Reluctance to Report

The nursing home failed to ensure resident 1 was free of verbal and physical abuse. The resident was verbally abused and treated roughly by LVN 1 during care. The deficient practice resulted in resident 1 feeling embarrassed, humiliated, and experienced pain during a rough care procedure, resulting in rectal bleeding due to LVN's aggressive rough handling during a dis-impaction procedure (a manual removal of stool due to rectal impaction) performed on resident 1.

Resident 1 had the ability to understand and be understood by others and required limited to extensive assistance with ADL care needs such as toileting and bathing. The resident was at risk of constipation related to decreased mobility and the use of, including side effects of narcotic pain medications.

Witness Interview Form indicated that the Director of Social Services (SSD) interviewed resident 1 and reported resident 1 overheard LVN 1 say (about resident 1), "Oh he wants me to go there and play with his [OBSCENITY]." Resident 1 stated LVN 1 told him, "I don't want to work with you anymore."

CNA 1 who witnessed the incident confirmed that LVN 1's made the comments towards the resident.

During an interview, resident 1 stated LVN 1 could be loudly heard in the hallway saying, "He just wants me to play with his [OBSCENITY]." Resident 1 stated LVN 1 continued to be angry and cursing at him in his bedroom. The resident stated LVN 1 "was rough and hurt me during the procedure" (referring to the fecal dis-impaction). The resident stated it made him feel terrible, embarrassed, and had pain. CNA 1 stated that LVN 1 was aggressive and verbally abusive to resident 1 and he reported it to the charge nurse.

The Assistant Director of Nursing indicated that LVN 1 was asked to de-impact resident 1 and LVN 1 responded, "I am not going to dis-impact you (resident 1) or play or touch your a**."

The LVN 1 denied cursing the resident and added that resident 1 "doesn't listen, that is why things got heated." LVN 1 denied seeing any blood. However, CNA 1 indicated that during the procedure, CNA 1 asked, "Is that blood?" and LVN 1 replied, "Yes, that's disgusting." LVN 1 stopped the procedure and left the bedroom. Resident 1 was moaning in pain and asked LVN 1 to stop the procedure prior.

The LVN 1 was suspended pending the investigation.

During an interview, the SSD stated that resident 1 was reluctant to report the incident for fear of retaliation. The SSD stated he encouraged resident 1 to report and provided him with assurance and support.

After the investigation, LVN 1 was let go from employment (two days after LVN 1's suspension).

Name of Nursing Home	Mirada Hills Rehabilitation and Conv Hospital / Provider ID: 055737
Address	12200 La Mirada Blvd. La Mirada, California
Date investigation completed	June 16, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055737/health/complaint?date=2021-06-16