not include the physician's signature or the date and did not include the representatives name, signature, or date. During a review of Resident 1's MAR dated 6/1/2026 to 6/30/2026, the MAR indicated the resident received quetiapine fumarate 12.5 mg oral tablet one time a day from 6/1/2026 to 6/17/2026 (a total of 17 doses) and quetiapine fumarate 25 mg oral tablet at bedtime from 6/1/2026 to 6/16/2026 (a total of 16 doses). The MAR indicated the resident received Trileptal 300 mg oral tablet two times a day from 6/1/2026 to 9 AM on 6/17/2026 (a total of 31 doses). During a concurrent interview and record review on 7/1/2026 at 4:53 PM with the DON, Resident 1's Psychotherapeutic Drug Informed Consent Form for quetiapine fumarate dated 4/15/2026 and 6/17/2026 and Trileptal dated 6/17/2026 was reviewed. The DON stated the physician did not sign the form and without the physician's signature, the facility staff were not allowed to give the medications. The DON stated the Consent Forms were not filled out entirely but should have been because the form was an agreement to continue treatment after the medications risk and benefits were explained. 2. During a review of Resident 2's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included dementia, mood affective disorder (a mental health condition where your baseline emotional state was persistently disturbed causing extreme lows [depression], extreme highs [mania] or both which interfered with daily life), and depression. During a review of Resident 2's MDS dated [DATE], the MDS indicated the resident had moderate cognitive impairment. The MDS indicated no issues were found during the resident drug regimen review. During a review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 4/22/2026, the Consent Form indicated risperidone (a prescription medicine used to calm the brain and balance chemicals like dopamine and serotonin) 0.25 mg oral tablet two times a (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	day for psychotic m/b agitation. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included the facility staff and representatives' name, signature, and date the consent was provided. The Consent Form did not include the physician's name, signature or date. During a review of Resident 2's H&P dated 4/23/2026, the H&P indicated the resident did not have the capacity to understand and make decisions. During a review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 4/29/2026, the Consent Form indicated donepezil (a prescription medication used to manage memory loss, confusion, and thinking problems in people with Alzheimer's disease [a progressive brain disorder that gradually destroyed memory and thinking skills) 5 mg at bedtime for dementia to help improve attention and memory. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included the facility staff and representatives' name, signature, and date the consent was provided. The Consent Form did not include the physician's signature or date. During a review of Resident 2's Comprehensive (complete) Medical Chart, the Medical Chart did not include a Psychotherapeutic Drug Informed Consent Form for donepezil HCl 10 mg, give one tablet by mouth at bedtime for dementia. During a review of Resident 2's Psychotherapeutic Drug Informed Consent Form dated 4/29/2026, the Consent Form indicated memantine HCl (a prescription medication used to manage symptoms of moderate to severe Alzheimer's disease) 5 mg tablet twice a day for dementia to help improve memory, attention, reasoning, and ability to perform activities. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included the facility staff and representatives' name, signature, and date the consent was provided. The Consent Form did not include the physician's signature or date. During a review of Resident 2's Comprehensive Medical Chart, the Medical Chart did not include a Psychotherapeutic Drug Informed Consent Form for memantine HCl 10 mg, give one tablet by mouth two times a day for dementia. During a review of Resident 2's Physician's Order dated 4/30/2026 at 3:03 PM, the Physician's Order indicated for the resident to have risperidone 0.25 mg, give one tablet by mouth two times a day for psychosis m/b rapid shift from calm to agitation. Informed consent was obtained by the physician from the RP. During a review of Resident 2's MAR dated 4/1/2026 to 4/30/2026, the MAR indicated the resident received risperidone 0.25 mg oral tablet two times a day on 4/30/2026 at 5 PM (a total of one dose). During a review of Resident 2's Physician' Order dated 5/23/2026 at 8:25 AM, the Physician's Order indicated for the resident to have memantine HCl 10 mg, give one tablet by mouth two times a day for dementia. During a review of Resident 2's Physician's Order dated 5/23/2026 at 8:32 AM, the Physician's Order indicated for the resident to have donepezil HCl 10 mg, give one tablet by mouth at bedtime for dementia. During a review of Resident 2's MAR dated 5/1/2026 to 5/31/2026, the MAR indicated the resident received donepezil HCl 10 mg oral tablet at bedtime