STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	055776	A. Building B. Wing	05/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Healthcare Center	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)
F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50517 Based on observation, interview and record review, the facility failed to ensure one of four sampled residents ' (Resident1) rights to be free from abuse was protected when Resident 2 was witnessed by staff fondling Resident 1 ' s breasts without her consent. This failure resulted in Resident 1 not free from abuse by Resident 2. Findings: During a review of Resident 1 ' s admission record (AR, front page of the chart that contains a summary of basic information about the resident) indicated, Resident 1 was admitted in February 2022 with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 1 ' s Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/24/25, indicated Resident 1 had moderate memory impairment. During a review of Resident 1 ' s Interdisciplinary Team note (IDT - documentation of care plan discussions and decisions made by the interdisciplinary team), dated 5/20/25, indicated, . per report from witness, Resident 1 was touched inappropriately (male resident [2] touched her breast) in the hallway after activity event . There was no documented evidence that Resident 1 gave consent for Resident 2 to touch her anywhere. During a review of Resident 2 ' s AR, the AR indicated, Resident 2 was admitted in May 2021 with diagnosis of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 2 ' s MDS, dated [DATE], indicated, Resident 2 had moderate memory impairment. During a concurrent observation and interview on 5/29/25 at 11:35 a.m. in Resident 2 ' s room, Resident 2 declined to do an interview and stated, Leave me alone. (continued on next page)

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 5/29/25 at 12:25 p.m. with Activity Director (AD), AD stated she witnessed Resident 2 ' s right hand inside Resident 1 ' s sweater fondling (caressing) her breasts. AD stated, Resident 1 cannot communicate well. AD described and stated, Resident 1 ' s face appeared surprised with eyes wide opened during the incident. During a concurrent observation and interview on 5/29/25 at 1:10 p.m. in Resident 1 ' s room, Resident 1 was alert but unable to communicate. Resident 1 ' s face turned red, observed to become restless and anxious when asked about the incident between her and Resident 2. During a concurrent interview and record review with the Director of Nursing (DON) on 5/29/25 at 1:40 p.m., the DON confirmed that the incident happened and was witnessed by the AD. The DON confirmed she wrote the IDT notes on 5/20/25. DON stated, all residents have the right to be free from any form of abuse. During a review of facility ' s policy and procedure (P&P) titled, Abuse Prevention Program, revised December 2016, the P&P indicated, Our residents have the right to be free from abuse, neglect .This includes but not limited to freedom from .verbal, mental, sexual, or physical abuse 1) Protect our residents from abuse by anyone including staff, other residents, friends or any individual. Based on observation, interview and record review, the facility failed to ensure one of four sampled residents' (Resident1) rights to be free from abuse was protected when Resident 2 was witnessed by staff fondling Resident 1's breasts without her consent. This failure resulted in Resident 1 not free from abuse by Resident 2. Findings: During a review of Resident 1's admission record (AR, front page of the chart that contains a summary of basic information about the resident) indicated, Resident 1 was admitted in February 2022 with diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 1's Minimum Data Set (MDS- a federally mandated resident assessment tool), dated 5/24/25, indicated Resident 1 had moderate memory impairment. During a review of Resident 1's Interdisciplinary Team note (IDT - documentation of care plan discussions and decisions made by the interdisciplinary team), dated 5/20/25, indicated, . per report from witness, Resident 1 was touched inappropriately (male resident [2] touched her breast) in the hallway after activity event . There was no documented evidence that Resident 1 gave consent for Resident 2 to touch her anywhere. During a review of Resident 2's AR, the AR indicated, Resident 2 was admitted in May 2021 with diagnosis of chronic obstructive pulmonary disease (COPD-a chronic lung disease causing difficulty in breathing). During a review of Resident 2's MDS, dated [DATE], indicated, Resident 2 had moderate memory impairment. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a concurrent observation and interview on 5/29/25 at 11:35 a.m. in Resident 2's room, Resident 2 declined to do an interview and stated, Leave me alone. During an interview on 5/29/25 at 12:25 p.m. with Activity Director (AD), AD stated she witnessed Resident 2's right hand inside Resident 1's sweater fondling (caressing) her breasts. AD stated, Resident 1 cannot communicate well. AD described and stated, Resident 1's face appeared surprised with eyes wide opened during the incident. During a concurrent observation and interview on 5/29/25 at 1:10 p.m. in Resident 1's room, Resident 1 was alert but unable to communicate. Resident 1's face turned red, observed to become restless and anxious when asked about the incident between her and Resident 2. During a concurrent interview and record review with the Director of Nursing (DON) on 5/29/25 at 1:40 p.m., the DON confirmed that the incident happened and was witnessed by the AD. The DON confirmed she wrote the IDT notes on 5/20/25. DON stated, all residents have the right to be free from any form of abuse. During a review of facility's policy and procedure (P&P) titled, Abuse Prevention Program, revised December 2016, the P&P indicated, Our residents have the right to be free from abuse, neglect .This includes but not limited to freedom from .verbal, mental, sexual, or physical abuse 1) Protect our residents from abuse by anyone including staff, other residents, friends or any individual.