"I'll Be Right Back"

The nursing home failed to: a. ensure dignity and respect was maintained for resident 1 when CNA 2 verbally demeaned her, did not provide her care properly and in a dignified manner; b. identify a second CNA who might have potentially witnessed the incident and failed to report it.

The failure had the potential to diminish resident 1's self-worth and self-esteem. Additionally, being left lying in urine for extended periods increased the risk of compromising her skin integrity.

Resident 1 was cognitively intact (BIMS score of 14 out of 15) and had functional limitation to lower extremity and used a wheelchair for mobility. The resident was admitted mid this year with a primary diagnosis of right knee infection following knee joint replacement surgery.

A review of resident 1's Progress Note indicated that during the afternoon shift, a CNA was assisting the resident into bed and the resident had knee pain. The resident asked the CNA to be careful and CNA stated, "You need to grow a set so we can get this done. If I baby you, it will take forever" and proceeded to aggressively swing the resident's legs into her bed. The CNA then began to prepare the resident for bed and remove her clothing. The CNA pulled the resident's pants down forcefully again causing pain to the resident's surgical knee. The resident grimaced and moaned, and the CNA said, "I'll be right back" and left the resident exposed in her bed uncovered with her pants around her knees and did not return to provide care to the resident for the duration of the shift. Resident 1 was tearful, felt helpless, and scared to report. According to the note, the night shift CNA reported the incident to the nurse.

During an interview, a nurse stated two CNAs reported to her about the incident. The nurse stated she went to resident 1's bedroom to interview the resident and the resident's report was clear about what happened, and it corroborated what the CNAs had reported to her. The nurse stated that resident 1 told her she was scared to report the incident because she feared retaliation from the CNA.

During an interview, the resident stated that during the incident she was left with a wet brief and that a night shift CNA came and cleaned her up at around 10:30 PM. The resident stated she was very upset about how she was treated by the CNA. Two CNAs confirmed that they found the resident very upset and crying when they arrived for their night shift.

The Director of Nursing stated that the CNA no longer worked at the nursing home. Social Services staff stated she/he "came to speak to the resident regarding the incident that happened over the weekend. The resident remembers the event clearly and is happy that the person is no longer in the facility."

Name of Nursing Home	Westview Healthcare Center / Provider ID: 055776
Address	12225 Shale Ridge Lane, Auburn, California
Date investigation completed	September 27, 2022
Type of deficiency issued	F557 – Respect and Dignity
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055776/health/complaint?date=2022-09-27