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	03/28/2025

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 0600 Level of Harm - Actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372 Based on interview, and record review the facility failed to ensure one of three sampled residents (Residents 1) were free from physical abuse by Certified Nurse Assistant (CNA) 1 by failing to: 1. Protect Resident 1 when Responsible Party (RP) 1 observed CNA 1 being rough during Resident 1 ' s peri care (also known as perineal care, refers to the cleaning and maintenance of the genital and anal areas), on 3/14/2025 and informed CNA 1 to be gentler. RP 1 reported to the facility ' s Infection Preventionist (IP) Nurse witnessing CNA 1 was rough during Resident 1 ' s peri care and complained of vaginal pain on 3/14/2025. 2. Protect Resident 1 from further abuse by CNA 1 when IP Nurse and Licensed Vocational Nurse (LVN) 1 allowed CNA 1 to continue caring for Resident 1 on 3/14/2025 and the next day, 3/15/2025. On 3/15/2025, RP 1 found Resident 1 in distress as reported by Resident 1 ' s roommate (Resident 2), who witnessed Resident 1 screaming, in distress and verbalized pain, while CNA 1 performed peri care towards Resident 1. CNA 1 continued to ignore Resident 1's screams and verbalization of pain on 3/15/2025 during peri care. These failures resulted in Resident 1 ' s rights violated when Resident 1 screamed and cried in tears and verbalized pain in the vaginal area during peri care and feeling scared towards CNA 1. Resident 2, verbalized being scared and uncomfortable on 3/15/2025, upon witnessing and hearing Resident 1 cried and screamed while CNA 1 rendered care to Resident 1. Findings: 1. During a review of Resident 1 ' s Admission Records (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage (a collection of blood between the brain and its outer covering due to a head injury, leading to a temporary or prolonged loss of awareness), Type 2 Diabetes(high blood sugar), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 3/13/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. (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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/20/2025, the MDS indicated the resident was severely impaired in cognition (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) with rolling to left and right, sit to lying, toilet transfer, tub/shower transfer. 2. During a review of Resident 2 ' s AR, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included joint replacement surgery (a surgical procedure that replaces a damaged joint with an artificial implant), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated the resident cognition is intact. During a review of Resident 2 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 3/7/2025, indicated Resident 1 is alert oriented, thought process, thought content without any abnormal thoughts, delusions, or hallucinations, normal cognition including orientation, attention, and memory, normal insight and judgment. During review of facility document titled Nursing Staffing Assignment and Sign in Sheet dated 3/14/2025 indicated CNA 1 was assigned to care for Resident 1 from 7 AM to 3 PM. During review of facility document titled Nursing Staffing Assignment and Sign in Sheet dated 3/15/2025 indicated CNA 1 was assigned to care for Resident 1 from 7 AM to 3 PM. During review of a facility document titled Alleged abuse dated 3/15/2025 timed at 4 PM, the document indicated the Director of Nurses (DON) spoke to [RP 1] who claimed she saw [CNA 1] performing peri care with Resident 1. The document indicated [RP 1] claimed that [CNA 1] wiped Resident 1 with the washcloth repeatedly in a rough manner. The document indicated [RP 1] claimed she told [CNA 1] to be gentle, but [CNA 1] ordered her [RP 1] out of the room, closed the curtain and continued with the care. The document indicated [RP 1] claimed [CNA 1] later came out of Resident 1 ' s room with the dirty briefs. The document indicated [RP 1] stated she did not like how CNA 1 responded so RP 1 called the police. During a review of Resident 1 ' s Care Plan (CP) dated 3/13/2025, the CP indicated Resident 1 ' s ADL (activities of daily living) function rehabilitation potential altered manifested by requires cues, reminders, and supervision ADL assistance needed: personal hygiene, toileting, bathing. The interventions included, Do not rush resident, allow enough time to complete task at own pace, explain all necessary procedure prior to rendering care and treatment plan. During a review of Resident 1 ' s Care Plan (CP) dated 3/15/2025, the CP indicated Resident 1 was At risk for psychosocial distress (a set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people) related to allegations by [RP 1] that staff [CNA1] was rough during care with interventions that included, Change caregiver to ensure immediate safety, monitor for psychosocial distress manifested by tearfulness, fearfulness related allegation of roughness. