Forced Out of Bed at 5 AM

The nursing home failed to ensure they developed and implemented abuse policies related to reporting all allegations of abuse and neglect.

The nursing home also failed to identify and report all allegations of abuse and neglect to the appropriate agencies within the appropriate time frames. Resident 24 made allegations of abuse which were not reported to the appropriate state agencies prior to surveyor's intervention.

A review of the complaints and concerns for the previous nine months found the following complaint form completed by resident 24:

Resident 24 was needing to speak with me. I went to her bedroom and she told me about an incident that happened with the night shift crew. She stated, "I rang my bell [at] about 5:00 AM this morning to go to the bathroom. The two girls came in. They always put my shoes on me and get my walker and I walk to the bathroom." This [was] what the girls did to her. She then continued to tell me, "I was on the commode, and they brought my clothes to me. I told them it was only 5:00 AM and I was not planning on staying up. I wanted to lay back down." She was very upset telling me about this incident. She went on to say, "They told me they were getting me up in my wheelchair because they had other things to do." I asked her if she wanted to file a grievance. She stated, "No" as she was afraid of making things worse and afraid of retaliation.

The complaint form went on to say that the shift nurse came in to take resident 24's blood pressure while we were talking. Resident 24's blood pressure was extremely high. The nurse stated she wanted to take it again since resident 24 was so upset. I started talking about happier things and resident 24 started calming down. The nurse took her blood pressure again. It went down some, but [it] was still way too high.

Review of the reportable incidents for the previous nine months found no evidence that this incident was reported as an allegation of abuse for forcing the resident to get out of bed before she was ready because "they had other things to do."

The Person In Charge was interviewed about this allegation. When asked if this incident was reported, she stated, "No because the resident did not want to file a grievance."

Name of Nursing Home	Pine View Nursing and Rehabilitation Center / Provider ID: 515184
Address	400 McKinley Ave. Harrisville, West Virginia
Date investigation completed	September 15, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 3; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/515184/health/standard?date=2021-09-15