

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 12/17/2024
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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>38834</p> <p>Based on interview and record review, the facility failed to follow physician orders for one of three sampled residents (Resident 1) when a physician's order for Prednisone (a steroid medication used to reduce the inflammation in the body) was not followed upon resident's discharge from the hospital and when the facility did not follow up on another physician's instructions to lower the Prednisone dose.</p> <p>These failures resulted in Resident's 1 to receive Prednisone for an additional 17 days which increased the potential to affect Resident 1's health and experienced unwanted side-effects such as oral thrush (infection in the mouth) and fluid buildup in the body (when fluid isn't removed from the body by normal methods).</p> <p>Findings:</p> <p>A review of the Admission Record indicated the facility originally admitted Resident 1 in 2021 with multiple diagnoses which included chronic obstructive pulmonary disease (COPD, a chronic lung disease causing difficulty in breathing) and kidney failure with dependence on dialysis (a treatment to clean the blood and extra fluids through a machine when the kidney has failed). Resident 1's clinical records indicated the resident was readmitted to the facility in November 2024 after a three day hospitalization for shortness of breath and pneumonia.</p> <p>A review of Resident 1's hospital discharge orders dated 11/19/24 contained the following order, Prednisone 20 mg [milligram, metric unit of measurement, used for medication dosage and/or amount] oral tablet 3 tab (s) by mouth once daily for 5 days, a total of 60 mg a day.</p> <p>A review of Resident 1's individualized resident-centered care plan related to Prednisone dated 12/2/24 indicated the resident had a potential for serious side-effects related to steroid medications which included bleeding, increased blood sugar, rash, prolonged infections, etc. The interventions directed nursing staff to administer medication as ordered by the physician and to observe the resident for side-effects.</p> <p>A review of Resident 1's medication administration records (MAR - a daily documentation record used by a licensed nurse to document medications and treatments given to a resident) for November 2024 indicated the resident continued taking Prednisone 60 mg every day from 11/20 through 11/30/24.</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 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of Resident 1's MARs for December 2024 indicated the resident continued taking Prednisone 60 mg every day from 12/1/24 through 12/11/24 when the dose should had been lowered.</p> <p>A review of Resident 1's clinical records indicated that the resident was seen by a Nurse Practitioner (NP) on 11/20, 11/22, 11/27, 11/29, 12/3, 12/6, and 12/9/24. A review of the NP's progress notes did not contain notes addressing Prednisone.</p> <p>During an observation and interview with Resident 1 on 11/17/24, at 12:50 p.m., the resident was observed in her bed. Resident 1 was alert, oriented, and replied to all questions appropriately. Resident 1 stated she was having a severe mouth thrush that caused her a lot of pain and she was not able to eat any food except cream of wheat for weeks now. Resident 1 stated that she had the issue with mouth thrush in the past, but it was not as bad as now and she knew that it was the Prednisone that she was still taking that caused it. Resident 1 added, When I saw my kidney doctor not long ago, he was puzzled why I have developed so much extra fluids in my body, and he prescribed extra dialysis .to remove that fluid. Resident 1 stated she was told by her nephrologist that taking a high dose of Prednisone caused all the fluid buildup and the mouth thrush problems.</p> <p>A review of Resident 1's clinical records indicated that on 11/22/24 the resident was identified to have multiple white patches and sores in her mouth and was diagnosed with mouth thrush. Resident 1 had been receiving multiple medications since then, but per nursing progress notes, the resident still complained of mouth pain and was not eating much food.</p> <p>During a phone call conversation with Resident 1's family member (FM) on 12/13/24, at 12:10 p.m., the FM stated she was very upset with the facility for not following the physician's orders for Prednisone. The FM stated that instead of five days of Prednisone therapy, her mother received more than 20 days of high dose of steroid medication. The FM added that because of such prolonged time of high dose of Prednisone, Resident 1 developed mouth thrush (a severe fungal infection) which causing the resident a lot of pain. The FM stated that Resident 1 had a pulmonary (lung) doctor appointment on 11/21/24 and in the visit notes, the physician indicated that the resident should have received Prednisone 60 mg dose for 4 more days and then the dose needed to be decreased. The FM stated the ' After visit' note with physician's instructions addressing Prednisone dated 11/21/24 was provided to the facility nurses upon Resident 1's return from the physician. The FM added that she also emailed the ' After visit' summary to facility's administrator (ADM), Director of Nursing (DON), and one of the Assistants of Director of Nursing (ADON) to make sure the facility had all needed information.