from 5/23/2026 to 5/31/2026 (a total of nine doses). The MAR indicated the resident received memantine HCl 10 mg oral tablet two times a day from 5/23/2026 to 5/31/2026 (a total of 18 doses). The MAR indicated the resident received risperidone 0.25 mg oral tablet two times a day from 5/1/2026 to 5/31/2026 (a total of 62 doses). During a review of Resident 2's MAR dated 6/1/2026 to 6/30/2026, the MAR indicated the resident received donepezil HCl 10 mg oral tablet at bedtime from 6/1/2026 to 6/30/2026 (a total of 30 doses). The MAR indicated the resident received memantine HCl 10 mg oral tablet two times a day from 6/1/2026 to 6/30/2026 (a total of 60 doses). The MAR indicated the resident received risperidone 0.25 mg oral tablet two times a day from 6/1/2026 to 6/30/2026 (a total of 60 doses). During a concurrent interview and record review on 7/1/2026 at 5:03 PM with the DON, Resident 2's Psychotherapeutic Drug Informed Consent Form for risperidone dated 4/22/2026, donepezil dated 4/29/2026, and memantine dated 4/29/2026 was reviewed. The DON stated the consent forms were not filled out entirely but should have been. The DON stated Resident 2's memantine should indicate (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 2's current dose so that facility staff would not be confused on the ordered dose. The DON stated because the RP gave us permission for a specific amount of medication, if the facility staff were giving another amount that would be an error in documentation. 3. During a review of Resident 3's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included depression (constant feeling of sadness and loss of interest, which stopped you from doing your normal activities), anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that was out of proportion to the actual situation), and insomnia (a common sleep disorder where you had trouble falling asleep, staying asleep, or waking up too early and being unable to fall back asleep). During a review of Resident 3's H&P dated 10/3/2025 at 11:10 AM, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated for the resident to have trazodone hydrochloric acid (trazodone HCl, a prescription antidepressant medication) oral tablet 150 mg, give one tablet by mouth at bedtime for insomnia m/b sleeplessness. Informed consent was obtained by the physician from the RP. During a review of Resident 3's Physician's Order dated 5/9/2026 at 3:17 PM, the Physician's Order indicated for the resident to have mirtazapine (a prescription antidepressant medication) oral tablet 15 mg, give one tablet by mouth at bedtime for depression m/b loss of interests in daily activities. Informed consent was obtained by the physician from the RP. During a review of Resident 3's Psychotherapeutic Drug Informed Consent Form dated 5/9/2026, the Consent Form indicated trazodone 150 mg, oral tablet, at bedtime for insomnia m/b sleeplessness. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included a facility staff's name, signature, and date the consent was provided. The Consent Form did not include the physician's name, signature or the date and did not include the representatives name, signature, or date. During a review of Resident 3's Psychotherapeutic Drug Informed Consent Form dated 5/9/2026, the Consent Form indicated mirtazapine 15 mg, oral tablet, at bedtime for depression m/b loss of interest in daily activities. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent form included a facility staff's name, signature, and date the consent was provided. The Consent Form did not include the physician's name, signature or date and did not include the representatives name, signature, or date. During a review of Resident 3's MDS dated [DATE], the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident was on antidepressant medications and no issues were found during the residents drug regimen review. During a review of Resident 3's Order Summary Report dated 5/29/2026, the Order Summary Report indicated for the resident to have mirtazapine oral tablet 7.5 mg, give one tablet by mouth at bedtime for depression m/b loss of interests in daily activities. Informed consent was obtained by the physician from the RP. During a review of Resident 3's MAR dated 5/1/2026 to 5/31/2026, the MAR indicated the resident received mirtazapine 15 mg oral tablet at bedtime from 5/9/2026 to 5/28/2026 (a total of 20 doses). The MAR indicated the resident received trazodone HCl 150 mg oral tablet at bedtime from 5/9/2026 to 5/31/2026 (a total of 23 doses). During a review of Resident 3's Comprehensive Medical Chart, the Medical Chart did not include a Psychotherapeutic Drug Informed Consent Form for mirtazapine 7.5 mg, oral tablet at bedtime. During a review of Resident 3's MAR dated 6/1/2026 to 6/30/2026, the MAR indicated the resident received mirtazapine 7.5 mg, oral tablet at bedtime from 6/1/2026 to 6/30/2026 (a total of 30 doses). The MAR indicated the resident received trazodone HCl 150 mg oral tablet at bedtime from 6/1/2026 to 6/30/2026 (a total of 30 doses). During a concurrent interview and record review on 7/1/2026 at 5:04 PM with the DON, Resident 3's Psychotherapeutic Drug Informed Consent Form for trazodone dated 5/9/2026 and mirtazapine dated 5/9/2026 was reviewed. The DON stated the consent forms were not filled out (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	entirely but should have been because that was an agreement to continue treatment after the risks and benefits were explained. The DON stated the medication for the consent was the treatment of choice proven to help the resident and if the resident did not receive the medication, they could deteriorate or be sent back to the hospital. 