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During a review of the Police Report dated 3/15/2025 timed at 5:48 PM, the Report indicated on Saturday, 3/15/2025 at approximately 6 PM, Police Officer responded at the facility regarding an abuse investigation concerning Resident 1. The Report indicated Resident 1 speaks a foreign language. On Friday 03/14/2025 at approximately 9 AM, [RP 1] visited Resident 1 at the facility. [RP 1] entered the room and noticed [Resident 1] was in distress and grasping for air attempting to say something. Resident 1 was in pain, stressed out, and agitated. [Resident 1] said CNA 1 was mistreating her. [RP 1] added that she witnessed CNA 1 aggressively grabbed her [Resident 1] by the arm, attempting to move her on her side to clean the resident ' s vaginal area. [RP 1] stated [Resident 1] was recovering from a dislocated shoulder and had fragile muscle. [RP 1] stated [CNA 1] was rough when cleaning [Resident 1] and ultimately causing pain. [RP 1] stated [CNA 1] showed no interest in treating [Resident 1] in a fair manner. [RP 1] asked [CNA 1] about what was going on, when [CNA 1] quickly closed the curtains on [RP 1]. [RP 1] reported the incident. The next day, Saturday 3/15/2025 at approximately 9 AM, [RP 1] went back to the facility. [CNA 1] was in the room changing [Resident 1] before she arrived. When [RP 1] arrived, she observed Resident 1 in distress again about to cry and took RP 1 some time to calm Resident 1 down. Resident 2 (Resident 1 ' s roommate) stated she heard Resident 1 screaming in pain before [RP 1] had arrived. [Resident 2] stated [CNA 1] continued to ignore [Resident 1] screams, closed the curtain and walked out of the room. During a review of an electronic (e-mail) mail sent by the DON on 3/28/2025 timed at 5:03 PM, the e-mail indicated the DON had just completed Resident 1 ' s roommate ' s interview with the help of a translator and would need to further investigate. The e-mail indicated the DON called CNA 1 and placed CNA 1 on administrative leave (a temporary, paid or unpaid, suspension of an employee's duties, typically initiated by an employer for specific reasons) pending further investigation. During an interview on 3/28/2025 at 9:40 AM with Resident 1, Resident 1 stated, CNA 1 hurt her many times. Resident 1 stated CNA 1 hold her body very hard and rough, and clean her vaginal area very rough. Resident 1 nodded her head and stated Yes in Resident 1 ' s primary language, when asked if she was scared with CNA 1. During an interview on 3/28/2025 at 9:50 AM with RP 1, RP 1 stated that on 3/14/2025, on a Friday at around 9 AM, RP 1 came to the facility to visit Resident 1. RP 1 stated when she entered Resident 1 ' s room, the privacy curtains were pulled back. RP 1 stated she heard Resident 1 moaning, so RP 1 opened the privacy curtain and saw CNA 1 was cleaning Resident 1. RP 1 stated CNA 1 asked her to get out and close the curtain, so RP 1 introduced herself and informed CNA 1 that she is Resident 1 ' s responsible party. RP 1 stated CNA 1 did not listen to her and still informed RP 1 to close the curtain and get out. RP 1 stated she closed back the privacy curtain but stayed inside the room. RP 1 stated that after a few minutes, RP 1 heard Resident 1 saying in her primary language You hurting me, it hurts. RP 1 stated she opened the privacy curtain and asked CNA 1 to be gentle, but CNA 1 continued wiping Resident 1 ' s peri area with the towel (wash cloth) repeatedly in a rough manner. RP 1 stated CNA 1 did not stop even after RP 1 had approached her. RP 1 stated that when CNA 1 finished Resident 1 ' s peri care, CNA 1 just left the room with no explanation. (continued on next page)

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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 0600 Level of Harm - Actual harm Residents Affected - Few	During the same interview on 3/28/2025 at 9:50 AM, RP 1 stated that on that same day (3/14/2025) at around 11 AM, the Infection Preventionist (IP) nurse came in and RP 1 reported witnessing CNA 1 was rough during Resident 1 ' s peri care and Resident 1 complained that her vagina hurts. RP 1 stated that IP nurse informed her that she would inform Licensed Vocational Nurse (LVN) 1. RP 1 stated that CNA 1 continued to be assigned to Resident 1 on 3/14/2025 until the end of the AM shift, up to the afternoon (7 AM to 3 PM). RP 1 stated CNA 1 was still the assigned CNA who assisted Resident 1 with incontinence care (refers to cleaning and drying of the perineal area after involuntary leakage of urine) in the afternoon. During the same interview on 3/28/2025 at 9:50 AM, RP 1 stated the next day, 3/15/2025, RP 1 stated she came back to the facility to visit Resident 1 at around 9 AM. RP 1 stated she found Resident 1 in tears, crying, and gasping for words. RP 1 stated Resident 1 informed RP 1 that CNA 1 was very rough during peri care and turned her from side to side forcefully. RP 1 stated she reported Resident 1 ' s allegations to Registered Nurse (RN) 1 on the same day, 3/15/2025 at around 10 AM. RP 1 stated that RN 1 