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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION               | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>055776 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                    | (X3) DATE SURVEY COMPLETED<br><br>05/02/2024 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Westview Healthcare Center |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>12225 Shale Ridge Lane<br>Auburn, CA 95602 |  |

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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| (X4) ID PREFIX TAG   | SUMMARY STATEMENT OF DEFICIENCIES<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>45718</p> <p>Based on observation, interview, and record review, the facility failed to ensure adequate supervision was provided for 1 of 9 sampled residents (Resident 7) when her fall risk care plan was not consistently implemented.</p> <p>This failure had the potential to increase the risks for falls for Resident 7 who sustained multiple falls in the past.</p> <p>Findings:</p> <p>A review of Resident 7's clinical records indicated, she was admitted to the facility summer of 2019 with multiple diagnoses that included muscle weakness (generalized) and repeated falls. Her most recent Minimum Data Set (MDS, an assessment tool) indicated she required assistance of two or more staff for transferring to wheelchair and to bed.</p> <p>A review of Resident 7's .Communication Form dated 3/30/24 and 4/10/24 indicated Resident 7 had a fall on both days.</p> <p>A review of Resident 7's REHAB -STATUS POST FALL SCREEN, dated 4/2/24 indicated, NSG[nursing] reports finding [Resident 7] sitting on the floor at her bedside on her bedside fall mat. [Resident 7] stated that she fell during an attempt to self-transfer. At baseline, [Resident 7] .is dependent on staff for bed&lt;&gt;w/c [bed to wheelchair] transfers .</p> <p>A review of Resident 7's Care plan indicated, Falls: Resident had an unwitnessed fall and is at risk for recurring falls .Date Initiated: 04/02/2024, Interventions .Keep call light within reach .Safety devices/procedures as ordered fall mat at bedside, OOB [out of bed] and at nurses[sic] station during days for fall prevention .</p> <p>During a concurrent observation and interview on 5/2/24 at 2:00 p.m., in Resident 7's room, the resident was sitting in a Geri chair (geriatric chair, reclining chair with armrest and tray) beside her bed. Resident 7 was observed trying to reach the call light attached to her bed. She stated, she wanted to transfer to her bed, but she could not reach the call light.</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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>During a concurrent observation and interview on 5/2/24 at 2:04 p.m., in Resident 7's room, a Certified Nursing Assistant (CNA 3) stated Resident 7 was a fall risk and she needed to be transferred to her bed. CNA 3 further stated the resident was not supposed to be left unattended while in the chair inside the room. CNA 3 further indicated the resident was supposed to be at the front of the nurse's station because she was a fall risk. CNA 3 verified Resident 7's call light was attached to her bed and she was not able to reach it.</p> <p>During an interview on 5/2/24 at 4:58 p.m., Licensed Nurse (LN 5) stated Resident 7 was a fall risk, and she should be at the nurse's station when she was out of bed in her chair. LN 5 further stated when Resident 7 wanted to go back to her room then she needed to go back to her bed and shouldn't be left alone because she might fall.</p> <p>During an interview on 5/2/24 at 5: 40 p.m., the Director of Nursing (DON) stated Resident 7 had several falls due to hallucinations. The DON verified that part of Resident 7's care plan was for her to be out of bed at the nurse's station to increase supervision. The DON stated, when Resident 7 needed to go back to her room she needed to be transferred back to her bed and the bed should be on the lowest position. The DON further stated the resident's call lights should always be within reach. The DON stated her expectations was for Resident 7's call light to be within reach at all times and she was not supposed to be left in the chair when she was back in her room.</p> <p>A review of facility policy titled, Falls and Fall Risk, Managing revised, March 2018, indicated, 1. The staff, with the input of the attending physician, will implement a resident-centered fall prevention plan to reduce the specific risk factor(s) of falls for each resident at risk or with a history of falls .</p> <p>A review of facility policy titled, Care Plans, Comprehensive Person-Centered revised, December 2016, indicated, .4. Each resident's comprehensive person-centered care plan will be consistent with the resident's rights to .: g. Receive the services and/or items included in the plan of care .</p> |   |  |