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 03/03/2026
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 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow resident to participate in the development and implementation of his or her person-centered plan of care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure the resident/resident representative was involved in the care planning for one of three sampled residents (Resident 1) when the care plan conference was not conducted as scheduled. This failure increased the risk for not meeting the needs of Resident 1. A review of the admission Record indicated Resident 1 was admitted middle of January 2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke, loss of blood flow to a part of the brain causing brain tissue to die due to lack of oxygen) affecting right dominant side, aphasia (a disorder that makes it difficult to speak) following cerebral infarction, and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control) with ketoacidosis (a complication of DM due to lack of insulin forcing the body to use fat for energy).Further review of Resident 1's admission Record indicated Resident 1's daughter was the responsible party (RP). A review of Resident 1's IDT (Interdisciplinary) Note dated 1/19/26 written by Social Services Assistant 1 (SSA 1) indicated, .call placed to [name of RP] . left VM [voicemail] . requested return phone call.A review of Resident 1's Social Service Note dated 1/20/26 written by SSA 2 indicated, CALLED RP .ASKING FOR THEM TO ATTEND CARE CONFERENCE AT 230PM- WILL BE THERE OVER THE PHONE.There was no follow up note from Social Services regarding the care conference with Resident 1's RP as scheduled. A review of the IDT Conference Note initiated 2/5/26 indicated under Social Services, Care conference conducted today with SSD, ADON [Assistant Director of Nursing], and DOR [Director of Rehabilitation]. Resident plans to discharge home with support . The note was signed by SSA 1 on 2/18/26. During a telephone interview on 3/5/26 at 8:14 a.m. with the SSA 2, the SSA 2 stated she wrote the note for Resident 1 on 1/20/26. The SSA 2 further stated it was the Social Services Director 1 (SSD 1) who scheduled the care conferences with the family. The SSA 2 added she does not know if Resident 1's RP attended the care plan conference.During a telephone interview on 3/5/26 at 8:23 a.m. with the SSD 2, the SSD 2 stated she replaced SSD 1 and she started on 3/2/26. The SSD 2 further stated care plan conference for new admission was done one time and usually scheduled within the first 7 days and they can schedule another one if there was a need. During a telephone interview on 3/5/26 at 8:30 a.m. with the SSA 1, the SSA 1 stated she wrote the note for Resident 1 on 1/19/26. The SSA 1 further stated Resident 1 was short term care, and at that time it was the SSD 1 who attended the care conferences. The SSA 1 added the IDT Care Conference Note was created by SSD 1 on 2/5/26 and she [SSA 1] completed the note on 2/18/26 since SSD 1 did not finish her notes. The SSA 1 further added the importance of care plan conference was to ensure efficiency, to make sure residents are getting appropriate amount of care and they normally invite and encourage resident's RP to attend the meeting. During a telephone interview on 3/10/26 starting at 10:17 a.m. with the Minimum Data Set Coordinator (MDSC), the MDSC stated the SSD schedules the care plan conference and the Assistant Director of Nursing (ADON) represents the Nursing Department. The MDSC further stated the care plan conference should be done within the first week of admission. The MDSC verified he completed (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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F 0553 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident 1's MDS assessment dated [DATE] and MDSC described Resident 1 as nonverbal, on tube feeding and bed bound. The MDSC added the importance of care plan conference is to involve the family in developing the overall plan of care, to know if there are concerns or questions on medication. The MDSC acknowledged Resident 1 had one IDT Conference Note created by SSD 1 on 2/5/26, the sections were completed by Dietary, Therapy, Activities, and Social Services. The MDSC further acknowledged the Nursing Services was not filled out and there was no documentation if Social Services was able to speak with Resident 1's representative. During a telephone interview on 3/10/26 at 11 a.m. with the Director of Nursing (DON), the DON stated her expectation was for the care conference to be scheduled within the first 7 days. The DON further stated if the family request for one, they work with the family's schedule, that's best practice for us.A review of the facility's policy and procedure revised February 2025 and titled, Resident Participation - Assessment/Care Plans indicated, The resident and/or the resident's representative are encouraged to participate in . the development and implementation of the resident's care plans .The resident's/representative's right to participate in the development and implementation of his or her plan of care includes the right to: .participate in the planning process .request meetings .be informed in advance, of changes to the plan of care .The care planning process .facilitates the inclusion of the resident and/or representative .A seven (7) day advance notice for care planning conferences are provided to the resident and his or her representative. Such notices may be provided by mail and/or telephone .The social services director, or designee, is responsible for notifying the resident/representative and maintaining records of such notices. Notices include .the date, time, and location of the conference .input from the resident or representative if they are not able to attend .