did not reassure her or Resident 1 that CNA 1 ' s roughness against Resident 1 will not happen again. RP 1 stated RN 1 did not inform her and Resident 1 what interventions RN 1 would do to prevent the incident from happening again. RP 1 stated that RN 1 assigned another CNA to Resident 1 around 12 PM, on 3/15/2025. RP 1 stated she tried to call the DON but was unsuccessful. RP 1 stated she called the police on 3/15/2025 between 4 to 5 PM, because she was concerned for Resident 1 ' s safety. RP 1 stated the police arrived at the facility on 3/15/2025 and the police was there for a while. RP 1 stated the DON called her after the police left the facility and informed her that what CNA 1 did was Bad customer service. During an interview on 3/28/2025 at 10:34 AM with CNA 2, CNA 2 stated on 3/15/2025 at around 12 PM, CNA 2 was informed by RN 1 that her assignment had changed, and CNA 1 would be assigned to Resident 1. During an interview on 3/28/2025 at 10:45 AM with CNA 1, CNA 1 stated she was assigned to Resident 1 on 3/14/2025 and 3/15/2025, during the AM shift, 7 AM to 3 PM. CNA 1 stated Resident 1 is confused and speaks in the resident ' s primary language. CNA 1 stated she does not speak and understand Resident1 ' s primary language. CNA 1 stated that during care Resident 1 would usually moan and say something in her primary language that she did not understand. CNA 1 stated that on Friday, 3/14/2025 at around 9 AM was the first time she had Resident 1 assigned to her. CNA 1 stated that while she was changing Resident 1 ' s incontinence brief, the privacy curtain was closed. CNA 1 stated that someone came into the room and pulled the curtain and stated she was RP 1. CNA 1 stated she told RP 1 to close the curtain so she can finish cleaning up Resident 1. CNA 1 stated she closed the curtain then Resident 1 said something in her primary language and then RP 1 opened the curtain again. CNA 1 stated RP 1 told her that Resident 1 was saying that it hurts, and RP 1 told her to just take it easy. CNA 1 stated she said Okay. CNA 1 stated that later the same day, she went back to Resident For the second change. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During the same interview on 3/28/2025 at 10:45 AM with CNA 1, CNA 1 stated that on Saturday, 3/15/2025, CNA 1 was assigned back to Resident 1. CNA 1 stated she performed peri care and changed Resident 1 ' s incontinence brief in the morning at around 9 AM. CNA 1 stated that later that day, the charge nurse (RN 1) called CNA 1 and stated she would be removed from that assignment with Resident 1. CNA 1 stated she did not get any report if Resident 1 required one person or two-person assistance for ADLs and did not get a report how Resident 1 communicate and the primary language that she speaks. CNA 1 stated she cleaned Resident 1 ' s peri area with a towel. CNA 1 stated that she was trying to finish Resident 1 ' s peri care that ' s why she did not stop, even if RP 1 approached her. CNA 1 stated that some residents are sensitive during peri care. During an interview on 3/28/2025 at 11:22 AM with LVN 2, LVN 2 stated that if the family member is the RP, the family member has the right to be present during the resident ' s care. LVN 2 stated that if CNA 1 did not understand Resident 1 ' s primary language, CNA 1 should find someone that speaks Resident 1 ' s language or ask RP 1 to help. LVN 2 stated if Resident 1 reported that it hurts during care, the staff or CNA 1 should call another staff to help with Resident 1 ' s ADL care and bed mobility (turning/repositioning). During an interview on 3/28/2025 at 12:08 PM with the IP Nurse, the IP Nurse stated on 3/14/2025 at around 11 AM, RP 1 reported to her that CNA 1 was rough with Resident 1 during peri care. The IP Nurse stated she informed LVN 1 on 3/14/2025. During an interview on 3/28/2025 at 12:30 PM with LVN 1, LVN 1 stated she was assigned to Resident 1 on 3/14/2025 during the AM shift, from 7 AM to 3 PM. LVN 1 stated on 3/14/2025 between 8 AM to 12 PM, the IP nurse reported to her that CNA 1 was rough with Resident 1 during peri care and RP 1 was not happy with the care. LVN 1 stated she did not talk to RP 1 or Resident 1 regarding their concern. LVN 1 stated she talked to CNA 1 and ask her to be gentler. LVN 1 stated some residents are more sensitive than others. LVN 1 stated she did not change CNA 1 ' s assignment and did not investigate and reported the allegation to the abuse coordinator, the Administrator. LVN 1 stated she did not document Resident 1 or RP 1 allegations towards CNA 1. LVN 2 stated she is a mandated reporter; however, she did not consider being rough as an allegation of abuse. During an interview on 3/28/2025 at 1:27 PM with RN 1, RN 1 stated on 3/15/2025 between 10 AM and 11 AM, RP 1 reported to her that CNA 1 was rough with Resident 1 when cleaning the peri area with a towel, and she was not happy and comfortable with CNA 1. RN 1 stated she assigned CNA 2 to Resident 1. RN 1 stated she did not see being rough as a form of abuse. RN 1 stated CNA 1 worked the