

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  03/26/2025
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42615</b></p> <p>Based on observation, interview, and record review the facility failed to follow its policy and procedure to ensure a comprehensive care plan was developed for one of four sample residents (Resident 1) when Resident 1 was not provided a plan of care to meet Resident 1 ' s nutritional needs.</p> <p>This failure had the potential to place a clinically compromised resident (Resident 1 ' s) overall health and safety at risk.</p> <p>Findings:</p> <p>During a review of Resident 1 ' s Admission Record (general demographics), the document indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included, dementia (loss of memory), cerebrovascular disease (conditions that affect blood flow to your brain), and muscle weakness generalized (loss of strength in your muscles).</p> <p>A review of Resident 1 ' s clinical record, POLST indicated, Long-term artificial nutrition, including feeding tubes.</p> <p>During an interview on March 26, 2025, at 1:05 PM with the Licensed Vocational Nurse (LVN 1), LVN 1 stated, We usually follow resident care plan in providing care.</p> <p>During an interview on March 26, 2025, at 1:10 PM with the Assistant Director of Nursing (ADON), ADON stated, Residents care plans are developed on admissions and nursing staff follow the care plans.</p> <p>During a concurrent interview and record review on March 26, 2025, at 1:20 PM, with the ADON, Resident 1 ' s records were reviewed. Resident ' s records did not include a nutritional care plan. ADON stated, A nutritional care plan should have been developed and included the resident ' s records.</p> <p>During a concurrent interview and record review on March 26, 2025, at 3:40 PM with the ADON, the facility ' s undated policy and policy and procedure (P&amp;P) titled, Policy. Consistent with the facility ' s policy of providing appropriate care and services to residents admitted to the facility, the facility shall ensure development of a comprehensive care plan for each resident to meet his/her medical, nursing, and mental and psychosocial needs as identified in the comprehensive assessment . ADON stated, There should have been a care plan in place to provide care for the resident (Resident 1).</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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID:	Facility ID: 555251
		If continuation sheet Page 1 of 1