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	01/22/2026

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a comprehensive, resident-centered care plan entailed specific objectives and interventions to provide adequate care for one (1) of five (5) sampled residents, (Resident 5), who continuously refused medications even after educational risk were provided from 12/1/25 to 1/23/26. This deficient practice had the potential to cause a negative outcome to residents' health condition.During a review of Resident 5's admission Record (AR), the AR indicated Resident 5 was originally admitted to the facility on [DATE]. The admitting diagnoses included but not limited to: atherosclerotic heart disease (a heart disease caused by plaque buildup in arterial walls), hypertensive heart disease with heart failure (a disease occurs when chronic high blood pressure causes the heart muscle to thicken and stiffen, limiting its ability to fill or pump blood effectively), cardiomyopathy (chronic disease of the heart muscle), and type 2 diabetes mellitus (a type of chronic condition with high blood sugar). During a review of Resident 5's Physician's Orders, the Orders details indicated Resident 5 had 15 active medications; 14 out of 15 medications were oral medications and 1 was a topical patch (a medicated, sticky patch applied to the skin that delivers a specific dose of medicine directly into the bloodstream over time, bypassing the digestive system for a slow, steady release). The 14 oral medications included 3 medications to treat high blood pressure and various heart diseases, 2 medications to treat or prevent blood clots, 5 vitamins and supplements, 1 as needed pain medication, 1 stool softener, 1 laxative, and 1 medication to prevent stomach upset caused by stomach acid. The topical patch was clonidine (medication to treat high blood pressure) 0.1 milligrams (mg, an unit to measure mass) per 24 hours transdermal (through the skin) patch, apply 1 patch on every Wednesday, ordered on 7/3/2025. During an observation on 01/22/2026 at 3:08 PM, Resident 5 was observed sleeping in bed. During a review of Resident 5's Care Plan for episodes of refusing medications, initiated on 6/30/25, revised on 7/29/25 and 10/14/2025, the Care Plan did not indicate new interventions for when Resident 5 refused medications. This care plan had four interventions, and all were initiated on 6/30/2025. The interventions included: assess the resident's reason for refusing medications, document all refusals and reasons and action taken, encourage to take medication as ordered and explained risks and benefits, and notify MD for complications. During a review of Resident 5's Physician Notes from 1/1/ 2025 to 1/22/2026, the Notes indicated the following:On 01/11/2025 and 5/28/2025 indicated Resident 5 tolerated medications and denied any complaints. The Physician Notes datedOn 7/11/2025 indicated Education provided to [Resident 5] regarding the importance of complying to medication to avoid complications associated with elevated [blood pressure (BP)]. [Resident 5] verbalized understanding and refused all medication except clonidine.On 9/25/2025 and 10/28/2025 indicated Resident 5 was noncompliant with BP medication except clonidine patch and unwilling to comply to medication. The physician notes datedOn 11/27/2025 indicated Resident 5 was noncompliant with BP checks at times and continued to be noncompliant (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: 056322	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	with BP medication except clonidine.On 12/4/2025 (most recent) indicated Resident 5 continued to remain noncompliant with medications and care despite education on risks. During a review of Resident 5's interdisciplinary team (IDT team, a collaborative group of professionals-including doctors, nurses, social workers, and therapists-who work together to create and implement a unified, patient-centered care plan) meeting notes from 1/1/ 2025 to 1/22/2026, indicated 4 IDT meeting notes. The IDT Note on 6/30/2025 indicated Resident has been refusing all meds. However, the following IDT meetings notes, dated 9/4/25, 10/18/25, and 11/20/25 indicated there was no discussion nor reassessment of Resident 5's refusal of medications. During a concurrent interview and record review on 1/22/2026 at 2:21 PM with licensed vocational nurse (LVN 2), Resident 5's electronic Medication Administration Record (eMAR) was reviewed. LVN 2 stated Resident 5 had been refusing medications which included blood pressure medications. Resident 5's eMAR for the month of January 2026 indicated that Resident 5 had refused all medications from 01/01/2026 to 01/22/2026, except the clonidine (a medication that treats high blood pressure) and patch (a topical application of medication). LVN stated when Resident 5 refused medications, the resident was educated and the refusal was documented on the eMAR. LVN 2 stated the nursing supervisor was then informed regarding Resident 5's refusal of medications. During an interview on 01/22/2026 at 2:24 PM with registered nurse supervisor (RN) 2, RN 2 stated Resident 5 was always refusing meds except the clonidine patch. RN 2 stated Resident 5's doctor and psychologist were aware of the medication refusal. RN 2 retrieved the last documented communication with Resident 5's doctor which was dated 8/18/2025. RN 2 stated she did not document other