

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  055776	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  08/06/2024
NAME OF PROVIDER OR SUPPLIER  Westview Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE  12225 Shale Ridge Lane 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0623</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48874</b></p> <p>Based on interview and record review, the facility failed to ensure one of four sampled residents (Resident 1) was given a 30-day discharge notice.</p> <p>This failure reduced the facility's potential to provide Resident 1 enough time to appeal the discharge.</p> <p>Findings:</p> <p>A review of an admission record indicated Resident 1 was admitted to the facility on [DATE], with several diagnoses which included diverticulitis (disease caused by an inflammation in a small pocket of lower part of the intestine), gastrointestinal hemorrhage (bleeding in the digestive system), breast cancer, difficulty in walking, and muscle weakness.</p> <p>A review of Resident 1's Physician's Orders, dated 5/8/24, indicated, Discharge home with home health, physical and occupational therapy, and Aide .</p> <p>During an interview on 8/6/24 at 11:59 a.m., with the Social Services Director (SSD), the SSD stated notice was given to Resident 1 on 5/8/24, and Resident 1 was discharged on that day.</p> <p>A review of Resident 1's Social Services progress note, dated 5/8/24, indicated Resident 1 was discharged at 5 p.m.</p> <p>A review of Resident 1's Noticed of Proposed Transfer/Discharge, dated 5/8/24, indicated the Resident 1 was notified of discharge at 3:12 p.m</p> <p>A review of Resident 1's Nursing progress notes, dated 5/8/24 at 6:27 p.m., indicated, Resident discharged at 5pm on this date .Family notified of intent to discharge .</p> <p>A review of Resident 1's medical record indicated no documented evidence that Resident 1 was provided a written or verbal notice of intent to leave the facility.</p> <p>During an interview on 8/6/24 at 1:15 p.m. with the Director of Nursing (DON), DON stated that they never give 30-day notices. The DON confirmed the facility did not give a 30-day notice to 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
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