

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/23/2026
NAME OF PROVIDER OR SUPPLIER Montrose Springs Skilled Nursing & Wellness Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review the facility failed to ensure a Significant Change in Status Assessment (SCSA) was completed for one of three sampled residents (Resident 1) following a significant change in the residents' condition, including significant weight loss and loss of the ability to ambulate. This deficient practice resulted in an inaccurate Minimum Data Set (MDS) for Resident 1, placing the resident at risk for receiving care and services that did not reflect Resident 1's current clinical condition. Findings: During a review of Resident 1's admission Record dated 7/7/2025, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM, Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced), Vascular Dementia (a state of decline in mental abilities resulting from reduced blood to the brain).^^^ During a review of Resident 1's History and Physical (H&P) dated 7/1/2026, indicated, Resident 1 does not have the capacity to make medical decisions. During a review of Resident 1's Quarterly Minimum Data Set (MDS - a resident assessment tool) dated 11/28/2025, indicated Resident 1 experienced a weight loss of 10% or more in the last six months and did not walk 50 feet with or without an assistive device. During an interview on 7/22/2026 at 2:53 PM with Certified Nurse Assistant (CNA 1), CNA 1 stated, Resident 1 is not ambulatory and requires two persons assist for transfers. CNA 1 stated staff does most of Resident 1's Activities of Daily Living (ADL- routine tasks activities such as bathing, dressing, and toileting a person performs daily to care for themselves). During an interview on 7/23/2026 at 10:47 AM with the MDS Coordinator (MDSC 1), MDSC 1 stated Resident 1 should have had a SCSA rather than a quarterly assessment since Resident 1 experienced two significant changes in condition that met the criteria for a SCSA. During an interview on 7/23/2026 at 5:41 PM with the Director of Nurses (DON), DON stated that when the change of condition affects more than one area of the resident's health status, it was considered a SCSA and required a care plan revision and for the MDS to be revised and updated. During a review of the facility's Policy and Procedure (P&P) titled Change of Condition Using Triage Trace, dated 10/24/2017, the P&P indicated the facility will complete a new MDS within 14 days when there is a significant change in condition.		

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review the facility failed to revise and update resident care plan (CP) for one of three sampled residents (Resident 1) when resident had a change of diet texture. This failure had the potential to result in inaccurate provision of services related to the resident's nutritional needs and swallowing status. Findings: During a review of Resident 1's admission Record dated 7/7/2025, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM, Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced), Vascular Dementia (a state of decline in mental abilities resulting from reduced blood to the brain). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 1's cognitive (the ability to process thoughts) was moderately impaired. The MDS also indicated Resident 1 was dependent on putting on putting on/taking off footwear. Substantial/maximal assistance on personal hygiene, lower/upper body dressing, shower/bathe self, toileting hygiene and supervision with eating. During a review of Resident 1's Order Summary Report, the Report indicated Resident 1 had an order on 2/28/2026 for No Added Salt (NAS) Consistent Carbohydrate (CCHO - consistent, constant, or controlled carbohydrate diet) diet Level 5 Minced and Moist Texture (soft and moist need very little chewing easy to mash with your tongue), level 2 mildly thick consistency (flows off a spoon quickly but slower than water) diet. During an observation on 7/22/2026 at 1:10 PM in Resident 1's room Resident 1 was observed eating a level 5 Minced and Moist Texture (soft and moist need very little chewing easy to mash with your tongue) diet. Family 1 (FM 1) who was present during the observation, stated Resident 1 did not like the texture of the food and was unaware why the change of food texture was done. During a review of Resident 1's Care Plan (CP) titled Resident has Potential for Alteration in Nutrition Secondary to Therapeutic Altered Diet revised on 12/2/2025, the CP indicated Resident 1 was on NAS CCHO level 6 soft & bite-sized texture with interventions for dietary evaluation and explain to the resident the rationale of diet. During an interview on 7/23/2026 at 10:47 AM with the MDS Coordinator (MDSC 1), MDSC stated that when there is a change in a resident's plan of care the care plan should be revised to indicate the resident's current condition. During an interview on 7/23/2026 at 5:41 PM with the Director of Nurses (DON), DON stated Resident 1's care plan should have been revised following the diet texture change to indicate the residents' current needs. During a review of the facility's Policy & Procedure (P&P) titled Person-Centered Care Planning revised 4/24/2025, the P&P indicated that the facility would develop person-centered care plans that identify the services necessary to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. The P&P further indicated that the Interdisciplinary Team (IDT - a coordinated group of experts from several different fields who work together) would review and revise the care plan following each quarterly and comprehensive assessment.		

