Long Term Care Community Coalition

www.nursinghome411.org

Read online at nursinghome411.org/retaliation.

‘They Make You Pay’

Fear of retaliation is a pervasive problem that results in emotional, psychological, and physical harm to vulnerable and frail residents. In far too many U.S. nursing homes, retaliation is a tool to scare and muzzle residents. Unfortunately, this phenomenon has been largely overlooked in policy and in academic literature.

In this project, we strive to raise awareness of this issue by capturing residents’ experiences of fear of retaliation and actual retaliation ***in their own words***, using direct quotations from standard surveys and complaint investigation reports on U.S. nursing homes.

The title of this project, **“They Make You Pay,”** is inspired by a survey report which detailed how residents at a Florida nursing home (Boca Ciega Center) chose not to report or file grievances related to poor care because they feared retaliation by staff.

In an interview with the surveyor, a resident said she did not file a grievance “because they get back at you… They are watching even now to see which rooms you go to and listen to what you ask.” According to the resident, staff and administration at this nursing home retaliated by delaying resident care or sabotaging meals. “They make you pay,” she said.

The resident then asked the surveyor to leave and return later because staff were lingering at the door.

This survey report is one of 100 examined in LTCCC’s project on resident fear of retaliation. In each report, we endeavor to highlight the lived experience of residents and show how they are directly impacted by this phenomenon. We hope that heightening awareness of fear of retaliation can result in real changes in policy, practice, and enforcement actions.

This project is dedicated to the residents impacted by fear of retaliation in nursing homes. Your voices and experiences matter.

Table of Contents

Introduction

For several decades, researchers have reported on the phenomenon of staff retaliation against residents in nursing homes.[1] More recently, we have learned that the *fear* of staff retaliation – the fear itself – is preventing residents from voicing concerns and from receiving the care and services to which they are entitled.[2]

When residents are silenced, the consequences (e.g., emotional/psychological suffering) can be dire. Too often, resident complaints are delayed or never reported and, thus, not investigated and resolved. Ultimately, this inaction leads to unnecessary suffering for residents and their families.

This project, **"They Make You Pay": How Fear of Retaliation Silences Residents in America's Nursing Homes,** examines fear of staff retaliation and the consequences of this fear by capturing residents' experiences *in their own words*. The residents' experiences of fear of retaliation are obtained from 100 standard surveys and complaint investigation reports on nursing homes in 30 U.S. states.

Project Goals

This project aims to raise awareness about the phenomenon of resident fear of staff retaliation and call for policy, practice, and research action to address and prevent it.

Primary goals of this project include:

- Identifying different types of residents' fear of retaliation (I. Fear of Retaliation, II. Alleged Threats of Retaliation, III. Perceived Retaliation, IV. Actual Retaliation).
- Raising awareness of the emotional consequences of retaliation.
- Shedding light on how the fear of retaliation inhibits reporting of (and, thus, accountability for) substandard care, abuse, and neglect.

Using these reports, we detail the residents' lived experience pertaining to the following aspects of retaliation: **I.** Fear of staff retaliation; **II.** Allegations of staff threats of retaliation; **III.** Perceptions of staff retaliation; and **IV.** Actual (confirmed) staff retaliation.

Additionally, the project identifies a wide range of disturbing emotional consequences residents suffer because of fear of or actual retaliation. Systematic examination of these consequences has yet to be conducted to date. In these regards, this project is novel and, we believe, groundbreaking. Lastly, this project examines how fear of retaliation poses barriers to reporting complaints of mistreatment, substandard care, and inhumane conditions.

This project responds to a 2011 University of Connecticut study that called for the implementation of interventions to address, among other issues, residents' fear of staff retaliation.[3] While exploratory in nature, we believe that this review represents the most in-depth examination of this phenomenon to date and hope

---

[1] Stannard, C. I. (1973). Old folks and dirty work: The social conditions for patient abuse in a nursing home. *Social Problems*, 20(3), 329-342. https://psycnet.apa.org/record/1973-29687-001

[2] Robison, J., Gruman, C., Reed, I., Shugrue, N., Kellett, K., Porter, M., Smith, P. Jo, A., Curry, L. (2007). Connecticut long-term care needs assessment: Connecticut Long Term Care Ombudsman Program. University of Connecticut's Health Center. https://health.uconn.edu/dev-aging/wp-content/uploads/sites/102/2017/03/ombudsman_program.pdf
Robison, J., Shugrue, N., Reed, I., Thompson, N., Smith, P., and Gruman, C. (2011). Community-based versus institutional supportive housing: Perceived quality of care, quality of life, emotional well-being, and social interaction. *Journal of Applied Gerontology, 30(3),* 275-303. https://journals.sagepub.com/doi/10.1177/0733464810369810

[3] Robison et al., 2011.

that it will contribute significantly to our understanding of this harmful yet largely invisible source of resident suffering in America's nursing homes.

The project's overarching goal is to raise awareness of fear of retaliation and call for policy, practice, and enforcement actions to address this human rights issue. We hope that **"They Make You Pay"** encourages further study of this phenomenon in nursing homes, assisted living, and other settings in which vulnerable older adults and disabled people live and receive care services.

Background

Resident fear of staff retaliation is a pervasive problem that results in emotional, psychological, and physical harm to vulnerable and frail individuals residing in U.S. nursing homes.[4] Fear of retaliation, moreover, is a barrier for reporting, detecting, and investigating abuse and neglect in nursing homes, according to the Centers for Medicare & Medicaid Services (CMS) and the National Ombudsman Reporting System.[5]

"Fear of retaliation is not something you can look up in a dictionary, but if you live in a setting where you depend on others to care for you, you know exactly what it is."
-Ronnie, a nursing home resident.

This widespread and multifaceted problem not only affects current and future residents, but should be of significant concern to researchers, providers, and policymakers. In recent years, however, it has been largely overlooked, according to our literature review.[6]

"They Make You Pay" aims to take initial steps toward filling the literature gap by identifying resident experiences related to retaliation (fear of retaliation, threats of retaliation, perceived retaliation, or actual (confirmed) retaliation), highlighting the emotional consequences of fear of retaliation, and examining the barriers to reporting posed by fear of retaliation.

A Crushing Sense of Terror

For decades, researchers have explored staff retaliation against vulnerable individuals across different care settings. In a 1961 analysis on life in institutions, sociologist Erving Goffman reported extensively on the disturbing and varied ways in which some care staff members retaliated against people living in total institutions such as psychiatric hospitals. Daily practices such as intimidation, threats of punishment, and punishments were found to produce anxiety, fear, and a crushing sense of "terror" among people living with mental illnesses in those care settings. These practices were described by Goffman as "stigmatization,"

---

[4] Robison et al., 2007; Robison et al., 2011.
[5] National Long Term Care Ombudsman Resource Center (2018). Responding to allegations of abuse: Role and responsibilities of the LTC Ombudsman Program: https://ltcombudsman.org/uploads/files/issues/ane-no-consent-ref-guide-july_2018.pdf
[6] Early research examined a particular sub-type of this phenomenon, that is, staff reactive ("reflexive") retaliation such as in the context of residents' rejection of personal care. Astrom, S. Karlsson, S. Sandvide, A. et al. (2004). Staff's experience of and the management of violent incidents in elderly care. Scandinavian Journal of Caring Sciences, 18(4), 410-416. doi: 10.1111/j.1471-6712.2004.00301.x; Shaw, M.M.C. (2004). Aggression toward staff by nursing home residents: Findings from a grounded theory study. Journal of Gerontological Nursing, 30(10), 43-54. 10.3928/0098-9134-20041001-11; Shaw, M.M.C. (1998). Nursing home resident abuse by staff: Exploring the dynamics. Journal of Elder Abuse & Neglect, 9(4), 1-21. doi: https://doi.org/10.1300/J084v09n04_01

"looping,"[7] "hectoring" (bullying), "mortifications," "sanctioning," "locking up," "errors of resistance," and "conversion" (i.e., "the inmate appears to take over the official or staff view of himself and tries to act out the role of the perfect inmate"). Goffman observed the secretive nature of these punishments and penalties, "typically administered in a closed cell or some other place away from the attention of most of the inmates and most of the staff."

In nursing homes, staff retaliation against residents has been documented for at least 50 years, including in a late 1960s study titled *Old Folks and Dirty Work: The Social Conditions for Patient Abuse in a Nursing Home*.[8] Some nursing homes, according to the study, temporarily neutralized or suspended the norm prohibiting abuse when residents behaved in a manner that contradicted the nursing home's expectations of proper behavior. Examples include:

- A resident abused after defecating on the floor or in a waste basket.
- Retaliation with force against residents who verbally and physically assaulted aides.
- A resident described as "mentally confused" who "did not know any better" allegedly placed by an orderly into a tub of hot water as punishment for cursing. The resident died two weeks later; his death was attributed to the scalding.

As shown above, staff retaliation against residents can take on different forms and lead to a range of harmful consequences. Among those consequences is the cultivation of fear – the complex phenomenon at the center of this project.

"Fear of retaliation is not something you can look up in a dictionary," said Ronnie, a nursing home resident, "but if you live in a setting where you depend on others to care for you, you know exactly what it is."[9]

Retaliation Is Abuse

"He'll beat me up again if I tell you."

- Ohio nursing home resident and victim of staff retaliation (2001)

In recent decades, resident fear of retaliation has garnered occasional attention among researchers, journalists, and advocates.[10] Notably, a 2001 U.S. House of Representatives report detailed the aftermath of an incident involving an Ohio nursing home resident who sustained severe lacerations and bruises. When asked by staff members about the incident, the resident replied, "He'll beat me up again if I tell you." Later, the resident identified a male aide who confessed to abusing the resident. In another case, a resident in a Texas nursing home was so afraid of an abusive staff member that he did not seek any assistance even after falling twice from his bed and suffering a fractured hip.

---

[7] Goffman defines *looping* as "An agency that creates a defensive response on the part of the inmate takes this very response as the target of its next attack. The individual finds that his protective response to an assault upon self is collapsed into the situation." Goffman, E. (1961). Essays on the Social Situation of Mental Patients and Other Inmates. Anchor Books: Garden City, New York.

[8] Stannard, C. I. (1973).

[9] Voices Speak Out Against Retaliation training video (2010), produced by the Connecticut Long Term Care Ombudsman Program, the Connecticut Department of Social Services (Office of Organizational and Skill Development), and the University of Connecticut School of Social Work. https://www.youtube.com/watch?v=feoQjIW3_bc

[10] U.S. House of Representatives, "Abuse of Residents is a Major Problem in U.S. Nursing Homes," July 30, 2001. https://www.cbsnews.com/htdocs/pdf/waxman_nursing.pdf

A 2017 *Star Tribune* report, *Speak Up, and Risk Eviction*, offers another striking example of resident fear of retaliation. The report details how a Minnesota senior home threatened eviction of an 84-year-old woman living with a "pulmonary condition so severe that her doctor ordered her to avoid smoke"[11] after she complained about the home's failure to uphold its rules prohibiting smoking.

"We were petrified. We were being labeled as troublemakers and had nowhere else to go."

- Minnesota resident, 84, after being threatened with eviction.

The woman and her husband were scolded by the administrator after she reported the smoking violations to management (collecting cigarette butts in a bag with the care home's "No Smoking" policy taped on, and hanging it on the manager's office door). They were then threatened with eviction for "misbehaving" and "stirring up trouble." The woman said, "We were petrified. We were being labeled as troublemakers and had nowhere else to go."

The couple – unable to live with the threat of eviction and the breathing difficulties caused by the smoke exposure – moved to a different assisted living residence. Reflecting on their experience, the woman asked, "How would you like to be forced out of the home where you've lived for 12 years?"

It is important to understand that CMS considers staff retaliation – such as the above examples – as a form of abuse against residents.[12] This includes emotional or psychological abuse, "verbal or nonverbal behaviors that inflict anguish, mental pain, or distress on an older adult."[13] [14]

In this project, we devoted considerable attention to staff retaliation that takes the form of emotional or psychological abuse. There is extensive overlap between manifestations of psychological abuse, staff threats of retaliation, and acts of staff retaliation against nursing home residents. However, to our knowledge, this issue has not been systematically examined to date.

[11] Serres, C. (November 15, 2017). Speak up, and risk eviction. Part 4 in the 5-Part series Left to Suffer. *The Star Tribune*. https://www.startribune.com/senior-home-residents-risk-eviction-when-they-speak-up/450626083/

[12] CMS, State Operations Manual – Appendix PP – Guidance to Surveyors for LTC Facilities. Available at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf.

[13] Centers for Disease Control and Prevention, "Fast facts: Preventing Elder Abuse." https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

[14] Psychological abuse is also defined as "an act carried out with the intention, or perceived intention, of causing emotional pain to another person (e.g., threats or insults)." See: Pillemer, K., & Moore, D. W. (1989). Abuse of patients in nursing homes: Findings from a survey of staff. *The Gerontologist*, 29(3), 314-320. https://academic.oup.com/gerontologist/article-abstract/29/3/314/642482

A Human Rights Issue

A growing body of research indicates that fear of staff retaliation is common in U.S. nursing homes. According to a study by the Atlanta Long-Term Care Ombudsman Program, *The Silenced Voice Speaks Out*, "44% of the residents who had seen abuse of other residents did not report it."[15] Of those residents, half did not report it due to fear of retaliation.

In 2005, more than 200 individuals representing 75 long-term care (LTC) homes – along with representatives from state agencies (e.g., Department of Health; Department of Social Services) and other organizations (e.g., AARP) – attended the Connecticut Long Term Care Ombudsman Program's (LTCOP) VOICES Forum.[16] Participants shared that residents feared retaliation when complaining about their care or other aspects of the environment in which they live, "thus limiting complaint reporting and resolution."

A month later, the topic of fear of retaliation resurfaced in a discussion led by the Washington State Resident Council group at the 30th Annual Meeting of the National Coalition of Citizens for Nursing Home Reform (now The National Consumer Voice for Quality Long-Term Care).[17] In 2006, the VOICES Forum held a workshop on fear of retaliation and in 2007, the Connecticut LTCOP assembled a statewide workgroup (Connecticut LTCOP Voices Speak Out Against Retaliation) to address the issue.[18]

How Ombudsmen Navigate Fear of Retaliation

Ombudsmen (advocates and resources for individuals residing in LTC homes) are increasingly focused on the issue of fear of retaliation. The National Long Term Care Ombudsman Resource Center notes that "Fear of retaliation is one of the most common reasons residents do not want to pursue a complaint and disclose their identity… It is critical that Long Term Care Ombudsman Program [LTCOP] representatives understand how fear of retaliation influences a resident's or another complainant's choices regarding complaint reporting and resolution."

Many LTCOPs are focusing on the complaint process in their efforts to address fear of staff retaliation and actual staff retaliation. We recommend residents, families, and advocates refer to LTCOP Complaint Code D06 (Retaliation), "Acts of retaliation/revenge by facility staff in response to a complaint to the facility, Ombudsman program, or state survey agency." (Unfortunately, D06 does not capture ***fear of*** retaliation. We believe this is a major gap in the LTCOP complaint system).

We also recommend referring to code D05 (Response to Complaints), "Facility staff ignores or trivializes a resident complaint or there is no facility grievance process thereby limiting the resident's ability to resolve a problem directly with the administration," if the grievance procedure is not followed or made known to residents.

[15] Broyles, K. (2000). The silenced voice speaks out: a study of abuse and neglect of nursing home residents. A report from the Atlanta Long-Term Care Ombudsman Program and Atlanta Legal Aid Society to the National Citizens Coalition for Nursing Home.
[16] The VOICES Forum is an annual meeting for nursing home residents to discuss current quality of care and life concerns and best practices to promote systemic public policy and advocacy issues.
[17] See Family Guide to Effective Family Councils, https://theconsumervoice.org/uploads/files/family-member/Guide-toEffective-Family-Councils.pdf.
[18] Voices Speak Out Against Retaliation training video (2010). https://www.youtube.com/watch?v=feoQjlW3_bc

A 2000 survey found that 44% of the residents who had seen abuse of other residents did not report it. Half of those residents did not report it due to fear of retaliation.

Atlanta Long-Term Care Ombudsman Program

A 2007 study conducted by the University of Connecticut's Center on Aging found that worry over retaliation was common among individuals in supportive housing and LTC settings. Roughly one-fourth of the residents interviewed in that study reported worrying about retaliation if they were to report a complaint or concern.[19] The study quoted nursing home residents saying:

- "Yes, I heard a girl say that they know how to get even so I try to keep my mouth shut."
- "Oh yeah, always. That's why nobody makes a complaint. The administrator scares everyone and he's very belittling and yells at people."
- "Yes, there's a lot of retaliation."

The researchers concluded that, "Retaliation and the fear of retaliation is a reality in any supportive housing situation."[20]

Advocates of nursing home residents are increasingly recognizing fear of retaliation as a widespread and multifaceted problem. It not only harms residents directly but it also deters reporting and investigating poor care and mistreatment (i.e., neglect of healthcare, abuse, financial exploitation, staff threats of retaliation, and actual staff retaliation). Residents and their families, afraid of the consequences, are discouraged from reporting on care concerns, filing grievances, and filing complaints with the nursing home, state survey agencies, and law enforcement.

Over the years, resident advocates have voiced concerns about fear of staff retaliation and the harmful effects of staff retaliation on residents and their families. Cheryl Hennen, Minnesota State LTCOP, said that fear of retaliation is "a human rights issue. Vulnerable adults with complex medical issues are being retaliated against for the simple act of speaking up. Someone needs to take the lead here and stop the practice."[21] Kristine Sundberg, Executive Director of Elder Voice Advocates in Minnesota, said that fear of retaliation is "a rapidly escalating problem that results in inconceivable suffering and it must be stopped."[22]

[19] This includes 23% of nursing home residents (plus 4% reporting that they do not want to complain and 1% who do not want others to get in trouble), 19% of residential care homes residents (plus 8% who do not want to complain and 4% who do not want others to get in trouble), and 13% of assisted living residents (plus 7% who do not want to complain and 4% who do not want others to get in trouble).

[20] Based on in-depth interviews, the research team also found: instances of retaliation are egregious or highly visible, but others are more subtle; many forms of retaliation may not be recognized by residents or staff; some residents feared concern over potential retaliation as much as they feared the experience of retaliation itself; and individuals who felt conflicted about whether to report retaliation reported feelings of hopelessness and despair.

[21] Serres, C. (November 15, 2017). Speak up, and risk eviction.

[22] Sundberg, K. personal communication (March 25, 2023).

Much work remains to address the critical problem of fear of retaliation in nursing homes. That's where this project comes in. **"They Make You Pay": How Fear of Retaliation Silences Residents in America's Nursing Homes"** examines fear of staff retaliation and the consequences of different aspects of retaliation by capturing residents' experiences documented in standard surveys and investigation reports.

This project builds on previous research by identifying residents' experiences pertaining to different aspects of retaliation (fear of staff retaliation, allegations of staff threats of retaliation, perceptions of staff retaliation, and actual (confirmed) staff retaliation), highlighting their emotional consequences, and examining how retaliation poses a barrier to reporting and complaints. We hope that this in-depth examination can improve our understanding of fear of retaliation, a far too prevalent source of suffering and form of abuse for America's nursing home residents.

Methods

This project used completed and de-identified standard surveys and complaint investigation reports (public records) called Statement of Deficiencies and Plan of Correction (Form CMS-2567 or SODs).[23] This CMS form is the official document on which state surveyors record substantiated deficiencies and document the determination of non-compliance. The Institutional Review Board (IRB) of the University of Minnesota determined the study to be "Not Human Research" and thus no IRB approval was needed.

In this project, we reviewed an initial pool of 835 Statements of Deficiencies (SODs) from standard surveys and complaint investigations containing variations of the word "retaliation." From these we identified 100 SODs with sufficient and compelling detail necessary to meet the project's goals. For each report, we provide a summary that includes:

- **A title:** Our attempt to capture the nature of the incidents, their pertinent aspects, and/or quotations of resident and others. Example: "They Make You Pay".
- **The deficient practice statement:** A statement detailing why the entity was out of compliance.[24] Example: The nursing home did not ensure residents could voice grievances in a safe way.
- **Evidence relevant to the project's goals**. Example: 16 residents expressed fear of retaliation related to reporting or filing grievances.
- **Summary table:** Information on the nursing home (provider name, federal identification number, and address) and the survey/complaint report (date completed, deficient practice(s) identified, severity level),[25] as well as the nursing home's Overall Rating (1-5) and Staffing Rating (1-5) at the month in which the survey/complaint report was completed.

Note: PDFs of investigation reports are available on **nursinghome411.org/retaliation**. See **Appendix A** for more information about methodology.[26]

---

[23] Researchers studying elder mistreatment face numerous barriers to access data on staff-to-resident abuse (reluctance by administration to grant study permission because of concerns over publicity, regulatory action, and legal liability; limited access to cognitively able and willing residents; challenges obtaining informed consent from families; fear of retaliation from prospective participants; and resource constraints). See: Hirt, J et al. (2022). Staff-to-resident abuse in nursing homes: a scoping review. BMC geriatrics, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9261065/.

[24] CMS defines the following terms: Deficient practice: "The action(s), error(s), or lack of action on the part of the entity relative to a requirement (and to the extent possible, the resulting outcome)."
Evidence: An integral part of the citation that begins with a description of the deficient entity practice and identifies the relevant individual findings and facts that substantiate the failure of the entity to comply with the regulation.
Finding: A generic term used to describe each discrete item of information observed or discovered during the survey about the practices of an entity relative to a specific requirement being cited as being not met."
Requirement: Any structure, process or outcome that is required by law, regulations, or the Life Safety Code." CMS defines "outcome" as "a result/consequence of entity practices.

[25] A deficiency's "severity level," determined by a state surveyor, represents the extent of harm to the resident(s). The severity levels range from 1-4, though the severity levels of deficiencies in this report range from 2-4 (**Level 2:** No actual harm with a potential for more than minimal harm that is not immediate jeopardy. **Level 3:** Actual harm that is not immediate jeopardy. **Level 4:** Immediate jeopardy to resident health or safety). See Appendix B for additional information.

[26] Most one-page summaries include a URL (web address) for the survey/investigation reports obtained via the federal Care Compare website. URLs for some reports are no longer active because CMS removes them from Care Compare after a certain amount of time.

Findings

Forms of Retaliation

Our research led to the identification of extensive evidence revealing the four main aspects of the phenomenon under study, including:

I. Residents' fear of staff retaliation;
II. Residents' allegations of staff threats of retaliation;
III. Residents' perceived staff retaliation; and
IV. Actual (confirmed) staff retaliation against residents.

The following section offers examples of situations underlying the four aspects of the phenomenon, including a discussion of themes of fear of retaliation.

I. Fear of Staff Retaliation

Fear of staff retaliation was a common experience for residents in the reports reviewed for this project.

Findings from a previous study show that residents' "worry about potential retaliation was just as fearsome for some residents as the experience of retaliation itself."[27]

Consequences of fear of retaliation included reluctance/avoidance to request staff assistance, reluctance to complain to staff/surveyors/ombudsmen, fear of abuse, fear that basic rights would be taken away, and more.

Below are examples of fear of staff retaliation from this project:

- A resident stated that a staff member smacked his forehead against the side rails of the bed and smacked and pinched his scrotum with a urinal "really hard." This

Themes: Fear of Staff Retaliation

This project identified numerous themes related to residents' fear of staff retaliation, including:

• **Fear.** Residents indicated that they believed reporting on poor care and mistreatment by staff would result in staff retaliation.

• **Emotional suffering**. Many residents experienced extensive fear if they considered reporting or actually reported inadequate care and mistreatment.

• **Lack of or delayed reporting**. Fear of staff retaliation contributed to lack of or delayed reporting of violations of residents' federal rights, care, neglect, abuse.

• **Lack of investigations.** Instances of mistreatment remained uninvestigated internally by the nursing home and/or externally by the state survey agency because of barriers to resident reporting.

• **Perpetuation of mistreatment**. Poor care and mistreatment continued due to lack of reporting and investigation; often despite red flags, suspected mistreatment, and known mistreatment. It was not uncommon for alleged perpetrators to be permitted to maintain access to residents.

• **Learned helplessness.** This review found preliminary evidence linking residents' fear of staff retaliation and their experience of learned helplessness.

• **Asymmetry of Power.** Findings from this review illustrate the gross asymmetry of power in the context of residents' fear of staff and/or managers' retaliation. Of note, many residents cited in this project were physically dependent on extensive staff assistance with activities of daily living.

[27] Robison et al. 2007; 2011

resident did not want to say anything because he was worried it would make things worse for him.

- A resident was worried he would be "starved out for talking to state surveyors" if he reported physical abuse. Another resident told the surveyor, "What am I supposed to do when you leave? I still must live here. I don't want to talk anymore."

- A resident initially told a social worker that she was screamed at and called a liar by staff, but later declined to speak about the incident with a surveyor. She explained, "I talked to someone about it and that just caused trouble and I am not going to cause trouble." She added, "My condemning her is my fault. I am not saying more."

