STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	056322	A. Building B. Wing	05/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave 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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview and record review, the facility failed to ensure treat 2 out of 5 sampled residents (Resident 2 and Resident 3) with respect and dignity, by not honoring their preferences, and choices regarding activities of daily living (ADL: bathing or showering, dressing, getting in and out of bed or a chair, walking, using the toilet, and eating) These deficient practices had the potential to negatively impact residents leading to decreased self- worth, fear of not having control over choices and preferences, and even depression. Findings: 1. A review of Resident 2 ' s Admission Record indicated the resident was admitted on [DATE] with a diagnosis that included depressive disorder (loss of pleasure or interest in activates) and adult failure to thrive (a state of decline, withdrawn, lonely and depressed). A review of Resident 2 ' s Minimum Data Set ([MDS], a standardized assessment and care screening tool) dated 3/15/2024, indicated Resident 2 required partial to moderate assistance with personal hygiene. A review of Resident 2 ' s care plan dated 9/10/2023, titled Activities of Daily Living-Toileting indicated staff would not rush resident, allow enough time to complete task at own pace, to encourage to perform self - care with morning care, oral and personal hygiene, and to explain all necessary procedures before rendering care and treatment. The goal of the care plan indicated Resident would not have an incident of fall. A review of Resident 2 ' s Progress Notes, dated 5/10/24 at 10:10 AM, indicated Resident 2 had a witnessed fall at 8:10 AM on 5/10/24 in Resident 2 ' s room. The Progress Note indicated Resident 2 ' s fall occurred during care with observed injury of a bump on the head. The Progress Note indicated Resident 2 was sent to the general acute care hospital (GACH) for a computerized tomography scan ([CT] an imaging that uses X-ray {a photographic image of the internal composition of the body} techniques to create detailed images of the body). (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 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 2 ' s Change in Condition (COC) Evaluation, dated 5/10/24 at 9:58 AM, indicated Resident 2 sustained a fall in the morning of 5/10/24. The COC indicated Resident 2 slid off the floor during care, face down. The COC indicated Resident 2 had a bump on her head and an ice pack was applied. A review of Resident 2 ' s undated care plan, titled At risk for falls indicated one of the interventions was to keep all Resident 2 ' s personal and frequently used items within easy reach. The goal of the Care plan indicated to reduce risk of falls and injuries. A review of Resident 2 ' s undated care plan for the use of antipsychotic medications, indicated one of the interventions was to approach the resident in a calm unhurried manner. A review of Resident 2 ' s undated care plan for behaviors problem indicated one of the interventions was to explain all procedures to the resident before starting and allow the Resident 15 minutes to adjust to change. The goal of the Care plan indicate Resident 1 would have no evidence of behavior problems and mood swings. A review of Resident 2 ' s undated care plan for the actual fall with redness on the forehead due to the resistance of care and fighting away from nurses during incontinence care, indicated one of the interventions was to leave resident if/when she gets agitated, return for care. The goal of the care plan indicated the redness on the forehead would resolve without complication. During a concurrent observation and interview with Resident 2 on 5/17/2024 at 11:19 AM, Resident 2 was observed with discoloration to the top and the bottom of Resident 2 ' s right eye. Resident 2 stated it was early in morning two certified nursing assistants (CNA) came into my room to change my diaper. Resident 2 stated I told them to leave me alone, it was cold and too early in morning. Resident 2 stated CNA 1 and CNA 2 tore her gown off her leaving her naked. Resident 2 stated CNA 1 and CNA 2 continued to change her diaper and holding her or him down. Resident 2 stated she screamed for CNA 1 and CNA 2 to stop and requested to be left alone. Resident 2 stated CNA1 and CNA 2 were holding her feet, arms, and legs while she was in bed. Resident 2 stated CNA 1 and CNA 2 were holding her down the entire time while cleaning her and she was screaming and crying for them to leave her alone. Resident 2 stated after CNA 1 and CNA 2 left her room she attempted to grab her personal belongings, that fell on the floor, using her grabber (a handheld mechanical tool used to extend the range of a person's reach to grab an objects). Resident 2 stated while grabbing her belongings off the floor, she fell from the bed. During an interview with Resident 2 on 5/17/2024 at 3:30pm, Resident 2 stated the incident that occurred on 5/10/24 involving CNA1 and CNA 2 changing her diaper made her feel upset, I was treated like nothing, not a person. That is how it made me feel. Resident 2 stated I want to leave this place. During an interview with the Director of Nurses on 5/17/2024 at 1:09 PM, the DON stated resident 2 did not inform him of mistreatment by night shift CNA 1 and CNA2. The DON Stated R2 is coherent and alert and oriented to person, place, and situation. 2. A review of Resident 3 ' s admission record indicated the resident was admitted on [DATE] with a diagnosis including heart disease and muscle weakness. (continued on next page)