whole shift on 3/15/2025 stated she did not report to the DON or ADM at that time (3/15/2025). RN 1 stated in the afternoon of 3/15/2025, RP 1 called the police, and the police showed up at the facility around 4 PM and that was the time, LVN 1 decided to report to the DON. RN 1 stated the DON informed RN 1 to file an allegation of abuse and investigate. During an interview on 3/28/2025 at 1:46 PM with the DON, the DON stated being rough is subjective (something is based on or influenced by personal feelings, opinions, or perspectives) and has a broad meaning. The DON stated if he would have received a complaint/report from a resident or family, that a facility staff was being rough with a resident, he would interview the resident and the family. The DON stated he would investigate and based on the findings he would know if it was abuse or not. The DON stated he would expect his staff to do the same. The DON stated if staff does not understand the resident during care, for example because the resident speaks a different language, the staff, like CNA 1 should get an interpreter to help them. (continued on next page)

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F 0600 Level of Harm - Actual harm Residents Affected - Few	During an interview on 3/28/2025 at 4:07 PM with Resident 2, Resident 2 stated she was roommate with Resident 1 on 3/15/2025. Resident 2 stated on 3/15/2025, after breakfast at around 9 AM, Resident 2 heard Resident 1 screaming and speaking in her language, You are killing me, stop. Resident 2 stated she speak and understand Resident 1 ' s language. Resident 2 stated she was sitting in bed and look through the curtain and saw Resident 1 lying in bed and CNA 1 was cleaning her. Resident 2 stated CNA 1 closed the curtain right away and she was not able to see anything anymore and just heard Resident 2 screaming. Resident 2 stated that for more than five minutes, Resident 1 was screaming You killing me. Resident 2 stated that after a few minutes, she saw RP 1 come and Resident 2 reported the incident to RP 1. Resident 2 stated during the night shift, there was another CNA, CNA 3 who assisted Resident 1 with cleaning and peri care, but she did not hear Resident 1 complained at all. Resident 2 stated this incident when Resident 1 cried and screamed while CNA 1 assisted Resident 1 made her scared and uncomfortable. Resident 2 stated she was planning to live at a nursing home in the future but after the incident she witnessed with Resident 1, Resident 2 would not consider living in the nursing home for long term in the future. During an interview on 4/1/2025 at 2:21 PM with the DON, the DON stated he interviewed the roommate, Resident 2 for the first time on 3/28/2025, with the help of a translator, and see the need for further investigation. The DON stated he placed CNA 1 on administrative leave pending further investigation on 3/28/2025. The DON stated CNA 1 worked on 3/14/2025, 3/15/2025, from 7 AM to 3 PM, but suspended at the end of shift on 3/15/2025. The DON stated CNA 1 worked on 3/18/2025, 3/19/2025, 3/20/2025, 3/21/2025 and 3/22/2025, 3/25/2025 and 3/26/2025, 3/27/2025, and 3/28/2025 during the AM shift (7 AM to 3 PM) and suspended on 3/28/2025 at the end of the shift, for further investigation. During a review of facility policy & procedure (P&P) titled Abuse - Prevention, Screening, and Training Program revised July 2018, the P&P indicated To address the health, safety, welfare, dignity, and respect of residents by preventing abuse, neglect, misappropriation of resident property, exploitation, and mistreatment . Abuse is defined as the willful, deliberate (intentional) infliction of injury, unreasonable confinement (the state of being forced to stay in a closed space) . not required to treat symptoms and/or imposed for the purposes of discipline or convenience, intimidation . mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish . During the review of facility P&P titled Abuse Prevention and Management revised 05/30/2024, the P&P indicated The Facility does not condone (to forgive or approve) any form of resident abuse, neglect, misappropriation of resident property . and/or mistreatment . Reports of resident abuse, mistreatment, neglect . or injuries of an unknown source, and any suspicion of crimes are promptly reported and thoroughly investigated. During a review of facility P&P titled Residents Rights revised 01/01/2012, the P&P indicated Residents of skilled nursing facilities have a number of rights under state and federal law. The facility will promote and protect those rights. Residents have freedom of choice, as much as possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules and regulations and applicable state and federal laws governing the protection of resident health and safety.