- A resident alleged rough care by an aide when assisted into bed and was so afraid of the aide that she asked other staff to put her to bed early. She reported the poor care to her family but due to fear of retaliation by the aide, she waited nearly a week to report it to the nursing home.

- Multiple reports contained examples of residents who feared losing basic rights, such as smoking, socializing with other residents, seeing family and friends, and going to church.

- Multiple residents feared retaliation in the form of wrongful involuntary discharge/eviction.

II. Alleged Threats of Staff Retaliation

Threats of retaliation by staff and managers were alleged and reported by residents frequently through the 100 reports. Examples included threats to delay or not provide services and care to residents, threats to neglect and abuse residents, threats of physical violence against residents, threats of retaliation if a resident reported on being sexually abused, and threats to discharge residents from the nursing home.

The alleged staff threats were triggered by residents' requests for assistance with needed care, residents' reports on lack of care and mistreatment, and after residents have been mistreated by staff members. Alleged threats were sometimes made to prevent residents from going forward with reporting on mistreatment to the nursing home and to the state survey agency. In one case, a staff member made a direct threat to a resident's family member saying, "You better not call state (regulatory services) or it will be worse for the residents."

These alleged threats exacerbated residents' fear of staff retaliation and led a subgroup of residents to be terrified of the prospect that the threats will materialize without their ability to defend themselves. Threats of retaliation by staff and managers were alleged and reported by residents frequently through the 100 reports. Consequences of this included delayed medication, delayed care, collective punishment, violence, discharge, and more.

A resident reported that a staff member threatened to "beat the s* out of me, and no one would know how she did it." The resident said, "I was terrified."**

Below are examples of alleged threats of retaliation from this project:

- A nurse told a resident who was concerned that pain medications weren't being given in time, "If you thought I was late before, watch now."

- After repeated refusals to assist a resident out of bed, a staff member told the resident, "If you fall, I won't let you up."

- A staff member told a resident to go to bed against her wish and made the following threat, "If you don't go now, I won't help you during the night shift."

- An administrator allegedly told a resident, "If you keep that up, I will make you a Troubled Resident in your file."

- A staff member told a resident's family, "You better not call state (regulatory services) or it will be worse for the residents."

- A resident reported that a staff member threatened to "beat the s*** out of me, and no one would know how she did it." The resident said, "I was terrified."

- An administrator threatened to discharge a resident (e.g., to be escorted out of the building by police, to be put on the street, and to be discharged to a homeless shelter) after mistakenly thinking the resident slammed the door loudly when he left the room.

III. Perceived (Unverified) Staff Retaliation

Residents reported experiencing an array of retaliatory actions by staff members and managers. These retaliatory actions came in response to residents' concerns, grievances, and complaints regarding care, substandard care, and mistreatment. Specifically, residents stated that staff and managers retaliated against them by neglecting them (e.g., not providing required care; not providing medications), delaying provision of needed care (e.g., delays in responding to call lights); psychologically abusing them (e.g., yelled at, cursed at, or mocked; treated as "the lowest form of life;" being bullied; and being ignored/receiving the silent treatment); physically abusing them (e.g., receiving rough or demeaning care); forcing residents to do things against their will (e.g., a resident who preferred to eat in her bedroom was placed in the dining room for lunch); resident right violations (e.g., withholding so-called "privileges"); and violations of rights to privacy.

Note: Incidents were classified as "perceived" retaliation when a resident made a statement about being retaliated against by staff, but the investigation report did not include sufficient evidence to meet the threshold of "actual (confirmed)" retaliation.

Below are examples of perceived retaliation identified in this study:

- A resident was afraid of voicing grievances "because it backfires on you...staff became aggressive (angry, pushy, forceful, intimidating, and loud)."

The employee came into the bedroom, slammed the resident's pills down, and said rudely, "Take them."

- Residents alleged they were not receiving care in retaliation for voicing concerns and making complaints. One example included staff not responding to or delayed responding to call lights.

- After residents complained about the quality of the food, they were cursed at ("bastard" and "son of a [expletive]") and "their intelligence was attacked, they were bullied, and they felt they were treated as the lowest form of life."

- After a resident reported to management on poor care from a staff member, the employee came into the bedroom, slammed the resident's pills down, and said rudely, "Take them."

- After a resident asked to be cleaned with towels instead of paper towels, the aide allegedly placed a towel with feces on resident's face/nose.

- A resident said that reporting on a kitchen staff member for being "very rude" resulted in the employee "not putting a food item on your tray or sabotaging your meal."

- A staff member alleged witnessing another staff member telling a resident that they are rude and "that's why your family doesn't visit."

IV. Actual (Confirmed) Staff Retaliation

Staff told a resident that he is an "a hole," and "a pain in the a**" and that she wanted to "beat the s**t out of him."**

This project identified numerous examples of confirmed staff or manager retaliation against residents. Staff members and managers retaliated against residents using verbal/psychological abuse (e.g., harassing, intimidating, humiliating, yelling at, or cursing at a resident); physical abuse (e.g., shower scalding, wringing a towel soaked with hot water over a resident's genitals, forcefully pulling a resident's neck forward towards her feet causing pain and c-2 displacement requiring hospitalization, or "reflexive" slapping), and threats of physical violence (e.g., staff member telling a resident she wanted to beat the s**t out of him).

Below are examples of perceived retaliation[28] from this project:

- After report on lack of hygiene care, staff told a resident, "You're a liar and you're messy."

- Staff told a resident that he is "a** hole," and "a pain in the a**" and that she wanted to "beat the s**t out of him."

- When a resident was masturbating in a room near the nursing area, a RN grabbed his penis, and screamed, "If you don't stop that, I am going to rip that thing off."

- An aide, in response to being struck by a resident with severe cognitive impairment, pried the resident's clenched hand open, grabbed his pinky finger, and bent it back toward his wrist until he screamed. A staff witness said they "never saw such evil" when they reported the physical abuse to the administrator.

- Staff forced a resident to move to an all-men secure care unit (without advance notice) after managers made an unfounded allegation that the resident inappropriately touched a female resident.

[28] Note: We refer to retaliation as "perceived" when it has been reported by the resident but not substantiated by the surveyor. This does not mean that the retaliation did not happen, only that it was not indicated as substantiated in the Statement of Deficiencies.

Consequences of Retaliation

"Staff acted like we were non-people" and added, "They don't even acknowledge that we are human."

In this project, we found that fear of retaliation and other aspects of retaliation had significant consequences on resident health care and well-being. Some residents reported suffering significant emotional, psychological, and/or physical consequences. Many residents, moreover, may have suffered additional consequences because fear of retaliation prevented them from expressing care concerns, filing grievances, and/or making complaints.

In this section, we discuss the consequences of retaliation experienced by residents.

Emotional Consequences

Residents reported experiencing a wide range of negative emotional consequences related to different aspects of retaliation (fear, alleged threats, perceived, actual). The severity of these emotional consequences varied in magnitude, though many residents experienced significant suffering.

Emotional states such as anxiety, fear, frustration, anger, sadness, and helplessness were commonly reported by residents. Many felt belittled, disregarded, ignored, and that they were treated as "less than a person." Resident dignity – "the quality or state of being worthy, honored or esteemed" – was frequently violated.[29]

Many residents expressed fear that required care would not be provided if they were to speak up about care concerns and mistreatment. Many residents were extremely fearful or terrified for their safety if they were to voice concerns about care and mistreatment.

One resident said, "I felt threatened for my life." The resident "kept saying she felt threatened, her life was in danger" due to physical abuse by an aide the night before. She said that she didn't report the abuse due to fear of retaliation from the aide, adding that she kept her reacher by her bedside in the bed to protect herself at night out of fear of the physically abusive aide.

Numerous residents requested anonymity when reporting concerns and mistreatment to employees and state surveyors. Some residents chose not to identify the name of the alleged perpetrators due to fear of retaliation. Some residents chose not to speak about violations of their rights, care concerns, or incidents of mistreatment.

Some residents urged family members to keep quiet about mistreatment. In one case, a resident told her family to stay quiet during an interview with a state surveyor, saying, "You don't understand, you have to keep your mouth shut." Some residents were so afraid of staff retaliation that they did not report poor care and mistreatment. This resulted in continued rights violations, lack of care, abuse, and neglect (e.g., a resident staying in their soiled diaper for hours).

Fear of staff retaliation combined with ongoing disregard of their care concerns led some residents to give up on expressing their care concerns, making grievances, and filing complaints. (Their experience in this context could be characterized as "learned helplessness," a phenomenon in which repeated exposure to

[29] Merriam-Webster Dictionary definition: dignity. Retrieved from https://www.merriam-webster.com/dictionary/dignity.

uncontrollable stressors results in individuals failing to use any controls options that may later become available, according to the American Psychological Association).[30]

Taken together, the wide range of negative emotional consequences identified in this study suggests that fear of retaliation is a significant source of resident suffering and harm. It also suggests that an unknown number of residents are being effectively silenced as they suffer from violations of resident rights, poor care, mistreatment, abuse, financial exploitation, fear of retaliation, and actual retaliation.

Below are examples of emotional consequences found in this project:

- A resident was "afraid nobody will show up and she will be left alone to die" if she reported an aide's rough and disrespectful care.
- Residents felt they were made to feel small, "less than a person," and as a "lowest form of life." One resident said, "Staff acted like we were non-people" and added, "They don't even acknowledge that we are human."
- A resident reported feeling "like he was a child being punished for something."
- A resident concerned about abrupt repositioning said that he "worried all day about what will happen at night." The resident declined to identify the staff responsible for poor care due to fear of retaliation.
- A resident stated that they did not receive a bed bath but was fearful of telling staff names and did not report it. "It breaks my heart," the resident said.

Physical Consequences

Residents reported experiencing a wide range of physical consequences related to retaliation. Specifically, several residents experienced physical pain (some extreme) due to physically abusive retaliation. Physical consequences were caused by assault, physical restraint, sexual abuse, neglect, and more.

Below are examples of physical consequences found in this project.

- A resident was pushed forcefully in her bed causing a c-2 dislocation requiring hospitalization.
- A resident's pinky finger bent backward toward their wrist until they screamed.
- A resident alleged that a staff member banged his head against the side rail ("really hard") and that the staff then took a urinal and smashed it against his genitals over and over ("really hard").
- A resident alleged a Certified Nursing Assistant (CNA) burned her by wringing a towel soaked with hot water over her private parts.

[30] As explained by Mairead Painter, Connecticut Long-Term Care Ombudsman (personal communication, March 16, 2023), "If you don't think anything is going to change and you don't see positive outcome in any way, that's when people give up. Once people become hopeless – despair and hopelessness – is when we see the most impact. That's what is most difficult for me to see residents going through."

- A resident was physically restrained during provision of personal care (e.g., when changing soiled depends of a resident rejecting the care).

- A resident with moderately impaired cognition was sexually abused by two CNAs. The resident stated that the CNAs verbally threatened him to stay quiet as they grabbed his right leg and caused him pain.

- A resident was forced to lay in their soiled adult diapers for several hours, which, in addition to being demeaning, can cause physical discomfort, pain, irritation, and skin rash.

A Barrier to Reporting

This project found that many residents, due to fear of staff retaliation and other aspects of retaliation, refrained from expressing their care concerns, filing grievances, and/or making complaints. This finding is concerning for numerous reasons. First, people living in nursing homes have a federal right to express concerns and file grievances and complaints with the nursing home, the state survey agency, and law enforcement without fear of discrimination, punishment, and retaliation.

Second, the nursing home complaint process is considered "the front-line system for addressing consumer concerns" and "a critical safeguard to protect vulnerable residents," according to reports by the U.S. Office of Inspector General (OIG).[31] This project generated extensive evidence indicating that fear of retaliation deters residents from reporting care concerns and filing mistreatment complaints. This barrier may represent a weak link in the above front-line system and deserves greater attention from policymakers and researchers.

A recent study, *Complaints Matter* (conducted by the author of this report), provides additional support for the importance of this safeguard with its finding that deficiencies in complaint investigations were generally cited as more severe compared those in standard surveys.[32] In other words, complaint investigations are potentially an effective mechanism for improving care.

In the 2017 *Star Tribune* series, *Left to Suffer,* journalist Chris Serres wrote that "the threat of retaliation not only terrifies residents..., it discourages them and their families from taking steps that would protect their rights or enforce public regulations." Our study further shows how fear of retaliation prevents many care concerns, right violations, and allegations of mistreatment from being reported. In some cases, serious issues were not investigated by the nursing home and/or the state survey agency. In other cases, residents' fear of retaliation led to delays in reporting care concerns and mistreatment. This limited the ability to conduct timely investigations and collect evidence necessary to substantiate the allegations. Left unaddressed, these care problems and forms of mistreatment will continue to place residents at risk of harm. (Relatedly, it is well

[31] U.S. Office of Inspector General. (2006). Nursing home complaint investigations. U.S. Department of Health & Human Services. https://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf; U.S. Office of Inspector General. (2017). A few states fell short in timely investigation of the most serious nursing home complaints: 2011–2015. U.S. Department of Health & Human Services. https://oig.hhs.gov/oei/reports/oei-01-16-00330.pdf

[32] Liu, P., Caspi, E. Cheng, C-W. (2021). Complaints matter. Seriousness of elder mistreatment citations in nursing homes nationwide. Journal of Applied Gerontology, 41(4), 908-917. https://pubmed.ncbi.nlm.nih.gov/34486438/

known that when lower severity care problems remain uninvestigated and unaddressed, they may escalate into more serious harm.)[33]

In addition, too many nursing homes underreport allegations of mistreatment to their state survey and law enforcement agencies. A study by the OIG found that nursing homes failed to report many incidents of potential abuse and neglect to their state survey agency in accordance with federal requirements.[34] Another OIG study found that "in most states, the agencies responsible for investigating abuse and neglect in nursing homes acknowledge their dependence on such reports from the facilities."[35] This is further evidence of the need for the filing of timely complaints and thorough investigations.[36]

Summary Statistics

This project was based on standard surveys and complaint investigation reports from 100 nursing homes. Given that there are approximately 15,000 U.S. nursing homes, it is important to note that this sample is small and not intended to be representative of nationwide trends. For example, it will not indicate whether fear of retaliation is more prevalent in some states vs. others or more common in 2022 vs. 2017.

Caveats aside, we believe that data on the characteristics of the selected survey and complaint reports provide useful insights and will, hopefully, spark ideas for future research. With that in mind, this section contains data on the characteristics of nursing homes (state, year, F-tag, severity level, Overall Quality Star Ratings, and Staffing Ratings) cited in the 100 survey and investigation reports. These reports contained compelling evidence pertaining to the four aspects of retaliation (fear of, allegations of threats, perceived, actual) as well as their emotional consequences. This project identified at least 240 residents who experienced fear of staff retaliation (average 2.4 residents per SOD; range 0-16; median 1).[37] This section also provides information on employee terminations related to retaliation.

Statements of Deficiencies (SODs) by State

This project examined 100 standard surveys and complaint investigation reports from 100 nursing homes from 30 states, including: California (17), Texas (11), Michigan (8), Illinois (6), Massachusetts (5), Indiana (5), Ohio (4), Minnesota (4), Florida (3), North Carolina (3), Pennsylvania (3), Washington (3), New York (3), Connecticut (2), Idaho (2), Colorado (2), Mississippi (2), Wisconsin (2), Montana (2), Missouri (2), Virginia (2), West Virginia

---

[33] U.S. Office of Inspector General. (2019). Incidents of potential abuse and neglect at skilled nursing facilities were not always reported and investigated. U.S. Department of Health & Human Services. https://oig.hhs.gov/oas/reports/region1/11600509.pdf; Minnesota Office of the Legislative Auditor (2005). Evaluation report: Nursing home inspections. https://www.auditor.leg.state.mn.us/ped/pedrep/0505all.pdf

[34] U.S. Office of Inspector General. (2019). Incidents of Potential Abuse and Neglect at Skilled Nursing Facilities Were Not Always Reported and Investigated.

[35] Hawes, C. (2003). Elder abuse in residential long-term care settings: what is known and what information is needed? In Elder mistreatment: Abuse, neglect, and exploitation in an aging America. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK98786/

[36] U.S. Office of Inspector General (2019).

[37] This figure (240 residents) represents a conservative estimate as an additional 32 residents possibly experienced fear of retaliation that was not documented. These residents included those who stated that they were retaliated against, that staff threatened to retaliate against them, or that retaliation was confirmed. In some of these cases, the residents had moderate to severe cognitive impairment and thus applying the reasonable person concept (CMS, 2023) may suggest that they experienced fear of retaliation after staff abused them, made threats or actually retaliated against them.

(1), Louisiana (1), Iowa (1), Vermont (1), New Mexico (1), Arizona (1), Maryland (1), Oklahoma (1), and South Carolina (1).

SODs by Year

The standard surveys and complaint investigation reports were completed by state surveyors between June 9, 2017 and September 27, 2022. Most SODs in this project are from surveys and complaint investigations in recent years (59% of sample from 2021-2022). Note: These data do ***not*** indicate that fear of retaliation was more likely to occur in recent years.

SODs by Year						
2017	2018	2019	2020	2021	2022	**Total**
3	5	20	13	29	30	**100**

SODs by F-tag

An estimated total of 157 state survey deficiency citations (F-tags) were issued by state surveyors in those parts of the 100 standard surveys and complaint investigation reports considered by the author of this report as most relevant to the phenomena examined and the project's goals. These citations spanned across 24 unique F-tags, indicating that there is a broad range of regulatory violations in which retaliation, or fear of retaliation, may take place.

Note: In many cases, F-tags issued by state surveyors were not necessarily issued for violations directly relevant to the four main aspects of retaliation examined in the report or to the emotional and physical suffering reported by residents. Caution is therefore required when interpreting these findings.

The most common F-tags identified included (for simplicity, old F-tags used by CMS prior to November 28, 2017 were added to the count of their equivalent new F-tags):

- F600 (Free from Abuse and Neglect; n=43)
- F585 (Grievances; n=19)
- F550 (Resident Rights / Exercise of Rights; n=15)
- F610 (Investigate/Prevent/Correct Alleged Violation; n=15)
- F607 (Develop/Implement Abuse/Neglect, etc. Policies; n=15)
- F609 (Reporting of Alleged Violations; n=14)
- F565 (Resident/Family Group and Response; n=7).

"These citations spanned across 24 unique F-tags, indicating that there is a broad range of regulatory violations in which retaliation, or fear of retaliation, may take place."

Definitions of the 24 F-tags identified in this project and details about other F-tags can be found in **Appendix B**.

The identification of these F-tags is important. To our knowledge, no other published project or study to date has identified a wide range of F-tags surrounding (directly and indirectly related to) the phenomenon of fear of retaliation in U.S. nursing homes. We believe that these findings can be used to advocate for and inform CMS efforts to centrally track standard surveys and complaint investigations for information necessary for improving understanding and the prevention of this phenomenon. This information could also be used by researchers, care advocacy organizations, and government watchdog organizations (e.g., U.S. Government Accountability Office and U.S. OIG) to conduct research aimed at improving understanding and prevention of these harmful resident experiences.

SODs by Severity Level

For each standard survey and complaint investigation, surveyors are required to identify violations (deficiencies) of minimum care standards and rate them in respect to their scope and severity.[38] The severity of a deficiency represents the extent to which the surveyor identified harm caused to one or more resident(s) as a result of a violation of a federal regulation.

Severity Level	**SODs**
Minimal Harm or Potential for Actual Harm	67
Actual Harm	14
Immediate Jeopardy	12
Actual Harm *and* Minimal Harm or Potential for Actual Harm	5
Immediate Jeopardy *and* Minimal Harm or Potential for Actual Harm	2
Total	**100**

Of the 100 SODs identified in this project, two-thirds (67) were not determined to have caused harm (Minimal Harm or Potential for Actual Harm). The remainder were considered Actual Harm (14), Immediate Jeopardy (12), Actual Harm *and* Immediate Jeopardy (5), and Immediate Jeopardy *and* Potential for Actual Harm (2). **Important note**: Numerous studies over the years have found that, too often, state surveyors fail to identify deficiencies and, even when they do, fail to identify the extent to which the deficiency resulted in physical or emotional harm.[39]

Thus, it is important to avoid inappropriate and potentially misleading interpretation of the findings related to the Severity Levels. Surveyors' determinations of F-tags and severity levels reported on in this project were often unrelated to resident harm in the specific context of the phenomenon examined in this report. For more about this limitation, see **Appendix A: Caveats**.

SODs by Overall Star Rating

The average overall quality star rating of 98 out of the 100 nursing homes in this project was 2.80 on a 1-5 Star rating scale.[40] This is slightly below the national average (2.87) based on CMS data from April 2023.[41]

Overall Rating of Nursing Home	**SODs**
1	22
2	25
3	18
4	16
5	17
Total	**98**

While this project focused on a small fraction of all U.S. nursing homes, the finding suggests that retaliation may be a reality in nursing homes across the star rating spectrum. Large-scale research is needed to systematically examine the relationship between the four aspects of retaliation and nursing homes' overall ratings.

[38] For more information, *see* LTCCC, "A Guide to Nursing Home Oversight & Enforcement," 2021. https://nursinghome411.org/reports/survey-enforcement/guide-oversight/

[39] See, for example, LTCCC's 2021 study, "Broken Promises: An Assessment of Nursing Home Oversight." https://nursinghome411.org/reports/survey-enforcement/survey-data-report/

[40] Ratings during the month when the standard survey or complaint investigation was completed. Two nursing homes were not assigned an overall rating, including one that was missing data and one that was a participant in the Special Focus Facility (SFF) program.

[41] CMS, Provider Information, obtained May 2023 via https://data.cms.gov/provider-data/dataset/4pq5-n9py

SODs by Staffing Star Rating

The average staffing rating of 96 out of the 100 nursing homes examined in this project was 3.01 on a 1-5 Star rating scale.[42] This is above the national average (2.60) based on CMS data from April 2023.[43]

Staffing Rating of Nursing Home	SODs
1	15
2	21
3	18
4	32
5	10
Total	**96**

The small sample of data on staffing ratings – as with that of overall ratings – suggests that fear of retaliation may be a reality in nursing homes across all staffing rating levels. Large-scale research is needed to systematically examine the relationship between the four aspects of retaliation and nursing homes' staffing rating levels.[44]

Employee Terminations

Many of the incidents documented in this project resulted in employee termination. Our review of 100 SODs found 31 employee terminations resulting from the identified incidents, including 22 terminations involving a single employee and five cases involving multiple staff. The actual number of employment terminations within this sample of incidents is likely higher, given that some state surveys and complaint investigation reports may have concluded prior to the termination of employees found to mistreat and/or retaliate against residents.

The 31 terminated employees included a range of staff positions: 17 were identified as nurse aides or personal care assistants), five "staff" (unspecified), one CNA orientee, three nurses (registered nurse, licensed vocational nurse, and "nurse" unspecified), one social worker, one housekeeping staff, one dietary aide/maintenance staff, one assistant psychiatric rehabilitation services coordinator, and one administrator.

Outcomes of employees following their termination were not detailed in most of the reports we examined (i.e., whether the employee was reported to the state's nurse aide registry, board of nursing, or law enforcement).

Our review indicates that employees in a range of positions were susceptible to employment termination if found to mistreat residents, threaten retaliation, or retaliate. Future research should examine important post-survey issues (including employment termination), assess provider responses and plans of corrections in cases of retaliation not reported in SODs, and explore the prevalence of employee termination and/or disciplinary action resulting from retaliation against residents along with the characteristics of employees who have been terminated and/or disciplined.

---

[42] Ratings during the month when the standard survey or complaint investigation was completed. Four nursing homes were not assigned a staffing rating including three that were missing data and one that was a participant in the Special Focus Facility (SFF) program.

[43] CMS, Provider Information, obtained May 2023.

[44] Given the far-reaching impacts of low and dangerously low staffing levels on care, neglect, abuse of residents – in combination with their effects on direct care staff's demanding and stressful working conditions – one would expect a more rigorous and nuanced analysis to identify some practically useful relationships.

Discussion & Policy Implications

Staffing

Staff retaliation causes significant emotional and physical harm to residents in U.S. nursing homes. As stated in CMS's guidance to state surveyors, "retaliation by staff is abuse, regardless of whether harm was intended, and must be cited."[45]

"Some staff treat residents like gold, but others are just not nice."

- Illinois nursing home resident to state surveyor

Unfortunately, too many nursing homes are fostering environments in which mistreatment and retaliation against residents is tolerated.[46] As one Illinois nursing home resident put it, "Some staff treat residents like gold, but others are just not nice."

Many direct care staff members in U.S. nursing homes are caring, compassionate, and hardworking. They strive to keep residents safe and meet their physical and psychological needs while working in difficult conditions (i.e., understaffed and overworked, lacking adequate training for dementia care, lacking supportive guidance from managers, receiving minimal compensation and benefits, and lacking recognition).