4. During a review of Resident 4's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included anxiety, unspecified psychosis (a person was experiencing a loss of contact with reality - such as hallucinations or delusions but their symptoms to not perfectly match the criteria for any specific mental health disorder), and alcohol abuse. During a review of Resident 4's MDS dated [DATE], the MDS indicated the resident's cognition was intact. The MDS indicated the resident was on antipsychotic and antianxiety medications (prescription drugs that helped calm an overactive brain and reduce symptoms like intense fear, worry, and panic attacks [a sudden surge of intense fear or overwhelming anxiety that peaked within minutes]. The MDS indicated no issues were found during the residents drug regimen review. During a review of Resident 4's H&P dated 5/30/2026 at 10:05 AM, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 4's Psychotherapeutic Drug Informed Consent Form dated 6/4/2026, the Consent Form indicated quetiapine 50 mg, two tablets, via jejunostomy tube (j-tube, a soft plastic feeding tube inserted directly into the middle part of the small intestine through a small opening in the abdomen), for psychosis m/b rapid shift from calm to agitation. The Consent Form did not indicate a frequency for how often the resident was to receive the medication. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent Form included the representatives name and signature but did not include a date and included the facility staff's name and date but not the signature. The Consent Form did not include the physician's name, signature or date. During a review of Resident 4's Psychotherapeutic Drug Informed Consent Form dated 6/4/2026, the Consent Form indicated Ativan (a prescription medication that slowed down the brain and nervous system) 1 mg via j-tube for anxiety m/b restlessness leading to SOB. The Consent Form did not indicate a frequency for how often the resident was to receive the medication. The Consent Form indicated side effects and significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent Form included the representatives name and signature but did not include a date. The Consent Form included the physician's signature but not the physician's name or date. The Consent Form included the representative's name and signature but did not include a date. During a review of Resident 4's Comprehensive Medical Chart, the Medical Chart did not include a Psychotherapeutic Drug Informed Consent Form for Ativan 1 mg oral tablet, give one tablet by mouth every six hours as needed for anxiety m/b agitation and restlessness leading to SOB for 14 days. During a review of Resident 4's Physician's Order dated 6/22/2026 at 3:03 PM, the Physician's Order indicated for the resident to have mirtazapine 7.5 mg oral tablet, give on tablet by mouth at bedtime for depression m/b loss of appetite and/or eating less than 50%. During a review of Resident 4's Physician's Order dated 6/26/2026 at 9:21 AM, the Physician's Order indicated for the resident to have Ativan 1 mg oral tablet, give one tablet by mouth every six hours as needed for anxiety m/b agitation and restlessness leading to shortness of breath (SOB) for 14 days; document non-pharmacological interventions (NPI): rest, reposition, cues, prompt reassure, redirection, diversion, re-orientation, other; and document result effectiveness of NPI: effective and non-effective. During a review of Resident 4's Physician's Order dated 6/28/2026 at 8:02 AM, the Physician's Order indicated for the resident to have mirtazapine 7.5 mg tablet, give one tablet via gastrostomy tube (g-tube, a medical tube placed directly into the stomach through a small opening in the belly) for depression m/b loss of appetite and/or eating less than 50%. During a review of Resident 4's undated Psychotherapeutic Drug Informed Consent Form, the Consent Form indicated mirtazapine 7.5 mg oral tablet at bedtime for depression m/b loss of appetite and/or eating less than 50%. The Consent Form indicated side effects and (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	significant risks associated with the use of psychotherapeutic drugs including non-pharmacological interventions that were attempted and ongoing. The Consent Form included the representatives name and signature but did not include a date. The Consent Form did not include the physician's name, signature or date and