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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 monitor blood glucose levels for one of three sampled residents (Resident 1) who had diagnosis of Diabetes Mellitus (DM - a disorder characterized by difficulty in blood sugar control and poor wound healing) had glucose (simple sugar - the body's primary source of energy from food) monitored when Insulin (a hormone that removes excess sugar from the blood, can be produced by the body or given artificially via medication) was administered twice a day for 12 days and had physician order with parameters (limits) to hold insulin if glucose was less than 70. This deficient practice resulted in Resident 1 not receiving appropriate daily blood sugar monitoring needed before safely administering insulin and placed Resident 1 at risk for undetected hypoglycemia (low blood sugar) and hyperglycemia (high blood sugar), delayed intervention for abnormal blood sugar levels, inappropriate insulin management, and preventable diabetic complications. Findings: During a review of Resident 1's admission Record dated 7/7/2025, the admission Record indicated Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM, Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced), Vascular Dementia (a state of decline in mental abilities resulting from reduced blood to the brain). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 1's cognitive (the ability to process thoughts) was moderately impaired. The MDS also indicated Resident 1 was dependent on putting on/taking off footwear. Substantial/maximal assistance on personal hygiene, lower/upper body dressing, shower/bathe self, toileting hygiene. During a review of Resident 1's Order Summary Report dated 6/17/2025, the Report indicated a physician order for lispro (a fast-acting insulin used to control blood sugar) inject 3 unit subcutaneously (SQ - under the skin in the layer of fatty tissue) two times a day for DM rotate site, hold if blood sugar is less than 70. During a review of Resident 1's Medication Administration Record (MAR) dated 6/1/2026 - 6/30/2026, the MAR indicated insulin was administered twice a day at 11:30 AM and at 4:30 PM without glucose monitoring. The MAR did not indicate a blood glucose result prior to the administration of insulin. Blood glucose on 6/26/2025 was 116, on 6/27/2025 was 151 and on 6/28/2026 was 110. During a review of Resident 1's Care Plan for The Resident has Diabetes Mellitus, dated 4/16/2025, the care plan indicated that Resident 1 would be free from any signs and symptoms of hypoglycemia. The care plan indicated to conduct fasting serum blood sugar as ordered by the physician. During a concurrent interview and record review on 7/23/2026 at 4:30 PM with Registered Nurse 2 (RN 2), Resident 1's MAR dated 6/17/2026 thru 6/28/2026 was reviewed. RN 2 stated the physician order indicated to hold insulin if Resident 1's blood glucose was less than 70 mg/dL. The MAR indicated from 7/17/2026 thru 7/28/2026 the glucose was not monitored, and insulin was still administered twice a day at 11:30 AM and at 4:30 PM. RN 2 stated it is important to monitor glucose levels to prevent hypoglycemia or hyperglycemia. During an interview on 7/23/2026 at 5:41 PM with the Director of Nurses (DON), DON stated the glucose should have been monitored as indicated by the physician's order and must be followed through. The DON stated the physician's order for insulin had parameters for when to administer and hold insulin, therefore Resident 1's blood sugar should have been obtained prior to insulin administration. During a review of the facility's policy and procedure (P&P) titled Physician Orders dated 8/21/2020, indicated, the License Nurse will confirm that physician orders are clear, complete and accurate as needed. The P&P indicated that medication orders will include condition or diagnosis for which medication is ordered.		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure one of three sample residents (Resident 1) who was admitted to the facility with an indwelling urinary catheter (tube inserted into the bladder to drain urine) received care and services in accordance with physician orders, by failing to follow-up on a physician ordered for a urology consultation. This deficient practice placed Resident 1 at risk for delayed evaluation and treatment of urinary conditions, prolonged use of the indwelling urinary catheter, urinary tract infection, catheter-related complications, urinary function, and avoidable decline in health status. Findings: During a review of Resident 1's admission Record dated 7/7/2025, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus (DM a chronic condition causing high blood sugar because the body does not make enough insulin, cannot use insulin properly, or both). Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced), Vascular Dementia (a state of decline in mental abilities resulting from reduced blood to the brain). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, the MDS indicated Resident 1's cognitive (the ability to process thoughts) was moderately impaired. The MDS also indicated Resident 1 was dependent on putting on/putting off footwear. Substantial/maximal assistance on personal hygiene, lower/upper body dressing, shower/bathe self, toileting hygiene. During a review of Resident 1's Order Listing Report dated 7/24/2026, the Order Listing Report included a physician order for a Urology Consult. During an interview on 7/23/2026 at 4:37 PM with Case Manager (CM 1), CM 1 stated several attempts were made to contact a urologist, however due to Resident 1's insurance, a urologist was not obtained. CM 1 stated she did not document the attempts in contacting a urologist. CM 1 stated that CM1 should have documented the attempts she has made to obtain Resident 1 a urology consult. During a review of Resident 1's Care Plan Possible Urinary Tract Infection (UTI) related to indwelling Foley Catheter, evidence by painful urination and strong-smelling urine dated 3/9/2026, indicated Extended Spectrum Beta-Lactamase Enzymes (ESBL - bacteria that are resistant to many common antibiotics). During a review of Resident 1's Care Plan for at risk of Urinary Elimination Problems, dated revised 5/5/2026, the care plan indicated Resident 1 would have no complications with urinary function During a review of Resident 1's Care Plan for Increased confusion and lower abdominal discomfort, dated 6/4/2026, the care plan indicated Resident 1 would be free of complications. During a review of Resident 1's Care Plan titled The Resident Has a Foley Catheter for Urinary Retention, revised 6/6/2026, the care plan indicated the goal was for Resident 1 to remain free of signs and symptoms of a urinary infection. During a review of Resident 1's Care Plan for Resident had episode of increased confusion with foul smelling urine, dated 6/17/2026, the care plan indicated Resident 1 would be free of complications. During a review of Resident 1's Progress Notes dated 6/20/2026, indicated Resident 1 had foul smell urine monitored for worsening symptoms. During a review of Resident 1's Care Plan for Potential for urinary tract infection related, dated 7/23/2026, the care plan indicated Resident 1 would be free from bladder infection. During an interview on 7/29/2026 at 5:41 PM with Director of Nurses (DON), DON stated physician orders should always be followed. The DON further stated that if staff are unable to carry out a physician order, they should notify the physician of their inability to fulfill the order. During a review of the facility's policy and procedure (P&P) titled Physician Orders dated 8/21/2020, indicated, the License Nurse will confirm that physician orders are clear, complete and accurate as (continued on next page)		

