

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 555251	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/03/2024
NAME OF PROVIDER OR SUPPLIER Knolls West Post Acute LLC		STREET ADDRESS, CITY, STATE, ZIP CODE 16890 Green Tree Blvd Victorville, CA 92395	

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)
<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 44909</p> <p>Based on interview, and record review, the facility failed to ensure that an allegation of physical abuse for one of three sampled residents (Resident 1) was reported to the local, state, and federal agencies immediately in accordance with their facility's policy.</p> <p>This failure had the potential for the alleged abuse to go uninvestigated and unreported thereby increasing the chances of health, safety, and psychosocial harm to Resident 1.</p> <p>Findings:</p> <p>During an interview with Administrator on September 5, 2024, at 2:30 PM, he stated that he did not feel there was enough evidence based on interviews with witnesses and resident to report it to the state. Stated the son came to him highly upset and he said he felt LVN 1 (Licensed Vocational Nurse) threw resident on the ground, states what LVN 1 said to him resident was threatening to leave the building and I redirected him and told him to go back to his room He stated I don ' t know why she started to stop him at the nurses station, I usually wait until they get to the main door and then I redirect, when talked to LVN 1, I said you should have let him get to the door, because then he could have told you he was not trying to leave the building I just wanted to get away from you he stated the resident ' s claims was LVN 1 failed to give him pain medicine. He stated the son gets very upset when his father does not get his pain medications, and they are planning to move him closer to the daughter. He stated the son also told him he did not believe LVN 1 did that, and the son called the nursing board where they told him she was under investigation, so he felt LVN 1 did do this. States the son did not witness it but there were 2 other witnesses that say same thing LVN 1 says. States resident went to hospital and there were no finding and was cleared to return to facility. Since then, resident was moved to another side of the building so LVN 1 has nothing to do with resident. He stated he did report it to the licensing board. Stated he did not report it to CDPH because when he had the son and LVN 1 in his office the son stated I agree with what you ' re saying maybe my dad was just confused so that is why I did not report it. I let him know that in his policy it states he must report any allegation or suspicion of abuse and he stated ok, I will report it today.</p> <p>(continued on next page)</p>

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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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with LVN 1 on September 5, 2024, at 3:00PM, She stated that resident 1 was always fighting with roommate, so Doctor added more meds, Ativan (is used in adults and children at least [AGE] years old to treat anxiety disorders. Ativan is also used to treat insomnia caused by anxiety) and Norco (is used to relieve moderate to severe pain) for pain. States son and resident told the doctor he wanted to go home. She states the resident was dependent on Ativan and that particular night he kept asking for Norco and she gave it to him. States she was on the phone with the resident ' s daughter and noted the resident wheeled himself out the door stating he was going home, they ae not giving me medication. States daughter wanted to speak to her dad father and at that time the resident threw himself on the floor, states she ran back to where the resident was and the resident was aggressive towards staff and swinging arms, states it took 4 staff to get him back in the wheelchair and she stuck her foot on the wheel so he would not move then the resident spoke to daughter on phone and resident calmed down. Stated the next day the son [NAME] came into facility screaming and telling her that he understood father could be difficult and then told her that he had been to jail, and he was not afraid to come in the facility and deal with her. States the resident ' s son came the next day and he smelled of alcohol and hugged and kissed her cheek and she pushed him away.</p> <p>During a review of Resident 1 Admission Record (general demographics) on September 5, 2024, at 2:30, the document indicated the resident was admitted to the facility on [DATE], with a diagnosis to include Spinal Stenosis, (a condition that occurs when the spinal canal narrows, putting pressure on the spinal cord and nerve roots) Muscle weakness, (a loss of muscle strength, or the feeling that you need to use more effort to move your muscles) Difficulty walking, major depressive disorder (when an individual has a persistently low or depressed mood, anhedonia or decreased interest in pleasurable activities, feelings of guilt or worthlessness, lack of energy, poor concentration, appetite changes, psychomotor retardation or agitation, sleep disturbances, or suicidal thoughts.) and anxiety disorder (a condition that causes excessive feelings of fear, dread, and worry that can interfere with daily life).</p> <p>During an interview with Resident 1 on September 5, 2024, at 3:25 PM He is Spanish speaking, he understands my questions and started to tell me that he was in his wheelchair and was wheeling himself around when the nurse came and put her foot on the wheel so that he could not move the wheelchair, he then stated the nurse turned the wheelchair around forcefully and he fell . States I ' m supposed to be going to a place near my daughter ' s home. States he feels safe in facility because that nurse is not allowed to get near him, states he likes the other nurses and has no complaints.</p> <p>During a review of the facility policy and procedure titled Abuse Investigation and reporting, revised January 12, 2021, indicated All reports of resident abuse, neglect, exploitation, misappropriation and /or injuries of unknown source (abuse), shall promptly reported to local, state and federal agencies (as defined by current regulations) and thoroughly investigated by facility management. Findings of abuse investigation will also be reported.</p>		