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	09/11/2025

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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. (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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview and record review, the facility failed to have the current Advance Health Care Directive (AD- legal document that gives instructions about healthcare decisions and to name someone to make decisions if unable) for one of eight sampled residents (Resident 5). This failure resulted in Resident 5's first and second Designated Agent (DA) for Power of Attorney for Health Care (POA- person who will make health care decisions for you when you cannot) not being notified by the facility of Resident 5's death. Findings:A review of Resident 5's admission Record indicated Resident 5 was admitted to the facility in January 2012 with multiple diagnoses including multiple sclerosis (disease in which the immune system eats away at the protective covering of nerves resulting in nerve damage between the brain and the body), epilepsy (seizure disorder), and dysphagia (difficulty swallowing foods and liquids).Further review of Resident 5's admission Record indicated Resident 5 was her own Responsible Party (RP), Resident 5's family member was listed as emergency contact (EC) 1 and a friend was listed as the EC 2. Resident 5's first and second DAs were listed as the ECs 3 and 4.A review of Resident 5's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 7/5/25, indicated Resident 5 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 9 out of 15 that indicated Resident 5 had moderate cognitive impairment. A review of Resident 5's order, dated 1/5/19, indicated .Resident Is Capable of Understanding Rights, Responsibilities, And Informed Consent . A review of Resident 5's Advance Health Care Directive, dated 11/14/11, indicated Resident 5's Power of Attorney for Healthcare, Designated Agents (DA) were DA 1 and DA 2. The document did not indicate that Resident 5's EC 1 and EC 2 were the DAs according to Resident 5's AD. A review of Resident 5's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 8/14/25, indicated .pt [patient] unarousable with sternal rub, pt moaned but did not open eyes .send out to hospital for further evaluation .Name of Family/Health Care Agent Notified: . [EC 1] . A review of Resident 5's Progress Note, dated 8/18/25, indicated .At approximately 2215 [10:15 p.m.], this LN [Licensed Nurse], observed res [resident] to be sleeping peacefully with eyes closed. Upon assessment res was not breathing and no vital signs obtained. RN [registered Nurse] notified and pronounced resident deceased . [EC 1] was informed of resident's passing. [EC 1] coordinated with Social Services regarding transportation arrangements. Res body is expected to be transported .with assistance from res good friend . A review of Resident 5's Progress Note, dated 8/19/25, indicated .Spoke with resident's [EC 1] to confirm mortuary resident will be going to . During a telephone interview on 9/4/25 at 10:57 a.m. with Resident 5's DA 2, DA 2 stated she was notified of Resident 5's death when she received a call from the mortuary. DA 2 stated she was not notified by the facility of Resident 5's death. DA 2 stated she was supposed to be the second emergency contact for Resident 5 and DA 1 was the main contact. DA 2 stated DA 1 was not notified of Resident 5's death by the facility either. DA 2 stated she spoke with the facility, but the facility was unable to locate the AD. DA 2 stated she faxed Resident 5's AD to the facility in 2013. DA 2 stated the AD was created in 2011. DA 2 stated she was not aware if it had been changed to indicate Resident 5's EC 1 was made a DA. During an interview on 9/11/25 at 2:40 p.m. with the Director of Nursing (DON), the DON stated Resident 5's EC 1 was the person the facility contacted. The DON stated that EC 1 was in the facility frequently and staff discussed concerns with her. The DON confirmed that there was no AD in Resident 5's electronic record. The DON stated all documents since 2022 had been uploaded into the electronic record. The DON stated there was no AD for 2011 in Resident 5's chart.During an interview on 9/11/25 at 3 p.m. with the Social Services Director (SSD), the SSD stated that Resident 5's EC 1 was her Responsible Party (RP). The SSD stated DA 1 was under the impression that she was EC 1 and the SSD notified DA 1 what was on the admission Record. The SSD stated Resident 5's EC 1 was the POA. Reviewed with the SSD that Resident 5's AD had been faxed to the facility in 2013 by DA 2. The SSD stated that electronic charting changed in 2022, but the document should have been uploaded to the new system. The SSD stated Resident 5's 2011 AD would still be in effect unless there was new documentation showing it was revoked or changed. During an interview on 9/11/25 at 4:07 p.m. with the Medical Records Assistant (MRA), the MRA stated she located Resident 5's AD dated 11/14/11 in past files. The MRA confirmed the document indicated DA 1 and DA 2 are the designated agents and that there was no other document that superseded it. During a subsequent interview on 9/11/25 at 4:10 p.m. with the SSD, reviewed Resident 5's AD provided by the MRA. The SSD stated she had no knowledge of it, and it should have been passed on to the new electronic record. The SSD stated, [AD] was buried. When asked what the consequence was of not