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	needed. The P&P indicated that medication orders will include condition or diagnosis for which medication is ordered.		

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F 0805 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food prepared in a form designed to meet individual needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to obtain a speech therapy evaluation for one of three sampled residents (Resident 1) after speech therapist (ST) 2 identified that Resident 1 had difficulty eating and prior to downgrading Resident 1's diet consistency. This deficient practice had the potential to result in Resident 1 experiencing inadequate nutritional and fluid intake, unintended weight loss, dehydration, and decline in overall nutritional status due to the lack of a timely speech therapy evaluation to determine the most appropriate diet consistency. Findings: During a review of Resident 1's admission Record dated 7/7/2025, the admission Record indicated, Resident 1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including DM, Cerebral Infarction (occurs when the blood supply to part of the brain is blocked or reduced), Vascular Dementia (a state of decline in mental abilities resulting from reduced blood to the brain). During a review of Resident 1's Minimum Data Set (MDS - a resident assessment tool) dated 5/25/2026, indicated Resident 1's cognitive (the ability to process thoughts) was moderately impaired. The MDS also indicated Resident 1 was dependent on putting on putting on/taking off footwear. Substantial/maximal assistance on personal hygiene, lower/upper body dressing, shower/bathe self, toileting hygiene and supervision in eating. During a review of Resident 1's Order Summary Report, the Report indicated Resident 1 had an order on 2/28/2026 for No Added Salt Consistent Carbohydrate (CCHO - consistent, constant, or controlled carbohydrate diet.) diet Level 5 Minced and Moist Texture (soft and moist need very little chewing easy to mash with your tongue), level 2 mildly thick consistency (flows off a spoon quickly but slower than water). During an observation on 7/22/2026 at 1:10 PM in Resident 1's room, Resident 1 was observed eating a level 5 Minced and Moist Texture (soft and moist need very little chewing easy to mash with your tongue) diet. Family 1 (FM 1) who was present during the observation, stated Resident 1 did not like the texture of the food and was unaware why Resident 1's diet consistency had been changed without any tests conducted to evaluate Resident 1. During an interview on 7/23/2026 at 2:50 PM with ST 1, ST 1 stated that by evaluating residents with different food textures is the most appropriate method to determine the safest and most appropriate diet. ST 1 stated that speech therapists assess residents using food trials to evaluate for signs and symptoms of dysphagia, including coughing, throat clearing, watery eyes, or other indicators of swallowing. Significant swallowing concerns such as food residual such as food pocketing indicates the need for a barium swallow study (a diagnostic imaging procedure that uses continuous X-ray fluoroscopy to evaluate swallowing). During an interview on 7/23/2026 at 4:15 PM with the Director of Rehabilitation (DOR), DOR stated Resident 1's diet was changed on 2/28/2026, after ST 2 was informed by staff that Resident 1 was having difficulty eating. The DOR stated that Resident 1 did not receive an evaluation by ST 2 after the diet was changed to No Added Salt, Consistent Carbohydrate (CCHO) Level 5 Minced and Moist Texture with level 2 mildly thick liquids. The DOR stated that Resident 1 should have been evaluated by ST 2 to determine the appropriate food consistency. During an interview on 7/23/2026 at 5:41 PM with Director of Nurses (DON), DON stated that Speech Therapists should have evaluated Resident 1 after Resident 1's diet texture was changed and that the resident's family should have been notified of the change. During a review of the facility's policy and procedure (P&P) titled, Rehab Rounding and Screening, revision date 8/28/2025, the P&P indicated that the facility would provide rehabilitation services to ensure residents with potential changes in condition are identified in a timely manner and receive appropriate assessment and skilled therapy services as clinically indicated.		