Frustrated, Mad, and Scared

Staff neglected to attend to four residents' needs in a timely manner (residents 1, 2, 3 and 4). Residents 2 and 3 expressed anger and frustration when they had to wait extended time for staff to meet their needs. Resident 1 (not interviewed due to medical condition) had a dislodged catheter (a tube used to drain urine from the bladder) and was not attended to for at least two hours. Resident 4 (not interviewed due to medical condition) did not receive staff assistance with his lunch tray for 58 minutes.

Resident 2 had no mental impairment (based on MDS assessment) and required extensive assistance of one staff for toileting. The resident and her daughter were interviewed. The resident stated that when she used her call light to ask for assistance, staff sometimes would not respond for one to two hours. Most times she asked for assistance it was for help going to the bathroom. She said that she would have to hold it (urine and bowel) in because she did not know when someone would come to answer her call light. The resident stated that she felt frustrated, mad, and scared to speak up because she was fearful of retaliation. The resident's daughter stated that her mom complained to her about this delayed response to call lights numerous times. The daughter added that the primary reason she visits the nursing home almost daily was to ensure her mom gets the assistance she needs.

During an interview, resident 1's daughter stated resident 1's Foley catheter was dislodged for two hours before staff came to re-insert the catheter (the daughter showed photos of the dislodged catheter). The daughter said, "Can you imagine telling my mom to stay in bed waiting. Not being able to go to the bathroom, soiling your bed, while you wait, not knowing when someone is coming or IF anyone is coming to help you." The RN stated that staff had asked her (the RN) a couple of time to take care of resident 1's Foley catheter but she was busy on that day ("I was the only nurse on that day") and that it took her, in her words, "maybe a couple of hours before I got to her."

Resident 4 had moderate to high nutrition risk and had difficulty using utensils likely due to dementia.

During an observation at 12:43 PM, resident 4 was in bed and his call light was going off. His untouched lunch tray was on his tray table about two feet away. There were two staff at the nursing station talking to each other and the chime of the call light was audible 10 feet away from the nursing station. Three staff members were around the corner talking to each other. During the 15-minute observation, resident 4's call light was ringing and none of the five staff attempted to answer the resident's call light. At 12:58 PM, the observation was discontinued, and the Director of Nursing (DON) was alerted regarding resident 4's call light. The DON asked a staff member to assist resident 4. A staff member was later seen assisting the resident with his lunch. During an interview, Dietary Cook 1 stated she brought resident 4's tray up to the floor around 12:00 PM. Resident 4's lunch tray sat untouched in his bedroom for at least 58 minutes.

Name of Nursing Home	City View Post Acute / Provider ID: 056203
Address	1359 Pine Street, San Francisco, California
Date investigation completed	May 23, 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056203/health/complaint?date=2022-05-23