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westview Healthcare Center	12225 Shale Ridge Lane Auburn, CA 95602

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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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observation, interview, and record review, the facility failed to ensure resident's rights to personal privacy and confidentiality of personal medical information was maintained when a document with resident's information was left on top of the medication cart, for a census of 167.This failure had the potential to compromise the privacy of residents. During a concurrent observation and record review on 3/3/26 at 11:52 a.m. in Station 3 hallway, a document was on top of the medication cart. The document had resident's information including their room number, cognitive status (describes if alert and oriented [A & O] to person, place & time, followed by a number indicating the areas of orientation), code status (determines if and how staff should perform life saving measures if heart or breathing stops), name, and diagnosis (specific illness or condition causing a person's symptom). During a concurrent interview and record review on 3/3/26 at 11:56 a.m. with the Licensed Nurse 1 (LN 1), the LN 1 stated he left the document containing resident's information such as the name, code status, diagnosis, if they take pills whole or not, on top of his medication cart. The LN 1 further stated he was not supposed to leave the document on top of the medication cart, and it was a violation of resident's rights.During an interview on 3/3/26 at 4:32 p.m. with the Director of Nursing (DON), the Nurse Surveyor showed the DON pictures taken of the document left on top of the medication cart. The DON stated, it should not be there. A review of the facility's policy and procedure revised April 2014 and titled, Protected Health Information (PHI), Management and Protection of indicated, .It is the responsibility of all personnel who have access to resident and facility information to ensure that such information is managed and protected to prevent unauthorized release or disclosure.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on interview and record review, the facility failed to ensure treatment and care was provided in accordance with professional standards of practice for one of three sampled residents (Resident 1) when Resident 1's blood sugar was not consistently monitored and reported to the physician.This failure increased the risk for Resident 1 to experience complications due to unrecognized low or high blood sugar level. A review of the admission Record indicated Resident 1 was admitted middle of January 2026 with diagnoses including hemiplegia (total paralysis of the arm, leg, and trunk on the same side of the body) and hemiparesis (weakness on one side of the body) following cerebral infarction (a type of stroke, loss of blood flow to a part of the brain causing brain tissue to die due to lack of oxygen) affecting right dominant side, aphasia (a disorder that makes it difficult to speak) following cerebral infarction, and type 2 diabetes mellitus (DM- a disorder characterized by difficulty in blood sugar control) with ketoacidosis (a complication of DM due to lack of insulin forcing the body to use fat for energy).A review of Resident 1's physician order indicated the following:-an order dated 1/16/26 for Empagliflozin (Jardiance, used to manage type 2 diabetes with heart disease) 25 milligram (mg, unit of measurement) give 0.5 tablet via peg tube (gastrostomy- a surgical opening fitted with a device to allow feedings/medications to be administered directly to the stomach for people with swallowing problems) one time a day; and,-an order dated 1/16/26 for Insulin Glargine (long acting, helps to control blood sugar between meals and overnight), inject 8 units subcutaneously (injection delivered into