Too often, however, staff are put in a position to fail residents as they work in nursing homes with dangerously low staffing levels and high staff turnover rates – problems that plagued LTC homes well before the COVID-19 pandemic.[47] Some nursing homes are also hiring more unqualified or poorly vetted individuals to care for vulnerable and frail residents. Too many nursing home are prioritizing profits over people, failing to invest in sufficient and qualified staff that can meet the needs of their residents.

When nursing homes are not sufficiently staffed with trained and qualified employees, their residents are at greater risk of poor outcomes, including the phenomenon covered in this project: **fear of retaliation**.

Oversight, Enforcement, & Transparency

The policy implications of this project go far beyond staffing. Our examination of 100 standard surveys and complaint investigation reports on nursing homes in 30 states demonstrates a need for systemic improvements in oversight, enforcement, and transparency.

First, CMS does not currently track standard survey and complaint investigation reports containing violations specifically related to residents' fear of staff retaliation, threats of retaliation, perceived retaliation, and actual (substantiated) retaliation. The wide range of circumstances identified in this project as underlying this phenomenon, combined with its serious and emotionally devastating effects on residents (described in residents' own words), demonstrate the urgent need for such tracking. Specifically, CMS should develop a unique survey deficiency citation (F-tag) or other mechanism to efficiently capture all violations of federal laws and regulations related to this phenomenon in its F-tags coding system. The array of pertinent F-tags in this

[45] CMS, State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities, hhs.gov/guidance/sites/default/files/hhs-guidance-documents/Appendix%20PP%20State%20Operations%20Manual.pdf.
[46] Pillemer, K., & Moore, D. W. (1989).
[47] Harrington et al. (2016). The need for higher minimum staffing standards in U.S. nursing homes. *Health Services Insights*, 9, 13-19. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/

research project could serve as a starting point in the development of such tracking.[48] In addition, while the National Ombudsman Reporting System tracks complaints related to "Retaliation" (D06 complaint code), it does not track complaints related to residents' *fear of* retaliation in the context of voicing care concerns and grievances. Bridging this major gap in centralized national tracking is critically important.

The recommended centralized tracking could open new opportunities for sorely needed research aimed at improving understanding of this source of suffering and form of mistreatment. Insights gleaned from such research could inform the development of interventions and staff training programs to increase awareness, early detection, prevention, and adequate and safe response.

Second, the heartbreaking findings identified in this project show the urgent need for CMS to develop and implement a data-driven national campaign aimed at addressing retaliation in nursing homes. This national campaign should focus on educating and raising awareness among residents, families, nursing homes, state survey agencies, Ombudsman programs, and other stakeholders.

An effective campaign could ultimately help restore residents' trust and confidence that they and their families should never have to fear staff retaliation when speaking up about care concerns and mistreatment in their home.

Third, over a decade ago, the state of Connecticut passed a law entitled *An Act Concerning Fear of Retaliation Training in Nursing Home Facilities* requiring annual in-service training on residents' fear of retaliation in nursing homes. The law states, "[a] nursing home administrator of a chronic and convalescent nursing home or a rest home with nursing supervision shall ensure that all facility staff receive annual in-service training in...residents' fear of retaliation."[49]

> It requires that nursing home administrators ensure that the in-service training in residents' fear of retaliation includes discussion of:
>
> (A) residents' rights to file complaints and voice grievances.
> (B) examples of what might constitute or be perceived as employee retaliation against residents.
> (C) methods of preventing employee retaliation and alleviating residents' fear of retaliation.[50]

There is an urgent need for other states to pass laws like Connecticut's given the prevalence of fear of staff retaliation and its significant emotional and physical consequences for residents in LTC homes.

Finally, Connecticut's retaliation training law requires "the State Long-Term Care Ombudsman to create and periodically update a training manual that provides nursing home administrators guidance on structuring and implementing this new training requirement." Insights gleaned from this report could inform awareness and educational initiatives as well as updates in the training manual.

---

[48] Note that the F-tags identified in the current study do not represent the complete list of F-tags under which violations related to this phenomenon are issued by state surveyors.
[49] State of Connecticut (April 16, 2012). An Act Concerning Fear of Retaliation Training in Nursing Home Facilities. https://www.cga.ct.gov/2012/FC/2012SB-00137-R000419-FC.htm
[50] *Id*.

Future Research

This project raises important questions warranting exploration in future research on fear of and actual retaliation in nursing homes. Potential research topics include:

- Improving understanding of risk and protective factors for staff psychological, physical, and sexual retaliation against nursing home residents. Such research could inform the development of interventions, staff training programs, and prevention efforts.

- Identifying the full range of emotional and physical consequences of the various aspects of this phenomenon on residents and their families.

- Evaluating the extent to which residents' care concerns, grievances, and complaints are left unvoiced and not investigated due to fear of retaliation (a potential blind spot in the CMS oversight system).

- Developing and evaluating the effectiveness of interventions (such as staff training programs) aimed at reducing residents' fear of staff retaliation, alleged staff threats of retaliation, perceived retaliation, and actual retaliation against residents.

- Studying the role of leadership (e.g., owners, administrators, directors of nursing, social workers) in addressing and reducing residents' fear of retaliation and actual retaliation.

- Studying the lived experience of residents in all stages of dementia in the context of fear of retaliation, threats of retaliation, perceived retaliation, and actual retaliation.

- Developing a screening tool to help detect retaliation-related sources of suffering and abuse.

- Evaluating the Long Term Care Ombudsman Program and its role in addressing and reducing residents' fear of and actual staff retaliation and in fulfilling the agency's duty to protect the residents' rights to be free from fear of retaliation when voicing concerns regarding care and mistreatment.

- Evaluating the role of assistive technology in early detection and reporting of residents' fear of retaliation, threats of retaliation, perceived retaliation, and confirmed retaliation. Such technology has recently been used in innovative ways for this purpose in Connecticut LTC homes.[51] For example, residents with smart phones in the state's LTC homes can use a QR code (displayed on posters in public spaces and cards handed to residents) to connect directly with and report their care concerns, mistreatment, and fear of retaliation to the Ombudsman program.

- Exploring retaliation against residents in assisted living residences. Residents' fear of staff retaliation has been previously identified as common in this largely for-profit and weakly regulated LTC setting. Various forms of resident mistreatment (such as serious and deadly neglect of healthcare) are frequently reported in this care setting.[52]

---

[51] Interview with E. Caspi and Mairead Painter, March 16, 2023.
[52] Caspi, E, "Life and Death in Assisted Living," *The Gerontologist*, Volume 61, Issue 8 (December 2021). https://doi.org/10.1093/geront/gnab132

- Examining fear of staff retaliation and actual staff retaliation as it is experienced by family members and friends of residents in nursing homes and assisted living residences.

- Studying staff fear of retaliation from supervisors, managers, and co-workers. According to CMS, "Actions that constitute retaliation against staff include: When a facility discharges, demotes, suspends, threatens, harasses, or denies promotion or other employment-related benefit to an employee, or in any other manner discriminates against an employee in the terms and conditions of employment because of lawful acts done by the employee." This problem was highlighted in a recent media report on a Veterans care home in Minnesota.[53]

Federal nursing home regulations grant residents the right to be free from fear of retaliation, stating that "[t]he facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility."[54] Regulations further state that "[t]he resident has a right to be free of interferences, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights."[55]

Unfortunately, these critical resident rights are too often violated in U.S. nursing homes. To date, this concerning and multifaceted phenomenon has been largely ignored by the research community.[56] We hope that this project draws attention to this critical issue and spurs new research to generate the empirical evidence necessary to inform meaningful improvements in policies and care practices in all residential care settings.

[53] Magan, C. (2023). "Caregivers allege 'harassment and retaliation' at Hastings veterans home," *The Pioneer Press*. https://www.twincities.com/2023/03/05/caregivers-allege-harassment-and-retaliation-at-hastings-veterans-home/
[54] CMS, 42 CFR § 483.10 - Resident rights, https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483.
[55] *Id.*
[56] With rare exceptions such as UConn's studies: Robison et al. 2007; Robison et al., 2011.

Retaliation Report Summaries

The following section includes one-page summaries for each of the 100 standard surveys and complaint investigation reports examined in this project. Within each summary, you will find:

- A summary title (our attempt to capture the nature of the incidents, some of their pertinent aspects, and/or direct quotes of resident and others)
    - Example: *"They Make You Pay"*
- The deficient practice statement (a statement at the beginning of the "evidence" that sets out why the entity was not in compliance with a federal regulation)
    - Example: *The nursing home did not ensure residents could voice grievances in a safe way and did not respond to grievances in a timely manner for concerns expressed by eight residents and other unnamed residents.*
- A summary of evidence relevant to the goals of this project. This comprises the bulk of the one-page summaries.
- Summary information about the nursing home and the deficiency identified by the surveyor.

Reader Tip: A Table of Contents with clickable links to each report summary is available on the next page. Though the report summaries are loosely organized by topic and theme (e.g., privacy, food, bathing, etc...), we encourage you to read in whatever order – or depth – that you please. If a title catches your attention, jump right to it!

Digital versions of these summaries – along with their accompanying survey and complaint reports – are available at **nursinghome411.org/retaliation**.

Table of Contents: Retaliation Report Summaries

"They Make You Pay"

The nursing home did not ensure residents could voice grievances in a safe way and did not respond to grievances in a timely manner for concerns expressed by eight residents and other unnamed residents.

During a Resident Council meeting, 16 residents who attended the meeting expressed fear of retaliation related to reporting or filing grievances. They said about staff, "They get back at you," "They sweep things under the rug," "No point reporting," "Don't know where to find forms," "They never acknowledge what is going on," No point submitting a grievance," "Don't write down our names," and "We don't want to cause trouble." The residents reported they had not filed grievances related to staff who were mean stating, "Can't say their names," and "Don't want to pay the price."

During an interview, resident 6 stated her sister filed a grievance on her behalf related to a staff member in the kitchen who was rude and mean. Resident 6 stated that she and her sister met with the Administrator and the Director of Nursing but that she was not provided feedback related to that grievance and the staff member treated her worse after she reported.

During an interview, the Administrator stated the same kitchen employee had a negative interaction with a resident this week. Specifically, resident 6 stopped the Administrator and stated that the same kitchen employee raised her voice to a resident who wanted a cup of hot water. The Administrator stated that the employee had been suspended pending the investigation.

During an interview, resident 71 stated there is a very rude staff member in the kitchen. The resident said, "If you report her, I know she will retaliate and not put something on your tray or who knows what else she will do." The resident stated that the Administrator knows about the issue and that residents have complained about this employee's behavior.

During an interview, resident 22 expressed concerns related to dietary [staff] and care. The resident stated she had not filed a grievance "because they get back at you." She added, "They are watching even now to see which rooms you go to and listen to what you ask. She said, "The residents are fearful." When asked who they were fearful of, the resident said, "Both staff and administration." She stated, "They make you pay." The resident stated that staff retaliate by delaying care or sabotaging meals. The resident asked the surveyor to leave the bedroom and return later because staff were lingering at the door.

During an interview, the Administrator stated that he had not heard of this concern related to residents' fear of retaliation. He added, "I am surprised that this is the culture. I am not aware that residents are afraid of voicing concerns. My door is always open." He added that he did not know residents were afraid of filling grievances regarding staff.

Name of Nursing Home	Boca Ciega Center / Provider ID: 105271
Address	1414 59th Street, S. Gulfort, Florida
Date investigation completed	February 17, 2022
Type of deficiency issued	F585 – Grievances
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/105271/health/complaint?date=2022-02-17

A Culture of Fear

The nursing home failed to ensure that residents were treated with respect and dignity for 11 residents.

The nursing home also failed to ensure that residents could voice grievances without fear of reprisal for six residents.

The deficient practice is likely to result in residents not voicing grievances due to fear of staff not assisting them when they need help with any of their activities of daily living, or when they ask a question, or when they try to correct a staff member when something is wrong, which could likely result in residents not getting the care and assistance they need.

During a Resident Council meeting, residents stated that they are not receiving medications on time.

Resident 301 stated when she needs to be changed or needs pain medications, staff will come in and turn off the light, say they will be back, and don't come back for hours.

Resident 27 stated that when she notes that staff are giving her the wrong pill, they argue; this has happened five or six times. A review of a grievance form indicated resident 27 stated CNAs want things done on their own time and that the residents' wants (i.e., requests to be changed) are not important. She stated she does not frequently use her call light so that staff don't get upset with her. The resident stated that they are always afraid of retaliation when they complain about something or put a grievance in.

Resident 19 stated the attitude that they get from some of the agency staff is monumental.

During an interview, resident 241 stated that this morning a CNA "was very rough when changing my underpants and caused me pain while cleaning my testicles." The Director of Nursing stated she spoke with resident 241 last night and he stated he did not want to file a grievance or get anyone in trouble.

During an interview, resident 48 stated that staff don't listen to you and added that she is afraid to say anything because she fears retaliation.

Review of a grievance form indicated that resident 393 had several complaints ranging from long wait times for call lights to be answered, to asking questions to the staff and no one having any information or answers, to resident 393 not wanting to complain; scared that the staff would retaliate.

During an interview, the Administrator and the Infection Preventionist stated that previously there had been a culture in the building that had created fear for residents that staff may retaliate.

Name of Nursing Home	Uptown Rehabilitation Center / Provider ID: 325042
Address	7900 Constitution Ave. NE, Albuquerque, New Mexico
Date investigation completed	January 10, 2019
Type of deficiency issued	F550 – Resident Rights F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: No longer available on *Care Compare* website.

"Because it Backfires"

The nursing home failed to ensure the Administrator managed the nursing home effectively to meet the needs of all 89 residents.

The nursing home failed to ensure resident/responsible party grievances and complaints were promptly reviewed, investigated, resolved, and documented for two residents.

The nursing home failed to provide goods and services and protect 39 residents from abuse and neglect.

Examples included:

- A video of a resident was circulated by CNA E on social media.
- Twenty-four residents were not offered showers routinely.
- Twenty-two residents had to endure prolonged call light response times.
- Six residents experienced abuse from the staff.
- Two residents experienced depression due to abuse.
- Two residents were not provided care services to meet their needs.
- Resident-to-resident altercations were not prevented to reduce abuse.
- One resident's hair was cut without permission.
- Seven residents voiced fear of staff retaliation.

These failures resulted in infringement of resident rights; residents remaining unclean and unkempt; depression, isolation, and injuries from resident-to-resident altercations, and fear of retaliation by staff, which could all lead to negative clinical and psychosocial outcomes.

During a group interview, five residents all stated that they were afraid to voice grievances "because it backfires on you," as "staff became aggressive (angry, pushy, forceful, intimidating, and loud)."

Residents stated further that they were unaware of how to file a formal grievance.

One resident stated that he called a staff member a name and was retaliated against by staff subsequently not answering her call light or offering the resident assistance, even after the resident apologized.

Name of Nursing Home	Riverside Convalescent Hospital / Provider ID: 055656
Address	375 Cohasset Road, Chico, California
Date investigation completed	April 28, 2022
Type of deficiency issued	F585 – Grievances F600 – Freedom from Abuse, Neglect, and Exploitation F835 – Administration
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/055656/health/standard?date=2022-04-28

"No Voice in Their Home"

The nursing home failed to ensure seven residents had a right to organize and participate in resident groups. Specifically, the nursing home did not have monthly Resident Council meetings. The failure could place residents at risk of not having the right to voice their concerns in a resident meeting setting.

During a confidential resident group meeting, seven residents said a Resident Council was not held on a regular basis. Three residents said it had been more than six months since the last Resident Council meeting. They added that when they had Resident Council meetings, it was held in the open dining room.

During an interview held in early August, CNA supervisor N (formerly the Activity Director) said that the nursing home had not had a Resident Council meeting since March. She said that the former Director of Nursing (DON) stole the previous meeting minutes because they had incriminating evidence related to poor resident care.

The Administrator said the lack of meetings could make residents feel unheard and voiceless in their home. She said, "This could lead to depression and anxiety because everyone deserved to have a voice."

The nursing home also failed to ensure that 10 anonymous residents had a right to organize and participate in resident groups. In a confidential resident group interview (the same meeting as above), residents said they felt that they could not complain about care without worrying that someone would retaliate. This deficient practice could place the residents at risk for decreased quality of life and feelings of hopelessness.

During the confidential group meeting, all 10 attending residents (who requested anonymity) felt like they could not be open about their concerns in the open for fear of retaliation. They said that they feared retaliation if they complained about CNAs and nursing staff. Several residents said the staff would retaliate by not answering call lights, delaying responses to call lights, and confronting residents about complaints.

During an interview, the DON said residents should know how to file grievances and should not feel like staff will retaliate against them. She said that the residents could feel depressed and scared if they cannot file grievance without fear of retaliation. During an interview, the Administrator said residents feeling like they cannot complain or file a grievance without retaliation was not acceptable. She said no resident deserved to feel they cannot make complaints known. She said, "If residents felt they cannot complain, then their quality of life will suffer." She added that she was unaware the residents felt this way.

Name of Nursing Home	Palestine Healthcare Center / Provider ID: 455565
Address	1816 Tile Factory Road, Palestine, Texas
Date investigation completed	August 22, 2022
Type of deficiency issued	F565 – Resident/Family Group and Response F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/455565/health/standard?date=2022-08-22

Scared to Call for Help

The nursing home failed to ensure the resident was free from abuse.

The resident had "intact cognition" and required two-person assistance with bed mobility and transfers, required assistance with toileting and personal hygiene, did not walk and utilized a wheelchair (based on information contained in the Minimum Data Set 3.0 (MDS).

The resident stated in his/her care conference that he/she can write a book on all the unprofessionalism and mistreatment he/she had endured.

The resident stated that he/she was "extremely fearful of retaliation" and due to that he/she did not wish to identify the nurse aides involved.

The resident further identified that "every day he/she is scared to ring his/her call bell as it irritates the nurse aides, and in turn, they will mistreat him/her."

The resident reported that staff are not attending to his/her needs timely, and staff are not responding to his/her calls appropriately. The resident had additional concerns including that nurse aides, at times, wipe his/her bottom too hard, and that once when he/she asked a nurse aide for a urinal, he/she was told by nurse aide 2, "Do it in your brief." The resident also reported that when he/she asked to be put in bed by nurse aide 2, nurse aide 2 had called him/her a "wuss" and told him/her to "man up."

The resident identified that he/she rang the call bell at 11:30 AM because he/she was in a wet brief from the previous day and was uncomfortable. The resident stated that he/she rang the bell a second time and could hear staff talking loudly, laughing, and having a great time in the dayroom.

Nurse aide 1 denied the allegations.

The nursing home had concluded their investigation which identified the resident's allegation of verbal abuse was substantiated. Nurse aide 1 was terminated. Nurse aide 2, an agency staff, would no longer be allowed to work at the nursing home.

The resident's right policy directed for employees to treat all residents with kindness, respect, and dignity. Residents have a right to a dignified existence and to be free from abuse, neglect, misappropriation or property, and exploitation.

Name of Nursing Home	Greentree Manor Nursing & Reha / Provider ID: 075113
Address	4 Greentree Drive, Waterford, Connecticut
Date investigation completed	May 10, 2022
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/075113/health/complaint?date=2022-05-10

Keeping His Mouth Shut

The nursing home failed to consistently provide a fully functioning call system to provide direct communication from the resident to the caregivers for six residents.

During an interview, RN (C2) revealed the nursing home's call bell system is not audible on the nursing unit. The employee stated that when a resident rings/activates the call bell, signs by the nursing station activate (illuminate) and identify the location/resident ringing for assistance. However, staff would need to be present near the nursing station to visualize the signs. She stated that all nursing employees should carry a pager that will alert them when a resident is ringing for assistance.

Observations revealed Employee C2, Nurse Aide 4, Nurse Aide 5, Nurse Aide 6, and LPN 7 were without the required pager to respond to residents' call bells as required by the nursing home's wireless call bell system. In response to surveyor inquiry, at that time, Employee C2 located the pagers on the counter behind the nursing station and began to hand them out to NURSING staff. Further it was noted that the pagers were not functional and Employee C had to replace the batteries in the pagers. Employee C confirmed that the pagers were not in working condition and all batteries needed to be changed.

Observation revealed that several residents had silver colored tap bells on their bedside tables.

During an interview, resident C1 stated that she required to have a tap bell on her bedside table due to staff not responding to her call bell when she pressed it for assistance. She stated that it can take up to an hour for staff to respond to her call bell and that she had to bang on the tap bell in effort to hurry the staff response to meet her needs. The resident added that she wasn't supposed to transfer herself to the bathroom because she may fall, but at times, she does take herself to the bathroom so that she doesn't soil her brief because she can no longer wait for staff assistance and ringing the call bell.

Residents C4 and B2 also expressed concerns about long wait times for assistance with their care needs.

Five other residents who wished to remain anonymous for fear of retaliation from staff reported similar concerns with long wait times for assistance. One of them stated that he wanted to keep his mouth shut about long waits for staff to answer call bells stating that it would get him in trouble, but he nodded yes when asked if he waited for extended periods of time for staff to respond to his call bell. Another resident said that on one occasion he had to call his family to ask them to call the nurse's station to ask a nurse to get him help.

During an interview, the Administrator confirmed that the nursing home failed to properly utilize the wireless call bell system to provide timely care and services to the residents upon their request.

Name of Nursing Home	Grandview Nursing and Rehabilitation / Provider ID: 395623
Address	78 Woodbine Lane, Danville, Pennsylvania
Date investigation completed	February 24, 2022
Type of deficiency issued	F919 – Resident Call System
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/395623/health/complaint?date=2022-02-24

Stay Quiet

It was determined that four anonymous residents could not exercise their rights without fear of interference and reprisal and were not treated with respect and dignity.

Two residents with "intact cognition" (BIMS scores of 14 and 15 out of 15) were admitted for short term skilled therapy. The residents stated to the surveyor that they were apprehensive to state issues they were having. Specifically, both residents stated that they were afraid of retaliation if staff knew they were complaining to the surveyors. Both residents (interviewed separately) stated that CNAs have attitudes when requesting care needs. Both stated that there were numerous times on a daily basis that they were afraid to request things from staff. They added that during many of the nights staff are making noise (yelling, laughing, and loud talking). The residents stated that they request staff to shut the entrance door, but staff refuse stating the doors must be left open to be able to view the residents in bed.

The following is a description of an interview with a randomly selected resident who is cognitively intact (BIMS score of 15 out of 15) and who is incontinent of bowel and bladder. The resident's Care Plan revealed that care would be provided at the request of the resident and on an as needed basis.

The resident reported that during the last weekend, the aides assigned to provide care left the resident unattended in urine and feces for more than 30 minutes. The resident stated that three days prior to this interview, they pressed the call light requesting for assistance at 6:02 PM. Someone entered the room, turned off the call light and said, "I'll be back." They returned over 30 minutes later at 6:35 PM. During that long 30-minute timeframe, the resident remained soiled and unable to care for self.

The resident said, "Out of frustration of reporting issues or complaining, I prefer to stay quiet, to prevent retaliation." The resident said that some of the CNAs do care, but "many of them act carelessly towards me."

The resident added, "My complaining is mostly for those who cannot advocate for themselves. Because while being cognitive and verbal, I get this kind of treatment, it saddens me even thinking about the kind of treatment those who cannot speak and are not cognitive are getting."

Name of Nursing Home	Memorial Manor / Provider ID: 105668
Address	777 South Douglas Road, Pembroke Pines, Florida
Date investigation completed	July 11, 2019
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/105668/health/standard?date=2019-07-11

Not Asking Why It Took Three Hours

The nursing home failed to provide incontinence care to four residents (resident 66, resident 5, resident 36, and resident 35). The residents expressed feelings of being upset, humiliated, being forgotten about and feeling like the staff members didn't care about them.

Resident 66 was cognitively intact and required extensive physical assistance with bed mobility, toilet use and personal hygiene. He was also occasionally incontinent of both urine and bowel. His Care Plan indicated, "Interventions included to assist with activities of daily living as needed and to assist with toileting/incontinence care routinely and as needed."

During an interview, resident 66 stated he had sat for three hours before he was provided with incontinence care. The resident stated this happened all the time on the evening shift. The resident said that one time, two nurse aides came into his room to turn his call lights off twice on the evening shift and told him that they would come back but they never did come back. The resident stated he ended up receiving incontinence care at 1:00 AM. He said that this incident upset him and that it made him feel like they didn't care about him. He added that he had given up on using the bed pan because it took them a while to get back to him to take him off and being on a bed pan for an extended period hurts his back. He stated he usually had to wait for two to three hours on the evening shift before his call light was answered.

During a second interview held three days later, resident 66 revealed he was very frustrated and confused about the continued lack of response from the staff especially on the evening shift. The resident reported that yesterday (Tuesday) he had turned his call light on before 7:00 PM because he needed incontinence care, but nobody came into his room until 10:15 PM when nurse aide 4 provided him incontinence care but he never asked her why it took her a long time to come because he feared being retaliated on. The resident knew they were short staffed but felt like they forgot him and didn't care about him.