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44372 Based on interview, and record review the facility failed notify CDPH, the Ombudsman, and Law Enforcement within two (2) hours of an allegation of abuse. The allegation of abuse was reported to CDPH via fax on 3/15/2025 at 8:06 PM (around 33 hours later), iin accordance with the facility's policy and procedure titled Abuse - Reporting & Investigations. The facility failed to: 1. Notify the allegation of physical abuse by Certified Nurse Assistant (CNA) 1 for Resident 1 when Responsible Party (RP) 1 observed CNA 1 being rough during Resident 1 ' s peri care (also known as perineal care, refers to the cleaning and maintenance of the genital and anal areas), on 3/14/2025 and informed CNA 1 to be gentler. RP 1 reported to the facility ' s Infection Preventionist (IP) Nurse around 11:00 AM witnessing CNA 1 was rough during Resident 1 ' s peri care and complained of vaginal pain on 3/14/2025. 2. Suspend the CNA on 3/14/2025 in accordnace with the facility's P&P. CNA 1 was assigned back to Resident 1 on 3/15/2025 after allegation of abuse was reported by RP 1 to IP nurse on 3/14/2025. 3. Investigate the allegation of abuse when RP 1 reported the incident to the IP Nurse on 3/14/2025. These failures resulted in the facility violating its policy of reporting, investigating and protecting Resident 1 from further abuse. Findings: During a review of Resident 1 ' s Admission Records (AR), the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included traumatic subdural hemorrhage (a collection of blood between the brain and its outer covering due to a head injury, leading to a temporary or prolonged loss of awareness), Type 2 Diabetes(high blood sugar), and major depressive disorder (a mood disorder that causes a persistent feeling of sadness and loss of interest). During a review of Resident 1 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 3/13/2025, the H&P indicated Resident 1 did not have the capacity to understand and make decisions. During a review of Resident 1 ' s Minimum Data Set (MDS, a federally mandated resident assessment tool), dated 3/20/2025, the MDS indicated the resident was severely impaired in cognition (problems with a person ' s ability to think, learn, remember, use judgement, and make decisions). The MDS indicated Resident 1 was dependent (helper does all the effort) with rolling to left and right, sit to lying, toilet transfer, tub/shower transfer. During a review of Resident 2 ' s AR, the AR indicated Resident 1 was admitted to the facility on [DATE] with diagnoses that included joint replacement surgery (a surgical procedure that replaces a damaged joint with an artificial implant), hypertension (high blood pressure), and hyperlipidemia (high cholesterol). (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of Resident 2 ' s MDS dated [DATE], the MDS indicated the resident cognition is intact. During a review of Resident 2 ' s History and Physical (H&P, a comprehensive physician ' s note regarding the assessment of the resident ' s health status), dated 3/7/2025, indicated Resident 1 is alert oriented, thought process, thought content without any abnormal thoughts, delusions, or hallucinations, normal cognition including orientation, attention, and memory, normal insight and judgment. During review of facility document titled Transition Verification Report dated 3/15/2025 and timed 8:06 PM, the document indicated 9 pages was faxed and indicates a result as ok. During review of facility document titled Nursing Staffing Assignment and Sign in Sheet dated 3/14/2025 indicated CNA 1 was assigned to care for Resident 1 from 7 AM to 3 PM. During review of facility document titled Nursing Staffing Assignment and Sign in Sheet dated 3/15/2025 indicated CNA 1 was assigned to care for Resident 1 from 7 AM to 3 PM. During review of a facility document titled Alleged abuse dated 3/15/2025 timed at 4 PM, the document indicated the Director of Nurses (DON) spoke to [RP 1] who claimed she saw [CNA 1] performing peri care with Resident 1. The document indicated [RP 1] claimed that [CNA 1] wiped Resident 1 with the washcloth repeatedly in a rough manner. The document indicated [RP 1] claimed she told [CNA 1] to be gentle, but [CNA 1] ordered her [RP 1] out of the room, closed the curtain and continued with the care. The document indicated [RP 1] claimed [CNA 1] later came out of Resident 1 ' s room with the dirty briefs. The document indicated [RP 1] stated she did not like how CNA 1 responded so RP 1 called the police. During a review of Resident 1 ' s Care Plan (CP) dated 3/13/2025, the CP indicated Resident 1 ' s ADL (activities of daily living) function rehabilitation potential altered manifested by requires cues, reminders, and supervision ADL assistance needed: personal hygiene, toileting, bathing. The interventions included, Do not rush resident, allow enough time to complete task at own pace, explain all necessary procedure prior to rendering care and treatment plan. During a review of Resident 1 ' s Care Plan (CP) dated 3/15/2025, the CP indicated Resident 1 was At risk for psychosocial distress (a set of painful mental and physical symptoms that are associated with normal fluctuations of mood in most people) related to allegations by [RP 1] that staff [CNA1] was rough during care with interventions that included, Change caregiver to ensure immediate safety, monitor for psychosocial distress manifested by tearfulness, fearfulness related allegation of roughness. (continued on next page)

