Four-Hour Bowel Movement

The nursing home failed to ensure residents were free from neglect, verbal, and mental abuse for three residents.

Resident 3 did not have memory problems (based on MDS documentation) and required extensive assistance with activities of daily living.

The resident was forced to sit in her bowel movement for four hours and missed her dinner because CNA 2 refused to clean her. Specifically, during an interview, the resident stated that she pressed the call light at 3:30 PM to be cleaned and changed following a bowel movement but staff did not respond until 5:00 PM when CNA 2 brought her dinner but refused to change her because it was dinner time. Resident 3 told CNA 2 she could not eat her dinner while sitting in her bowel movement. CNA 2 said, "Oh well." She could not eat her dinner and was not cleaned and changed until around 7:30 PM. The resident stated she did not report the incident because she was afraid of retaliation from CNA 2.

The resident also stated CNA 2 was very aggressive and often rude towards her. The resident stated that a few days ago, CNA 2 yelled at her to get in the shower. The resident stated, "I could not do it (get in the shower) because my right leg is amputated."

Resident 2 stated she requested CNA 2 who worked the afternoon shift (3:00 PM to 11:00 PM) to shower her, but CNA 2 told her that she should have requested the shower in the morning shift. The resident said that CNA 2 became aggressive, yelled out profanities, and was disrespectful. Resident 3 (resident 2's roommate) stated that resident 2 and CNA 2 argued with each other, and she heard CNA 2 use profanities. Resident 3 said resident 2 told her she felt humiliated and disrespected.

Resident 1 required one-person assist with bed mobility, transfers, dressing, toilet use, personal hygiene, and bathing. The resident had the capacity to understand and make decisions. At 12:30 PM, during an observation, the surveyor was passing by resident 1's bedroom when she heard CNA 1 yelling at resident 1. CNA 1, speaking in a non-English language (understood by the Surveyor), stated, "You are the only one in this room that gets up to the bathroom."

Ten minutes later, during an interview with the surveyor, resident 1 stated CNA 1 yells at her all the time and she had to get used to the yelling. The resident stated she had to make her own bed because CNA 1 would not help her. The resident stated she did not report CNA 1 to any supervisor.

The nursing home determined that CNA 1's tone towards resident 1 was rude. A review of resident 1's Change in Condition document indicated CNA 1's conduct constituted verbal abuse to resident 1.

Name of Nursing Home	Sunray Healthcare Center / Provider ID: 055870
Address	3210 W. Pico Blvd. Los Angeles, California
Date investigation completed	August 2, 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 3; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055870/health/complaint?date=2022-08-02