During an interview, nurse aide 4 revealed she was usually assigned to resident 66 on the evening shift but had to work by herself on the hall at least three times a week. Nurse aide 4 confirmed that she worked by herself (on the same Tuesday) on the evening shift and didn't get to resident 66's call light until after 10:00 PM. The aide said that that evening was very busy. She added that she usually started at the beginning of the hall and worked her way to the end of the hall so she could get everyone done. She said that was why it took her so long to get to resident 66's call light because his room was located all the way at the end of the hall. The aide added that there was nobody to help her do her rounds.

During interviews held the next day, the Director of Nursing (DON) and the Administrator stated they were not aware of the instances when resident 66 was not provided incontinence care until the end of the evening shift. The DON said that providing incontinence care at least every two hours would be great but not possible with only one nurse aide assigned to the hall.

Name of Nursing Home	Lenoir Healthcare Center / Provider ID: 345138
Address	322 Nuway Care Circle, Lenoir, North Carolina
Date investigation completed	July 9, 2021
Type of deficiency issued	F550 – Resident Rights
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/345138/health/standard?date=2021-07-09

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

"Extremely Fearful"

The nursing home failed to: a. ensure call lights were answered in a timely manner and that all residents were treated in a dignified manner for eight residents (R1, R2, R3, R4, R5, R8, R9, R10); b. ensure residents were free from verbal abuse for residents R1 and R9; c. ensure an allegation of verbal abuse was immediately reported to the Administrator/Abuse Coordinator and State Agency for R1; and d. act upon the facility Abuse Protocol to protect residents from potential verbal abuse by an alleged perpetrator and thoroughly investigate an allegation of verbal abuse.

This summary below only addresses those violations specific to residents' fear of retaliation.

The Ombudsman (V9) stated that several residents have recently reported to her that staff are using abusive language towards them and/or other residents. V9 stated there has been a recent incident of administrative staff being informed of a staff member being verbally abusive towards a resident, and the Administration did nothing about the incident. V9 stated that the resident involved is extremely fearful of staff retaliation if they know the verbal abuse has been reported. Resident 1 had no cognitive impairment (BIMS score of 15 out of 15) and required extensive assistance of two staff for bed mobility and toileting.

A review of Grievance/Complaint Report indicated that Resident 1 said that CNA (V3) told her to "shut her mouth and learn how to talk to people." The resident stated that CNA (V3) always talks to her like that. The resident stated that she is fearful of this third shift staff member, and feels she cannot express her wants and needs, due to how the third shift staff responds back to her. The resident added that the statements the third shift staff makes towards her makes her feel uncomfortable and scared.

In a separate interview, Activity Director (V5) stated that resident 1 told her that the incident in which CNA (V3) told the resident to shut her mouth took place when CNA (V3) was repositioning the resident in in bed and the resident was worried that she might fall off the bed.

Social Service Director (V6) stated she interviewed resident 1 regarding the allegation of verbal abuse she made the previous day. V6 stated that resident 1 was very anxious even telling her what happened, because she isn't the type of person that wants anyone to be in trouble. V6 stated that resident 1 did ask that CNA (V3) not take care of her anymore, because she feared CNA (V3). V6 concluded that resident 1 had never made allegations of abuse by staff before or asked that specific staff not provide her care. V6 stated that resident 1 did seem truly fearful of CNA (V3) after the incident occurred.

Name of Nursing Home	River Crossing of Peoria / Provider ID: 145647 [Alternative name: University Rehab at Northmoor]
Address	1500 West Northmoor Road, Peoria, Illinois
Date investigation completed	March 4, 2021
Type of deficiency issued	F550 – Resident Rights F600 – Freedom from Abuse, Neglect, and Exploitation F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145647/health/complaint?date=2021-03-04

"Like a Sack of Potatoes"

The nursing home failed to: a. thoroughly investigate and implement corrective action to keep residents safe after an allegation of staff abuse of residents 1 and 2. This resulted in Immediate Jeopardy; b. report timely to the Administrator and State Agency allegations of abuse for resident 2; and c. thoroughly investigate allegations of abuse of resident 1 who alleged staff physical abuse and rough care.

Resident 2 had intact cognition (based on MDS assessment) and required extensive assistance of one staff with bed mobility and extensive assist of two with transfers. During an interview, resident 2 stated staff AP "is rough when putting me to bed, I feel like a sack of potatoes and afraid I might fall out of the other side of the bed!" The resident said that if AP is working night shift, she asks the evening staff to just put her to bed early to avoid AP putting her to bed. The resident stated it hurts when AP puts her to bed.

During an interview held nearly a week later, Social Services Designee stated resident 2 reported to her/him about the AP's rough care and had told her family but not the nursing home. Resident 2 stated she was afraid of retaliation from the staff member.

Resident 1 had severe impaired cognition (based on MDS assessment) and required extensive assistance of one staff with bed mobility, transfers, and toileting. An allegation of abuse was reported to the State Agency, indicating resident 1 alleged a dark hair heavyset aide shoved her into the wall while providing care in the bathroom on overnights. The resident stated that because the aide was mad, she wet the bed.

Review of the nursing home investigation: The nursing home showed resident 1 pictures of different overnight staff who fit the description of AP. Resident 1 was able to point out two possible staff but was unsure. The report lacked evidence of any other steps the nursing home took as part of the investigation such as interviewing staff (only three were interviewed), residents, or other strategies to determine who the AP was. The report did indicate action to prevent reoccurrence was to place resident 1 on a two-person buddy system. However, nurse aide B later stated AP toileted resident 1 alone a couple of times.

During the State Agency investigation held a week after the abuse allegation was reported to the State Agency, resident 1 confirmed the staff who worked last night was AP. The resident reported that the AP shoved her into bed last night. The resident stated, "It's like I am too slow for her and she shoves me to be quicker. I tell her don't be so mean to me, and she says I am not mean to you! She does it every time she works with me. She is just rough and pushy. She has pushed me into the bathroom wall."

During an interview, the AP stated she had never been rough with the residents and that she treats them like her own grandparents and would never hurt them. However, four other residents alleged abuse against the same staff member during the nursing home Immediate Jeopardy removal plan implementation.

Name of Nursing Home	Annandale Care Center / Provider ID: 245364
Address	500 Park Street East, Annandale, Minnesota
Date investigation completed	September 30, 2021
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	*Immediate Jeopardy ** Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/245364/health/complaint?date=2021-09-30

Fat Shaming

The nursing home failed to ensure that: a. resident 18 was treated in a dignified manner; and b. an allegation of possible verbal abuse for resident 18 was reported immediately to the Administrator.

Resident 18 had intact cognition (BIMS score of 13 out of 15) and required extensive assistance with bed mobility, personal hygiene, and was totally dependent with transfer, dressing, toilet use, and bathing.

During an interview, resident 18 stated that a CNA had said she was fat, a problem to move, and lazy. The resident also stated that she asked the CNA to leave or get another staff member to assist, but the CNA continued the care and gave the resident an evil smile. The resident stated that she had not told the administration staff, but that she did tell the nurses. She also stated that she had told other CNAs.

The resident stated that she did not want to disclose the CNA's name because she did not want the CNA to lose her job, and she was afraid of retaliation.

The resident said that the CNA worked on the day shift yesterday, and still made fun of her and added that this causes emotional pain. She stated she knows she's fat, but the CNA does not need to be mean.

The surveyor notified the Administrator about the resident's allegations and stated that she would begin the investigation process. Though staff members knew the resident's allegations (e.g., CNA using demeaning names to the resident and saying she is fat), there was no evidence that the resident or other staff had reported any concerns regarding the resident's care/treatment by the CNA.

During an interview, the resident's roommate stated that she heard a CNA saying that a resident was fat but declined to name the resident or staff.

During a telephone interview, a CNA (staff 82) stated that one day, she and staff 77 were providing care to the resident, and staff 77 said that the resident needed to go on a diet because she was fat and did not look good. Staff 82 said that she gave staff 77 a look before they completed the care. Staff 82 stated that the resident told staff 77 to stop it and that she was short and fat. Staff 82 added that she (staff 82) did not report the incident immediately because she wasn't sure if they were kidding or not. The Administrator stated it is never okay for staff to say to a resident she/he is fat, even if they are kidding.

Social Services revealed that the resident felt offended by the comments and was upset when it happened.

The Administrator stated they had substantiated inappropriate words/behavior by staff 77. Staff 77 denied the allegations.

Name of Nursing Home	Yuma Nursing Center / Provider ID: 035152
Address	1850 West 25th Street, Yuma, Arizona
Date investigation completed	May 27, 2022
Type of deficiency issued	F550 – Resident Rights F609 – Reporting of Alleged Violations
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/035152/health/standard?date=2022-05-27

"I'll Be Right Back"

The nursing home failed to: a. ensure dignity and respect was maintained for resident 1 when CNA 2 verbally demeaned her, did not provide her care properly and in a dignified manner; b. identify a second CNA who might have potentially witnessed the incident and failed to report it.

The failure had the potential to diminish resident 1's self-worth and self-esteem. Additionally, being left lying in urine for extended periods increased the risk of compromising her skin integrity.

Resident 1 was cognitively intact (BIMS score of 14 out of 15) and had functional limitation to lower extremity and used a wheelchair for mobility. The resident was admitted mid this year with a primary diagnosis of right knee infection following knee joint replacement surgery.

A review of resident 1's Progress Note indicated that during the afternoon shift, a CNA was assisting the resident into bed and the resident had knee pain. The resident asked the CNA to be careful and CNA stated, "You need to grow a set so we can get this done. If I baby you, it will take forever" and proceeded to aggressively swing the resident's legs into her bed. The CNA then began to prepare the resident for bed and remove her clothing. The CNA pulled the resident's pants down forcefully again causing pain to the resident's surgical knee. The resident grimaced and moaned, and the CNA said, "I'll be right back" and left the resident exposed in her bed uncovered with her pants around her knees and did not return to provide care to the resident for the duration of the shift. Resident 1 was tearful, felt helpless, and scared to report. According to the note, the night shift CNA reported the incident to the nurse.

During an interview, a nurse stated two CNAs reported to her about the incident. The nurse stated she went to resident 1's bedroom to interview the resident and the resident's report was clear about what happened, and it corroborated what the CNAs had reported to her. The nurse stated that resident 1 told her she was scared to report the incident because she feared retaliation from the CNA.

During an interview, the resident stated that during the incident she was left with a wet brief and that a night shift CNA came and cleaned her up at around 10:30 PM. The resident stated she was very upset about how she was treated by the CNA. Two CNAs confirmed that they found the resident very upset and crying when they arrived for their night shift.

The Director of Nursing stated that the CNA no longer worked at the nursing home. Social Services staff stated she/he "came to speak to the resident regarding the incident that happened over the weekend. The resident remembers the event clearly and is happy that the person is no longer in the facility."

Name of Nursing Home	Westview Healthcare Center / Provider ID: 055776
Address	12225 Shale Ridge Lane, Auburn, California
Date investigation completed	September 27, 2022
Type of deficiency issued	F557 – Respect and Dignity
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055776/health/complaint?date=2022-09-27

"I Felt Threatened for My Life"

The nursing home failed to ensure a resident's right to be free from abuse.

The resident who was cognitively intact (BIMS score of 15 out of 15) required limited assistance of one person for bed mobility, transfer, walk in room, dressing, eating, toileting, and personal hygiene.

Incident investigation revealed that the resident told an LPN: "I felt threatened for my life last night by Personal Care Assistant (PCA) S9. I didn't report it out of fear of retaliation."

The LPN stated, "She kept saying she felt threatened, her life was in danger. She said PCA S9 threw a water bottle at her and hit her on the surgical site on her right side. She said S9 PCA didn't put up her side rail up because PCA S9 said, "If you can drink all of this water, you can go to the bathroom by yourself."

The resident said that to protect herself if something were to happen during the night, she kept her reacher [an assistive device designed to enable physically disabled people reach and grab objects they are unable to reach or have difficulty reaching] by her side in the bed out of fear of PCA S9.

During an interview, PCA S9 said she threw the water bottle on the side of the rail. She added, "I would not throw the water to hurt the lady." When asked why she threw the water bottle at all, she replied: "I don't know why I threw it."

Nurse Manager S1 confirmed that the incident was investigated by the nursing home and "physical abuse was substantiated."

PCA S9's employment was terminated.

Name of Nursing Home	Baton Rouge Gen Med Ctr, Snf / Provider ID: 195139
Address	3600 Florida Blvd, Baton Rouge, Louisiana
Date investigation completed	February 16, 2022
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/195139/health/complaint?date=2022-02-16

"Oh, It Will Come Back on Me"

The nursing home failed to: a. identify and prevent abuse, and ensure residents felt free of retaliation in reporting abuse for residents 1 and resident 3; b. investigate an allegation of abuse and determine when to report the allegation for resident 1; and c. follow nursing home policies and provide evidence that an alleged abuse violation was thoroughly investigated, as well as implemented measures to prevent further potential abuse during an investigative process for resident 1.

The grievance form stated: Resident 1 said that LPN 3 came to her bedroom asking why she did not want to be changed; [the resident was reported to be wet]. The resident says she does not need to be changed and would ring the light when she did. The resident said she was in too much pain at the time to be moved. The resident stated the LPN "is always so mean. She yells at me, so I yelled back. She is such a bully. I know I should have let them change me, but I just hurt so bad. She can't just talk to people that way" and "She is always hard and rude. I hate day shifts when she is here. I try not to get the light on when she is here."

The resident stated that LPN 3 was "loud, pushy, and a bully" and inquired whether LPN 3 would find out if she said anything about her, saying "Is she going to know I said anything? She won't treat me good." The resident stated that staff knew LPN 3 upset her and made her cry, "but what can they do?" She stated LPN 3 did not know how to provide proper incontinence care and would make her cry, adding, "I don't cry when others do [incontinence care]." She said that she didn't report it to the Director of Nursing (DON) but added that others may have. "It's going to all be on me, because no one else may not say anything," the resident said.

CNA 2 stated when she changes resident 1, she tries to be gentle while others might try to get the job done quickly without considering her pain. CNA 1 thought resident 1 was intimidated by LPN 3.

When asked about the outcome of the grievance investigation, the DON stated that resident 1 reported there was no problem and stated resident 1 and LPN 3 had apologized. When asked if resident 1's abuse allegation was investigated, the Administrator stated, "I normally don't when it seems to be okay."

Resident 3 was asked if she was treated well by staff. The resident asked the surveyor to shut the door and then stated, "Will anyone find out what I say to you?" The surveyor said that every effort would be made to ensure she remained anonymous but added that it was a small nursing home with few residents. The resident stated that LPN 3 was rude to residents and staff and described LPN 3 as being sarcastic and nasty. The resident stated she had talked to the charge nurses but added that she was hesitant to talk to anyone. When asked about her hesitation, resident 1 stated, "Oh, it will come back on me" and added, "It would be abusive. It would be bad. She would figure out a way where I couldn't defend myself."

Name of Nursing Home	Memorial Nursing Center / Provider ID: 375567
Address	319 East Josephine, Frederick, Oklahoma
Date investigation completed	July 21, 2022
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F609 – Reporting of Alleged Violations **F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	*Actual Harm **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/375567/health/complaint?date=2022-07-21

"It Breaks My Heart"

The nursing home failed to ensure Resident 14 and Resident 38 had the right to voice grievances without fear of retaliation. This affected two residents attending the Resident Council meeting.

Resident 38 who was cognitively intact (BIMS score 15 out of 15) required extensive two-person assistance for bed mobility, transfers, dressing, and toilet use.

During an interview at a Resident Council Meeting, resident 38 revealed that she felt intimidated to voice concerns to the care staff. The resident shared, "I was set up for a bed bath and my roommate was going to get a shower and the State tested nursing assistants (STNA) bailed on us and left for an hour. This has happened twice. I am afraid to tell the staff names. I was left stark naked and got cold. I didn't report this. The issues do not get resolved. It breaks my heart." The resident revealed STNA 8 and STNA 62 were the two STNAs who had left.

STNA 8 denied leaving a resident in the bed during a bed bath for extended time, except during an emergency, such as a fall.

Resident 14 was cognitively intact (BIMS score of 15 out of 15). During an interview at the Resident Council Meeting, resident 14 revealed that she felt intimidated to voice concerns to the care staff. The resident shared concerns that she received looks from staff when she voices complaints or concerns, and she is frightened that she will not receive the care that she needs.

Review of the nursing home's Grievance Committee Policy revealed that each resident has the right to voice grievances to the nursing home without fear of reprisal.

Name of Nursing Home	Sienna Skilled Nursing & Rehabilitation / Provider ID: 366331
Address	250 Cadiz Road, Wintersville, Ohio
Date investigation completed	April 19, 2018
Type of deficiency issued	F585 – Grievances
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 3; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/366331/health/standard?date=2018-04-19

Degrading Treatment

The nursing home failed to report an allegation of abuse for resident 12.

The resident had "no cognitive impairment" (BIMS score of 15 out of 15).

A review of a Complaint/Grievance Report filed by resident 12 and signed by the Social Service Director (SSD) and the Director of Nursing (DON) revealed that the resident had self-reported that LPN 2 cursed her, especially when she didn't have her oxygen on. When the nurse gave her a shot, she told her to move her big butt. The DON's documentation revealed that resident 12 continued to state that LPN 2 continued to refer to her buttocks as big.

The Complaint/Grievance Report documentation reflected that this was not reportable to the State Agency and was signed by the DON and SSD.

During an interview with resident 12, the resident stated that she was having problems with LPN 2.
The resident stated that LPN 2 was very rude and mean to her. She added that a month or so ago, LPN 2 had come into her room to give her a shot and told her to move her big butt.

The resident stated that she did not like being treated like a child by LPN 2 and that her anxiety level rises when LPN 2 is working.

The resident stated that she had not been physically abused but felt like LPN 2 was degrading in her treatment.

The resident stated she feared retaliation from LPN 2 if she found out that the resident reported her to the state. She added that she loved living at the nursing home and didn't want to move unless she got stronger with therapy.

When interviewed, LPN 2 stated she had never referred to resident 12 as having a big butt.

The DON confirmed she had not reported the incident as abuse.

The Administrator confirmed she was not aware of resident 12's complaint/grievance regarding LPN 2.

The nursing home policy titled Policy for Reporting revealed that the nursing home "must ensure that all alleged violations involving mistreatment, neglect, and abuse, are reported immediately to the Administrator of the facility and to other officials in accordance with State Law through established procedures including the State Survey and Certification Agency."

Name of Nursing Home	Queen City Nursing Center / Provider ID: 255166
Address	1201 28th Avenue, Meridian, Mississippi
Date investigation completed	June 9, 2017
Type of deficiency issued	F225 – Report and investigate abuse, neglect or mistreatment
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 2; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/255166/health/standard?date=2017-06-09

Honey. Sweetie. Baby.

The nursing home failed to implement its Policy and Procedure on filing grievances/complaints by residents when residents:

- Did not know where to get the grievance forms.
- Did not know how to file grievance when their rights were violated.
- Feared discrimination and retaliation from staff when they voiced their concern or grievance.

These failures had the potential to result in violation of residents' rights, maltreatment, neglect, and unresolved grievances.

During a Resident Council meeting, five residents stated they were in fear of retaliation and discrimination when a grievance was filed.

During an interview, resident 5, resident 40, and resident 36 stated that the Director of Nursing (DON) talked to them like children. They stated the DON called them "honey," "sweetie," or "baby" when talking to them in the hallway. The three residents stated they felt disrespected when treated like children. The residents stated they were angry because they were older and should not be talked to like children. The three residents stated they were afraid of retaliation from the DON and that they were afraid to report to Administration because of fear of retaliation.

Unlicensed staff O stated that the DON spoke to residents like they were little kids.

During an interview, resident 49 stated that she felt isolated after she filed a complaint about a staff member which she refused to identify. The resident stated she felt that after she complained that staff member stopped talking to her and just ignored her in the hallway.

A review of Resident Council minutes from six consecutive monthly meetings revealed that residents complained about call lights not being answered timely, noise level from staff, Cell phone usage by staff during resident care, dietary menu, and Primary doctor not seeing residents. The minutes were approved by the Administrator and the note taker during the Resident Council meeting. The above monthly council meetings indicated that all concerns presented by the residents continued to be unresolved.

During the Resident Council meeting (the same meeting described above), 10 residents out of 15 attending indicated that they don't know where to get the grievance form. Ten residents also indicated that they don't know how to file a grievance.

Name of Nursing Home	Rocky Point Care Center / Provider ID: 055499
Address	625 16th Street, Lakeport, California
Date investigation completed	July 15, 2022
Type of deficiency issued	F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055499/health/standard?date=2022-07-15

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

"Scared to Death of What He Will Do"

The nursing home failed to ensure a CNA reported an injury to nursing staff for resident 901, resulting in delayed treatment and pain.

Resident 901 was cognitively intact (BIMS score of 15 out of 15) and required extensive one person assist for most activities of daily living.

A nursing home incident report was submitted to the State Agency alleging that one night at 11:00 PM, CNA L either hit or ran over resident 901's foot with a wheelchair causing it to bleed, applied bandages on their own, and failed to report the incident/injury to a nurse for an assessment.

A day after the incident at around 7:00 AM, a physical therapist approached Nurse P and stated, "Can you come look at R901, she is not herself...she is emotional...she has a bandage on her leg that has blood on it, you can tell that she is just not herself." S/he later indicated, "the resident was in pain and "felt scared about reporting what happened because she was fearful, he (CNA L) would retaliate against her."

Nurse P went and assessed resident 901 immediately. Upon arrival, the resident was emotional and had four Band-Aids on her right shin area noted kerlix wrap to the right lower leg with dried blood. The nurse noted minimal swelling to the resident's right foot (the resident's operative leg).

The nurse asked what has happened and resident 901 began crying and said, "CNA L hit my leg and was rough...he yelled at me." The resident said that CNA L told her, "It's 11 o'clock, I am not doing any incident reports. It takes too much paperwork." The resident said that CNA L proceeded to put the band aid on her "after a bleed everywhere." She added, "After he got me to the bathroom, he either hit my foot on the wheelchair or ran over it with the wheelchair," said while pointing to her right foot.

The nurse noted three skin tears rolled under with some purplish bruising...with active bleeding on the right lower leg. The resident was offered an icepack and [name of medication] for right foot pain. The resident rated the pain at 8 out of 10 and added, "This is not the first time."

The nurse called the Director of Nursing and the Administrator to inform them about the incident.

The next morning after the physical therapist discovered it, resident 901 reported she is "scared that CNA L is going to find out she had to report this and is scared to death of what he will do."

When interviewed, CNA L stated, "I think the only thing I did wrong is that I did not tell the nurse the resident got a skin tear. I know I did wrong. I should have reported it."

Name of Nursing Home	Fox Run Village / Provider ID: 235634
Address	41215 Fox Run Road, Novi, Michigan
Date investigation completed	November 23, 2021
Type of deficiency issued	F684 – Quality of care
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235634/health/complaint?date=2021-11-23

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

Tasted Like an Eraser

The nursing home dietary staff failed to prepare, distribute, and serve food in accordance with acceptable and safe temperatures based on professional standards for food service safety for six residents who received hot foods served at cold temperatures. In addition, the milk was served at a temperature of 53.4 degrees Fahrenheit (F) (should be less than 41 degrees F) and the chicken salad sandwiches were served at a temperature of 62.8 degrees F (should be below 41 degrees F). The deficient practices resulted in improper holding of food temperatures, food was stored, uncovered with a utensil left inside of the food, which had the potential to promote the growth of pathogens that cause foodborne illness.

For illustration, the summary below includes descriptions of four residents' food service experience.

Resident 2 had no memory problems and no impaired decision-making.

During an interview, resident 2 stated she had never enjoyed the food at the nursing home since her admission. The resident stated that the nursing home's food was tasteless, disgusting, and the roast beef tasted like an eraser with mushy overcooked vegetables. The resident added that the coffee was served cold, and staff would get an attitude when they were asked to heat the cold coffee. The resident stated she was afraid of retaliation, so she avoided telling staff she was unhappy with the food.

Resident 1 had no memory problems and no impaired decision-making. During an interview, the resident stated the food was terrible and had no flavor. The resident shared that he had received rotten food and the food sometimes was overcooked. He added that he has a sensitive stomach, and the food is always cold. The chicken salad looked to the resident like cottage cheese or vomit chunks, smelled funny, and made his stomach upset.

Resident 3 who had no memory problems and no impaired decision-making stated that the food was lousy, and most of the time the hot food was served cold. The rice was hard, and the beans had an aluminum taste like can.

Resident 5 who had no memory problems and no impaired decision-making stated that the food was always awful, and she eats only because she was very angry. The resident added that hot food was always cold, which made it taste bad. The resident said that she did not ask the staff to reheat the food or for food exchanges because the staff was rude and would make comments that made her feel upset.

