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	04/20/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure clinical records were complete and accurately documented for two of four sampled residents (Resident 1 and Resident 2) by failing to record intravenous (IV, liquids administered directly into a vein to rapidly hydrate the body, replace electrolytes, or deliver medication and nutrition) medication administration. This deficient practice had the potential to lead to medication errors, inability to monitor therapeutic responses, and potential adverse outcomes.Findings: a. During a review of Resident 1's admission Record (AR), the AR indicated the resident was admitted to the facility on [DATE] and re-admitted to the facility on [DATE], with diagnoses that included sepsis (a life-threatening blood infection) due to Escherichia coli (E. coli, bacteria commonly found in the intestines of humans and animals), urinary tract infection (UTI, a common infection caused by E. coli, entering and multiplying within the urinary system), and extended spectrum beta lactamase resistance (ESBL, enzymes produced by bacteria that made them resistant to many common antibiotics). During a review of Resident 1's History and Physical (H&P) dated 3/23/2026, the H&P indicated the resident had fluctuating capacity to understand and make decisions. During a review of Resident 1's Minimum Data Set (MDS, a resident assessment tool) dated 3/17/2026, the MDS indicated the resident had moderate cognitive impairment (a person was experiencing noticeable and significant difficulties with thinking, learning, remembering, and other cognitive skills that impact their daily life). During a review of Resident 1's Order Listing Report dated 3/22/2026, the Order Listing Report indicated for the resident to have meropenem (a very strong, broad-spectrum antibiotic used to treat serious bacterial infections in the skin, stomach, or brain) IV solution reconstituted (the process of adding a liquid [diluent] to a powered medication to turn the medication into a usable liquid solution for IV injection) 1 gram (gm, unit of measurement), use 1 gm intravenously three times a day for pneumonia (PNA, an infection/inflammation in the lungs) until 3/28/2026 at 11:59 PM. During a review of Resident 1's Intravenous Therapy (IVT) Administration Record dated 3/1/2026 to 3/31/2026, the IVT Administration Record indicated there was no documentation that the resident received meropenem on 3/24/2026 at 6 AM. During an interview on 4/20/2026 at 3:26 PM, the Registered Nurse Supervisor (RNS) stated after a medication was administered to the Resident, the licensed nurse's (LN) must document the medication was given to prove the medication was administered. The RNS stated if there was no documentation, there would not be proof the medication was given and facility staff could have thought the dose was missed and the whole process would be ineffective for the resident. During a concurrent interview and record review of Resident 2's IVT Medication Record on 4/20/2026 at 3:32 PM, the RNS stated the IVT Medication Record for 3/24/2026 at 6 AM did not indicate documentation that the resident received the medication meropenem but should have been documented. The RNS stated this medication was for the resident's PNA and if Resident 2 did not receive the whole antibiotic course the resident's chest x-ray (quick, painless imaging test that used a small amount of radiation to take pictures of the inside of the chest, including the heart, lungs, ribs, and diaphragm) would not show the infection was resolved. b. During a review of Resident 2's AR, the AR indicated the resident was admitted to the (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
	056322	A. Building B. Wing	04/20/2026

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility on [DATE], with diagnoses that included sepsis, E.coli, and UTI. During a review of Resident 2's H&P dated 4/13/2026 at 1:15 PM, the H&P indicated the resident was alert and oriented to person, place, and time. The H&P indicated the resident had normal appearance and behavior, speech, mood, affect, thought process, normal cognition including orientation, attention, and memory, normal insight and judgement. During a review of Resident 2's Order Listing Report dated 4/12/2026, the Order Listing Report indicated for the resident to have ampicillin sodium solution (a liquid, injectable antibiotic used to treat a wide range of bacterial infections by breaking down bacterial cell walls) reconstituted 2 gm, use pharmacy 2 gm intravenously every six hours for sepsis secondary to E. coli UTI for six days. During a review of Resident 2's IVT Administration Record dated 4/1/2026 to 4/30/2026, the IVT Administration Record indicated there was no documentation that the resident received ampicillin on 4/15/2026 at 6 AM. During a concurrent interview and record review of Resident 2's IVT Medication Record on 4/20/2026 at 3:43 PM, the RNS stated the IVT Medication Record for 4/15/2026 at 6 AM did not show documentation that the resident received the medication ampicillin but should have been documented. The RNS stated Resident 2 was receiving the medication for UTI with a primary diagnosis of sepsis so the antibiotic was very important for the resident to receive. During a review of the facility's policy and procedure (P&P) titled Medication - Administration, dated 8/19/2025, the P&P indicated All medications shall be administered by licensed nursing staff according to physician orders, current best practices, and federal and state regulations. The facility shall ensure residents receive the correct medications in a timely, safe, and documented manner. The P&P indicated, The Licensed Nurse will verify the resident's identity before administering the medication using the 6 rights of medication administration: right resident - confirm with two identifiers, right medication - verify against the MAR and pharmacy label, right dose - ensure accuracy based on provider order, right route - confirm oral, topical, injection etc., right time - administer within ordered time window, right documentation - immediately document after administration. The P&P indicated, The time and dose of the medication or treatment administered to the resident will be recorded in the resident's individual medication record by the person who administers the medication or treatment.