did not include the facility staff's name, signature, or date. During a review of Resident 4's Comprehensive Medical Chart, the Medical Chart did not include a Psychotherapeutic Drug Informed Consent Form for mirtazapine 7.5 mg, one tablet via g-tube for depression m/b loss of appetite and/or eating less than 50%. During a review of Resident 4's Physician's Order dated 6/28/2026 at 8:10 AM, the Physician's Order indicated for the resident to have quetiapine fumarate 50 mg, two tablets, via g-tube at bedtime for psychosis m/b rapid shift from calm to agitation. Informed consent was obtained by the physician from the RP. During a review of Resident 4's MAR dated 6/1/2026 to 6/30/2026, the MAR indicated the resident received mirtazapine 7.5 mg oral tablet at bedtime from 6/23/2026 to 6/26/2026 (a total of four doses) and mirtazapine 7.5 mg via g-tube at bedtime from 6/28/2026 to 6/30/2026 (a total of three doses). The MAR indicated the resident received quetiapine fumarate 50 mg, two tablet at bedtime from 6/28/2026 to 6/30/2026 (a total of three doses). The MAR indicated the resident received Ativan 1 mg oral tablet every six hours as needed from 6/26/2026 to 6/30/2026 (a total of 15 doses). During an interview on 7/1/2026 at 4:12 PM, the Licensed Vocational Nurse (LVN) 3 stated medication consent forms should indicate the name of the medication, the dose, the route, the explanations of the pros (advantages, benefits, or reasons for taking the medication), side effects of the medications, and the name, signatures, and dates of the RP, facility staff, and the physician. LVN 3 stated all of that information must be on the consent form to ensure the RP had the knowledge to accept or deny signing the form. During an interview on 7/1/2026 at 4:30 PM, the DON stated the facility staff must obtain consent for psychotropic medications (prescription drugs that affected how the brain worked to change your mood, thoughts, feelings, or behavior) prior to the administration of that specific medication and must be verified by the physician before. The DON stated the consent form should indicate the purpose of the medication, diagnosis, manifestation of the behavior, the dose, the quantity, the frequency, and the risks and benefits of the medication. The DON stated that when psychotropic medications were initiated, the physician should have explained and obtained consent from the resident/RP with both the physician and the resident/RP's signature. During a concurrent interview and record review on 7/1/2026 at 5:06 PM with the DON, Resident 4's Psychotherapeutic Drug informed Consent Form for quetiapine dated 6/4/2026, Ativan dated 6/4/2026, and the undated mirtazapine was reviewed. The DON stated the consent forms were not filled out entirely but should have been because that was an agreement to continue treatment and if the resident was not getting the medication they could deteriorate or be sent back to the hospital. During a concurrent interview and record review on 7/1/2026 at 5:07 PM with the DON, the facility's P&P titled Psychotropic Medication Use dated February 2025 was reviewed. The P&P indicated the psychotropic medication management was an interdisciplinary process that involved the resident, family, and/or the representative and included determining adequate indications for use; establishing appropriate dose and duration; adequate monitoring for efficacy and adverse consequences; and preventing, identifying, and responding to adverse consequences. The P&P indicated resident who have not used psychotropic medications were not to be prescribed or given these medications unless the medication was determined to be necessary to treat a specific condition that was diagnosed and documented in the medical record. The P&P indicated prior to initiating the use of, increasing the dose of, or switching to a different psychotropic medication, the staff and physician would review the following with the resident/representative prior to obtaining documented consent or refusal: non-pharmacological alternatives, the indications and rationale for the recommendation, the potential risk and benefits, and the resident's/representatives right to accept or decline the treatment. The DON stated the facility staff were not following the policy but should have been because the policy was the rule to follow and guided the facility staff in what the right thing to do was. The DON stated if the facility staff did not (continued on next page)