An anonymous staff member stated the residents always complained about the food. The staff member added that if she goes to the kitchen to ask for a meal alternative, the Dietary Service Manager is rude and would respond, "Just tell the residents we don't have that."

Name of Nursing Home	Avalon Villa Care Center / Provider ID: 056023
Address	12029 Avalon Blvd, Los Angeles, California
Date investigation completed	September 7, 2021
Type of deficiency issued	F812 – Food Procurement, Store/Prepare/Serve – Sanitary
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056023/health/complaint?date=2021-09-07

I Won't Help You

The nursing home failed to ensure the residents' right to be free from abuse and neglect for seven residents (31, 24, 18, 36, 53, 29, 55). The nursing home failed to monitor residents and recognize abuse and neglect by CNA A who admitted to abusing residents.

The nursing home failed to ensure that residents felt safe to report abuse without fear of retaliation which resulted in psychosocial harm as evidenced by residents expressing fear and not wanting to reveal identifying information to surveyors at the risk of further harm.

The nursing home failed to ensure staff reported to the abuse coordinator all concerns reported to them by residents including CNA A reportedly being rough when caring for residents.

Resident 31 was cognitively intact (BIMS score of 12 out of 15) and needed limited to extensive assistance with ADLs with one-person physical assists and the need for wheelchair for mobility.

During an interview, resident 31 stated that an aide was rough with her. She added that the aide isn't personable and has said, "If you don't go now, I won't help you during the night shift." The resident felt pressure to go to bed when she didn't want to. The resident said she didn't want to say the name of the staff as she might get in trouble. She might not get assistance when needed if she said the staff member's name. She added that staff get mad if she turns her call light on. She said that she waits up to an hour for an aide to assist her. She stated that she reported it to the administrator but felt that because the nursing home was short staffed, they continue to let this aide work because they felt like it's better than nothing. Resident 30 stated, "The ADMIN needs people. It doesn't matter what happens." The resident added, CNA A is "evil" and that she told the administrator that CNA A is physically rough but fears retaliation.

Resident 31 identified that "CNA A" was the staff member she was afraid of revealing. She stated she told the Resident Council and felt more comfortable saying it because others also mentioned her by name.

During a Resident Council meeting, resident 53 who was cognitively intact, stated she feels as if staff will retaliate against her for complaining. She stated that CNA A was rough when she turned her over in bed. She added, CNA A "does not have the personality to care for elderly people."

CNA A stated the nursing home was "very short staffed." She stated, "I am kind of abusing them because we're not attending them." She admitted to being rough during care and that if the residents don't like her, she tries to avoid them and doesn't assist them.

Residents were glad and felt safe when the Plan of Removal of the Immediate Jeopardy consisted of CNA A not returning to work at the nursing home.

Name of Nursing Home	Bastrop Nursing Center / Provider ID: 675356
Address	400 Old Austin Hwy, Bastrop, Texas
Date investigation completed	March 8, 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/675356/health/standard?date=2022-03-08

Soiled for Several Hours

The nursing home failed to ensure that enough CNAs were available to provide the residents' treatment and care (such as personal hygiene) in a timely manner for two residents. These failures resulted in the delay of care and treatment, subsequently affecting the residents' well-being.

Resident 44 required total assistance in all activities of daily living.

During an interview, resident 44's representative (RR) stated that she stayed at the nursing home from 11:00 AM to about 12:00 AM every day. The RR stated there were times when the nursing home only had one CNA working on the night shift (11:00 PM to 7:00 AM) for the entire building (the nursing home had 99-bed capacity). The RR stated she hired a sitter for resident 44 for a couple of hours in the morning to ensure resident 44 got repositioned while lying in bed and kept clean by the staff.

Another (confidential) resident was cognitively intact (BIMS score of 15 out of 15), incontinent, and required extensive assistance in toileting.

During an interview with the resident who wished not to be identified for fear of retaliation, the resident stated she waited for about six hours to get changed and was soiled in her incontinence brief as the nursing home had insufficient staff most of the time usually in the afternoon shift (3:00 PM and 11:00 PM) and the night shift (11:00 PM to 7:00 AM). The resident stated she developed redness on her buttocks because she was left soiled for six hours before she was cleaned and changed.

The CNA Assignment Sheet (six days after the latter interview with the confidential resident) for the AM shift (7:00 AM to 3:00 PM) indicated that the nursing skilled unit had a census of 80 residents. The document indicated that there were six CNAs assigned. Each CNA was assigned to 13 to 14 residents.

During an interview, the Director of Staff Development (DSD) stated six CNAs assigned for 80 residents were not enough to provide care for 13 to 14 residents assigned to each CNA. The DSD stated the nursing home did not have an adequate number of CNAs during the prior month (July 2019). The DSD further stated when CNA staffing was inadequate, the quality of the residents' care could be diminished.

During an interview, CNA 2 (AM shift) stated she was not able to provide personal hygiene to residents when she was assigned more than 13 residents during her shift. The CNA stated upon starting her shift, she would find her residents soiled from night shift.

During an interview, CNA 4 stated she had 13 residents assigned to her. The CNA stated the nursing home should provide more CNAs to be able to deliver quality care for the residents.

Name of Nursing Home	Asistencia Villa Rehabilitation and Care Center / Provider ID: 555379
Address	1875 Barton Road, Redlands, California
Date investigation completed	August 12, 2019
Type of deficiency issued	F725 – Sufficient Nursing Staff
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/555379/health/standard?date=2019-08-12

Fear of Repercussions

The nursing home failed to provide dignified care including timely answering of call lights and/or not providing medical supplies for five residents (5, 53, 60, 66, and 425) and six confidential residents. This deficient practice resulted in feelings of frustration, helplessness, and incontinence episodes.

The nursing home also failed to provide an atmosphere of openness to voice concerns and grievances without reprisal and failed to act on grievances expressed by 11 confidential residents requesting anonymity. The deficient practice resulted in residents choosing not to express grievances regarding care and perceived staff shortages due to feelings of possible retaliation and resulted in potential for unmet care needs and lack of grievance resolution.

During a confidential group meeting, all the residents attending the meeting stressed their strong desire to remain anonymous. The group for the most part had BIMS scores of 13-15 indicating intact cognition.

The group voiced a main concern that the nursing home was understaffed. Resident C6 stated the midnight shift recently had scheduled one CNA for more than 20 people and it is "inhumanely possible to provide the needed care." Resident C8 said call lights were not answered. Resident C6 said many residents had confided in her that briefs were often not being changed and residents were soaking wet. These residents have told her but did not want to talk to management. Resident C7 said she often had to wait for an hour and a half at night. She added, "We tell them (management), but things do not change." Resident C8 stated she felt helpless and frustrated, and said she knew others felt helpless too.

During a confidential interview, resident C11 stated, "Things are not good" but would not elaborate on why as there was a fear of retaliation. The resident asked that no name be given.

During a confidential interview, resident C10 stated he was not interested in talking because the nursing home would know it was him who had reported issues to the State Agency. He stated care was not being provided due to lack of staff. He asked this surveyor to leave and not use his name.

Resident C5 stated, "At night, they have no help. You can just forget it if you think someone will help. The resident asked that she remain anonymous saying, "I certainly would not want anyone to know my name when talking to you." Resident 36 (one of the Resident Council presidents) said many residents felt there may be repercussions and would not speak up.

The Director of Nursing stated she was unaware that there were residents who did not want to come forward and express their concerns for fear of retaliation.

Name of Nursing Home	Chelsea Retirement Community / Provider ID: 235021
Address	805 W. Middle Street, Chelsea, Michigan
Date investigation completed	June 29 2022
Type of deficiency issued	F550 – Resident Rights F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235021/health/standard?date=2022-06-29

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

Burned

The nursing home failed to implement its written abuse prevention policy and procedure, including: a. investigating alleged incidents of abuse, when resident 9 alleged that CNA 3 had a fist fight with resident 9 and that CNA 2 had wrung a towel soaked with hot water over resident 9's genitals; b. ensuring CNA 3 and CNA 2 were suspended pending completion of an abuse investigation; c. reporting the results of the investigation of the alleged abuse to the State Survey Agency.

These deficient practices had the potential to result in an unidentified abuse of all residents who were assigned to CNA 3 and CNA 2 and placed resident 9 at risk for the potential of ongoing abuse and resulted in resident 9 feeling of intimidation, retaliation, neglect, and decline in emotional well-being.

The nursing home also failed to ensure resident 9 was not subject to physical abuse from CNA 3 and CNA 2, failed to investigate the alleged abuse, and protect the resident from possible further abuse.

Resident 9 had an "intact cognitive response" (based on MDS assessment) and was totally dependent on staff for bed mobility, transfer, toileting, eating, and personal hygiene. During an interview, resident 9 stated she suffered pain after CNA 3 pulled the towel under her buttocks real hard during incontinence care. The resident stated a fist fight happened between her and CNA 3 because CNA 3 forced her to be cleaned, despite her objections. The resident stated that she did not report the fist fight incident to staff but reported it to her family member (FM3).

Resident 9 stated there was another incident of abuse where CNA 2 burned her by wringing a towel soaked with hot water over her private parts. The resident stated she reported this incident to FM3.

During an interview, FM3 stated the Administrator was notified of the allegations of abuse from CNA 3 and CNA 2. FM3 stated the Administrator told FM3 it will be taken care of. However, in an interview held on the following day, the Administrator stated that he was not aware of the alleged abuse incidents.

Two days later, resident 9 informed LVN 7 that she had a fist fight with CNA 3 and that something must be done. The resident stated, while crying, that the incident made her feel less than a person. The resident stated that she wanted to go home because she is scared for her life; that CNA 3 will continue the abuse. The resident stated that she did not tell anybody about the fist fight incident because she felt like the staff would retaliate against her. The resident stated she reported the abuse by CNA 3 and CNA 2 to FM3 and FM3 made complaints to the Administrator. LVN 7 said he will take care of it.

Five days later, resident 9 stated CNA 3 was assigned to her last night and that she was really scared and wanted to go home. She felt intimidated and neglected by the abuse incidents from CNA 3 and CNA 2.

Name of Nursing Home	Briarcrest Nursing Center / Provider ID: 056220
Address	5648 East Gotham Street, Bell Gardens, California
Date investigation completed	December 22, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 3; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056220/health/standard?date=2021-12-22

"A Lot of Anxiety"

The nursing home failed to provide an environment free from staff to resident verbal abuse / intimidation of resident 104 resulting in the resident's fear of retaliation following reported care concern, and the potential for a decline in resident's physical, mental, and psychosocial well-being.

Resident 104 was cognitively intact (BIMS score 15 out of 15).

During an interview, resident 104 reported that she had concerns with the manner that CNA I provided her cares. The concerns were related to not answering her call light, rushing during cares, and immature behavior. Later on, LPN FF stated that the resident also reported that CNA I was making rude comments about her weight. The resident stated that she talked to the Unit Manager about her concerns but that the issues continued without any follow-up from the Unit Manager. Therefore, the resident reported her concerns to LPN FF.

Resident 104 stated that a few hours after reporting the concerns to LPN FF, she heard yelling and cursing in the hallway and then CNA I "ran up to my bed, got in my face and said, 'We're good, we're good, right!'" Resident 104 reported that LPN FF came to the doorway and asked CNA I to leave the bedroom. Then, the yelling and cursing started again in the hallway, but she never saw CNA I again.

Resident 104 reported that she was worried about her safety that evening and stated, "I had a lot of anxiety, and I was worried about the safety of LPN FF."

During an interview, LPN FF reported that s/he brought resident 104's concerns to the Director of Nursing who then assigned CNA I to work on a different hall. LPN FF added that later that day, when CNA I reported to work, she became very angry when she found out about her new assignment. LPN FF stated, "She got very defensive and said she was not going to move. She accused me of reporting her."

LPN FF added that CNA I then started going down the hallway, went into resident 104's bedroom, and confronted her very loudly, "Are we good, are we good, we good, right?" LPN FF stated that she asked CNA I to come out of the bedroom and that resident 104 was looking at her (LPN FF) wide eyed. LPN FF stated, "I was sick to my stomach. I felt bad that I let the patient down."

CNA I then yelled and screamed down the hallway. LPN FF asked her to leave the building, but she walked down the hallway in the opposite direction. LPN FF then called 911 and while on the line with 911, was informed that was CNA I was escorted out of the building. The Administrator contacted the agency employing CNA I and notified them that CNA I will not be allowed to work in the nursing home and that she would be reported to the state about the abuse.

Name of Nursing Home	Skld Beltline / Provider ID: 235103
Address	2320 E. Beltline SE, Grand Rapids, Michigan
Date investigation completed	July 22, 2022
Type of deficiency issued	F600 – Free from Abuse and Neglect
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/235103/health/complaint?date=2022-07-22

"It Will Come Back to You"

The nursing home failed to ensure allegations of abuse and neglect were identified, investigated, and appropriate action taken to protect five residents (31, 183, 4, 14, and 000) who reported being afraid, felt unsafe and were handled roughly by nursing assistant (NA) A and NA C. The failure to investigate and protect the residents resulted in immediate jeopardy which had the potential to affect 42 residents.

The following summary focuses only on one of these residents – resident 31. The resident had "moderate cognitive impairment" and required extensive assistance of two staff for all activities of daily living.

Resident 31's family member asked to meet the surveyor. During the meeting with resident 31 and her family member, resident 31 reported that a nurse aide pulled the mechanical lift harness roughly from behind her. When asked if she had reported this to anyone, she indicated she was afraid of retaliation. The family member stated that the resident told her to stay quiet. The resident went on to say, "You have to be careful of what you say around here, it will come back to you." When asked if she has ever been hurt, she would not answer and turned her head to look at the door while saying, "They are out there, they are listening to everything." While her family member was talking, the resident told her, "You don't understand, you have to keep your mouth shut." Two days later, the resident stated, "staff were rough and rude during cares, and fearful of retaliation if she reported the incidents."

During an interview, another family member of resident 31 stated that NA A is "disrespectful, rough, and rude" to resident 31, which she has reported to staff previously. She added that resident 31 will try not to ask for help if she knows NA A is working so she (resident 31's family member) had asked NA A not to work with resident 31 but was told she will work wherever she is needed. The family member stated that resident 31 is "afraid nobody will show up and she will be left alone to die." She added, "She is afraid of retaliation because the family is causing waves." Resident 31 believed NA A would be rougher and hurt her because her family members reported her.

A review of the nursing home's grievance reports revealed that the latter family member had called the social worker several times and complained of staff neglecting residents, especially resident 31. There was no indication these grievances had been followed up on.

NA A's last Employee Job Performance Evaluation revealed six disciplinary actions regarding respect and dignity to residents. Her last disciplinary action indicated it was NA A's second written warning and required NA A to "avoid making statements which may be demeaning, hurtful or condescending" to residents. Although this was a report of abuse, the nursing home only filed an internal grievance and failed to file a report with the state agency. The nursing home continued to allow NA A to work with all residents, even though she had a pattern of allegations against her.

Name of Nursing Home	South Shore Care Center / Provider ID: 245596
Address	1307 South Shore Drive, Worthington, Minnesota
Date investigation completed	June 4, 2019
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/245596/health/standard?date=2019-06-04

"Worried All Day About What Will Happen at Night"

The nursing home failed to ensure voiced grievances pertaining to care were addressed with resolution sought for resident 31 who voiced repeated concerns regarding care during the night.

Resident 31 had "intact cognition" with "no difficulty with recalling information" (based on MDS).

During an interview, the resident stated that his regular nurse assistant is fine, but the replacement nurse assistant was sometimes the person he was having problems with. He stated that the nurse assistant would be "very abrupt with him and moves his legs suddenly." He added that the nurse assistant doesn't always understand his [REDACTED CONDITION(S)] and the intermittent nature of his being in control of moving and repositioning at night. Resident 31 became teary when sharing this frustration.

Resident 31 declined to identify the nursing assistant stating, "If we could mask it, I would tell you their names," and added that he was worried about retaliation.

The resident stated he had spoken with management, who he was not willing to name, on multiple occasions regarding treatment during the night such as abrupt treatment in response to call light requests for repositioning (expressing frustration that the issue has not been resolved). The resident became teary again when discussing what had happened. He added that he "worried all day about what will happen at night," stating, "When I get up in the morning, my biggest concern is what will happen in 12 hours when I go to bed at night."

A review of the nursing home's grievances indicated that it did not include grievances written by or on behalf of resident 31. Nurse assistant I stated she could say with confidence that resident 31 had registered a complaint. She added that she observed the Registered Nurse (RN) and Unit Manager (RN E) speaking with resident 31.

RN E indicated resident 31 had expressed several concerns regarding the nursing assistant's treatment at night, and 99% of the time resident 31 declined the grievance form and believed he just wanted to vent concerns to her. RN E stated typically resident 31 doesn't like the nurse aide's approach during the night and added that resident 31 has made this complaint more than three times and was not sure why there had not been anything recorded on them.

An interview with the Social Services Director (SSD) who is the grievance official responsible for managing all grievances. She was also the social worker responsible for resident 31. The SSD was not aware of any grievances submitted by or on behalf of resident 31. The SSD explained that there was no system to track and trend grievances and ensure resolution of grievances if they were not documented.

Name of Nursing Home	Good Samaritan Society – Stillwater / Provider ID: 245207
Address	1119 Owens Street North, Minnesota
Date investigation completed	November 7, 2019
Type of deficiency issued	F585 – Grievances
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/245207/health/standard?date=2019-11-07

Taking It Out on the Residents

The nursing home failed to treat five residents in a manner that promoted and enhanced dignity and respect.

During an interview, resident 116 disclosed a reluctance to request assistance when a couple of nurse aides were working as these nurse aides often expressed anger at the resident for activating the call bell to ask for help and made remarks that made the resident feel as though they shouldn't be bothering them. The resident revealed not knowing the names of the nurse aides and that they felt the nurse aides would possibly retaliate in response.

During interviews, residents 8, 79, 81, and 87 expressed concerns that staff were deliberately slow in response time when their assistance was required and that they were afraid to complain because they felt that they would be treated differently in retaliation.

Residents expressed concerns with lack of respect given to them from nurse aides, staff not wearing identification badges, and at times sarcastic towards residents when answering call bells. Residents stated they experienced fearfulness to report and that nurse aides will seek to take it out on them by not responding timely to bells and needs.

During an observation at 1:17 PM, resident 87 was sitting on a straight-back chair between the bed and window of his/her bedroom and wearing a white V-neck tee shirt. He/she was alert, oriented, and non-verbal. The resident was observed to have a large amount of wet, to various degrees drying, thick yellowish drainage on his/her [CONDITION(S)] (temporary or permanent opening in the neck to place a tube into a person's windpipe) dressing. There was also a brown liquid with dark solid (flaky) substance near the collar on his/her shirt and on the chest wall. There were also various spilled liquids on the front of his/her shirt. At 2:41 PM on the same day, the resident remained in the same condition.

The next day at 11:23 AM, the resident was wearing the same soiled white V-neck shirt as yesterday. His/her [CONDITION(S)] dressing was soiled with moderate-large amount of medium brown colored secretions. There was also an orange-colored staining along with the previously observed brown liquid with dark solid (flaky) substance near the collar. The resident stated that they changed his/her last night and this morning.

The next day at 10:20 AM, the resident was in the same condition, in the same white V-neck tee shirt from two days ago and yesterday. There was additional staining on the front of the shirt. His/her [CONDITION(S)] dressing was clean and intact. During an interview on the same day, a Nurse Educator confirmed that the resident's shirt was soiled with brown, orange, tan stains ranging from dry and crusty to wet.

Name of Nursing Home	Lecom at Presque Isle, Inc / Provider ID: 395404
Address	4114 Schaper Avenue, Erie, Pennsylvania
Date investigation completed	August 27, 2019
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights
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/395404/health/standard?date=2019-08-27

Unchanged for Hours

The nursing home failed to provide sufficient staffing to respond to call lights in a timely manner as expressed by residents in a confidential group meeting. The nursing home also failed to provide sufficient staffing to ensure provision of incontinence care and personal hygiene for resident 2. The deficient practice resulted in actual unmet care needs including residents soiling themselves when staff were untimely in response and actual unmet care needs for resident 2.

Six residents with intact cognition (BIMS score 15 out of 15) met in a confidential group meeting. Resident 2 stated there was a long wait for assistance to use the bathroom. She said that staff "don't care if you have to go right now. It makes me mad...I have had accidents (incontinence)" and "The facility needs more staff" but "Corporate doesn't give you more staff. They just take (admit) more residents."

The six residents in the confidential group meeting agreed that they usually had to wait at least 30 minutes for help after a call light was pressed. Resident 1 said, "Staff would come to the bedroom after 30 minutes had passed and would turn off the lights and say, 'Oh, we will be back,' and they do not ask you what you need. They don't come back." Resident 3 agreed the nurse aides turn the call light off and do not help. She added, "I have had an accident (soiled herself) quite a few times." Resident 1 said that after pushing the call light at 6:00 PM, she did not receive help until 4:00 AM. She added that she has had many days when after waking up in the morning she was not changed until 2:00 PM in the afternoon.

The residents expressed concerns of retaliation and wished to remain anonymous.

During an interview, Contracted Therapist L who provided services to residents at all hours of the day and night found that staffing was an issue. She revealed, "I have seen call lights be on for hours. Long waits were the case particularly for those residents who needed two staff members for transfers." On the evening shift, she often observed only one nurse aide working per hall and one nurse working between two halls. She said that she has seen residents "have to wait more than six hours." She said she has timed the call light response time and estimated the average wait time for residents who needed two staff members to help transfer was two hours. She stated that she has seen residents "have the call light on at night and have to wait until the day shift comes in to be changed." She added, "If residents need to be changed or need water, it is low priority" and that sometimes there are eight lights going off and only one staff member present.

The surveyor's observations of resident 2 (e.g., leaking catheter; soiled bedsheet), review of staffing records, and interviews with staff provided support for the residents' concerns. For example, Medical Records Staff R acknowledged that on many days there were entire shifts or spans of hours where there were no CNAs or Nurses assigned to the care units.

Name of Nursing Home	Autumnwood of McBain / Provider ID: 235438
Address	220 Hughston Street, MC Bain, Michigan
Date investigation completed	March 1, 2022
Type of deficiency issued	F725 – Sufficient Nursing Staff
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235438/health/standard?date=2022-03-01

"We Are Scared of the Nurses"

The nursing home failed to ensure nine residents were not neglected, physically, verbally, and emotionally abused by the staff nurses and had a fear free environment.

Selected examples include:

Residents 3, 4, 5, 6, 7, 8, and 9 felt harassed, humiliated, intimidated, worthless, and like objects when the staff nurses would leave them wet all night, and at times would refuse to answer their call light and/or answer the call lights in a rude manner by smacking their lips when answering the call lights, forcing the residents to have bowel movement in their adult brief and forcing them into bed by 7:30 PM.

Resident 5 had intact cognition and required extensive assist with one-person physical assist for toilet use, personal hygiene, and bed mobility. The resident stated the nurses do not answer the call lights, specifically at night. The resident complained of being left wet on several occasions. The resident stated, "It's bad, it makes me feel like nobody cares, like we are a burden on the staff."

Resident 3's cognition was intact and required extensive assist with a one-person assist for toilet use, personal hygiene, and bed mobility. The resident stated that one night she asked the staff to change her adult depends but had to wait until the next day at 9:00 AM to be changed leaving her wet with urine all night. The resident stated that it was not the first time she was left wet all night feeling hopeless, neglected, and humiliated. The resident stated that residents brought up the call light issue during a Resident Council meeting, but the issue continued to reoccur. She said, "We are scared of the nurses" and that a staff member from the 3-11 PM shift told her it was her fault the Department of Health was investigating the nursing home and that the nurses will be in trouble because of her complaint.

Resident 6 with intact cognition said with tearing eyes, "Staff from night shift don't answer the call lights. I felt worthless and nasty. The resident stated that the staff takes two hours or sometimes all night to answer the call light. The resident said that it was depressing and humiliating to be left wet as an adult. The resident added that a couple of nights prior, while sleeping, she was awakened by a staff member hitting her in the stomach twice. The resident stated she did not want to state the nurse's name due to fear of staff retaliation.

Resident 9 who was "usually able to understand and make herself understood" was totally dependent with a two-person physical assist for toilet use, personal hygiene, and bed mobility. The resident that stated she was being left wet for extended periods of times making her feel uncomfortable, "as if I do not matter." She stated mentioning to the staff to not leave her wet because it worsens the wound in her back. She stated that three nights prior, she cried for over an hour due to pain and being left wet. The resident stated she did not want to report the nurses because she was afraid of them.

Name of Nursing Home	Country Villa Bay Vista Hcc / Provider ID: 056042
Address	5901 Downey Ave. Long Beach, California
Date investigation completed	March 17, 2020
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 4; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056042/health/complaint?date=2020-03-17

Afraid of Speaking with Surveyor and Ombudsman

The nursing home failed to ensure resident 176 was free from intimidation when reporting abuse. This failure resulted in psychosocial harm due to fear of intimidation and retaliation by the nursing home in reporting abuse and neglect by staff. Resident 176 was cognitively intact (based on MDS assessment).

