

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 09/03/2020
NAME OF PROVIDER OF SUPPLIER WESTVIEW HEALTHCARE CENTER		STREET ADDRESS, CITY, STATE, ZIP 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 0550 Level of harm - Minimal harm or potential for actual harm Residents Affected - Some	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, interview, and record review, the facility failed to ensure 3 of 3 sampled residents (Resident 1, Resident 2, and Resident 3) were treated with respect and dignity when a certified nursing assistant (CNA) was physically rough and verbally disrespectful to the residents. This failure had the potential to result in physical injury and psychosocial distress for the residents. Findings: 1. According to the admission record, Resident 1 was admitted in March of 2019 with [DIAGNOSES REDACTED]. Review of the clinical record for Resident 1 included: A minimum data set (MDS, an assessment tool), dated 6/20/19, which reflected Resident 1 was cognitively intact without memory problems. The MDS indicated Resident 1 required extensive assistance for toilet use, with staff providing weight bearing support. A progress note, dated 9/10/19 at 1:24 p.m., written by Licensed Nurse 1 (LN 1) indicated Resident 1 reported she was about to sit on the toilet when CNA 1 grabbed her arm, and instructed her not to sit. The progress note indicated Resident 1 sustained a 4.5 cm bruise on her right forearm. In a concurrent interview and observation, dated 9/19/19 at 10:25 a.m., Resident 1 described her treatment by CNA 1. Resident 1 stated she has frequent diarrhea from her [MEDICAL CONDITION] treatment, and needs help from a CNA getting to the toilet each time. Resident 1 recounted being grabbed by CNA 1, and pointed to her right forearm where an approximately one inch circular bruise was visible. Resident 1 stated she was told not to sit down so CNA 1 could remove her incontinence brief. Resident 1 stated CNA 1 had not meant to hurt her, but she did. Resident 1 stated she did not like the way CNA 1 spoke to her, and described CNA 1 as bossing people around. Resident 1 stated CNA 1 was sweet before getting her CNA credential, but had changed, and was no longer speaking respectfully to the residents. Resident 1 expressed concern that CNA 1 might hold a grudge since Resident 1 had complained about her. Resident 1 was tearful while discussing this incident. In an interview on 9/19/19 at 12:45 p.m., CNA 2 confirmed Resident 1 had reported CNA 1 grabbed her arm, and complained of rough treatment from CNA 1 since she obtained her CNA license. CNA 2 stated she had worked with CNA 1, and had noticed CNA 1 was more snappy, and impatient with the residents after receiving her CNA license. In an interview, on 9/19/19 at 12:55 p.m., family member 1 (RP 1) for Resident 1 confirmed she and Resident 1 had noticed a change in CNA 1 over the previous month. She stated CNA 1 was not the same, and had become more stern, mean, snippy. 2. According to the admission record, Resident 2 was admitted in September of 2018 with [DIAGNOSES REDACTED]. A MDS assessment, dated 9/4/19, reflected Resident 2 was cognitively intact without memory problems. The MDS indicated Resident 2 required extensive assistance for transfers, with staff providing weight bearing support. In an interview, on 9/19/19 at 1:10 p.m., Resident 2 stated CNA 1 had tried to bully people. Resident 2 stated CNA 1 had said, You will do this, You won't do that. Resident 2 stated she felt disrespected by CNA 1. Resident 2 described CNA 1 as not yelling, but did not use a polite tone of voice. Resident 2 stated she had a wound on the back of her leg, and knew the way to sit down with the least amount of pain. Resident 2 stated CNA 1 made her sit more quickly, which hurt her. Additionally, Resident 2 said CNA 1 did not let her move at her preferred pace, and at my own abilities. In an additional interview, on 9/19/19 at 1:20 p.m., Resident 1 (Resident 2's roommate) confirmed she saw CNA 1 force Resident 2 to sit down quickly. Resident 1 stated she felt if she reported CNA 1's behavior, CNA 1 would come back at her. 3. According to the admission record, Resident 3 was admitted summer of 2019 for paralysis and weakness on the left side after a stroke. A MDS assessment, dated 8/15/19, reflected Resident 3 was cognitively intact without memory problems. The MDS indicated Resident 3 was able to perform most of her activities of daily living with staff supervision, but required physical help for part of her bathing, with one staff member's support required. In an interview, on 9/20/19 at 9:50 a.m., Resident 3 stated she had difficulty getting CNA 1 to help her with her shower. When Resident 3 asked for a shower again, CNA 1 acted as if Resident 3 was imposing on her. When CNA 1 worked with Resident 3 in the shower, Resident 3 stated she felt like she was in prison. Resident 3 stated CNA 1 ordered her to perform each step. Resident 3 described CNA 1 as curt and snippy. Resident 3 stated CNA 1 rushed her, and repeatedly tried to end the shower before Resident 3 had finished. Resident 3 stated the shower was the first one since her stroke where she was able to use her left hand. Resident 3 stated CNA 1 kept making her pick up wet towels, and telling her to sit down in a shower chair, even though Resident 3 could stand without difficulty. After the shower, Resident 3 went back to her room, and felt upset about the shower, and reported it to staff. Resident 3 stated she was crying when she reported the treatment she had during the shower. Resident 3 stated being around CNA 1 made her feel anxious after this event. Resident 3 stated the incident made her feel intimidated, and it pulled the rug out from beneath me. Resident 3 stated she did not think CNA 1 should be working as a nursing assistant. In an interview, on 11/08/19 at 2:41 p.m., LN 3 stated she worked with CNA 1 directly. LN 3 stated CNA 1 did not like the job, and did not have the patience for it. LN 3 described CNA 1 as being negative toward the residents, and had heard from several residents CNA 1 treated them roughly. LN 3 stated Resident 1 had frequent diarrhea, called for assistance often, and CNA 1 became impatient with her. Review of the facility policy titled, Resident Rights, dated 10/09, indicated Our facility will make every effort to assist each resident in exercising his/her rights to assure that the resident is always treated with respect, kindness, and dignity.</p>		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE		(X6) DATE

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.