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	follow the policy that would have been a violation and the facility could have had a deficiency. During a concurrent interview and record review on 7/1/2026 at 5:09 PM with the DON, the facility's P&P titled Psychotherapeutic Drug Informed Consent dated January 2026 was reviewed. The P&P indicated the purpose of the P&P was to ensure residents and/or their representative were fully informed of the benefits, risks, frequency/duration, possible side effects and alternate approaches before initiating the administration of psychotherapeutic drugs. The P&P indicated prior to obtaining informed consent, the prescriber must provide the residents or their representatives with information on the following topics, including but were not limited to: the reason for the treatment and the nature and seriousness of the Resident's illness; the nature of the procedures to be used in the proposed treatment including probably frequency and duration, and possibility of medication adjustment and/or gradual dose reduction, as indicated; and the resident's and/or resident's representative's right to accept or refuse the proposed treatment, and if they consent, their right to revoke their consent for any reason at any time. The P&P indicated the prescriber must sign an informed consent form after explaining all necessary information to the residents or their representatives and the residents and/or their representatives have the right to accept, decline, or revoke consent at any time and choose between verbal or signed consent. The P&P indicated a licensed nurse would verify the informed consent information and sign the form to confirm accuracy and completeness. The DON stated the facility staff were not following the policy but should have been because the policy was the rule to follow and guided the facility staff in what the right thing to do was. The DON stated if the facility staff did not follow the policy that would have been a violation and the facility could have had a deficiency.

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	055135	A. Building B. Wing	07/01/2026

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

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to ensure medications were administered according to physician's order for two of four sampled residents (Resident 3 and Resident 4) by failing to: Ensure Resident 3 and Resident 4's medications were consumed and not left at the resident's bedside for later self-administration in accordance with the facility's Policy and Procedure (P&P) titled Self Administration of Medications. Ensure Resident 4 had an order for Pepto-Bismol (a popular over-the-counter pink medicine used to soothe an unhappy stomach) prior to the administration of this medication in accordance with the facility's P&P titled Administering Medications. This deficient practice had the potential to result in missed doses, medication errors, or unauthorized access to medications. Findings: 1. During a review of Resident 3's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included congestive heart failure (a condition where the heart pumping power became weaker than normal), hypertension (HTN, a condition where the force of blood pushing against the artery wall was consistently too high), and anxiety disorder (a mental health condition characterized by excessive, persistent, and uncontrollable fear or worry that was out of proportion to the actual situation).and being unable to fall back asleep). During a review of Resident 3's History and Physical (H&P) dated 10/3/2025 at 11:10 AM, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 3's Minimum Data Set (MDS) dated [DATE], the MDS indicated the resident's cognition was intact (sufficient judgement and self-control to manage the normal demands of the environment). The MDS indicated the resident was on diuretic medication (also known as a water pill to help the body eliminate excess salt [sodium] and water through urine). During a review of Resident 3's Self-Administration of Medication Record dated 5/9/2026 at 2:48 PM, the Record indicted the resident required assistance administering oral medications and a licensed nurse (LN) was to administer prescribed medications to the resident. The Record indicated the resident was not approved to self-administer medications and was not able to keep medications at the bedside. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have GlycoLax Powder (also known as polyethylene glycol 3350, a gentle over-the-counter powder laxative [a medicine or natural substance that relieved constipation (when stool was hard, dry, or painful to pass, and you went fewer than three times a week) by making having a bowel movement easier]), give 17 gram by mouth two times a day for constipation, mix with eight ounces (oz, unit of measurement) of water, hold for loose bowel movement (LBM). During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have senna (an herbal, over-the-counter medication used to treat short-term constipation) oral tablet 8.6 milligram (mg, unit of weight), give one tablet by mouth two times a day for constipation, hold for LBM. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have multivitamin-minerals (a daily supplement designed to fill in any nutritional gaps when your everyday diet falls short) oral tablet, give one tablet by mouth one time a day for wound healing/supplement. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have ferrous sulfate (mineral iron) 325 mg tablet, give one tablet by mouth one time a day for supplement. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have ascorbic acid (Vitamin C) tablet, 500 mg, give one tablet by mouth one time a day for wound healing/supplement for two months until finished. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have digoxin (a prescription medication derived from the foxglove plant used to help the heart pump more efficiently and stabilize irregular heartbeats), give 0.125 mg by mouth one time a day for arrhythmia, (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	hold if apical pulse (AP, the heartbeat you hear when you place a stethoscope directly over the pointed bottom tip [apex] of the heart) less than 60. During a review of Resident 3's Physician's Order dated 5/9/2026 at 2:32 PM, the Physician's Order indicated the resident to have diltiazem HCl (prescription heart medication), oral tablet 120 mg, give one tablet by mouth two times a day for HTN, hold if systolic blood pressure (SBP, the pressure of blood on the walls of the arteries [a thick, muscular tube (or blood vessel) that acted like a water pipe] as the heart pumped blood around the body) was less than 110 or heart rate was less than 60. During a review of Resident 3's Physician's Order dated 5/9/2026 at 3:12 PM, the Physician's Order indicated the resident to have Lasix (a prescription water pill or diuretic forcing the kidney to flush extra salt and water from the body into the urine), oral tablet 20 mg, give one tablet by mouth two times a day for CHF, hold if SBP was less than 100. During a review of Resident 3's Physician's Order dated 5/9/2026 at 3:18 PM, the Physician's Order indicated the resident to have docusate sodium (an over-the-counter stool softener) oral capsule, 100 mg, give two capsule by mouth two times a day for constipation, hold for loose stool. During a review of Resident 3's Vitals Summary dated 7/1/2026 at 7:53 AM, the Vitals Summary indicated the resident's BP was obtained on Resident 3's right arm while lying down with results that indicated 142/75 millimeters of mercury (mmHg, unit used to measure pressure; a normal blood pressure reading was less than 120/80) During a review of Resident 3's Vitals Summary dated 7/1/2026 at 7:54 AM, the Vitals Summary indicated the residents HR was 73 beats per minutes (BPM). During a review of Resident 3's Vitals Summary dated 7/1/2026 at 10:45 AM, the Vitals Summary indicated the resident BP was obtained on Resident 3's right arm while lying down with results that indicated 142/73 mmHg and the resident's HR was 67 BPM. During a review of Resident 3's Medication Administration Record (MAR) dated 7/1/2026 to 7/31/2026, the MAR indicated the resident received:Ascorbic acid 500 mg tablet at 9 AM on 7/1/2026.Digoxin 0.125 mg tablet at 9 AM on 7/1/2026. Ferrous Sulfate 325 mg tablet at 9 AM on 7/1/2026.Multivitamin-Minerals 1 tablet at 9 AM on 7/1/2026.Diltiazem HCL 120 mg tablet at 9 AM on 7/1/2026.Docusate Sodium 100 mg capsule at 9 AM on 7/1/2026.GlycoLax Powder 17 gram at 9 AM on 7/1/2026.Lasix 20 mg tablet at 9 AM on 7/1/2026.Senna 8.6 mg tablet at 9 AM on 7/1/2026. During a concurrent observation and interview in Resident 3's room on 7/1/2026 at 10:35 AM, a medicine cup was observed on the bedside table with one round shaped beige colored pill, two small round shaped white colored pills, one long oval shaped white colored pill, one oval shaped burgundy and white colored capsule, one round shaped red colored pill, one round shaped peach colored pill, one round shaped brown speckled colored pill (eight pills total) inside the medicine cup and a cup of red colored juice that spilled over onto the resident's bedside table. Resident 3 stated the pills belonged to him and did not want to take them right now and would take them later. During a concurrent observation and interview on 7/1/2026 at 10:43 AM with Licensed Vocational Nurse (LVN) 1 in Resident 3's room, Resident 3 was observed with a medicine cup containing eight medications inside and a cup of red colored juice that spilled over onto the resident's bedside table. LVN 1 stated Resident 3 usually took the medications right away and LVN 1 felt confident that Resident 3 would take his medications and that was why LVN 1 left the medications in the medicine cup and placed the medicine cup on Resident 3's beside table. LVN 1 stated the medications should not be left at Resident 3's bedside because another resident could take the medication. LVN 1 further stated some of the medications inside the medication cup left on Resident 3's bedside table were heart medications, and if another resident took those medications, it could affect the residents BP and heart rate (the number of times the heart beat in one minute). 