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	03/27/2026

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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to choose his or her attending physician. Based on interview and record review, the facility failed to ensure that the resident's right to choose their own physician was honored for one of four sampled residents (Resident 1), when the facility did not promptly act upon Resident 1's Responsible Party (RP, a person designated by the resident to make decisions on their behalf) request regarding psychiatry provider.This failure deprived Resident 1's RP from exercising her rights to participate in Resident 1's plan of care and to make informed decisions about the care and treatment for Resident 1 and had the potential to negatively impact Resident 1's care.A review of the admission record indicated the facility admitted Resident 1 in 2016 with multiple diagnoses, which included after care for cerebral infarction (stroke).A review of Resident 1's clinical records indicated that the resident did not have capacity to make health-care decisions. Resident 1's wife was listed as Responsible Party (RP) and Power of Attorney (POA, a legal document that lets someone else makes decisions for person).A further review of the physician order for Resident 1 dated 6/12/24 at 3:44 p.m., contained the following order, Call spouse with any changes to medications, treatments, diets, diagnosis, behaviors, change to care plan - any change at all must be approved by spouse. Progress note the communication and consent for any and all changes.A review of Resident 1's ?Depression' care plan dated 12/18/22 and revised on 3/12/26 indicated the resident was at risk for ineffective coping related to his diagnoses. One of the interventions indicated, Encourage family to actively participate in resident's care.During a telephone interview on 3/26/26 commencing at 2:53 p.m., with Resident 1's RP, the RP stated she was upset with the facility handling her request for her husband not to be seen by any specific psychiatry doctor (PD, a doctor specializing in managing mental disorders). The RP explained that Resident 1 have been followed up by [name of medical insurance] psychiatrist for years. The RP stated that in December of 2025 she noticed another PD's name on her husband's profile. The RP stated during 12/30/25 care conference she informed the Social Services Assistant (SSA) that she did not want Resident 1 to be seen by other psychiatrist, including PD listed in Resident 1's profile, except the one that resident had been seeing for years. The RP added that she provided a letter to SSA and addressed to facility's Director of Nursing (DON), Administrator, and nursing regarding withholding a consent for consultation or evaluation by any psychiatric, psychological and mental health practitioner associated with or contracted by [facility's name].I request that any such persons be removed from the list of [Resident 1's name] care providers. During a further telephone interview on 3/26/26 at 2:53 p.m., the RP stated it was very frustrating that the facility did not act upon her request timely and she brought up the concerns regarding PD with Assistant Director of Nursing (ADON) again on 3/19/26. The RP stated that ADON assured her that the PD's name will be removed from Resident 1's profile and her husband (Resident 1) will not be seen/evaluated by this provider. The RP stated that the same day, several minutes later, the same PD that she specifically requested not to see her husband, entered Resident 1's room when the RP was visiting. The RP stated the PD had a list with residents' names in her hand and read Resident 1's name from the list. The RP stated she intervened at that moment and stopped PD from talking to Resident 1 and/or evaluating him. The RP added, .It's a breach of privacy and HIPPA [Health Insurance Portability and Accountability Act, when personal medical information is not kept private] violation. I'm very concerned about this. I am his POA and the facility is aware about (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 0555 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	this.A review of Resident 1's clinical records, including face sheet (a summary document with resident's most important information) and profile on 3/27/26 at 11:30 a.m., contained the name of the PD that Resident 1's RP had been requesting to be removed since December 2025. There was no evidence that the facility took appropriate steps to accommodate RP's request and to notify the PD about the RP's request.During an interview and review of Resident 1's profile on 3/27/26 at 12:27 p.m., the SSA stated that during care conference in December 2025, Resident 1's RP verbalized that she did not want Resident 1 to be seen by PD, who was facility's contracted psychiatrist. The SSA stated she was not aware if Resident 1 had been seen by PD. Upon reviewing Resident 1's clinical records, the SSA stated, I see this [PD] name on resident's profile, but it doesn't look like the resident was seen by her.During a joint interview and record review on 3/27/26 at 12:40 p.m., with DON and ADON, the ADON stated Resident 1's RP was involved in the resident's care and made all treatment decisions on behalf of Resident 1. The ADON acknowledged that Resident 1's physician's orders contained an order dated 6/12/24 to call spouse with any changes to medications, treatments. any change to care plan - any change at all must be approved by spouse. The ADON validated that the facility was aware that Resident 1's RP did not want contracted PD to oversee Resident 1's care. The ADON stated that Resident 1 had been managed by outside psychiatrist selected by resident's RP. The ADON stated, We discussed this with her in the past, I think December and recently she brought up this concern again.During a further interview and record review on 3/27/26 at 12:40 p.m., with DON and ADON, the ADON reviewed resident's profile and confirmed that PD's name was listed on Resident' 1s profile. The ADON stated that last week Resident 1's RP brought up her request regarding Resident 1 not be seen by PD. The ADON added, I have told her that I will remove [PD's] name, but I did not do it yet, did not have chance. I explained to [RP's name] that before the PD sees any residents, she checks with me or nurses. The ADON stated she did not communicate Resident 1 RP's request to PD. The ADON stated that she was not aware that the same day she assured Resident 1's RP that PD's name will be removed from the resident's profile, the PD went to Resident 1's room to see the resident. The ADON stated, .not aware that she went to see [Resident 1]. She should not have his name on her list. When the ADON was asked if PD stopped by and discussed with ADON which residents she was going to see on that day, the ADON replied No.During a continued interview with DON and ADON on 3/27/26 at 12:40 p.m., the DON stated, We are doing the right things for resident. There is no harm done to resident. There were no new orders and no changes to [Resident 1's name] care plan. The DON and ADON were asked whether having Resident 1's name on psychiatrist's list and who was able to access resident's clinical records prior coming to resident's room, was violation of his rights to privacy, the DON and ADON did not provide the answer. The DON and ADON did not reply if Resident 1's HIPPA and rights to privacy were violated when his clinical records were reviewed without Resident 1's authorization by RP. A review of the facility's policy titled, Resident Rights, revised in 10/2024, indicated that all residents in the facility had certain rights that were guaranteed by the federal and state laws. The policy indicated that the resident rights included right to, .Choose a physician and treatment and participate in decisions and care planning.Privacy and confidentiality. The policy further indicated that the facility prohibited the unauthorized access or disclosure of resident's information.