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	056322	A. Building B. Wing	03/28/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Montrose Springs Skilled Nursing & Wellness Center	2635 Honolulu Ave Montrose, CA 91020

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a review of the Police Report dated 3/15/2025 timed at 5:48 PM, the Report indicated on Saturday, 3/15/2025 at approximately 6 PM, Police Officer responded at the facility regarding an abuse investigation concerning Resident 1. The Report indicated Resident 1 speaks a foreign language. On Friday 03/14/2025 at approximately 9 AM, [RP 1] visited Resident 1 at the facility. [RP 1] entered the room and noticed [Resident 1] was in distress and grasping for air attempting to say something. Resident 1 was in pain, stressed out, and agitated. [Resident 1] said CNA 1 was mistreating her. [RP 1] added that she witnessed CNA 1 aggressively grabbed her [Resident 1] by the arm, attempting to move her on her side to clean the resident ' s vaginal area. [RP 1] stated [Resident 1] was recovering from a dislocated shoulder and had fragile muscle. [RP 1] stated [CNA 1] was rough when cleaning [Resident 1] and ultimately causing pain. [RP 1] stated [CNA 1] showed no interest in treating [Resident 1] in a fair manner. [RP 1] asked [CNA 1] about what was going on, when [CNA 1] quickly closed the curtains on [RP 1]. [RP 1] reported the incident. The next day, Saturday 3/15/2025 at approximately 9 AM, [RP 1] went back to the facility. [CNA 1] was in the room changing [Resident 1] before she arrived. When [RP 1] arrived, she observed Resident 1 in distress again about to cry and took RP 1 some time to calm Resident 1 down. Resident 2 (Resident 1 ' s roommate) stated she heard Resident 1 screaming in pain before [RP 1] had arrived. [Resident 2] stated [CNA 1] continued to ignore [Resident 1] screams, closed the curtain and walked out of the room. During a review of an electronic (e-mail) mail sent by the DON on 3/28/2025 timed at 5:03 PM, the e-mail indicated the DON had just completed Resident 1 ' s roommate ' s interview with the help of a translator and would need to further investigate. The e-mail indicated the DON called CNA 1 and placed CNA 1 on administrative leave (a temporary, paid or unpaid, suspension of an employee's duties, typically initiated by an employer for specific reasons) pending further investigation. During an interview on 3/28/2025 at 9:40 AM with Resident 1, Resident 1 stated, CNA 1 hurt her many times. Resident 1 stated CNA 1 hold her body very hard and rough. Resident 1 nodded her head and stated Yes in Resident 1 ' s primary language, when asked if she was scared with CNA 1. During an interview on 3/28/2025 at 9:50 AM with RP 1, RP 1 stated that on 3/14/2025, on a Friday at around 9 AM, RP 1 came to the facility to visit Resident 1. RP 1 stated when she entered Resident 1 ' s room, the privacy curtains were pulled back. RP 1 stated she heard Resident 1 moaning, so RP 1 opened the privacy curtain and saw CNA 1 was cleaning Resident 1. RP 1 stated CNA 1 asked her to get out and close the curtain, so RP 1 introduced herself and informed CNA 1 that she is Resident 1 ' s responsible party. RP 1 stated CNA 1 did not listen to her and still informed RP 1 to close the curtain and get out. RP 1 stated she closed back the privacy curtain but stayed inside the room. RP 1 stated that after a few minutes, RP 1 heard Resident 1 saying in her primary language You hurting me, it hurts. RP 1 stated she opened the privacy curtain and asked CNA 1 to be gentle, but CNA 1 continued wiping Resident 1 ' s peri area with the towel (wash cloth) repeatedly in a rough manner. RP 1 stated CNA 1 did not stop even after RP 1 had approached her. RP 1 stated that when CNA 1 finished Resident 1 ' s peri care, CNA 1 just left the room with no explanation. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview on 3/28/2025 at 9:50 AM, RP 1 stated that on that same day (3/14/2025) at around 11 AM, the Infection Preventionist (IP) nurse came in and RP 1 reported witnessing CNA 1 was rough during Resident 1 ' s peri care and Resident 1 complained that her vagina hurts. RP 1 stated that IP nurse informed her that she would inform Licensed Vocational Nurse (LVN) 1. RP 1 stated that CNA 1 continued to be assigned to Resident 1 on 3/14/2025 until the end of the AM shift, up to the afternoon (7 AM to 3 PM). RP 1 stated CNA 1 was still the assigned CNA who assisted Resident 1 with incontinence care (refers to cleaning and drying of the perineal area after involuntary leakage of urine) in the afternoon. During the same interview on 3/28/2025 at 9:50 AM, RP 1 stated the next day, 3/15/2025, RP 1 stated she came back to the facility to visit Resident 1 at around 9 AM. RP 1 stated she found Resident 1 in tears, crying, and gasping