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	08/25/2025

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** Based on interview and record review, the facility failed to protect Resident 1's right to be free from physical abuse when Resident 2 threw a cup at Resident 1's face, a deficient practice identified for one of six sampled residents reviewed for abuse.This failure caused Resident 1 to be covered with water and left a red mark on his cheek.Findings:Resident 1 was admitted to the facility late 2016 with diagnosis that included difficulty speaking and stroke (condition where blood flow to the brain is interrupted).Review of Resident 1's Minimum Data Set (MDS, an assessment tool) dated 5/29/25, the MDS showed a Brief Interview for Mental Status (BIMS, a cognitive screening tool) score of 14/15 which indicated normal cognition.Resident 2 was admitted to the facility in mid-2025 with diagnosis which included a seizure disorder, stroke, and difficulty communicating.Review of Resident 2's MDS dated [DATE], the MDS showed a BIMS score of 10/15 which indicated moderate cognitive impairment.Review of Resident 1's Progress Notes (PN) Type: Nurse's Note, dated 8/17/25 at 8:19 p.m. the PN indicated, Notified by LN [licensed nurse] that [Resident 1's] roommate had thrown a hard plastic cup full of thicken (sic) fluid at him accompanied by verbal aggression as well. Upon entering the room there was thicken (sic) fluid covering [Resident 1], who was laying in bed. Then a red mark noted to his left face cheek.Review of Resident 2's PN Type: Nurse's Note, dated 8/17/25 at 6:46 p. m. the PN indicated, Notified by LN that [Resident 2] had thrown a plastic cup full of thicken liquid at his roommates face and there was verbal aggression as well.When asking [Resident 2] why he did this, resident described that his roommate had stole (sic) his cigarettes.During an interview on 8/25/25 at 11:07 a.m. with Resident 1 in the hallway, Resident 1was unable to speak in full sentences but confirmed Resident 2 threw a cup of water at him during an argument. During an interview on 8/25/25 at 12:26 p.m. with Resident 2 in his bedroom, Resident 2 stated he had a disagreement with Resident 1 over cigarettes, .I threw water at him. I threw the cup too.During an interview on 8/25/25 at 1:57 p.m. with the Director of Nursing (DON), the DON confirmed Resident 2 threw a cup of thickened liquid at Resident 1 which resulted in a little red mark on his [Resident 1] cheek, and stated residents have the right to be free from abuse.Review of the facility's policy and procedure (P&P) titled, Abuse Prevention Program, dated 4/24, the P&P indicated, Our residents have the right to be free from abuse, neglect, misappropriation of resident property and exploitation.

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