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	02/26/2026

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to notify the attending physician and the responsible party for one of two sampled residents (Resident 2) after Resident 2 sustained a fall with a resulting laceration to the forehead on 2/18/2026. In addition, Resident 2 did not receive range of motion (ROM-movement of the joints) exercises on 2/23/2026, 2/24/2026, 2/25/2026, and 2/26/2026 as ordered by the physician. Staff reported that the resident refused the exercises due to feeling ill; however, the physician was not notified of these refusals. This deficient practice had the potential to delay timely clinical evaluation and treatment, which may lead to worsening of the injury, inadequate pain management, and delays in updating the plan of care, thereby placing the resident at risk for avoidable complications. During a review of Resident 2's admission Record, dated 2/12/2026, the admission Record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy (a brain disease that occurs when toxins that are normally cleared by the liver build up in the brain), dysphagia (difficulty swallowing), cognitive communication deficit. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 2/19/2026, the MDS indicated the resident's cognition (though process) is moderately impaired and required supervision on toileting hygiene, shower/bathe self, lower body dressing. Partial/moderate assistance with eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 2's Progress Notes dated 2/18/2026 indicated Resident 2 was found on the floor with a cut on the forehead measuring 2.0 X 0.1 centimeters (cm - a small unit of length in the metric system). The Note indicated 911 (Emergency Medical Services) was called and it was deemed that he has no significant injuries to warrant him to be transported to the hospital, the cut was cleansed with normal saline and was monitored throughout the night. During a review of Resident 2's Progress Notes change in condition fall dated 2/18/2026 at 3:45 AM no documentation found of physician and family notification. During a review of Resident 2's Telephone/Verbal Order, dated 2/23/2026, indicated a physician order for Restorative Nurse Assistant (RNA - to perform active range of motion (AROM) of right and left upper extremity three times a week every Monday, Wednesday, and Friday. RNA for ambulation with front wheel walker three times a week, as tolerated by patient for three months. During a review of Resident 2's Restorative Treatment Record, for 2/23/2026 - 2/26/2026 the record indicated that no treatments were provided as ordered by the physician. The records indicated blanks from 2/23/2026 - 2/26/2026 (4 days). During an interview on 2/26/2026 at 2:13 PM with Resident 2 stated that he would like to get out of bed but felt his legs were heavier and felt tired. During an interview on 2/26/2026 at 2:38 PM with the Registered Nurse Supervisor (RNS), RNS stated that resident is currently being monitored for fluid retention. During an interview on 2/26/2026 at 5:20 PM with Restorative Nurse Assistant (RNA) 1, RNA 1 stated that she had not performed the ROM and ambulation treatments to Resident 2 because Resident 2 had not been feeling well on 2/23/2026, (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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/24/2026, 2/25/2026, and 2/26/2026. RNA 1 stated she did not report Resident 1's refusal of ROM exercises to the charge nurse and did not document in RNA progress notes. During an interview on 2/26/2026 at 2:13 PM, Resident 2 stated that he was asleep and must have been in deep sleep that he turned to the side and must have rolled out of bed onto the floor. Resident 2 stated he got a cut on his forehead, and the paramedics came to see him but did not feel that he had to go to the hospital. During an interview on 2/26/2026 at 3:28 PM with the MDS Coordinator (MDSC), the MDSC stated that there was no documented evidence in Resident 1's records that the resident's family and the attending physician was notified of the fall with injury on 2/18/2026. The MDSC stated that the family and the physician should have been notified of Resident 1's fall with injury immediately after the fall on 2/18/2026 regardless of the 911 notification. During an interview on 2/24/2026 at 5:06 PM with License Vocational Nurse (LVN 1) stated that according to the facility's protocol, when a resident sustained a fall with injury, the physician and family must be notified, the care plan gets revised and a post-fall assessment is completed. During an interview on 2/24/2026 at 5:30 PM with the Director of Nurses (DON), the DON stated that there was no documented evidence that Resident 2's physician, and family had been notified after the resident's fall on 2/18/2026. The DON stated the physician must be made aware of significant changes in order to give medical treatment. During an interview on 2/26/2026 at 5:45 PM with the Director of Nurses (DON), the DON stated that the RNA should have communicated and documented the resident's ROM exercises refusals, with the charge nurse, or supervisor of not doing the ROM and ambulation exercises so that Resident 2's physician could have been notified. During a review of the facility's policy and procedure (P&P) titled Change of Condition Notification revised 8/25/2022, the P&P indicated that the facility will promptly inform the resident's physician and interested family member when the resident endures a significant change in their condition caused by an accident. During a review of the facility's policy and procedure (P&P) titled Restorative Nursing Program Guidelines, revised 1/30/2026, the P&P indicated that the RNA will carry out the restorative program according to the care plan and will document the amount of time spent in the activity and the tolerance to the program.