for words. RP 1 stated Resident 1 informed RP 1 that CNA 1 was very rough during peri care and turned her from side to side forcefully. RP 1 stated she reported Resident 1 ' s allegations to Registered Nurse (RN) 1 on the same day, 3/15/2025 at around 10 AM. RP 1 stated that RN 1 did not reassure her or Resident 1 that CNA 1 ' s roughness against Resident 1 will not happen again. RP 1 stated RN 1 did not inform her and Resident 1 what interventions RN 1 would do to prevent the incident from happening again. RP 1 stated that RN 1 assigned another CNA to Resident 1 around 12 PM, on 3/15/2025. RP 1 stated she tried to call the DON but was unsuccessful. RP 1 stated she called the police on 3/15/2025 between 4 to 5 PM, because she was concerned for Resident 1 ' s safety. RP 1 stated the police arrived at the facility on 3/15/2025 and the police was there for a while. RP 1 stated the DON called her after the police left the facility and informed her that what CNA 1 did was Bad customer service. During an interview on 3/28/2025 at 10:34 AM with CNA 2, CNA 2 stated on 3/15/2025 at around 12 PM, CNA 2 was informed by RN 1 that her assignment had changed, and CNA 1 would be assigned to Resident 1. During an interview on 3/28/2025 at 10:45 AM with CNA 1, CNA 1 stated she was assigned to Resident 1 on 3/14/2025 and 3/15/2025, during the AM shift, 7 AM to 3 PM. CNA 1 stated Resident 1 is confused and speaks in the resident ' s primary language. CNA 1 stated she does not speak and understand Resident1 ' s primary language. CNA 1 stated that during care Resident 1 would usually moan and say something in her primary language that she did not understand. CNA 1 stated that on Friday, 3/14/2025 at around 9 AM was the first time she had Resident 1 assigned to her. CNA 1 stated that while she was changing Resident 1 ' s incontinence brief, the privacy curtain was closed. CNA 1 stated that someone came into the room and pulled the curtain and stated she was RP 1. CNA 1 stated she told RP 1 to close the curtain so she can finish cleaning up Resident 1. CNA 1 stated she closed the curtain then Resident 1 said something in her primary language and then RP 1 opened the curtain again. CNA 1 stated RP 1 told her that Resident 1 was saying that it hurts, and RP 1 told her to just take it easy. CNA 1 stated she said Okay. CNA 1 stated that later the same day, she went back to Resident For the second change. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During the same interview on 3/28/2025 at 10:45 AM with CNA 1, CNA 1 stated that on Saturday, 3/15/2025, CNA 1 was assigned back to Resident 1. CNA 1 stated she performed peri care and changed Resident 1 ' s incontinence brief in the morning at around 9 AM. CNA 1 stated that later that day, the charge nurse (RN 1) called CNA 1 and stated she would be removed from that assignment with Resident 1. CNA 1 stated she did not get any report if Resident 1 required one person or two-person assistance for ADLs and did not get a report how Resident 1 communicate and the primary language that she speaks. CNA 1 stated she cleaned Resident 1 ' s peri area with a towel. CNA 1 stated that she was trying to finish Resident 1 ' s peri care that ' s why she did not stop, even if RP 1 approached her. CNA 1 stated that some residents are sensitive during peri care. During an interview on 3/28/2025 at 11:22 AM with LVN 2, LVN 2 stated that if the family member is the RP, the family member has the right to be present during the resident ' s care. LVN 2 stated that if CNA 1 did not understand Resident 1 ' s primary language, CNA 1 should find someone that speaks Resident 1 ' s language or ask RP 1 to help. LVN 2 stated if Resident 1 reported that it hurts during care, the staff or CNA 1 should call another staff to help with Resident 1 ' s ADL care and bed mobility (turning/repositioning). During an interview on 3/28/2025 at 12:08 PM with the IP Nurse, the IP Nurse stated on 3/14/2025 at around 11 AM, RP 1 reported to her that CNA 1 was rough with Resident 1 during peri care. The IP Nurse stated she informed LVN 1 on 3/14/2025. During an interview on 3/28/2025 at 12:30 PM with LVN 1, LVN 1 stated she was assigned to Resident 1 on 3/14/2025 during the AM shift, from 7 AM to 3 PM. LVN 1 stated on 3/14/2025 between 8 AM to 12 PM, the IP nurse reported to her that CNA 1 was rough with Resident 1 during peri care and RP 1 was not happy with the care. LVN 1 stated she did not talk to RP 1 or Resident 1 regarding their concern. LVN 1 stated she talked to CNA 1 and ask her to be gentler. LVN 1 stated some residents are more sensitive than others. LVN 1 stated she did not change CNA 1 ' s assignment and did not investigate and reported the allegation to the abuse coordinator, the Administrator. LVN 1 stated she did not document Resident 1 or RP 1 allegations towards CNA 1. LVN 2 stated she is a mandated reporter; however, she did not consider being rough as an allegation of abuse. During an interview on 3/28/2025 at 1:27 PM with RN 1, RN 1 stated on 3/15/2025 between 10 AM and 11 AM, RP 1 