communication she made with Resident 5's doctors. RN 2 stated there were no other interventions or assessments conducted for Resident 5 besides re-education of the importance of taking medications and documenting the episodes. RN 2 stated Resident 5 thought the medications were causing excessive spits During an interview on 01/22/2026 at 2:32 PM with the Administrator (ADM), the ADM stated she was not aware that Resident 5 had been refusing medications. ADM stated Resident 5 was alert and oriented and often went out on pass with resident's nephew. During a concurrent observation and interview on 01/22/2026 at 4:05 PM, with licensed vocational nurse (LVN) 3 in Resident 5's room, Resident 5 was still in bed sleeping. LVN 3 stated Resident 5 usually takes a nap around this time in the afternoon and wakes up around dinner time. During an interview on 01/22/2026 at 4:11 PM, RN 2 stated she had not contacted the pharmacist to investigate if there might be potential medication issues that could cause Resident 5 to refuse medications. During an interview on 01/22/2026 at 4:49 PM with the ADM and the director of staff development (DSD), both stated IDT meetings were held quarterly. ADM agreed that prolonged refusal of medications may lead to a decline in residents' health conditions. During a review of the facility Policy and Procedures (P&P), titled Person-Centered Care Planning, revised 4/24/2025, the policy indicated a person-centered care plan included an effort to understand the importance to each resident. The P&P indicated the comprehensive care plan must be furnished to attain or maintain the resident's highest practical physical, mental, and psychosocial wellbeing. The P&P Indicated interventions were actions, treatments, procedures, or activities designed to meet an objective (a statement describing the results to be achieved to meet the resident's goals). The P&P indicated care plan must be prepared by the IDT and be reviewed and revised but the IDT after each assessment.

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NAME OF PROVIDER OR SUPPLIER Montrose Springs Skilled Nursing & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2635 Honolulu Ave 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 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. Based on observation, interview, and record review, the facility failed to ensure the medication administration process (med pass, the process of preparing and administering medications to residents) observed, for one (1) of one resident (Resident 1), was performed in the right time. Resident 1 received 7 medications more than 1 hour after the scheduled time. This deficient practice had the potential of medication error (wrong time) that may or may not affect resident's health condition. Findings: During a concurrent observation and interview on 01/22/2026 at 10:45 AM with licensed vocational nurse (LVN) 1, LVN 1 was observed outside Resident 1's room with a medication (med) cart. LVN 1 stated he was about to prepare and perform medication pass to Resident 1. During an observation on 01/22/2026 at 10:47 AM, LVN 1 measured Resident 1's blood pressure at the bedside and then proceeded to prepare the Resident 1's medications. LVN 1 prepared the following medications: Docusate sodium (an over-the-counter stool softener) 100 milligrams (mg, an unit to measure mass), 1 tablet. Escitalopram (generic for Lexapro, used to treat depression and/or anxiety disorder) 10 mg, 1 tablet Keppra (levetiracetam, an antiepileptic drug used to treat seizures) 500 mg, 1 tablet Losartan (generic for Cozaar, used to treat high blood pressure) 50 mg, 1 tablet Multiple vitamin w/ minerals, 1 tablet Vitamin D3, 125 micrograms (mcg, unit to measure smaller mass), or 5000 international unit (IU), 1 capsule 7.Ferrous Sulfate (an iron supplement used to prevent or treat iron deficiency) 325 mg, 1 tablet During a concurrent observation and interview on 01/22/2026 at 11 AM in Resident 1's room, LVN 1 administered Resident 1's medications. Resident 1 was observed seated up in his wheelchair. LVN 1 stated she was assigned to pass medications to 34 residents. During an interview on 01/22/2026 at 1:30 PM, the registered nurse supervisor (RN 1) stated the morning medications are scheduled at 9 AM and the nurses had a 2 hours' time window, between 8 AM to 10 AM, to complete all medication administrations. With an average of 30 residents per nurse and roughly 5 minutes per resident, RN 1 stated sometimes it could take nurses 150 minutes (or 2.5 hours, calculated from multiplying 30 residents with 5 minutes per resident) to complete all the medication administrations; some administrations would be over the 2 hours' time window. During an interview on 01/22/2026 at 3:25 PM, LVN 1 stated he was aware of the late medication administration to Resident 1. LVN 1 stated medications to Resident 1 was late this morning because there were unforeseen events that happened at the nursing unit which caused the delay in medication administration. During a review of the facility policy and procedures, Medication - Administration (revised 6/26/2025), the policy indicated . Medication must be administered within one hour before or one hour after the scheduled time. Licensed Nurse will verify. before administering the medication using the 6 rights of medication administration. Right Time: Administer within ordered time window.