2. During a review of Resident 4's AR, the AR indicated the resident was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included gastroesophageal reflux disease (GERD, a chronic digestive condition where stomach acid frequently flowed backward into the esophagus [the tube connecting your mouth and stomach]), anxiety, and unspecified psychosis (a person was experiencing a loss of contact with reality - such as hallucinations or delusions but their symptoms to not perfectly match the criteria for any specific mental health disorder). During a review (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	of Resident 4's MDS dated [DATE], the MDS indicated the resident's cognition was intact. The MDS indicated the resident had an active diagnoses of GERD. During a review of Resident 4's H&P dated 5/30/2026 at 10:05 AM, the H&P indicated the resident had the capacity to understand and make decisions. During a review of Resident 3's Comprehensive (complete) Medical Chart, the Medical Chart did not include an order for Pepto-Bismol. During a review of Resident 4's Self-Administration of Medication Record dated6/4/2026 at 4:48 PM, the Record indicted the resident required assistance administering oral medications and a licensed nurse was to administer prescribed medications to the resident. The Record indicated the resident was not approved to self-administer medications and was not able to keep medications at the bedside. During a concurrent observation and interview in Resident 4's room on 7/1/2026 at 11:10 AM, the resident had a medicine cup filled with a pink liquid inside the cup. Resident 4 stated the medicine was from last night. Resident 4 stated he had an upset stomach and was going to take the medicine but because Pepto-Bismol had a coating, the resident did not want the medicine to interfere with the other medications the resident already took and decided not to take the Pepto-Bismol. During an interview on 7/1/2026 at 4:18 PM, LVN 3 stated medication should not have been left at the resident's bedside because the resident might not take the medication or another resident could take the medication. LVN 3 stated if medications were left at the bedside the resident could have missed a dose and if the medication was for the resident's BP, the BP could be high. During an interview on 7/1/2026 at 4:20 PM, LVN 3 stated Resident 4 should have had an order for Pepto-Bismol if facility staff were going to give him the medication otherwise the resident was unable to take the medication even for over-the-counter medications. LVN 3 stated the resident should have had an order because that was the law otherwise the resident could have had an allergic reaction to the medication. During an interview on 7/1/2026 at 4:35 PM, the Director of Nursing (DON) stated medications should not be left at the residents bedside because the facility staff would not know if the resident took the medication, there was a possibility for another resident to take the medication, and if the resident took the medication on their own there was a possibility that the resident could choke. The DON stated if medications were left at the resident's bedside, the resident's health could deteriorate and could cause an emergency situation. During an interview on 7/1/2026 at 4:38 PM, the DON stated if an order was not placed for medication, the resident should not have been given the medication because the resident would need a physician's order. The DON stated the physician was the only person who could authorize medications and if the physician did not order the medication, the resident was not permitted to take the medication. The DON stated if an order was not placed for medication and the resident received the medication, that would have been considered a medication error. During a concurrent interview and record review on 7/1/2026 at 5:11 PM with the DON, the facility's policy and procedure (P&P) titled Administering Medications dated April 2019 was reviewed. The P&P indicated medications were to be administered in a safe and timely manner, and as prescribed and only persons licensed or permitted by this state to prepare, administer, and document the administration of medications may do so. The P&P indicated the individual administering the medication initials the resident's MAR on the appropriate line after giving each medication and before administering the next ones. The P&P indicated as required or indicated for a medication, the individual administering the medication records in the resident's medical record must record the date and time the medication was administered, the dosage, the route, and the signature and title of the person administering the medication. The P&P indicated residents may self-administer their own medications only if the attending physician, in conjunction with the interdisciplinary care planning team, had determined that the resident had the decision-making capacity to do so safely. The DON stated the facility staff were not following the policy but should have been because the policy was the rule to follow and guided the facility staff in what the right thing to do was. The DON stated if the facility staff did not follow the policy that would be considered a medication or documentation error especially if facility staff were unsure if the resident took the medication, signing for the medication would be a discrepancy. During a concurrent interview and record review on 7/1/2026 at (continued on next page)

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