The resident reported that the abuse started because he was telling staff A that he shot the biggest bear in Idaho and staff A "called BS on me." The following incident allegedly took place a couple of days later:

An Incident Report documented that the resident reported to an unnamed CNA that staff A smacked his forehead against the side rails of the bed and smacked and pinched his scrotum with a urinal. He added that he did not want to say anything because he was worried it would make things worse for him.

A follow-up interview in the Incident Report documented that the resident stated he had a verbal disagreement with staff A. Staff A turned the resident and inadvertently bumped his head on the side rail. When staff A was providing care, the resident's thigh was inadvertently pinched by the urinal. The report documented the resident stated he felt safe in the nursing home and denied any abuse.

When the resident was asked about his statement in the follow-up interview, he denied that he made the statement that he felt safe in the nursing home and denied he stated that abuse did not happen. He stated, "I am not stupid, and I never said that." A family friend who was present at the interview confirmed it. The resident stated that the nursing home was "sweeping things under the rug" and that he was not at all comfortable about his safety in the nursing home.

The resident reviewed the investigation report and said, "They minimized what I said." He added that staff A "was just really, really bad." He stated staff A went to turn him and banged his head against the rails over and over ("really hard"). He added that staff A then took the urinal and smashed it against his genitals over and over ("really hard"). He stated that he got "thumped up pretty good" and staff A was reassigned to work on another hall. He added that he only felt safe once staff A left the nursing home.

He said, "I am afraid of retaliation" and added that he was currently concerned about retaliation for talking to the state and worried he will be starved out for talking to state surveyors. When asked to clarify, the resident stated he was not afraid of physical abuse but worried about things staff control, such as his medications being late, call light not being answered, and not getting food served to him.

He said that he contacted the Ombudsman at the time, but then changed his mind about discussing the incident when he was asked for information because he was afraid of repercussions from staff. The resident stated that the nursing home fired staff A after another resident complained about abuse.

Name of Nursing Home	Ivy Court / Provider ID: 135053
Address	2200 Ironwood Place, Coeur D'Alene, Idaho
Date investigation completed	March 6, 2020
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/135053/health/standard?date=2020-03-06

Fear of Retaliation from Sexual Abuser

The nursing home failed to: a. ensure resident 40 was free from sexual abuse by a staff member; b. implement their abuse policy to ensure that resident 40 was free from sexual abuse by a staff member; c. ensure all allegations of staff to resident sexual abuse were reported to the State Agency for resident 40; and d. ensure all allegations of staff to resident sexual abuse were thoroughly investigated for resident 40.

Resident 40 had no cognitive deficits. The resident was discharged to a hotel, then returned to the nursing home, then discharged to the hospital for a surgical procedure, and did not return to the nursing home.

One day at 12:30 PM, Resident 40 shared with Medical Records Clerk (MRC) she received inappropriate text messages from NA 99. The text messages included a video of two people having sex. Resident 40 replied to the text stating it was disgusting and she didn't like things like that. NA 99 sent another text to resident 40 stating, "Can I [expletive] you in the [expletive] tonight?" When recounting the incident, resident 40 became tearful and was afraid of retaliation. At 12:55 PM, the nursing home notified the police of the alleged sexual abuse. At 3:10 PM, the Social Worker offered counselling services to resident 40 and she declined. The resident was also offered transport to the hospital for an evaluation, and she declined. At 4:10 PM, a Self-Report Incident was submitted to the State Agency regarding the sexual abuse allegation. At 8:45 PM, NA 99 was suspended and nine days later his employment was terminated.

A witness statement by MRC revealed resident 40 came to her and stated she was scared to come back to the nursing home, but she did so because she had nowhere else to go. She felt like an employee was sexually harassing her. At this time, the resident would not name the alleged perpetrator because the employee had friends and family who resided in the nursing home, and she was worried about retaliation. The resident added that one time a phlebotomist caught her and the employee in a very compromising position. The phlebotomist later confirmed witnessing it but did not report it to any staff.

Police detective statement revealed: Resident 40 reported she had non-consensual sex with an employee at the nursing home a handful of times because he threatened her, and she was scared of him. The resident would not reveal the employee's name because she was afraid of what he would do to her. Later that day, the resident named the employee as NA 99 and stated she was afraid NA 99 would have her kicked out of the nursing home if she did not comply with what he wanted her to do.

NA 99 admitted sending nasty text messages to resident 40 but stated he never acted on any of the texts. The aide denied ever having sex or any type of intimacy with resident 40 or ever threatening her. Nearly a month after the initial allegation was made to her, the MRC visited resident 40 at the new care home she now resided at, and the resident revealed she was still fearful of NA 99.

Name of Nursing Home	Promedica Skilled Nursing & Rehab Westerville / Provider ID: 365611 [Alternative name: Heartland of Westerville]
Address	1060 Eastwind Drive, Westerville, Ohio
Date investigation completed	November 5, 2019
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: No longer available on *Care Compare* website.

"It Would Come Back to Haunt Me..."

The nursing home failed to ensure grievances voiced by the Resident Council and individually documented resident grievances were acted upon for two residents.

Resident 4 indicated he required assistance to the bathroom, and when he would turn on the call light for assistance, staff would come in and turn off the call light and leave telling him they would be back, but they do not return. He added, "They act like I could hold it forever, but I can't, that's why I wore a brief." He added, "I didn't like to complain because it would come back to haunt me, the staff would retaliate."

Five days later, the resident indicated he had talked to a nurse with concern regarding a Certified Resident Care Assistant (CRCA) and a few minutes afterwards the CRCA came to his bedroom and confronted him saying his concern was not right. The resident stated that later that day, the CRCA would not talk to him, and has since rarely answered his call light telling him she had other things to do. He was unsure if the nurse turned in a grievance to management. The resident indicated he knows the names of the nurse and CRCA but was afraid to give names due to fear of retaliation.

The nursing home's policy titled Resident Rights Guidelines stated, among others, "Our residents have a right to: Freedom to talk with staff and express concerns/grievances without fear of reprisal."

Review of Resident Concern Log does not indicate a grievance by resident 4 regarding CRCA care issue. Review of a document titled Trilogy Resident Concern Log indicated nine separate incidents had been recorded of resident concerns regarding call lights and response wait times, including a concern by resident 4 approximately three months prior to the resident's report to the state surveyor.

During a closed-door Resident Council meeting, resident 10 stated that there were two episodes recently where the call light was placed in a location where she could not reach it and she had to yell for help and to get the call light. The resident stated she was not sure staff responded to concerns in a timely manner.

The Director of Health Services said she was not aware of a lot of complaints regarding call lights. She added that the staff to resident ratio was high so there should have been no problem with response time.

She stated, however, that the call light system did not track calls to include when the light was turned on, the length of time the call light had been on, or the time the light was answered.

Review of Health Services In-Service document indicated, "All call lights need to be answered in a timely manner. If you answer a call light, you must address the reason why the call light was on. These are all our residents. You do have an assignment you are responsible for, but call lights belong to all of us."

Name of Nursing Home	Wellbrooke of Avon / Provider ID: 155811
Address	10307 East County Road 100 North, Indianapolis, Indiana
Date investigation completed	December 20 2017
Type of deficiency issued	F565 – Resident/Family Group and Response
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: No longer available on *Care Compare* website.

Abuse Allegation Recanted

The nursing home failed to protect a resident from abuse and neglect; failed to adequately address a resident's concerns associated with care provided by a staff member; and failed to implement strategies to mitigate a resident's fear of ongoing neglect associated with reporting of concerns for resident 38. The deficient practice caused the resident to experience feeling fear of neglect by staff L, and possible retaliation, which occurred over extended time. The nursing home also failed to report an allegation of abuse to the State Survey Agency within 24 hours of notification for resident 38.

During an interview, resident 38 stated there was a staff she had a problem with. Resident 38 was very resistant to discussing the issue. Resident 38 stated Staff L tickled the ears and necks of female residents. She stated, "He would not stop even when asked."

The resident stated he had yelled at her, yelled across the dining room, and had refused to assist her with care requests. The resident added that she had also witnessed staff L handling her roommate roughly when he lifted her roommate under the arms with his hands and slamming her into a chair. The resident described a similar transfer having occurred in the dining room with another resident.

Resident 38 was upset and wanted something to be done. The resident stated she wanted to remain anonymous because she was afraid of how she might be treated if others knew she had complained.

Because the resident stated she had not previously reported the allegations to the nursing home, this was immediately reported to the Administrator.

A review of the nursing home's Complaint Log showed a complaint from resident 38, alleging staff L was refusing to help her when requested. The log showed the original statement was recanted.

During an interview, when asked why she recanted her complaint, resident 38 stated she was afraid that staff L would still be assigned to her hall, and he would not take care of her.

Resident 38 stated staff L continually expected her to walk to the bathroom when she was not able. The resident stated she did not think she deserved to be treated that way. She added that she was afraid of being neglected if she complained about staff L.

A review of staff L's Corrective Action Notification showed a resident reported she was not getting help when requested and was told by staff L to "Do it yourself." The form documented a history of disrespect towards residents, and an expectation for immediate, significant, and sustained improvement in this area.

Name of Nursing Home	Sidney Health Center Extended Care / Provider ID: 275121
Address	104 14th Ave NW, Sidney, Montana
Date investigation completed	December 12, 2019
Type of deficiency issued	F600 – Free from Abuse and Neglect F609 – Reporting of Alleged Violations
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/275121/health/standard?date=2019-12-12

"I Don't Know What Would Happen If They Kicked Me Out"

The nursing home failed to institute and operationalize policies and procedures to ensure an environment free from abuse for resident 705, resulting in resident 705 being subjected to verbal and mental abuse, including intimidation, fear of retaliation, emotional distress, embarrassment, shame, and fear.

Resident 705 was cognitively intact (based on MDS assessment) and totally dependent on staff for the completion of all activities of daily living. They were quadriplegic with no feeling from the chest down.

During an interview, resident 705 revealed they wanted to discuss an incident that occurred with Registered Nurse (RN) E but were worried about retaliation from the nursing home and staff. The resident stated they are not crazy and added, "I don't know what would happen if they kicked me out." When asked what happened, the resident stated RN E was buying alcohol for them for a while.

The resident stated that one night RN E was doing my medication pass which was bringing me my Vodka so I could go to sleep at 12:30 AM. RN E brought a little over half a fifth of Vodka into my bedroom, sat at the edge of my bed, and gave me my Vodka. The resident stated, "I was supposed to get 60 milliliters, but RN E gave me a lot more than that." They said that nursing staff administer the Vodka through his gastrostomy tube. RN E "was taking a med cup and doing shots with me. We finished off the bottle."

The resident revealed RN E told them they had breast implants and showed them a picture of when they first got their implants. The resident revealed they were quite drunk and stated, RN E "ended up taking their top off. Bra and everything." During the interview, the resident became emotionally distraught and stated, "The door was shut, the curtain was closed. RN E's bra was off and everything. RN E got over me, showing me their breasts" and putting their breasts "in my face and in my mouth." The resident added, RN E "took a video of themselves masturbating and put my hand down there so I could feel them."

RN E came in the next day and was telling me that the alcohol shots hit them on the way home, and they put a dent in their new car. The resident said that RN E told everyone else here that they hit a deer.

The resident expressed concern that no one would believe what they were saying and label them as crazy and that they just wanted to forget the whole thing, that they "feel horrible," and that they had drank too much alcohol. He added, "It is embarrassing as hell. It's embarrassing to think I would let that happen. Everyone is going to know about it, and it disgusts me." The resident stated that he was concerned they would be kicked out of the nursing home and added that they were concerned and scared of what RN E might do now especially after they told the truth. The resident stated that not long after that, RN E started acting weird and has done things purposely (such as turning on the light in the hallway because they know I want it off) to intimidate them. They stated, "It made me feel like employees here can do anything they want and can abuse anyone they want, and nothing will happen to them."

Name of Nursing Home	Medilodge of East Lansing / Provider ID: 235283
Address	1843 N. Hagadorn Road, East Lansing, Michigan
Date investigation completed	August 12, 2022
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235283/health/complaint?date=2022-08-12

Terrified, Powerless, and Helpless

The nursing home failed to: a. provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with professional standards of practice consistent with the resident's comprehensive assessment and plan of care for residents 3 and 4; b. ensure visitation of friends for resident 4 and resident 3, which resulted in decline in resident 4's physical and mental/emotional well-being as well as sadness and disappointment by resident 3; and c. ensure the Administrator refrained from demeaning remarks to, about, and in the presence of residents.

Resident 4 who had no cognitive impairment (BIMS score of 15 out of 15) stated that the Administrator would not allow him to see his friends (FR A and FR B). The resident overheard the Administrator telling FR B, "I will toss you out" when she arrived to visit a Hospice nurse who had asked her to come into the nursing home to talk about her loved one. Resident 4 said that he tried to intervene, saying State guidelines say that FR B could visit, and that the Administrator told him, "I run the facility, not the state."

The resident added that the Administrator once told him, "If you keep that up, I will make you a Troubled Resident in your file." The resident stated that he did not recall what he was doing to prompt that response and stated that he feared the Administrator and feared every day he would be evicted.

Resident 4's family member stated that the issue that occurred with FR B being told she would be tossed out was just devastating for resident 4. She stated resident 4 became terrified of being evicted and feels powerless and helpless. She added, "It is abuse of power by the Administrator." She stated because she is complaining, resident 4 is afraid the Administrator will prevent her from visiting her son.

Resident 3 who had no cognitive impairment (BIMS score of 14 out of 15) stated she saw FR B in her neighbor's bedroom and wanted to go see them but was afraid of what the Administrator would do and feared he might throw her out of the nursing home. She stated it made her mad and hurt her so bad because those were her only friends outside the nursing home. She stated if her friend's family members tried to visit with her or other residents on the hall, the staff would tell them to go to their bedrooms and shut their doors. She had tears in her eyes and stated she did not know what to do and that it made her afraid of being kicked out and helpless. She stated she is afraid of the Administrator because he is loud and scary and carries a cane and sometimes shakes it at the residents. She stated that she is afraid he might keep her family from visiting her like he did with another resident.

Resident 5 stated that he was afraid of the Administrator because he was a big man with a big voice and carried a big stick and he would swear sometimes. The resident added that the Administrator is just a big bully getting these kids (residents 3 and 4) crying.

Name of Nursing Home	Lbj Medical Center / Provider ID: 676486
Address	206 Haley Road, Johnson City, Texas
Date investigation completed	November 19, 2021
Type of deficiency issued	F675 – Quality of Life
Severity level	Actual Harm
Overall Quality Star Rating: Missing data; Staffing Rating: Missing data	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/676486/health/complaint?date=2021-11-19

Bored and Fearful

The nursing home failed to support the residents' right to voice any grievances without discrimination, reprisal, or the fear of discrimination or reprisal.

During a group interview, six alert and oriented residents (who do not wish to be named for fear of retaliation), stated that they felt treated differently by staff if the residents lodged a grievance or complaint with or against the nursing home. They stated that staff ignored them, would call them names, were slower to care for them, and were not as nice to them after grievances were filed.

Individual residents interviewed (who wished to remain anonymous) also voiced concerns about making a complaint for fear of reprisal from staff.

During an interview, the Director of Nursing and the Administrator were unable to provide evidence that the nursing home supported residents' right to voice any grievance without discrimination, reprisal, or the fear of discrimination or reprisal or explain why the residents' impression of their treatment was not consistent with the nursing home's policy.

The nursing home also failed to provide an ongoing program of activities throughout the day to meet residents' interests and promote the physical, mental, and psychosocial well-being of three residents.

A review of the December and January activity calendars revealed a very limited schedule of activities with very little variety in the type of programming provided. For example, on Monday through Friday there were only two activities for the nursing home scheduled at 10:00 AM and 2:00 PM. Many of the 2:00 PM activities were manicure, with no indication of an alternative activity for men.

Interviews with residents conducted throughout the survey including residents 55, 9, and 36, and other residents (who wished to remain anonymous for fear of retaliation), revealed that they are bored in the nursing home and that there are limited activities. The residents stated that they have been stuck in their bedrooms with very little to do.

Interview with the Administrator revealed that she/he was unable to provide evidence that there were adequate and varied activities being offered to meet residents' interests and promote the physical, mental, and psychosocial well-being of the residents.

An interview with administrative staff in late February revealed that the nursing home had been without an Activity Director since July the previous year. An Occupational Therapist was acting as the Activity Director from July last year through January this year when a new Activity Director was hired.

Name of Nursing Home	Gardens at Scranton, The / Provider ID: 395273
Address	824 Adams Ave. Scranton, Pennsylvania
Date investigation completed	February 26, 2021
Type of deficiency issued	F585 – Grievances F679 – Activities Meet Interests / Needs of Each Resident
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/395273/health/standard?date=2021-02-26

Invading Privacy of Resident Council

The nursing home failed to allow for private Resident Council meetings by failing to provide 10 residents private space to conduct group meetings without nursing home staff present.

In a confidential resident group interview, 10 residents were unaware they had the right to organize and participate in a group meeting in a private space and the staff could only attend if invited by the Council.

The failure restricted the privacy of these residents and placed the remaining nursing home residents at risk of not having the right to voice their concerns without staff being present or overhearing their concerns and to conduct Resident Council meetings without interference.

During a resident group interview, the 10 residents in attendance stated that the Resident Council meetings were always held with the Activity Director in attendance. All residents in the group interview were unaware that the staff could not attend the Resident Council meeting unless invited. All residents expressed surprise at this information and all residents stated they would feel more willing to express their views without a staff person being in the meeting.

During an interview, the Activity Director stated she always attends the Resident Council meetings so she can help guide the meetings. She stated the previous Administrator told her she had to set the meeting up and stay in the meeting with the group while it was being held. She stated that she did not know the Resident Council was supposed to meet privately and she was to be invited to the meetings.

The Activity Director stated the consequences of residents not having a group meeting in private would be not being able to talk freely and feeling isolated.

During an interview, the Administrator stated that she was aware the Resident Council was supposed to meet in private. She stated that she was not aware the Activity Director was not invited to the meetings by the council. She added that the consequences of the residents not meeting alone would be fear of retaliation from staff if they expressed their feelings and concerns.

A policy was requested but never received.

Name of Nursing Home	Pampa Nursing Center / Provider ID: 675327
Address	1321 W. Kentucky, Pampa, Texas
Date investigation completed	April 15, 2022
Type of deficiency issued	F565 – Resident/Family Group and Response
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/675327/health/standard?date=2022-04-15

Shhh, Do Not Disturb!

The nursing home failed to provide residents with a private space to participate in resident groups and to ensure that staff attended resident group meetings only with the group invitation. This involved 10 residents participating in a Resident Council meeting.

The Activities Director (AD) and Resident Council President scheduled a Resident Council meeting which was held one day at 10:30 AM in the nursing home's dining room.

The AD advised all nursing home staff present in the area where the meeting was to be held to leave, as this was to be a resident-only meeting. The AD also placed a sign on the outside door which read:

Ssshhh RESIDENT COUNCIL MEETING IN SESSION. Please do not disturb!

There were 10 residents in attendance, including the President and Vice President of the Resident Council. During the meeting, multiple staff members were observed entering and exiting the area of the meeting causing the meeting to be paused.

The residents in attendance stated that they preferred to meet without the staff present. However, staff still came in and out of their meetings without regard to the sign placed on the door. The residents stated that this was a violation of their privacy, and they had made reports to the nursing home's staff. The residents voiced concerns with staff obtaining information discussed during the meeting and reporting it to other staff possibly resulting in retaliation.

During an interview, the Administrator and AD could not explain why staff would continuously come in and out of the Resident Council meeting. They agreed that this should not have been happening. They acknowledged previous concerns from the Resident Council regarding fear of reprisal.

In addition, a review of the meeting minutes provided by the AD revealed no concerns from the Resident Council during the meetings. When asked about this, the Resident Council President stated that the minutes were not accurate, and these were not the minutes that she had taken during the meetings. A record review revealed inconsistencies between the meeting minutes taken by the Resident Council President and the minutes provided by the AD for meetings held in January 2021 and February 2021. During the meeting in January 2021, the council documented concerns with being treated with respect and dignity from the staff. This information was not included in the meeting minutes for the same date provided by the AD. The Administrator stated she was not aware of concerns being raised. When asked about the discrepancies, the AD stated she sometimes re-wrote the minutes when the Resident Council President's writing was not legible. She did not address the inconsistencies.

Name of Nursing Home	St Augustine Health and Rehabilitation Center / Provider ID: 105315
Address	51 Sunrise Blvd, Saint Augustine, Florida
Date investigation completed	March 11, 2021
Type of deficiency issued	F565 – Resident/Family Group and Response
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/105315/health/standard?date=2021-03-11

Intruding a Private Resident Council Meeting

The nursing home staff did not allow a private Resident Council meeting with state agency surveyors for seven residents in attendance. Staff entered the Private group council meeting, while in progress, to interrupt the proceedings on four occasions during the hour-long meeting. This staff intrusion in a confidential meeting, made residents feel uncomfortable, and fearful of retaliation, should they share complaints with surveyors.

A Resident Council private session with state agency surveyors commenced at 11:00 AM. Approximately 20 minutes into the session, and during resident disclosure of grievances, a private duty sitter for a resident entered the room and was told that this was a private meeting and please to place signs on the door to restrict access to all staff while the private meeting was being held, and to let the Unit Manage know this. She stated she would do so and proceeded out of another door after greeting several residents.

The meeting continued but 10 minutes later, a laundry staff member entered the room with a laundry cart full of clean linen. The laundry staff member was told a meeting was being held, and the same instructions were given to her as she exited the room.

Ten to 15 minutes later, two CNAs entered the room to obtain a weight scale, and were told the same information, with the addition of asking for the unit managing nurse to come to the room to make sure staff entry was restricted.

Approximately 10 minutes later, another CNA entered the room, and simply walked through without speaking to anyone.

At this point, the residents refused to speak further as they feared sharing negative information would result in retaliation. They also stated that they were being watched.

At this time, the meeting was adjourned, as the residents were not being afforded their right to a private meeting with surveyors.

The Unit Manager nurse never responded to the request of her presence at the meeting.

Name of Nursing Home	Beth Sholom Home of Virginia / Provider ID: 495291
Address	1600 John Rolfe Parkway, Richmond, Virginia
Date investigation completed	March 14, 2019
Type of deficiency issued	F565 – Resident/Family Group and Response
Severity level	Minimal Harm or Potential for Minimal Harm
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/495291/health/standard?date=2019-03-14

Staff's Derogatory Facebook Post Results in Fear of Retaliation

The nursing home failed to ensure resident 19 was treated with dignity and respect and not retaliated against following a staff to resident altercation when staff posted on social media (Facebook) conversation that was derogatory in nature directed to and about resident 19. The social media exchange was viewed by the resident and the local Ombudsman.

A nursing progress note revealed resident 19 was using profanities and running into a nurse aide with her motorized wheelchair. The next day the nursing home submitted a self-report incident (SRI) involving an allegation of physical abuse involving resident 19. The SRI revealed resident 19 reported she approached nurse aide 103 at the nurse's station in her electric wheelchair. The resident asked nurse aide 103 if she had stolen her lotions. Nurse aide 103 reported she did not take the resident's lotions. The resident began swearing and yelling at nurse aide 103. The resident used her wheelchair to pin nurse aide 103 against the nurse's station. Nurse aide 103 kept asking the resident to back up. Nurse aide 103 reached out and caught the resident's neck with her hands. The two were separated and the police were called. The resident continued to yell vulgar names while police were interviewing staff.

Review of nurse aide 103's social media (Facebook) page revealed that the nurse aide listed the nursing home as her current employer. A post on the same date the SRI was submitted revealed nurse aide 103 wrote, "If you must try to hurt other people to feel powerful, you are an extremely weak individual."

Nurse aide 48 responded to the post, "Should've smacked the [expletive]. Something had to be done."

Nurse aide 103 responded to nurse aide 48, "From the sexual harassment that you witnessed to trying to be a bully now the racist remarks and trying to actually hurt someone, yeah I'm not having it."

Nurse aide 103 posted, "Nobody deserves to work in an atmosphere that she presents, she always had and always will make it a complete hostile environment to work in. She'll manipulate everyone in the building to ruin one person's reputation. I am not having it anymore. Elderly residents shouldn't have to have such a violent bullying racist neighbor. She tries to intimidate anyone she can, staff and residents. She's a loser."

An interview with the Ombudsman revealed that resident 19 reported to her that staff posted comments about her on social media (Facebook). The Ombudsman read the Facebook comments about the resident.

An interview with resident 19 revealed she saw the post on Facebook made by nurse aide 103 and the other comments under it and knew it was about her. Resident 19 stated it was very upsetting and hurtful to see those things posted on Facebook, especially sexual stuff and that she was racist. She revealed that she was afraid the other staff would retaliate against her after reading those remarks.