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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 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 observation, interview and record review, the facility failed to ensure a plan of care was developed and implemented to provide effective communication with the language that the resident was able to understand for two of two sampled residents (Resident 1 and 2). This deficient practice prevented the residents from communicating with the staff and had the potential to delay receiving appropriate care/treatment the residents needed. 1. During a review of Resident 1's admission Record, dated 2/6/2026, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, Malignant neoplasm of the large intestine and rectum (Cancer of the large intestine and rectum). During a review of the Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/13/2026, the MDS indicated the resident's preferred language was another language aside from the dominant language at the facility and wants an interpreter to communicate with the doctor or health care staff. During an interview on 2/26/2026 at 2:45 PM with Resident 1, Resident 1 stated he understands some words in English but is not fluent. Observed the Registered Nurse Supervisor with another Licensed Nurse translating in Resident 1's primary language. Resident 1 stated he cannot communicate his needs in English and needs assistance in communicating his needs. 2. During a review of Resident 2's admission Record, dated 2/12/2026, the admission Record indicated, Resident 2 was admitted to the facility on [DATE] with diagnoses that included hepatic encephalopathy (a brain disease that occurs when toxins that are normally cleared by the liver build up in the brain), dysphagia (difficulty swallowing), cognitive communication deficit. During a review of Resident 2's Minimum Data Set (MDS - a resident assessment tool) dated 2/19/2026, the MDS indicated the resident's cognition (though process) is moderately impaired and required supervision on toileting hygiene, shower/bathe self, lower body dressing and partial/moderate assistance with eating, oral hygiene, upper body dressing, and personal hygiene. During a review of Resident 2's Progress Notes dated 2/19/2026, the Note indicated Resident 1 needs and wants an interpreter to communicate with a doctor or health care staff. During an interview on 2/26/2026 at 2:13 PM Resident 2 was lying in bed in his room. The resident was observed not using the dominant language of the facility. During the interview using Resident 2's primary language, he stated he could not make himself understood and was not able to fluently understand the language spoken in the facility. Resident 2 stated he has a television in his room but could not explain to the staff that the television does not work and that the only channel that he was able to hear but not see was not the language he understood. During an interview on 2/26/2026 at 3:18 PM with the Social Services Director (SSD), SSD stated that it is important for the resident to be able to communicate with their preferred language and not being able to communicate can impact the ability to make requests or be able to communicate when the resident is not feeling well. During an interview on 2/26/2026 at 3:28 PM with the MDS coordinator, the MDS coordinator stated that the information that was entered on Resident 1 and 2's MDS assessments indicated the resident should have had a person-centered care plan reflecting their limitations and interventions needed to meet their needs related to their preferred languages. The MDS coordinator stated there was no care plans developed for Residents 1 and 2's communication limitations and needs for preferred language aside from the dominant language used at the facility. During an interview on 2/26/2026 at 5:30 PM, the Director of Nursing (DON) stated that it was important for Residents 1 and 2 to be able to make their needs known, and that effective communication is essential for staff to understand what the residents are trying to communicate so staff can respond (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	appropriately. During a review of the facility's facility and procedure (P&P) titled Accommodation of Residents Communication Needs dated 2/24/2026 indicated, the facility is responsible for identifying each resident's communication requirements and providing accommodations that meet those needs. The P&P indicated that the resident's plan of care will be updated as necessary to reflect the interventions to meet the resident needs. During a review of the facility's facility and procedure (P&P) titled Resident Rights dated 1/1/2012 indicated, the facility will gather information about the resident's preferences on the initial assessment and document these preferences in the medical record and include them in the resident's care planning.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure 1 out of 2 sampled residents (Resident 2) received treatment and care in accordance with the physician's order by failing to monitor the resident's blood glucose level on 2/7/2026 at 6:30 AM, as required prior to administering hypoglycemic oral medications. This deficient practice had the potential to cause Resident 2 to experience a hypoglycemic (low blood sugar) episode. During a review of Resident 1's admission Record, dated 2/6/2026, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] with diagnoses that included Diabetes Mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing), muscle weakness, Malignant neoplasm of the large intestine and rectum (Cancer of the large intestine and rectum). During a review of the Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 2/13/2026, the MDS indicated the resident's cognition (thought process) is moderately impaired and required supervision on eating, and oral hygiene. Partial/moderate assistance in upper body dressing, and substantial/maximal assistance in toileting hygiene, shower/bathe self, lower body dressing, and putting on/taking off footwear. During a review of Resident 1's Telephone/Verbal Orders dated 2/7/2026 Glipizide oral tablet 2.5 milligrams (mg - metric unit of measurement, used for medication dosage and/or amount). Metformin HCL tablet 500 mg one tablet by mouth two times a day for Diabetes with meals. Fasting blood sugar before breakfast at 6:30 AM and at bedtime 9:00 PM. Call the physician if blood sugar is less than 70 or more than 400. During a review of Resident 1's Care Plan for Diabetes dated 2/7/2026, the care plan indicated that the resident will be free from any signs and symptoms of hypoglycemia. During a review of Resident 1's Medication Administration Record dated 2/7/2026 fasting blood sugar before breakfast and scheduled at 6:30 AM and bedtime at 9:00 PM. The order indicated to call the physician if the blood sugar is less than 70 or higher than 400. The MAR further indicated no blood sugar was done prior to administering medications for one day on 2/7/2026 at 6:30 AM. Continued review of the MAR indicated Resident 1 received Metformin (medication that treats high blood sugar) 500 mg twice a day with meals at 9:00 AM and Glipizide (medication that treats high blood sugar) 2.5 mg one tablet at 9:00 AM on 2/7/2026. During an interview on 2/26/2026 at 5:45 PM with the Director of Nurses (DON), DON stated that the blood sugar should have been checked in the morning prior to medication administration as ordered by the physician and if it was not marked in the MAR it was because it was not done stated that when the order was enter it was timed to begin at 9:00 PM and not before breakfast. During a review of the facility's policy and procedure (P&P) titled Medication Administration revised 6/26/2025, indicated that when medication is dependent upon vital signs or testing the vital signs/testing will be completed prior to administration of the medication and recorded in the medical record for example the point of care blood glucose.