the fatty tissue layer between the skin and muscle) every 12 hours.A review of Resident 1's Medication Administration Record (MAR) for January 2026 indicated an order dated 1/18/26 for Fingerstick blood glucose testing as needed for hypo/hyperglycemia [low/high blood sugar]. There was no blood glucose testing recorded in the MAR for January 2026.A review of Resident 1's MAR for February 2026 indicated an order dated 2/4/26 for Blood sugar monitoring AM [every morning] & HS [at bedtime]. A review of Resident 1's Blood Sugar (BS) Summary indicated Resident 1's BS for 9 out of 14 readings were above 200 milligrams per deciliter (mg/dL, unit of measurement). The nine BS readings were recorded over 200 were as follows:-on 1/16/26 @ 21:30 [9:30 p.m.], BS was 220;-on 1/19/26 @ 08:52 [8:52 a.m.], BS was 231;-on 1/31/26 @ 08:48 [8:48 a.m.], BS was 204;-on 2/2/26 @ 21:24 [9:24 p.m.], BS was 445;-on 2/4/26 @ 05:54 [5:54 a.m.], BS was 291;-on 2/4/26 @ 21:03 [9:03 p.m.], BS was 400;-on 2/5/26 @ 05:46 [5:46 a.m.], BS was 315;-on 2/5/26 @ 22:17 [10:17 p.m.], BS was 405; and,-on 2/5/26 @ 22:18 [10:18 p.m.], BS was 405.There was one physician notification dated 2/2/26 when Resident 1's BS was 445. There was no other documented evidence in the clinical records of physician notification when Resident 1's BS was over 200 and when BS was over 400 mg/dL on 2 consecutive days (on 2/4/26 and 2/5/26). A review of Resident 1's SBAR (Situation, Background, Assessment, Recommendation- a communication tool used by healthcare workers when there is a change of condition) Summary dated 2/6/26 indicated, .Other change in condition .BS 405 on 2/5/26 [10:18 p.m.]. There was no BS reading recorded in the morning of 2/6/26 when the SBAR was initiated. The SBAR Summary further indicated Resident 1's oxygen saturation (O2 sat- a measurement of how much oxygen the blood is carrying as a percentage) still remained in the low 80's with 5 liters of oxygen, emergency service was called and Resident 1 was transferred to the hospital. A review of Resident 1's Discharge Summary during hospital stay from 2/7/26 to 2/18/26 indicated, .[Resident 1] was transferred to [name of hospital] on 2/6/26 for worsening hypoxemia [low levels of oxygen in the blood]. Found to have blood glucose >500 [greater than 500] .Treated in ICU [Intensive Care Unit-provides round the clock monitoring] with IVF [Intravenous fluids-to replenish fluids], antibiotics [treat infections] .repatriated [transferred back] to [name of hospital] on 2/7/26.During a concurrent telephone interview and record review on 3/10/26 starting at 11 a.m. with the Director of Nursing (DON), Resident 1's physician order, MAR, BS Summary, SBAR dated 2/6/26, and physician notification were reviewed. The DON stated Resident 1 was taking Jardiance and insulin glargine for diabetes. The DON further stated Resident 1's BS order (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was PRN (as needed) in the beginning and on 2/4/26 another order was received to monitor BS in the morning and at bedtime. The DON added her expectation was for licensed nurse to notify the physician when Resident 1's BS was above 200, and she will be concerned if the BS was above 200 mg/dL. The DON further stated she completely agree Resident 1's BS should have been checked on a regular basis, not just PRN. A review of the facility's policy and procedure revised March 2025 and titled, Diabetes- Clinical Protocol indicated, .Examples of blood glucose monitoring for various situations might include the following .For the resident receiving insulin who is well controlled .monitor blood glucose levels twice a day if on insulin (for example, before breakfast and lunch and as necessary .Staff will notify the practitioner s soon as possible when .the resident has two or more blood glucose readings higher than 250 mg/dL within a 24-hour period accompanied by a new medical problem or a change in condition .