"If You Thought I Was Late Before, Watch Now"

The nursing home failed to: a. ensure resident 2 and resident 5 were free from verbal abuse. LVN 1 verbally threatened and argued with residents 2 and 5 when they requested their pain medication; b. ensure five residents (1, 2, 6, 10, and 11) were free from misappropriation of property when the residents' narcotic pain medications were reported missing on three different days of the same month; c. implement their written policies to prevent the misappropriation of residents' property when the above five residents had missing opioid pain medications; and d. implement policies to ensure drug records were maintained and reconciled periodically for four residents (2, 3, 10, and 11).

During an interview, resident 2 stated that he and LVN 1 did not get along, "just a personality clash." Resident 2 stated he went out of his bedroom to request his pain medication from LVN 2 when she was his nurse. Resident 2 stated that LVN 1 told him she had an hour before and an hour after the scheduled administration time to give him the pain medication. Resident 2 stated LVN 1 was often late administering his medication. Resident 2 stated LVN 1 told him, "If you thought I was late before, watch now." Resident 2 stated even when he went out of his bedroom to ask LVN 1 for his pain medication, LVN 1 would not bring it to him for another 15 or 20 minutes. The resident stated he should receive his pain medication every four hours.

Resident 2 stated that LVN 1 gave him a medicine cup with his medications. The resident stated he swallowed his medications and then realized the pain pill was not in the cup. The resident reported it to LVN 1 but LVN 1 insisted the pain pill was in the medicine cup. The resident insisted that it was not in the cup. LVN 1 ended up giving him a pain pill, and told him, "Here, shut up, you can leave me alone." The resident felt trapped because he was dependent on LVN 1 to give him his medication on time. He stated that he had no concerns about timely medication administration with the other nurses who cared for him. He added that he wrote a letter to the Director of Nursing (DON) about the problems he had getting his medications from LVN 1. The resident stated he was concerned about retaliation from LVN 1.

During an interview, LVN 6 stated resident 2 complained to her on multiple occasions that LVN 1 was not giving him pain medication on time. LVN 6 stated resident 2 told her when he asked LVN 1 for his pain medication, LVN 1 was rude and would give him attitude. LVN 6 stated resident 2 stated LVN 1 told others he was drug seeking. LVN 6 stated resident 1 wrote a letter and she took it to the DON's office. LVN 6 stated resident 2 stated he was afraid that LVN 1 would find out he complained and retaliate.

Resident 5, who had moderately impaired cognition, stated that he had issues getting his pain medication when LVN 1 was his nurse. The resident stated that when he asked LVN 1 for his pain medication, LVN 1 would give the medication but with a "just shut up and take it" attitude.

Name of Nursing Home	Healthcare Centre of Fresno / Provider ID: 055626
Address	1665 M Street, Fresno, California
Date investigation completed	September 22, 2020
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F602 – Free from Misappropriation/Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies F755 – Pharmacy Services
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055626/health/complaint?date=2020-09-22