Name of Nursing Home	Dixon Healthcare Center / Provider ID: 365629
Address	135 Reichart Avenue, Wintersville, Ohio
Date investigation completed	July 22, 2021
Type of deficiency issued	F550 – Resident Rights
Severity level	Minimal Harm or Potential for Actual Harm
No Star Ratings Due to Special Focus Facility Designation	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/365629/health/complaint?date=2021-07-22

The Price of Dignity

The nursing home failed to ensure residents were treated with dignity and respect. This affected four residents (6, 16, 32 and 33). The nursing home also failed to complete resident showers per resident preference. This affected resident 33.

Resident 33 was cognitively intact (based on MDS assessment) and required extensive assistance of one staff for bed mobility, transfers, dressing, toileting, and personal hygiene.

During an interview, resident 33 revealed she was unhappy with the attitude of Nurse Assistant (NA) 47 during her care. She stated that she requested to receive showers on Tuesdays and Fridays before dinner, and on the afternoon of [DATE REDACTED] at 4:00 PM. When she asked NA 47 when she would be getting her shower, NA 47 told her that she would get a shower when she said she could get a shower.

The Director of Nursing confirmed that resident 33 didn't receive showers per her preference.

Resident 16 and resident 32 both had intact cognition (based on MDS assessment).

A Resident Council Meeting revealed resident 16 and resident 6 complained about attitudes and demeanor of NA 47 and NA13. They stated the two staff were short with the residents, they yelled at times and the residents feared retaliation if the nursing home punished the two NAs.

The Administrator verified she completed interviews with residents and residents 16, 32, and 33 complained about NA 47 and NA 13 not treating them in a respectful manner.

Name of Nursing Home	New Albany Care Center / Provider ID: 366155
Address	5691 Thompson Road, Columbus, Ohio
Date investigation completed	December 28, 2019
Type of deficiency issued	F557 – Respect and Dignity F561 – Self-determination
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/366155/health/standard?date=2019-12-28

Robbed and Scared

The nursing home failed to implement its policy for residents' "Rights – Theft and Loss" and protect a resident from being financially abused.

A resident was "able to understand and understood others" and was totally dependent on a one-person physical assist for dressing, eating, personal hygiene, and bathroom use (based on MDS assessment).

The resident's bank card was used to purchase food for various staff and CNA 1 ordered food to be delivered to her (CNA 1) home address without the resident consent.

The deficient practice resulted in a total of $678 used from the resident's bank account to purchase unauthorized food from various online vendors and left the resident "feeling sad and scared of retaliation for speaking up."

The nursing home's investigation confirmed the "financial abuse" the resident sustained from CNA 1 who would be terminated from employment.

In an interview with the Social Services Director, the resident stated that upon checking his bank account, he noticed the amount went from $800 to $400 and did not know where the money was going to.

The written statement indicated CNA 1 went to apologize to the resident and stated "I have something to tell you, I've been taking money off your card. I did not want to tell you because I did not want to lose my job." The statement indicated CNA 1 gave $100 to the resident and would give the resident another $100 after getting paid. The resident "felt something in her heart" when CNA 1 reported this to her.

The resident confirmed she gave her card to CNA 1 on several occasions to order her food online but was not aware CNA 1 was taking money without her permission. The resident stated she was not aware staff was ordering food for themselves and added, "there were times I would offer, but not all the time."

The resident stated, "she was scared to say something and did not want to be treated differently and felt sad the staff took advantage of her kindness."

The Administrator stated that the staff members were aware of the policy that indicated that they are not allowed to take money or gifts from residents.

When interviewed, CNA 1 stated she "knew what she did was not right."

Name of Nursing Home	Colonial Care Center / Provider ID: 056043
Address	1913 E. 5th Street, Long Beach, California
Date investigation completed	April 22, 2021
Type of deficiency issued	F602 – Free from Misappropriation / Exploitation
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/056043/health/complaint?date=2021-04-22

Gaslighting After Credit Card Theft

The nursing home failed to protect a resident from misappropriation of property by staff resulting in a resident experiencing financial and identity theft and financial hardship leading to psychosocial harm.

The Administrator stated that the resident's belongings were secure in her bedroom in her stand next to her bed and clothes in the closet when she was transferred to the hospital on a Wednesday. On Saturday morning the resident's belongings were to be picked up by her family so the Housing Supervisor (V10) asked Housekeeper (V8) to pack up resident 1's bedroom on the same day to prepare for the pickup.

The Administrator stated that the resident notified LPN 13 that on Saturday evening her debit card was used by someone at the nursing home (after noticing unauthorized charges on her account). She added that LPN 13 reported that the resident called again and reported that her daughter picked up her purse and used a debit card at a restaurant. This false statement made the resident very angry and upset. She said that she is the victim of theft and the nursing home tried to make it appear to the police that she was not in her right mind; making up an imaginary daughter to cover up what had been done.

The next day LPN 13 informed the Administrator that the police were at the nursing home and that the resident reported to police that her card was stolen and that she did not have a daughter. Video footage from local businesses showed Dietary Aide/Maintenance Staff (V9) using the resident's credit cards.

The Administrator stated she believes when Housekeeper (V8) packed up the resident's bedroom, she found the resident's purse and gave it to Dietary Aide/Maintenance Staff (V9). Housekeeper (V8) and Dietary Aide/Maintenance Staff (V9) were related. V9 is V8's son. Police investigation revealed V8 did remove the resident's purse from her bedroom and V9 obtained the cards and used them.

The resident was reluctant to take the surveyor's call for fear of retaliation from the nursing home and because the nursing home had already made a false report to law enforcement on her behalf, and she wasn't sure if the surveyor's attempt to reach her was another attempt by the nursing home to trick her.

The resident stated she was going through hell because of her stolen purse. She stated that she can't afford to replace the following stolen items: expensive earbuds, prescription medication, identification cards, and every credit card she had. She added that her Church had to assist her financially because she could not acquire the items she needed. The resident stated that while all this is going on, she is in the middle of trying to learn to walk again. She feels mistreated by the nursing home and because she was in fear for her safety, she refused to return to the nursing home.

The employment of Housekeeper (V8) and Dietary Aide/Maintenance Staff (V9) was terminated. Dietary Aide/Maintenance Staff (V9) was arrested and charged with felony identity theft.

Name of Nursing Home	Generations at Applewood / Provider ID: 145781
Address	21020 Kostner Avenue, Matteson, Illinois
Date investigation completed	January 5, 2022
Type of deficiency issued	F602 – Free from Misappropriation / Exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 3; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145781/health/complaint?date=2022-01-05

"I See Everything. It's Humiliating."

The nursing home failed to ensure: a. resident 19 received care that was provided in a respectful and dignified manner and was free from physical restraints; and b. resident 19 had a plan of care developed with resident-specific interventions to address resistive behavior during peri-care (cleaning private area).

As a result of these deficient practices, resident 19 experienced care that a reasonable person would find humiliating, embarrassing, and distressing. In addition, resident 17 experienced psychosocial distress after witnessing staff holding down her roommate (resident 19) and forcing care.

Resident 19 was severely cognitively impaired (BIMS score of 0 out of 15), paralyzed on one side of her body, and required extensive assistance from staff for ADLs and extensive to total assistance for bed mobility. CNAs stated the resident rejected care by pushing away staff, pinching, and scratching them.

During an interview, resident 17 (cognitively intact; BIMS score of 14 out of 15) stated the CNAs were extremely rough with resident 19. Resident 17 stated, "They throw resident 19 around like a rag doll from the resident's bed to the wheelchair and back to the bed." Resident 17 added, "They make her cry."

Resident 17 stated she was afraid to name the CNA who had done this to her roommate because the CNA had a lot of friends, and the other CNAs did what she told them to do. She stated that she reported the concern to the Administrator but did not want anyone to know she had reported it. Resident 17 stated she reported it because she "couldn't take seeing what was done to her roommate any longer." Resident 17 began to cry, sobbed, and asked for confidentiality. Resident 17 was aware confidentiality would be difficult to maintain after she reported her concern to the Administrator, but she wanted to continue the interview because it was important and serious. She added she was afraid of CNA 40 and of retaliation.

Resident 17 stated that CNA 40 "is so rough" while providing care for resident 19 as she "pushes and pulls" her in bed. She stated CNA 40 would tell CNA 30, "You don't have to be gentle with her, she doesn't understand and can't say anything." She said that the CNAs never pull the curtain and, "I see everything. It's humiliating." Resident 17 said that she cried often when thinking about resident 19's care. She stated, "The way she is treated...it's really terrible what they do to her."

CNA 30 stated that using a towel to restrain resident 19's right arm was used to prevent the CNAs from getting injured by pinches and scratches while the resident resisted care and to avoid resident's bruises. However, the Director of Nursing stated that using a bath towel to restrain a resident refusing care was unacceptable and inappropriate. CNA 42 stated that such restraint would make her feel, "Awful. Mistreated." CNA 45 stated she would feel, "Traumatized. I'd be upset, scared, mad." A nurse stated, "She would feel terrified." Another staff member said, "It would give me nightmares."

Name of Nursing Home	Valle Vista Post Acute / Provider ID: 055500
Address	1025 W. Second Ave. Escondido, California
Date investigation completed	May 24, 2022
Type of deficiency issued	*F604 – Right to be Free From Physical Restraints **F656 – Comprehensive Care Plans
Severity level	*Actual Harm; **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055500/health/complaint?date=2022-05-24

"I Am Not Saying More"

The nursing home failed to: a. protect resident 1 from verbal abuse. Verbal abuse occurred when a staff person screamed at resident 1 and called her a liar and the nursing home failed to take immediate action to protect resident 1 from further abuse; b. ensure allegations of abuse/neglect were reported to the Administrator and State Agency within two hours as required for resident 1; c. ensure a thorough investigation was completed and adequate protection provided to ensure resident 1's freedom from abuse.

Resident 1 was cognitively intact (based on MDS assessment) and dependent on staff for bed mobility, transfers, locomotion on the care unit, dressing, toileting, and hygiene.

During an interview with Social Worker A, resident 1 stated she loves all the girls except one who she did not get along with. She added that a staff member had screamed in her face and called her a liar. Resident 1 went on to say that she did not want her to do anything about it for fear of retaliation, adding that if she said too much, the staff person might yell at her more. Following this allegation, Social Worker A spoke to Social Worker B and RN B about the allegation, but no further action was taken.

Social Worker A's interview with nurse aide (NA) B indicated that on Christmas Eve resident 1 was crying because NA A was rude and mean. Resident 1 got off the bed pan and still had to go. NA A said, "I am not dealing with her." NA B answered resident 1's call light and resident 1 said she had an accident because NA A wouldn't bring her the bed pan. NA B has reported it to RN A, but nothing was done.

That same evening, RN A emailed the Director of Nursing (DON) and Social Workers A and B indicating NA C told RN A that resident 1 does not want NA A in her bedroom. Resident 1 did not tell NA C and RN A why. It was not until four days later that the DON instructed NA A not to go into resident 1's bedroom during the investigation. NA A stated that at that point, she had already been there 2-3 times.

During an interview, when asked how she was treated by staff, resident 1 stated, "I talked to someone about it and that just caused trouble and I am not going to cause trouble." When asked if a staff person yelled at her, resident 1 stated, "I will not answer that. I've prayed that she finds happiness and completeness." The resident added, "My condemning her is my fault. I am not saying more." About an hour later, resident 1 confirmed that she was referring to NA A. During an interview, NA A denied the allegations.

A week after the abuse allegation, RN A stated, "I didn't think there was physical harm, so I didn't report it." RN A didn't think any abuse occurred. The Administrator stated that he first learned of the abuse allegation four days after it was made. He added, "I completely missed it." Social Worker B stated the Administrator should have been notified about it as soon as possible. She added, "It was my bad."

Name of Nursing Home	St Johns on Fountain Lake / Provider ID: 245635
Address	1771 Eagle View Circle. Albert Lea, Minnesota
Date investigation completed	January 7, 2021
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F609 – Reporting of Alleged Violations *F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/245635/health/complaint?date=2021-01-07

"This Is My Home. I Do Not Want to Live Here and I Fear Retaliation."

The nursing home failed to ensure staff recognized and promoted residents' individuality for two residents reviewed for allegations of staff treating them without dignity and respect.

This summary addresses only one of these residents due to relevance to fear of retaliation.

Resident 66 was alert and oriented and required extensive two-person assistance for bed mobility and transfer with a sit-to-stand mechanical device.

During an interview, the resident stated during an evening shift, staff D told her she was not going to shower the resident until the resident stated the magic word – please. The resident reported the incident to LPN (staff Q) about staff D not bathing her without the resident saying please.

The resident also reported she told LPN (staff Q) twice about another incident when staff D transferred the resident by herself with the sit-to-stand lift and the resident almost fell to the floor. The resident asked that staff D not take care of her anymore. The resident stated staff D scared her and wondered how many other residents were treated that way.

Additionally, the resident told Social Services Director (staff J) about the allegations. The resident voiced a concern that staff D continued to come to her bedroom to give out snacks. The resident learned from other nurse aides that staff D talked about how the resident was rude.

The resident stated, "This is my home. I do not want to live here and I fear retaliation."

The Director of Nursing Services stated he had heard about the allegations and was aware of resident 66's complaints with staff D but did not choose to investigate these issues.

Name of Nursing Home	Columbia Crest Center / Provider ID: 505320
Address	1100 East Nelson Road, Moses Lake, Washington
Date investigation completed	November 8, 2018
Type of deficiency issued	F550 – Resident Rights
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/505320/health/standard?date=2018-11-08

"I Don't Want to Talk Anymore."

The nursing home failed to follow their abuse policy and procedures to prevent residents from being the subject of verbal abuse, sexual abuse, and intimidation from staff members (V31, V20, V33). This applies to seven sampled residents and has the potential to affect all 61 residents in the nursing home.

During the Survey Resident Council Meeting, residents voiced concerns regarding direct care staff members. The residents initially spoke freely during the group interview, but then two residents wished to remain anonymous because they were afraid of retaliation, as the subjects of the concerns being voiced were related (Nurse V33 is the mother of CNAs V20 and V31) and were known to work different shifts.

Anonymous resident 2 said, "CNA V31 is a relative of CNA V20 and Nurse V33 and never gives help when I need it. One time, CNA V31 handed me a diaper, told me they had showers to do and walked out of the room. I felt humiliated because I am not able to change or clean myself up, and I felt that is what she (CNA V31) expected me to do."

Resident 54 stated, "I witnessed CNA V20 tell my roommate (resident 49) to shut the f*** up. We told the Administrator and the Charge Nurse, and they didn't do anything about it. And we must see him (CNA V20) every day. He keeps working in our room. His mother (V33) is a Nurse that works here."

Resident 49 had high level of cognitive functioning (BIMS score of 14 out of 15).

During an interview, the resident stated that a couple of weeks ago he had a verbal altercation with CNA V20. He said that he reported it to "the lady who runs this establishment." She said she'll talk to him (CNA V20) and his mother (Nurse V33). The resident became increasingly irritated with the interview, sat up visibly angry and said, "Now that you are asking me and bringing this up again, what am I supposed to do when you leave? I still must live here. I don't want to talk anymore." The surveyor agreed to come back to speak with the resident later in the afternoon. When the surveyor returned, she/he asked the resident, "How do you feel about your interaction with CNA V20?" The resident stated, "I feel upset." The resident indicated that he feels scared and at risk of retaliation.

The surveyor confirmed that one of the actions the nursing home took to remove the Immediate Jeopardy determination was that it terminated the employment of CNA V31, CNA V20, and Nurse V33.

The nursing home also stated, "Resident Council will be held to ensure residents understand the reporting process, have access to facility's hotline and the Administrator. Residents will be notified that retaliation by staff will not be tolerated, and staff will be disciplined up to and including termination."

Name of Nursing Home	Aperion Care Hillside / Provider ID: 145996
Address	323 Oakridge Ave. Hillside, Illinois
Date investigation completed	April 14, 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145996/health/standard?date=2022-04-14

No Eating, No Church

The nursing home failed to promote self-determination for two residents (54 and 16) when staff failed to help them shave at least every other day, a choice about aspects of life they deemed significant and have those preferences care planned. The nursing home also failed to ensure residents who were unable to carry out their own activities of daily living received the necessary services to maintain good personal hygiene when staff did not provide appropriate care of facial hair for resident 54, clean fingernails for resident 7, and provide oral care for resident 59.

This summary focuses on resident 54 who was "cognitively able to make daily decisions" (based on MDS documentation). It was very important for the resident to attend Church activities and practices.

During an interview, resident 54 was in his/her bedroom, seated on his/her bed with a table with two open Bibles in front of him/her. The resident had a full, gray, black and white "goatee" that ran down from both sides of his/her lips down to and under his/her chin at least [LENGTH REDACTED] of an inch long.

The resident said if he/she did not eat enough (or what the nurses thought was enough), they would keep him from going to Church. He/she added that he/she ate all he/she wanted and thought he/she weighed enough. The resident had a ride to get to Church and back to the nursing home.

The resident felt a lot of conflict and "over-powerment" (sic) from the nurses and did not want them to retaliate because he/she said something. If he/she did not do things the nurses' way, he/she could not do what he/she wanted to do. He/she was afraid of the nurses.

During another interview, the resident said that he/she had gotten a shower this morning and asked to be shaved but staff would not shave him/her because they were too busy.

The resident planned to go to Church this evening but did not like going to Church with chin whiskers. While rubbing his/her hand over his/her chin, he/she said, "it is embarrassing to have these like this."

On two days during subsequent weeks, the resident was observed to have a full "goatee" of facial hair. The resident stated that he/she used to shave the whiskers every day and would like that now.

LPN A stated that staff had not shaved the resident because the resident did not ask to be shaved.

The Director of Nursing (DON) stated that chin whiskers should be removed any time a resident wants them removed. The DON added that chin whiskers should be removed with every shower and that a resident should not have to ask more than once to have the chin whiskers removed.

Name of Nursing Home	Eastview Manor Care Center / Provider ID: 265730
Address	1622 East 28th Street, Trenton, Missouri
Date investigation completed	May 20, 2021
Type of deficiency issued	F561 – Self Determination F677 – ADL Care Provided for Dependent Residents
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/265730/health/standard?date=2021-05-20

No Food for You

The nursing home failed to: a. protect residents from abuse by staff members for resident 10. This failure caused ongoing feelings of resident 10 being scared and had the potential to affect all residents in the nursing home; b. implement the nursing home's policy to protect resident 10 from abuse; c. report allegations of abuse or mistreatment, and the results of all investigations to the State Survey Agency for resident 10; and d. promptly investigate, prevent, and correct all allegations of abuse for resident 10.

During an observation on a Monday at 9:04 AM, resident 10 told staff member E that she had been mistreated three days earlier when she was forced to stay in bed. She stated she had woken up and wanted to get out of bed, and staff members G and O told her, "No." She stated that staff members G and O told her she had to stay in her bed and that she was not going to get any dinner. Staff member E told resident 10 he would fill out a grievance and inform staff member B.

Later that day at 1:32 PM, resident 10 stated staff members G and O told her they were not going to get her up after her nap and they were not going to bring her supper. Resident 10 said she was scared, and she had called her son and told him about this when it happened. The resident stated her son had to call the nursing home to get her supper.

The following morning at 7:30 AM, resident 10 was sitting in the hall across from the nursing station. The resident said that staff members G and O were there and she was scared. She added that staff members E and B had not talked to her yet. During an interview at 8:15 AM on that day, staff member B stated resident 10 told her yesterday about the incident. She stated resident 10 told her the two staff members would not let her get up. Staff member B said she was going to talk with staff members G and O that day as they had not been on shift. She stated the nursing home had not started the investigation.

During an observation on the same day at 8:24 AM, resident 10 was sitting in the dining room finishing her breakfast. Staff member O was in the same dining room assisting another resident with her meal. Four minutes later, resident 10 stated she was afraid that staff members G and O were going to retaliate against her because she had said she had been mistreated.

The nursing home failed to protect resident 10 from alleged abuse. The nursing home was notified of the allegation on Monday at 9:04 AM but failed to act on the allegation and it allowed staff members G and O to work with resident 10 during the next day without an investigation or interviewing resident 10 or other residents on the unit about abuse. Resident 10 continued to voice to the surveyor that she was scared.

Name of Nursing Home	Continental Care and Rehabilitation / Provider ID: 275103
Address	2400 Continental Drive, Butte, Montana
Date investigation completed	July 21, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/275103/health/standard?date=2021-07-21

"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

"Don't You Ever Call and Tell Someone I Am Not Doing My Job"

The nursing home failed to recognize and prevent abuse and neglect and failed to immediately protect residents after allegations of abuse and neglect were reported to staff for three residents (55, 157, 158). The neglect of resident 55 rose to the harm level when she voiced concerns about fear of retaliation. The nursing home also failed to implement their policy and procedure to protect residents from abuse and to thoroughly investigate and report allegations of abuse and neglect to the State Agencies for 3 residents.

Resident 158 had no cognitive impairment (BIMS score of 15 out of 15) and required extensive assistance of one staff member with activities of daily living for bed mobility, transfers, dressing, and toileting.

Grievance Investigation revealed that on a Sunday at 3:00 PM, resident 158 turned on the call light. She needed a nurse to look at her ostomy bag because it was leaking. At the same time, resident 158 felt her blood sugar drop. At 3:30 PM, LPN 142 came and checked her blood sugar. It was 95. LPN 142 told the resident to eat a couple of more M&Ms but did not check the ostomy bag. LPN 142 told the resident she would return later. The resident was concerned about her bag. A friend of resident 158 called the nursing home and said that resident 158 needed help. At 6:58 PM, LPN 142 returned to the bedroom and yelled, "I told you I was coming back. Don't you ever call and tell someone I am not doing my job."

Resident 55 had no cognitive impairment (BIMS score of 15 out of 15) and required extensive assistance of one staff member with bed mobility, transfers, toileting, and personal hygiene.

Grievance Investigation revealed that at 3:00 AM resident 55 called for CNA 143 because she needed to go to the bathroom. CNA 143 told the resident she was making rounds and she would get her when it was her turn. CNA 143 came back at 5:28 AM (the buzzer went off at the desk) and asked her what she needed. Resident 55 told her she needed help going to the bathroom. CNA 143 told her to roll over so she will change her pad. Resident 55 said "no" and that she needed help going to the bathroom. CNA 143 told her that patients could not get up to go to the bathroom at night. The resident said, "Then I will take myself." CNA 143 left the bedroom and complained to the nurse that she was refusing to cooperate. LPN 144 came in and asked if she said she was going to walk to the bathroom herself. The resident said, "No. I wouldn't do that." The resident sat on the edge of the bed, still neither LPN 144 nor CNA 143 helped her to the bathroom or helped her get her leg back in bed. The resident was finally able to pull her leg back into the bed. No one helped her to the bathroom until 7:00 AM shift came. The resident was concerned for fear of retaliation. When the day shift came, she told the CNA, "My diaper will probably drag to the floor, it was so full" and that this had happened every night since she came. They come in and expect her to use the pad. The Director of Nursing (DON) communicated to CNA 143 that residents should get up to the restroom anytime they need to go. The DON stated that the incident "could be neglect."

Name of Nursing Home	Desoto Healthcare Center / Provider ID: 255296
Address	7805 Southcrest Parkway, Southhaven, Mississippi
Date investigation completed	April 7 2019
Type of deficiency issued	F600 – Freedom from Abuse, Neglect F607 – Develop/Implement Abuse/Neglect, etc. Policies F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Actual Harm
Overall Quality Star Rating: 3; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/255296/health/standard?date=2019-04-07

"You Reported Me"

The nursing home failed to: a. keep residents 52 and 125 safe and free from abuse; b. report allegations of abuse for residents 125 and 89 to the appropriate agencies; and c. complete a thorough investigation for allegations of abuse for residents 52 and 125.

During the survey, concerns were brought to the survey team that involved resident 52 and resident 125.

According to the nursing home's investigation, a meeting with the Director of Nursing (DON) and resident 52's family member, the resident's family reported multiple concerns, one in which staff made fun / laughed at the size of resident 52's genitalia and would pick it up and lure others to come over to see the resident's genitalia. The resident identified the employee as staff 14.

During an interview held approximately four months later, the DON and Corporate Nurse (CN) 1 stated that staff 14 no longer works at the nursing home. The DON further stated that staff 14's employment was terminated due to an incident in which staff 14 retaliated against resident 125.

Review of the nursing home investigation revealed that resident 125 completed a concern form regarding an incident that involved staff 14. According to the investigation, staff 14 was very nasty, confrontational, and disrespectful. The investigation indicated that staff 14 went into resident 125's bedroom, closed the door, and asked another staff to stay in the bedroom as a witness. Staff 14 then proceeded to confront the resident (for submitting a grievance form), became very aggressive, got into the resident's face, and said, "You reported me." Staff 14 wanted to know what resident 125 told administration. According to the investigation, the DON was made aware of the incident via a letter submitted by staff 15. Resident 125 told staff 15 that s/he was fearful of staff 14 and repeated the events of the incident.