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of Resident 3 ' s History and Physical dated 2/16/2024 indicated Resident 3 had a fluctuated capacity to understand and make decisions. A review of Resident 3 ' s care plan for ADL function dated 2/15/2024, indicated staff would not rush resident, allow enough time to complete tasks at the resident own pace and will encourage to perform self-care with morning care, oral and personal hygiene, explaining all necessary procedures before rendering care and treatment. The goal indicated resident would have no incident of fall. During an interview with Resident 3 on 5/17/2024 at 12:29 pm, Resident 3 stated early in the morning around 4 AM or 5 AM, while she was sleeping an unnamed CNA 3would come into her room, snatches her covers off, grabbing her legs to flip her over. Resident 3 stated the CNA3 would first remove the blanket off from her and then turn her over on her back and then inform her that she (CNA 3) would change her diaper. Resident 3 stated the unnamed CNA 3 would state I need to change your diaper before morning. Resident 3 stated CNA 3 tore the diaper off her. Resident 3 stated she was telling CNA 3 to stop, and that CNA 3 was hurting her leg. During an interview with the licensed vocational nurse (LVN 3) on 5/17/24 at 12 PM LVN 3 stated when a resident does not want to be changed it was the residents ' rights to refuse and that the residents wish must be honored. A review of the facility ' s policy and procedure (P&P), titled Resident Rights, revised 1/1/12, indicated Facility staff would provide all resident with kindness, respect, and dignity and honor the exercise of resident ' s rights. The P&P indicated the facility ' s staff would encourage resident to participate in planning their daily care routines including activities of daily living. Each resident was allowed to choose personal care needs, such as bathing methods, grooming styles, and health care scheduling, such as times of day for therapies and certain treatments. The P&P indicated residents were encouraged to make choices about aspects of his or her life in the facility.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48219 Based on observation, interview, and record review, the facility failed to ensure the call light (a button the patient pushes at the bedside that notifies the nursing staff to request assistance) within reach for 1 out of 5 sampled residents (Resident 4). This deficient practice has the potential to delay necessary assistance, not meeting the needs of the resident promptly. Ensuring that the call light is always within reach is crucial for the safety and well - being of resident. Finding: A review of Resident 4 ' s Admission Record indicated the resident was originally admitted to the facility on [DATE], with diagnoses the at included Hemiplegia (severe or complete loss of strength or on one side of the body) and Hemiparesis (partial weakness on one side of the body) and Parkinsonism (tremor, slowness, stiffness, and walking and balance problems). A review of Resident 4 ' s History and physical dated 1/4/2024, indicated resident had fluctuating capacity to understand and make decision known. A review of Resident 4 ' s Minimum Data Set (MDS, a standardized assessment and care - screening tool) dated 3/16/2024 indicated resident required substantial / maximal assistance with activities of daily living and toileting hygiene and shower/bathing self. A review of Resident 4 ' s Care Plan titled Activity assistance needed, indicated intervention to keep call light within easy reach. During a concurrent observation and interview on 5/17/2024 at 2:00pm with Resident 4, in Resident 4 ' s room, Resident 4 ' s call light was on the floor. Resident 4 stated she could not reach her call light, Resident 4 would yell to get the attention of staff when Resident 4 required assistance. During a Concurrent observation and interview, on 5/17/2024 at 2:02pm with licensed vocational nurse (LVN)4 in Resident 4 ' s room, Resident 4 ' s call light was observed. LVN4 stated the call light was on floor. LVN4 stated it was important for resident ' s call lights to be within reach of each residents, so that residents can call for help when residents required assistance. LVN4 stated facility staff, such as licensed nurses and CNA ' s were responsible to ensure residents call lights were within reach. A record review of facility ' s policy and procedure titled, Communication - Call System Policy No. - NP- 29 revised date 1/1/2012, indicated the purpose of policy was to provide a mechanism for residents to promptly communicate with nursing staff. The Facility will provide a call system to enable residents to alert the nursing staff from their rooms and toileting/ bathing facilities. Call Cords will be placed within the resident ' s reach in the resident ' s room.