

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 08/19/2025
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)
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. (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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<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to protect the rights to be free from abuse for 1 of 5 sampled residents (Resident 2) when Resident 3 witnessed Resident 1 grab and place Resident 2's hand on Resident 1's groin. This failure resulted in Resident 2 not being free from abuse. Findings: During a review of Resident 1's admission record (AR), the AR indicated Resident 1 was admitted to the facility in June 2025 with multiple 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 7/2/25, the MDS indicated Resident 1 was cognitively intact. During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility in June 2025 with multiple diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 2's MDS dated [DATE], the MDS indicated Resident 2 was cognitively impaired. During a review of Resident 3's AR, the AR indicated Resident 3 was admitted to the facility October 2024 with multiple diagnosis including malignant neoplasm (a cancerous tumor) of left lung. During a review of Resident 3's MDS, dated [DATE], the MDS indicated Resident 3 was cognitively intact. During a review of Resident 1's Social Service Note, dated 8/11/25, the Social Service Note indicated, "On 8/11/25 at approximately 10:15 a. m. - 10:30 a.m., a resident came to the office to report an incident involving another resident. He stated that the previous evening he observed concerning physical contact between this resident and a female resident with no capacity. During a review of facility document, dated 8/19/25, the facility document indicated, "[Resident 1] was observed taking hold of [Resident 2's] hand and placing it on his groin area. During an interview on 8/19/25 at 11:00 a.m. with Social Services Director (SSD), SSD stated on 8/11/25 it was reported to Social Services Assistant (SSA) that Resident 3 witnessed Resident 1, take and place Resident 2's hand on Resident 1's groin. SSD further stated Resident 1 had a history of inappropriate behavior towards female residents. SSD further stated residents had a right to be free from abuse. SSD acknowledged Resident 1's behavior of grabbing Resident 2's hand and placing it on his groin was abusive towards Resident 2. Concurrent interview and record review on 8/29/25 at 11:15 a.m. with Director of Nursing (DON), DON stated Resident 1 had a history of inappropriate behaviors towards female residents. During a review of Resident 1's behavior note dated 6/30/25, the behavior note indicated, "Resident seen acting inappropriately with other residents. Resident was found in a female room. Also was touching another residents arm in the hallway. DON acknowledged the interactions on 6/30/25 should have been reported and interventions should have been in place to prevent further incidents with Resident 1. DON further stated when Resident 1 grabbed and placed Resident 2's hand on Resident 1's groin that was inappropriate. During an interview on 8/19/25 at 11:56 a.m. with Resident 3, Resident 3 stated on 8/10/25 at approximately 5 p.m. in the smoking area, he witnessed Resident 1 grab and place Resident 2's hand on Resident 1's groin. Resident 3 further stated he notified a staff member that separated Resident 1 and Resident 2. Resident 3 further stated this is not the first incident between Resident 1 and Resident 2. 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."</p>		

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<p>F 0609</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities.</p> <p>Based on interview and record review, the facility failed to ensure an allegation of abuse was reported within the required regulatory timeframe for two of five sampled residents (Resident 1 and Resident 2) when an allegation of abuse was reported to the California Department of Public Health (CDPH), three days after staff were made aware of the allegation. This failure of timely reporting had the potential to cause a delayed response by enforcement agencies to ensure resident safety. Findings: During a review of Resident 1's admission record (AR), the AR indicated Resident 1 was admitted to the facility in June 2025 with multiple diagnoses including dementia (a progressive state of decline in mental abilities). During a review of Resident 2's AR, the AR indicated Resident 2 was admitted to the facility in June 2025 with multiple diagnosis including diabetes mellitus (DM-a disorder characterized by difficulty in blood sugar control and poor wound healing). During a review of Resident 1's Social Service Note, dated 8/11/25, the Social Service Note indicated, .On 8/11/25 at approximately 10:15 a.m. - 10:30 a.m., a resident came to the office to report an incident involving another resident. He stated that the previous evening he observed concerning physical contact between this resident and a female resident with no capacity. During a review of facility document, dated 8/14/25 and received by CDPH on 8/14/25, the facility document indicated, .It was reported that [Resident 1].took a hold of [Resident 2]'s hand and placed it on his groin area. During an interview on 8/19/25 at 11:07 a.m. with Social Services Assistant (SSA), SSA stated on 8/11/25 she notified the administrator (ADM) that a resident reported he witnessed Resident 1 grab and place Resident 2's hand on Resident 1's groin. During an interview on 8/19/25 at 12:47 p.m. with Administrator (ADM), the ADM stated he was the abuse coordinator. ADM confirmed on 8/11/25 he was notified of allegations of abuse between Resident 1 and Resident 2 but did not report the incident until 8/14/25. ADM further stated allegations of abuse should have been reported within 2 hours to enforcement agencies. ADM acknowledged the risk for ongoing abuse when allegations of abuse were not reported within 2 hours. Concurrent interview and record review on 8/29/25 at 11:15 a.m. with Director of Nursing (DON), DON stated Resident 1 had a history of inappropriate behaviors towards female residents. During a review of Resident 1's behavior note dated 6/30/25, the behavior note indicated, .Resident seen acting inappropriately with other residents. Resident was found in a female room. Also was touching another residents arm in the hallway. DON acknowledged the interactions on 6/30/25 should have been reported and interventions should have been in place to prevent further incidents with Resident 1. DON further stated when Resident 1 grabbed and placed Resident 2's hand on Resident 1's groin that was inappropriate. During a review of the facility's policy and procedure (P&P) titled Abuse Investigation and Reporting revised July 2017, the P&P indicated, .All reports of resident abuse shall be promptly be reported to local, state, and federal agencies. An alleged violation of abuse will be reported immediately, but no later than Two (2) hours if the alleged violation involves abuse.</p>		