

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

Printed: 08/27/2026
Form Approved OMB
No. 0938-0391

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 06/12/2026
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)		
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure the policy and procedure (P&P) for change of condition was followed for one (1) of three (3) sampled residents (Resident 1), when one License Vocational Nurse (LVN 1) did not notify the physician and Resident 1's family promptly after Resident 1 eloped (Resident leaves facility without being officially discharged) on June 11, 2026. This failure resulted in delayed communication regarding a significant change in Resident 1's condition and location placing Resident 1 at risk for injury without timely medical evaluation and follow-up. Findings: During a review of Resident 1's face sheet (contains demographic and medical information), the face sheet indicated, Resident 1 was admitted to the facility on [DATE], with diagnoses which included encephalopathy (any brain disease, damage, or malfunction that alters how your brain works), and epilepsy (a brain condition that causes a person to have repeated, unexpected seizures). During a review of Resident 1's Change of Condition (COC) report, dated June 11, 2026, the COC report indicated, Resident [Resident 1] eloped from facility between the hours of 2:00 AM to 3:00 AM. Resident was picked up and taken to the hospital. [name of the hospital] called facility around 5:00 AM and spoke to Registered Nurse [RN]. RN supervisor informed charge nurse that hospital called and that he was there. Charge nurse called Daughter and notified daughter about situation. AM [morning] nurse notified. During a concurrent telephone interview and record review on June 12, 2026, at 12:20 PM, with LVN 1, Resident 1's COC report, dated June 11, 2026, was reviewed. The COC report indicated Resident 1 had eloped from facility between the hours of 2:00 AM to 3:00 AM. LVN 1 stated that at around 4:00 AM, a Certified Nurse Assistant (CNA) informed her Resident 1 could not be located. LVN 1 stated she completed the COC report and documented the estimated time Resident 1 eloped between the hours of 2:00 AM to 3:00 AM based on CNA's last contact. LVN 1 further stated the facility staff searched both inside and outside the facility after Resident 1 was discovered missing. LVN 1 stated, on June 11, 2026, after 5:00 AM, the RN Supervisor (RNS 1) informed her the hospital had called and reported Resident 1 had been found and transported there. LVN 1 stated she notified Resident 1's family regarding the elopement at approximately 6:30 AM, after receiving information from RNS 1 but she failed to communicate with the physician. LVN 1 stated failure to report to the physician was not acceptable and did not align with facility policy. During an interview on June 15, 2026, at 8:14 AM, with RNS 1, RNS 1 stated he instructed LVN 1 to complete the COC report and to inform Resident 1's family and the physician. RNS 1 stated he did not contact Resident 1's family or the physician himself because he had already directed LVN 1 to do so. During a concurrent telephone interview and record review on June 15, at 11:40 AM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Change of Condition, dated August 2017, was reviewed. The P&P indicated, .1. The licensed nurse in charge of resident's care shall be responsible for notification of resident (as applicable), resident's primary care physician, family member(s) and/or legal representatives of any change in a resident's status and condition as soon as possible. The DON stated LVN 1 did not comply with the policy by not informing Resident 1's family as soon as the resident was found to be missing and for forgetting to notify the physician.		

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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(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 maintain a complete and accurate medical record for one (1) of three (3) sampled residents (Resident 1), When one Licensed Vocational Nurse (LVN 1) mistakenly documented that the physician was notified of Resident 1's elopement (Resident leaves the facility without being officially discharged). This failure resulted in an inaccurate medical record and had the potential to affect communication among healthcare providers and the delivery of resident care. Findings: During a review of Resident 1's face sheet (contains demographic and medical information), the face sheet indicated Resident 1 was admitted to the facility on [DATE], with diagnoses that included encephalopathy (any brain disease, damage, or malfunction that alters how your brain works), and epilepsy (a brain condition that causes a person to have repeated, unexpected seizures) During a review of Resident 1's Change of Condition (COC) report, dated June 11, 2026, the COC report indicated, Resident 1 eloped from facility between the hours of 2:00AM to 3:00AM. Resident representative/family notified: June 11, 2026, at 00:00. Physician notified: June 11, 2026, at 00:00. During a concurrent telephone interview and record review on June 12, 2026, at 12:20 PM, with LVN 1, Resident 1's COC report, dated June 11, 2026, was reviewed. The COC report indicated that Resident 1's family and physician were notified on June 11, 2026, at 00:00. LVN 1 stated that she informed Resident 1's family about the elopement around 6:30 AM but in the COC report she did not document the time when Resident 1's family was notified, which is why it appeared as 00:00. LVN 1 also admitted that she did not inform the physician, she wrote the physician's name on the COC form but forgot to contact the physician. LVN 1 acknowledged that inaccurate documentation was not acceptable and did not align with facility policy. During a concurrent telephone interview and record review on June 15, 2026, at 3:37 PM, with the Director of Nursing (DON), the facility's policy and procedure (P&P) titled, Documentation Principles, dated August 22, 2017, was reviewed. The P&P indicated, .4. Entries in the clinical record must be accurate, legible, clear and timely (recorded within the required time period) .11. Each entry in the clinical record must be dated with month, date and year. The DON stated in this case, LVN 1 was not compliance with the policy.		