reported to her that CNA 1 was rough with Resident 1 when cleaning the peri area with a towel, and she was not happy and comfortable with CNA 1. RN 1 stated she assigned CNA 2 to Resident 1. RN 1 stated she did not see being rough as a form of abuse. RN 1 stated CNA 1 worked the whole shift on 3/15/2025 stated she did not report to the DON or ADM at that time (3/15/2025). RN 1 stated in the afternoon of 3/15/2025, RP 1 called the police, and the police showed up at the facility around 4 PM and that was the time, LVN 1 decided to report to the DON. RN 1 stated the DON informed RN 1 to file an allegation of abuse and investigate. During an interview on 3/28/2025 at 1:46 PM with the DON, the DON stated being rough is subjective (something is based on or influenced by personal feelings, opinions, or perspectives) and has a broad meaning. The DON stated if he would have received a complaint/report from a resident or family, that a facility staff was being rough with a resident, he would interview the resident and the family. The DON stated he would investigate and based on the findings he would know if it was abuse or not. The DON stated he would expect his staff to do the same. The DON stated if staff does not understand the resident during care, for example because the resident speaks a different language, the staff, like CNA 1 should get an interpreter to help them. (continued on next page)

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/28/2025 at 4:07 PM with Resident 2, Resident 2 stated she was roommate with Resident 1 on 3/15/2025. Resident 2 stated on 3/15/2025, after breakfast at around 9 AM, Resident 2 heard Resident 1 screaming and speaking in her language, You are killing me, stop. Resident 2 stated she speak and understand Resident 1 ' s language. Resident 2 stated she was sitting in bed and look through the curtain and saw Resident 1 lying in bed and CNA 1 was cleaning her. Resident 2 stated CNA 1 closed the curtain right away and she was not able to see anything anymore and just heard Resident 2 screaming. Resident 2 stated that for more than five minutes, Resident 1 was screaming You killing me. Resident 2 stated that after a few minutes, she saw RP 1 come and Resident 2 reported the incident to RP 1. Resident 2 stated during the night shift, there was another CNA, CNA 3 who assisted Resident 1 with cleaning and peri care, but she did not hear Resident 1 complained at all. Resident 2 stated this incident when Resident 1 cried and screamed while CNA 1 assisted Resident 1 made her scared and uncomfortable. Resident 2 stated she was planning to live at a nursing home in the future but after the incident she witnessed with Resident 1, Resident 2 would not consider living in the nursing home for long term in the future. During an interview on 4/1/2025 at 2:21 PM with the DON, the DON stated he interviewed the roommate, Resident 2 for the first time on 3/28/2025, with the help of a translator, and see the need for further investigation. The DON stated he placed CNA 1 on administrative leave pending further investigation on 3/28/2025. The DON stated CNA 1 worked on 3/14/2025, 3/15/2025, from 7 AM to 3 PM, but suspended at the end of shift on 3/15/2025. The DON stated CNA 1 worked on 3/18/2025, 3/19/2025, 3/20/2025, 3/21/2025 and 3/22/2025, 3/25/2025 and 3/26/2025, 3/27/2025, and 3/28/2025 during the AM shift (7 AM to 3 PM) and suspended on 3/28/2025 at the end of the shift, for further investigation. During an interview and record review of Facility policy and procedure titled Abuse - Reporting & Investigations with DON on 4/1/2025 at 2:25 PM with the DON, the DON stated based on policy the Administrator, or designated representative should notify within two hours notify CDPH, the Ombudsman and Law Enforcement any allegation of abuse including no serious body injury . During an interview and record review of Facility policy and procedure titled Transition Verification Report with DON on 4/1/2025 at 2:27 PM with the DON, the DON stated according to the fax machine's timestamp, the fax to CDPH on 3/15/2025 was sent at 8:06 PM. However, he believes the fax machine's clock is incorrect, running 20 minutes ahead. As a result, he maintains that the documents were actually faxed at 7:50 PM rather than 8:06 PM. During a review of facility policy & procedure (P&P) titled Abuse - Prevention, Screening, and Training Program revised July 2018, the P&P indicated To address the health, safety, welfare, dignity, and respect of residents by preventing abuse, neglect, misappropriation of resident property, exploitation, and mistreatment . Abuse is defined as the willful, deliberate (intentional) infliction of injury, unreasonable confinement (the state of being forced to stay in a closed space) . not required to treat symptoms and/or imposed for the purposes of discipline or convenience, intimidation . mistreatment, and injuries of unknown source or punishment with resulting physical harm, pain, or mental anguish . (continued on next page)

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