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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	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. (continued on next page)

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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	Based on observation, interview, and record review, the facility failed to protect one of eight sampled residents from physical abuse (Resident 1), when Resident 1 was struck on the face by Resident 2.This failure resulted in Resident 1 experiencing psychosocial distress and fear in the facility. Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in April 2025 with multiple diagnoses including amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function), dysphagia (difficulty swallowing food and liquids), and cachexia (extreme weight loss and muscle loss).A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 8/6/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS-tool to assess cognition) score of 15 out of 15 that indicated Resident 1 was cognitively intact. Further review of Resident 1's MDS, Functional Abilities, dated 8/6/25, indicated Resident 1 had impairment on both sides of upper and lower extremities, was dependent for bed mobility and transfers, used a wheelchair, and was able to mobilize in the wheelchair with set up assistance. A review of Resident 1's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 8/28/25, indicated .Resident notified staff, that she was allegedly struck on the face by another resident while out on patio. Skin observation completed with no redness, swelling, or bruising noted . A review of Resident 1's Progress Note, dated 8/28/25, indicated .AT 2155 [9:55 p.m.] resident came down the hall in electric wheelchair asking this nurse to call 911 because she got hit in the face by another resident in smoking area. This writer immediately notified RN [Registered Nurse] supervisor to handle situation. When arrived back to station, I advised this resident the RN supervisor was handling it. Resident stated I will get my phone and call 911 myself . A review of Resident 1's Progress Note, dated 8/29/25 at 8:14 a.m., indicated . Brought to SSD [Social Services Director] attention that res [resident] was slapped in the face by another resident. Altercation occurred in the smoking area, res was apparently in the walk way and was not able to move. Other resident made statements Get the f*** out of my way Im gonna beat your a** after comments, res was then slapped. After incident res called the police to make a report . A review of Resident 1's Progress Note, dated 8/29/25 at 1:37 p.m., indicated .Resident on monitoring for being slapped by a male resident on 8/28/25 .Kept both residents separated throughout shift .LN [Licensed Nurse] observed that resident had slight swelling and redness to left side of face. Also resident had sore to left lower lip, resident stated that the sore opened up after she was slapped by the other resident . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in August 2023 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is interrupted causing tissue damage), diabetes (too much sugar in the blood), and aphasia (inability to produce speech as a result of brain damage).A review of Resident 2's MDS, Cognitive Patterns, dated 5/29/25, indicated Resident 2 had a BIMS score of 6 out of 15 that indicated Resident 2 had severe cognitive impairment. Further review of Resident 2's MDS, Functional Abilities, dated 5/29/25, indicated Resident 2 was able to transfer and ambulate with set up assistance and did not use an assistive device. A review of Resident 2's SBAR Communication Report, dated 8/28/25, indicated . It is alleged that resident hit another resident with an open hand to her left temple area. This allegedly occurred after other resident told this resident he could not be out in the smoking section and told him to go inside, making him upset. This resident unable to make statement from his perspective as he does not produce clear or understandable speech at baseline . A review of Resident 2's Progress Note, dated 8/28/25 at 10:15 p.m., indicated .at 2200 [10 p.m.] it was brought to writers attention that an alleged incident happened between this resident and another in the smoking area outside. Other resident told this resident he was not welcome to be outside and that he should go back inside. Allegedly, this resident then got in her face and hit her with an open hand .Resident was unable to give personal account of the incident due to dysphasia which is residents baseline . A review of Resident 2's Progress Notes, dated 8/29/25 at 10:09 a.m., indicated . Brought to SSD attention that resident allegedly hit a female resident near the smoking area. Res was reported to shadowbox with her then slapped her in the face. Also reported that resident was cussing, but res has dysphagia and is very hard to understand . A review of Resident 3's admission Record indicated Resident 3 was admitted to the facility in December 2025 with multiple diagnoses including burns of left and right feet, diabetes, and heart failure (heart does not pump blood as well as it should). A review of Resident 3's MDS, Cognitive Patterns, dated 7/16/25, indicated Resident 3 had BIMS score of 14 out of 15 that

