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	04/07/2026

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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure a 72-hour neurological check (neurocheck, a comprehensive assessment of the functions of brain and body) was continuously conducted and documented for one of three sampled residents (Resident 1) in accordance with the facility's policy and procedures (P&P) titled Fall Management Program after Resident 1 sustained an unwitnessed fall on 3/29/26. This deficient practice had the potential to place Resident 1 at risk for missed detections of neurological deterioration and delayed interventions which could lead to serious health compilations.Findings: During a review of Resident 1's admission Record (AR), the AR indicated the facility originally admitted Resident 1 on 3/22/2017 and readmitted on [DATE] with diagnoses that include type 2 diabetes mellitus (a disease of inadequate control of blood levels of sugar) and acquired absence of left leg below knee (a surgical removal of the left lower leg). During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool), dated 3/28/2026, the MDS indicated Resident 1 had intact cognition (ability to understand and make decisions) and memory. The MDS indicated Resident 1 required supervision or touching assistance with eating and oral hygiene, partial/moderate assistance with toileting hygiene, shower/bathe self, lower body dressing, and chair/bed-to-chair transfer. During a review of Resident 1's Progress Notes (PN), dated 3/29/2026 timed at 4:17 AM, the PN indicated Resident 1 had an unwitnessed fall. During a review of Resident 1's Change in Condition Evaluation (COC), dated 3/29/2926 timed at 4:45 AM, the COC indicated Resident 1 had a fall on 3/29/2026. During a review of Resident 1's PN, dated 3/29/2026 timed at 7:56 AM, the PN indicated Resident 1 sustained an abrasion on right side of the face after a fall. During a review of Resident 1's Telephone/Verbal Order, dated 4/7/2026, there was no documentation indicating physician ordered to stop the 72-hour Neurocheck for Resident 1 after the fall on 3/29/2026. During a telephone interview on 4/6/2026 at 9 AM with Family Member (FM) 1, FM 1 stated the facility staff called and informed her that Resident 1 had a fall on 3/29/2026 in the early morning. FM 1 stated facility staff told her Resident 1 did not hit his head. FM 1 stated when she saw Resident 1 in the General Acute Care Hospital (GACH), Resident 1 had an abrasion on the right side of his face and Resident 1 told FM 1 that he hit his face on the nightstand which was located to the left side of Resident 1's bed, FM 1 stated she was concerned whether facility staff conducted an accurate assessment after Resident 1 fell on 3/29/26. During a concurrent interview and record review on 4/6/2026 at 3:20 PM with the MDS Nurse (MDSN), Resident 1's Neurological Check Lists, dated 3/29/2026 to 3/30/2026 and the facility's policy and procedure (P&P) titled, Fall Management Program, dated 11/11/2025, were reviewed. The MDSN stated according to the P&P, for an unwitnessed fall with suspected head injury, the licensed nurses would complete neurological checks for 72 hours following the fall incident as scheduled: every 15 minutes for one hour, then, every 30 minutes for two hours, then, every one hour for four hours, then, every four hours for 65 hours. The MDSN stated there was no documentation indicating the nurses performed a neurocheck on Resident 1 on 3/30/2026 at 1 PM, and 3/31/2026 at 1 AM and 5 AM. MDSN stated if the neurocheck was not documented the neurocheck was not done and she did not know if Resident 1 had any neurological (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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	changes at those times. The MDSN stated it was important to perform neurocheck continuously for 72 hours after any unwitnessed fall with a suspected head injury since it was critical to identify any changes in the early stage and intervene immediately, especially for a resident who was on certain medication, such as a blood thinner. The MDSN stated Resident 1's head scan did not indicate any abnormality during his emergency room visit, and it was still important to continue to perform and complete the 72-hour Neurocheck to ensure Resident 1 was safe because complications may show up in the next hours and/or days. During a concurrent interview and record review on 4/7/2026 at 12:05 PM with Registered Nurse (RN) 1, Resident 1's Neurological Check Lists, dated 3/29/2026 to 3/30/and the facility P&P titled, Fall Management Program, dated 11/11/2025, were reviewed. RN 1 stated there was no documentation indicated the neurological check list that the nurses performed and completed the continuous 72-hour Neurocheck for Resident 1 on 3/30/2026 at 1 PM and 3/31/2026 at 1 AM and 5 AM. RN 1 further stated as scheduled and according to the facility's P&P, Resident 1 should receive a neurocheck on 3/30/2026 at 5 PM and 9 PM, but the licensed nurse performed and documented his Neurocheck on 3/30/2026 at 5:46 PM and 10:53 PM. RN 1 stated both Neurochecks were delayed. RN 1 stated it was important to perform and document Neurocheck as scheduled to detect any neurological changes and intervene timely to prevent complications. During a review of the facility's P&P titled, Fall Management Program, dated 11/11/2025, were reviewed. The MDSN stated according to the P&P, for an unwitnessed fall with suspected head injury, the licensed nurses would complete neurological checks for 72 hours following the fall incident as scheduled: every 15 minutes for one hour, then, every 30 minutes for two hours, then, every one hour for four hours, then, every four hours for 65 hours.