</p> <p>A review of Resident 1's clinical records on 12/17/24, at 2 p.m., failed to reveal the pulmonologist's post-visit summary dated 11/21/24. The clinical records contained a one page letter from Resident 1's pulmonologist dated 11/21/24 addressing a different medication.</p> <p>A review of the copy of the email communication with facility's management staff, provided by Resident 1's FM included an email sent on 11/21/24 at 4:37 p.m. The email contained a 6 page document titled, Patient Care Summary for [Resident 1's name]. Among other medication instructions, the pulmonologist's summary contained the following direction, You are currently on Prednisone 60 mg for the next 4 days. After that, if needed, start Prednisone 40 mg (2 tablets) daily for 5 days.</p> <p>(continued on next page)</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview with NP on 11/17/24, at 3:50 p.m., the NP stated she was not aware of the hospital transfer order to continue Prednisone 60 mg for 5 days after the discharge. The NP stated she did not remember if the nurses contacted her to clarify the Prednisone and added that another physician managed Resident 1's Prednisone. The NP confirmed that Resident 1 had a severe mouth thrush for a few weeks now and had been receiving medications to manage the thrush without much effect. The NP mentioned that in the past, the resident's mouth thrush was not as severe and responded well to one medication.</p> <p>A joint interview and concurrent record review with ADON and ADON 1 was conducted on 12/17/24 at 2:15 p. m. During the interview the DON stated that Resident 1 was readmitted from the hospital with the order for Prednisone 60 mg to receive for 5 days from 11/20 through 11/24/24. The DON stated that the Prednisone was not stopped and added, It should have been stopped after 5 days, on 11/24/24 . The stop date was never entered [into Resident 1's orders] upon readmission from the hospital .The resident received . Prednisone 60 mg until 12/11/24. The DON stated that there were no additional orders to continue the same dose of Prednisone nor there were any changes to the dose during the time Resident 1 received Prednisone 60 mg. The DON stated she could not find any documented evidence if the Prednisone order was verified with Resident 1's physician upon her re-admission or thereafter.</p> <p>During a continued interview with DON and ADON 1 on 12/17/24, at 2:15 p.m., the DON was asked if there were any orders obtained from Resident 1's pulmonologist's 11/21/24 appointment addressing Prednisone. The DON stated she was not aware of any order related to prednisone and added that the resident brought with her one page letter which contained the order for a different medication. I don't recall seeing any post visit summary and no records of it on file., the DON confirmed for the second time that Resident 1's clinical records did not contain the post visit summary completed by pulmonologist on 11/21/24. When the DON was asked if the facility management staff, including the Administrator, DON, and ADON 1 received the email from Resident 1's POA on 11/21/24, which contained 6 pages visit summary in which in the pulmonologist directed staff to lower Prednisone dose, the DON replied, Possible that we got it and missed it. I don't recall seeing the post visit summary and [there are] no records of it on file.</p> <p>A review of the facility's policy titled, Physician Order, revised 10/2023, indicated, Prescribed medication and treatment orders will be carried out in accordance with the physician/nurse practitioner order .Orders for medication may include: .name and strength of the drug. Number of doses, start and stop date, and/or specific duration of therapy.</p> <p>A review of the facility's ' Medication Therapy' policy, dated 2001 indicated, All medication orders will be supported by appropriate care processes and practices .Upon or shortly after admission, and periodically thereafter, the staff and practitioner (assisted by the consultant pharmacist) will review an individual's current medication regimen to identify whether .the dosage is appropriate .the duration of use are appropriate.</p> <p>A review of the Mayo Clinic's (ranked number one in the US) article written by Mayo Clinic Staff (MCS), titled, Prednisone and Other Corticosteroids: Balance the Risks, was accessed on 12/18/24 at https://connect.mayoclinic.org/steroids. The article indicated that in addition with helping to reduce inflammation with certain health conditions, including lung diseases, the Prednisone affects the entire body and can cause multiple health issues. According to the article, Side effects depend on the dose of medication . how long you take it . and may include .A buildup of fluid, causing swelling in lower legs, high blood pressure .can cause fungal infection in the mouth, known as oral thrush.</p>		