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, interview, and record review, the facility failed to ensure that Care Plans were updated and documentation was complete for three of eight sampled residents (Resident 1, Resident 2, and Resident 4) when Resident 1 and Resident 2 were involved in a resident-to-resident altercation and Resident 4 reported abuse by a staff member.This failure had the potential for Resident 1, Resident 2, and Resident 4 to not receive the necessary interventions to maintain psychosocial and physical wellbeing.Findings:A review of Resident 1's admission Record indicated Resident 1 was admitted to the facility in April 2025 with multiple diagnoses including amyotrophic lateral sclerosis (a nervous system disease that weakens muscles and impacts physical function), dysphagia (difficulty swallowing food and liquids), and cachexia (great weight loss and muscle loss).A review of Resident 1's Minimum Data Set (MDS- federally mandated assessment tool), Cognitive Patterns, dated 8/6/25, indicated Resident 1 had a Brief Interview for Mental Status (BIMS- tool to assess cognition) score of 15 out of 15 that indicated Resident 1 was cognitively intact. A review of Resident 1's SBAR [Situation, Background, Assessment, Recommendation] Communication Form, dated 8/28/25, indicated .Resident notified staff, that she was allegedly struck on the face by another resident while out on patio . A review of Resident 1's Progress Note, dated 8/28/25, indicated .AT 2155 [9:55 p.m.] resident came down the hall in electric wheelchair asking this nurse to call 911 because she got hit in the face by another resident in smoking area. This writer immediately notified RN [Registered Nurse] supervisor to handle situation. When arrived back to station, I advised this resident the RN supervisor was handling it. Resident stated I will get my phone and call 911 myself . A review of Resident 1's Progress Note, dated 8/29/25 at 8:14 a.m., indicated . Brought to SSD [Social Services Director] attention that res [resident] was slapped in the face by another resident. Altercation occurred in the smoking area, res was apparently in the walk way and was not able to move. Other resident made statements Get the f*** out of my way Im gonna beat your a** after comments, res was then slapped. After incident res called the police to make a report. SSD will continue to look into incident with proper follow up . A review of Resident 2's admission Record indicated Resident 2 was admitted to the facility in August 2023 with multiple diagnoses including hemiplegia (paralysis on one side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (stroke-blood flow to the brain is interrupted causing tissue damage), diabetes (too much sugar in the blood), and aphasia (inability to produce speech as a result of brain damage).A review of Resident 2's MDS, Cognitive Patterns, dated 5/29/25, indicated Resident 2 had a BIMS score of 6 out of 15 that indicated Resident 2 had severe cognitive impairment. A review of Resident 2's SBAR Communication Report, dated 8/28/25, indicated . It is alleged that resident hit another resident with an open hand to her left temple area. This allegedly occurred after other resident told this resident he could not be out in the smoking section and told him to go inside, making him upset. This resident unable to make statement from his perspective as he does not produce clear or understandable speech at baseline . A review of Resident 2's Progress Note, dated 8/28/25 at 10:15 p.m., indicated .at 2200 [10 p.m.] it was brought to writers attention that an alleged incident happened between this resident and another in the smoking area outside. Other resident told this resident he was not welcome to be outside and that he should go back inside. Allegedly, this resident then got in her face and hit her with an open hand .Resident was unable to give personal account of the incident due to dysphasia which is residents baseline . A review of Resident 2's Progress Notes, dated 8/29/25 at 10:09 a.m., indicated .Brought to SSD attention that resident allegedly hit a female resident near the smoking area. Res was reported to shadowbox with her then slapped her in the face. Also reported that resident was cussing, but res has dysphagia and is very hard to understand . A review of the Report of Suspected Dependent Adult/Elder Abuse, for incident between Resident 1 and Resident 2, dated 8/28/25, indicated .On August 28th, 2025 [Resident 1] reported that [Resident 2] made physical contact with her using his open hand . A review of Resident 1 and Resident 2's Care Plans did not reflect a Care Plan was initiated for either Resident 1 or Resident 2 for this incident. A review of Resident 4's admission Record indicated Resident 4 was admitted to the facility in December 2015 with multiple diagnoses including chronic pulmonary obstructive disease (lung disease that blocks airflow and makes it difficult to breathe), bipolar disorder (mental disorder associated with mood swings ranging from depressive lows to manic highs), and adult failure to thrive (inability to sustain weight leading to progressive decline). A review of Resident 4's MDS, Cognitive Patterns, dated 6/2/25, indicated Resident 4 had BIMS score of 12 out of 15 that indicated Resident 4 had moderate cognitive impairment. A review of Resident 4's Report of Suspected Dependent