An interview was conducted with CN 1 and s/he stated that the nursing home was able to substantiate resident 125's concerns and that staff 14's employment was terminated as a result.

CN 1 was asked at 11:00 AM if the nursing home reported this incident to the Board of Nursing and s/he stated, "No." She/he stated that the Board of Nursing was notified later that day at 4:31 PM.

Name of Nursing Home	Autumn Lake Healthcare at Glen Burnie / Provider ID: 215266 [Alternative name: Glen Burnie Health and Rehabilitation Center]
Address	7355 Furnace Branch Road East, Glen Burnie, Maryland
Date investigation completed	June 15, 2018
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
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/215266/health/standard?date=2018-06-15

"If You Fall, I Won't Let You Up"

The nursing home did not ensure an allegation of abuse of resident 4 was reported to the Administrator and the State Agency in a timely manner.

The nursing home's 5-day investigation, submitted to the State Agency stated that resident 4 told staff that night shift CNA C whispered in her/his ear: "If you get up, I hope you fall."

The report stated resident 4 was teary-eyed and afraid to say anything due to retaliation from staff.

After CNA F notified Registered Nurse (RN) E that resident 4 reported an allegation of abuse earlier that morning, an investigation contained a statement from RN E that indicated RN E spoke with resident 4 and her/his spouse. The resident stated that at 5:20 AM s/he asked CNA C to help her/him use the bathroom and get dressed for the day. The resident said that her/his request was denied multiple times before CNA C whispered in resident ear, "I hope you fall."

Following the incident, the resident called her/his spouse due to fear of CNA C.

During an interview with the surveyor, CNA F stated that resident 4 seemed "distraught and out of sorts" on the morning after the night incident.

The Director of Nursing investigated the allegation. S/he interviewed CNA C who stated that resident 4 twice activated her/his call light to get out of bed. CNA C stated s/he denied the resident's request both times because it was too early to get up. CNA C also stated that s/he told the resident in a joking manner, "If you fall, I won't let you up."

The Administrator and the Social Services Director verified that the resident's allegation of abuse was not reported to the State Agency within 24 hours of discovery.

CNA C was suspended pending the outcome of the investigation and her/his employment was subsequently terminated.

Name of Nursing Home	Good Shepherd Services Ltd / Provider ID: 525509
Address	607 Bronson Road, Seymour, Wisconsin
Date investigation completed	October 26, 2021
Type of deficiency issued	F609 – Reporting of Alleged Violations
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/525509/health/complaint?date=2021-10-26

"She Was Trying to Punish Everybody"

The nursing home failed to protect resident rights to be free from mental abuse as evidenced by staff who were witnessed speaking inappropriately to residents. This failure resulted in residents expressing feelings of fear and sadness. This failure applied to four residents (R3, R4, R5, & R6).

The Assistant Director of Nursing (ADON) stated she/he was notified that yesterday the Assistant Psychiatric Rehabilitation Services Coordinator (APRSC) V13 was called to the care unit to find out why the residents were having so many behaviors that day and to see what was going on. The ADON stated that APRSC V13 "became verbally aggressive towards the residents."

The Central Supply Manager (V11) witnessed APRSC V13 "screaming at the top of her lungs!" S/he heard her saying, "I will shut down the whole seventh floor smoking down and no one will smoke. I've done it before and I will do it again." V11 added, "She was talking to the residents like they were her children." V11 stated, "I went to my administrators V6 and V14 and told them what happened."

V13 was sent home immediately. The managers interviewed the residents about the incident and found that four residents were affected by it.

Resident 5 said that APRSC V13 was hostile and volatile when she addressed everyone, adding, "I got scared because she said she would shut down everything on the unit. I was scared that I was going to lose my privileges of socializing on the unit and not be able to smoke or be able to use my pass to see my family."

Resident 4 stated, APRSC V13 "came up to the floor saying if the floor gets out of hand again, we would not be able to smoke. She was yelling and screaming. I think V13 would have retaliated. It made me feel sad when she was raising her voice at me. I thought she would punish us all because she said she would. Personally, I got scared the whole day." The resident added, "Some of us look up to the staff and I think we have the right to get treated with respect and dignity. We feel let down because this is a person who we go to when we need something."

Resident 6 shared her/his thoughts about APRSC V13's yelling and threats, "I felt kind of bad because she was going to shut down the smoking. I think she should have done something about the people who were doing it. She was trying to punish everybody. I felt it was unfair."

Resident 3 shared his/her thoughts about APRSC V13's yelling at the residents, "I just ignored her because based on something I say, the staff will stick me with needles and send me out to the hospital."

APRSC V13 was terminated for violating the abuse policy and for verbal abuse.

Name of Nursing Home	City View Multicare Center / Provider ID: 145850
Address	5825 West Cermak Road, Cicero, Illinois
Date investigation completed	July 1, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: Missing data	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145850/health/complaint?date=2021-07-01

"They Would Turn on You Like a Pack of Wolves"

The nursing home failed to maintain a resident's right to privacy during a confidential conversation.

Resident 35 was cognitively intact (based on MDS assessment). During an interview, resident 35 indicated he previously had concerns related to his bath/shower days and really had to fight to get his baths on time, but since he complained, they [unnamed staff members] started treating him poorly and at times "it felt like 4 or 5 of them would turn on you like a pack of wolves, it was hard to say anything without them listening in on him, and making it worse."

Two days later, resident 35 told staff members and the Executive Director (ED) that the aides who just given care to his roommate were "the dirtiest talking women he had ever known." He could not believe the things they said to one another as they cared for his roommate. The ED asked him if he would like to have a private conversation and express his grievance. The resident agreed and they went to his bedroom.

Six minutes later, CNA 27 was observed outside resident 35's closed door. She leaned forward and pressed her ear to the door, stood quietly, and listened. After a few seconds, she left the door but shortly afterwards she returned to resident 35's closed door and pressed her ear to it once more. After she listened for several more seconds, she gave a thumbs up gesture to a CNA standing behind the nurses' station. The ED stated, "Staff should not be listening through closed doors, because all residents had the right to be treated with respect and dignity, which included the right to a private, confidential conversation."

The nursing home also failed to ensure the residents' rights to file grievances without fear of retaliation from staff. This deficient practice had the potential to affect six residents who anonymously complained.

An anonymous resident indicated agency staff were "too rough" and "mean." The resident began to cry and indicated they felt like they had to let things go because it was just part of being in a nursing home. The resident felt it did not do any good to tell anyone, because the facility kept adding more agency staff, and if the residents did tell someone, they would just be treated worse. The resident indicated they knew other residents felt the same way. If residents said anything about it, it just comes back on them.

Another anonymous resident stated LPN 31 brought them medication, but the resident noticed something was off and asked about it. LPN 31 got very upset and told the resident to either take the medication or refuse it. After that, LPN 31 was mean to the resident. One day LPN 31 came up behind the resident, leaned over to give them a hug, but then whispered in their ear, she could beat the s*** out of me, and no one would know how she did it. The resident said, "I was terrified." The resident was afraid to say anything, but finally had to when she noticed multiple medication discrepancies. The resident said she was happy that LPN 31 was not allowed to care for her but was afraid for any residents LPN 31 might work with.

Name of Nursing Home	Majestic Care of Avon /Provider ID: 155338
Address	445 S. County Road 525 E., Avon, Indiana
Date investigation completed	July 25, 2019
Type of deficiency issued	F583 – Personal Privacy / Confidentiality of Records F585 – Grievances
Severity level	Minimal Harm or Potential for Minimal Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/155338/health/standard?date=2019-07-25

Swept Under the Rug

The nursing home failed to thoroughly investigate concerns brought up at a Resident Council Meeting and grievances filed by four residents – resident 84, resident 447, resident 91, and resident 2.

During a Resident Council Meeting, the residents stated that staff were very disrespectful, rude, and nasty with their earbuds in their ears, talking on the phone or to other staff about their personal lives while providing care. Residents felt they were treated as though everyone had dementia, stating they were afraid to complain or file grievances because they feared retaliation.

Resident 84 (cognitively intact based on MDS assessment) stated that during a Resident Council Meeting, the former Administrator said he was going to reduce cigarette shopping for smokers to once a month. The resident said he was upset with this news and asked the Activities Director (AD) for assistance going outside to the smoking area. When he got outside with his wheelchair, the door slammed loudly because of the wind.

The former Administrator came outside and started yelling at the resident saying that he would get him out of the nursing home and that he was going to call the cops on him. The resident told him to leave him alone, but the former Administrator kept yelling at him like he was a child. The resident said that he filed a grievance with therapy staff member (TSM) 1 but he did not hear anything back about it. He added that he felt like the residents did not matter to them and they did not care about them.

An interview with the AD revealed that resident 84 got upset because he worried that he might run out of cigarettes. The AD added that when the resident left the day room, the door slammed shut loudly behind him because of the wind; the resident did not slam it. The former Administrator thought that the resident slammed the door so he went out and told the resident that if he didn't stop, he would put him out on the street and that he would call the police and have him escorted out of the nursing home.

Resident 447 was cognitively intact (based on MDS assessment). An interview with TSM 1 stated that the resident approached him visibly upset and told him that the former Administrator threatened him and told him that he was going to be discharged to a homeless shelter. The resident stated that he was scared, and that the former Administrator would retaliate against him.

The AD was present at the morning meeting in which the former Administrator said that he was going to take care of residents 84 and 447's grievances and investigate them, but the AD said he felt like it was swept under the rug and was not investigated. The AD added that TSM 1 thought there was a conflict of interest because the residents' concern was regarding the way the former Administrator had treated them.

The new Administrator stated the former Administrator should not have investigated the grievances about himself and it should have been submitted to corporate office who was over the former Administrator.

Name of Nursing Home	Carolina Pines at Asheville / Provider ID: 345174
Address	91 Victoria Road, Asheville, North Carolina
Date investigation completed	June 1, 2022
Type of deficiency issued	F585 – Grievances
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/345174/health/standard?date=2022-06-01

"I Am Going to Rip That Thing Off"

The nursing home failed to prevent mental, verbal, and physical abuse from a Registered Nurse (V4) to eight residents (R1, R2, R4, R5, R6, R7, R8, R9). These failures resulted in the eight residents experiencing increased anxiety, crying, and fearfulness, R4 and R5 sustaining physical abuse, and R7 sustaining bullying/disparaging comments regarding her disease. The nursing home also failed to a. immediately remove the alleged perpetrator RN (V4) after allegations of verbal, physical, and mental abuse were made; b. thoroughly investigate these allegations, and c. report these allegations to the state agency for the eight residents. These failures resulted in RN (V4) remaining in the nursing home and working directly with the eight residents, which resulted in these residents suffering continual abuse, fear, retaliation, and bullying from RN (V4). The Administrator and Director of Nursing (DON) failed to immediately act upon and follow-up on numerous physical, verbal, and mental abuse allegations.

Due to the extensive scope of the alleged abuse by RN (V4), only examples are included in this summary. The RN (V4) was described by residents as "very disrespectful," "mean," "very hateful," and "bullying."

Resident 4 had moderately impaired cognition (based on MDS assessment). Service attendant (V5) stated, "Around 6:30 PM, resident 4 was masturbating in the little room connected to the nursing area. RN (V4) went up to resident 4, grabbed his penis, and screamed, "If you don't stop that, I am going to rip that thing off." Resident 4 screamed because the RN (V4) grabbed it so hard.

Resident 5 who is cognitively intact reported that RN (V4) was openly mocking resident 7 at mealtime. Resident 7 has dementia and a repetitive verbal tick where she frequently says, "the-the-the." Resident 5 witnessed RN (V4) mock and repeat this tick to the resident and to other staff. Resident 5 feels that other residents and staff are fearful of RN (V4) and concerned about retribution if they were to report her.

During an interview, resident 5, who at times stood up to RN's (V4) abusive behavior toward other residents, stated, "The CNAs would tell me to watch my back. I was worried every night I lived there that RN (V4) would do something bad to me. I asked that RN (V4) not take care of me, but she still continued to take care of me. I was worried that she would try to kill me by overmedicating me."

Resident 6 was cognitively intact. The resident stated that one day RN (V4) "jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told RN (V4) my feet were bleeding and RN (V4) said,' Good.'" The RN (V4) "then swung me around and threw me on my bed...I feared for my life."

Resident 8 stated, "I am not going to tell you anything about who has been mean to me. If I do not tell, then I do not get in trouble. If I told you what she has done to me, she would just make my life worse."

Name of Nursing Home	Sunset Home / Provider ID: 145800
Address	418 Washington Street, Quincy, Illinois
Date investigation completed	April 28 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F610 – Investigate/Prevent/Correct Alleged Violation F835 – Administration
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 3; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145800/health/complaint?date=2022-04-28

Whispers to Surveyor, "I Am Afraid They Are Going to Retaliate"

The nursing home failed to ensure freedom from abuse for 10 residents. This deficient practice resulted in pain, bruising, humiliation, embarrassment, fearfulness, increased anxiety, frustration, and feelings of being unsafe in the nursing home based on a reasonable person standard for residents with impaired cognition and statements by cognitively intact residents resulting in Immediate Jeopardy to vulnerable residents' health and safety.

Resident 27 had intact cognition and required dependent, two-person assistance with transfers, and extensive one to two-person assistance with bed mobility, dressing, toileting, and personal hygiene.

During an interview, when asked about the care and treatment provided by staff, the resident stated, "CNA F is horrible! He man handles me (is rough) when he dresses me." The resident stated, "You are almost afraid to open your mouth. He is like cruel or mean. I try to say, "Please get my sling" or "Don't forget my sling," and CNA F will say, "I KNOW!!"

During a continued interview, resident 27 reported overhearing CNA I in the next bedroom shouting at resident 50, "You just shut up and grab those things." She also heard CNA I yell at resident 50 and told him if he rang the call light one more time, CNA I would rip the call light out of the wall.

Resident 27 stated CNA JJ is dealing with a lot of frustrations and then she will come in and take it out on me. The resident stated she defecates (poops) on a pad placed underneath her on the bed. When asked why, the resident said it was too much waiting for them to find a sling to get her out of bed. The resident said that recently CNA JJ had put a pad under her (for catching the bowel movement) when resident 27 did not have a bowel movement and she told CNA JJ that she did not have to poop. CNA JJ told her to stay in bed to see if she could (poop) for her. The resident turned on the call light and told CAN JJ she did not have to have a bowel movement, so CNA JJ said, "Then I'll come back when you have a BM." The resident said she stayed in bed all day that day, and since that day CAN JJ would sarcastically ask if the resident had to have a BM. During a repeat interview, resident 27 asked the surveyor to come into her bedroom, to shut the door, and whispered, "I am afraid they are going to retaliate against me."

Resident 50 (intact cognition, BIMS score of 15 out of 15) required one-person physical assistance with dressing, toileting, and personal hygiene and required supervision with transfers. The resident stated that CNA F gets right in my face and says, "Shut the F*ck *p!" The resident added that CNA J has grabbed his right arm causing it to bruise. The resident stated, "I talked to administration, but it seems like (it is) falling on deaf ears. Nothing happens." The resident quietly asked this surveyor to make sure no one was outside the door listening to what he was saying and stated, "CNA F has ears listening on everything." The resident said he was afraid of CNA F and commented that he would normally challenge him (CNA F) but he was [AGE REDACTED] years old and too old to be fighting.

Name of Nursing Home	The Villa at Traverse Point / Provider ID: 235412
Address	2828 Concord St. Traverse City, Michigan
Date investigation completed	July 11 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 1; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235412/health/standard?date=2022-07-11

Threatening Discharge

The nursing home failed to treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life.

Residents were pressured by the nursing home to move from their bedrooms so that opposite sexes didn't share a restroom and to separate sexes by hall. This resulted in residents experiencing anxiety, confusion, and fear of being discharged from the nursing home.

During confidential interviews, resident L stated, "I was moved out of the hall (300) because I am a man, they want only women on that hall and men on another." The resident said, "I was in (a room on hall 300). They came one day and said, 'We're moving you' without any warning. I said, 'No' and the Administrator said he would kick me out, so I moved." The resident added that this happened at 4:00 PM on a Friday. The resident stated that he asked what was the reason for the move? The resident stated they were going to make it (hall 300) an all-women hall. The resident said, "Isn't that discrimination?" They said that men and women can't share the same restroom. I asked them several times to let me ask the Ombudsman about it. Their response was, "We are moving you out." The resident stated that there was no written notice for the move (the Director of Nursing (DON) later confirmed that they told the residents about the move on that same day). The resident stated, "If given time, I could've contacted the [Ombudsman]." The resident added, the [Administrator] "didn't give me time to process it." The resident stated that management did not sit down with the residents as a group about the moves. He said, "They act like we are three years old. They act like they have complete autonomy." Resident J said that resident L stated that it was "against the law" and that "it's prejudice" because of the situation.

Resident A, who said they were sad about the plan to separate residents by sex, said "They say if I don't want to move, I have five days to leave the facility." Resident E said, "They were moving real fast. They moved resident L and resident J on the same day." Resident P stated, "They told me to move that day."

The Administrator stated, "I did not say I would discharge him [resident L] if he didn't move. I said if he would like to move, I would find a place." The DON was asked if resident L was given an option to stay in his bedroom and said, "He had no option to stay in that room. That's where the 5-day letter comes in."

The surveyor noted that the nursing home's reasoning for all-men and all-women halls was not clear. Examples of additional reasons provided by leadership for the moves included: a. there were two confused female residents on hall 300 that were nervous and skittish around males; b. monitoring the whereabouts of residents, which was somewhat related to monitoring thefts; c. wanting hall 200 to be a Medicare only hall; and d. not permitting residents on Medicaid to have a full private bedroom.

In addition, during a Resident Council meeting, residents E, L, M, and N stated they were reluctant to complain about staff in the nursing home because they felt they would be retaliated against.

Name of Nursing Home	Bender Terrace of Lubbock / Provider ID: 676163
Address	4510 27th Street, Lubbock, Texas
Date investigation completed	January 25, 2019
Type of deficiency issued	F550 – Resident Rights
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: No longer available on *Care Compare* website.

Froze In the Moment

The nursing home failed to implement its polices for abuse to prevent an alleged perpetrator CNA 2 from having access to two residents during an ongoing investigation of alleged sexual abuse.

Resident 29 was cognitively intact and always incontinent of bladder (urine) and bowel (stool) functions.

During an interview, Police Officer stated he was called to the nursing home to investigate an alleged sexual abuse against CNA 2, which was reported by both resident 29 and resident 60.

During an interview, resident 29 stated CNA 2 have touched her inappropriately about 15 times in the last three years. Resident 29 stated CNA 2 would put gloves on and put lotion on his gloves and finger me. The resident stated the last time it occurred was three weeks ago when CNA 2 started "playing with me by sticking a couple of fingers up my vagina." She didn't notify the nursing home because she was embarrassed. The resident stated her responsible party notified the nursing home about not wanting a male CNA assigned to her care. The resident was afraid and did not feel safe at the nursing home.

During an interview held three days later, resident 29 stated CNA 2 called her and told her to get together with resident 60 and retract the allegations of sexual abuse made by them because he loved them. The resident stated CNA 2 stated only the two residents could save him from jail and from losing his job. The resident told CNA 2 he should have thought about it before. The resident stated not feeling safe in the nursing home because of what CNA 2 could possibly do to both the residents coming forward about the alleged sexual abuse. The resident stated being afraid of CNA 2 coming back to the nursing home.

During an interview, resident 60, who was cognitively intact (based on MDS assessment), stated that about a month ago, she told CNA 2 she was not feeling good. CNA 2 responded to her, "I am going to come and make you feel good tonight baby." CNA 2 gave her a massage which the resident thought was inappropriate because CNA 2 was rubbing lotion on her legs up to her thighs telling her he had a crush on her and asked if he could kiss her. The resident stated she said "No" because it was inappropriate. She did not report the alleged sexual abuse because she was a prior rape victim and froze in the moment when CNA 2 sexually solicited her. Resident 60 stated she was asked by CNA 2 to drop the allegations of abuse because he could lose his job. The resident stated she was afraid CNA 2 would come back and attack her and resident 29 because his job was at stake and there was a chance for him to go to jail. The resident stated she was afraid of retaliation because CNA 2 felt attacked.

CNA 2 denied the sexual abuse allegations and stated he called resident 29 and 60 to clarify why they made false sexual abuse allegations and called resident 29 again to ask her to drop the allegations because they were not true. CNA 2's employment was terminated due to his interference with the investigation.

Name of Nursing Home	Los Palos Post-Acute Care Center / Provider ID: 055527
Address	1430 West 6th Street, San Pedro, California
Date investigation completed	July 2, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055527/health/standard?date=2021-07-02

Sexual Abuse Followed by Threat of Retaliation

The nursing home failed to: a. ensure three residents were free from sexual abuse from CNA 1; b. identify CNA 1's inappropriate sexual behaviors observed and exhibited prior to the alleged sexual abuse to residents 1, 2 and 3, and immediately implement safeguards to prevent further potential sexual abuse.

The deficient practice resulted in non-consensual sexual abuses to these three residents by CNA 1.

Resident 1 was moderately impaired in cognitive skills (based on MDS assessment) and required extensive assistance for bed mobility, transfers, toileting, and personal hygiene.

A review of resident 1's Progress Notes indicated that the resident alleged that on a Saturday at 8:00 PM, two staff members (unidentified) performed inappropriate sexual actions and told him not to speak regarding the incident. The notes indicated the curtains were closed and a staff member (unidentified) pulled his pants down and touched the resident's hands and offered to participate in oral sex and anal sex. The notes indicated the resident denied participating in the activity.

A review of Police Narrative indicated: a. at approximately 8:00 PM that day, CNA 1 and CNA 2 entered resident 1's bedroom and CNA 1 exposed his buttocks and asked resident 1 if he wanted to have sex while CNA 1's buttocks were exposed; b. CNA 2 threatened the resident with retaliation if resident 1 said anything about the incident and that there were numerous victims (unidentified number).

During an observation and interview, resident 1 stated that on that same day at around 8:00 PM or 9:00 PM inside his bedroom, CNA 1 showed him his butt, touched his arm in a sexual manner, and asked him for sexual favors. Resident 1 stated he was afraid because CNA 1 and CNA 2 told him not to say anything and stated they grabbed his right leg causing him to have pain.

During an interview, CNA 3 stated she had been working at the nursing home for about nine years and CNA 1 tended to flirt with men since CNA 1 started working at the home. She stated CNA 1 would pull his pants down and would say, "Look at my butt" to other male staff and CNA 2 would laugh.

Resident 2 and resident 3 were both cognitively intact (based on MDS documentation). Police Narrative indicated that CNA 1 also exposed his buttocks to and fondled resident 2's genital area (testicles) on two occasions and that CNA 1 also fondled resident 3's genitals (penis and testicles) on two occasions.

The Director of Nursing stated he believed the three residents' statement and felt the allegations were substantiated. CNA 1 was suspended on Monday (two days after the sexual abuse of resident 1) and could return to work on Friday (the same week).

Name of Nursing Home	Royal Palms Post Acute / Provider ID: 055899
Address	630 W. Broadway, Glendale, California
Date investigation completed	October 21, 2020
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055899/health/complaint?date=2020-10-21

Refusal to Speak and Provide Care

The nursing home failed to ensure three residents were free from fear of staff retaliation.

The three residents were cognitively intact (based on MDS assessment).

An Incident Report submitted to the Department of Health indicated: Resident 325 states that CNA 5 was rude. The nursing home's investigation indicated that two residents stated CNA 5 was rude and hateful.

Confidential interviews conducted during the survey revealed:

Resident 325 indicated CNA 5 was reported to the management staff a while back and since that time, CNA 5 has been rude, vindictive, and refused to speak to him or provide care to him. CNA 5 would answer his call light and stated, "Your light is on, what do you want?"

Resident 325 indicated a fear of retaliation from CNA 5 regarding the reported concerns of having been rude.

Resident 350 indicated CNA 5 was rude and ignored the resident. The resident was fearful of retaliation.

Resident 375 indicated in a written statement that CNA 5 was rude and spoke hatefully. The resident indicated a fear of retaliation.

The nursing home's Abuse Prohibition, Reporting and Investigation Policy indicated, among others:

Provide each resident with an environment that is free from abuse and neglect. This includes but is not limited to verbal abuse, physical abuse, mental abuse, and protection of residents from retaliation.

The nursing home's Resident Concerns and Grievances policy indicated:

Resident concerns/grievances occurring during the resident's stay shall be responded to promptly and without fear of reprisal or discrimination.

Name of Nursing Home	Beech Grove Meadows / Provider ID: 155072
Address	2002 Albany Street, Beech Grove, Indiana
Date investigation completed	October 16, 2019
Type of deficiency issued	F585 – Grievances
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/155072/health/standard?date=2019-10-16

"No Matter What You Say, They Will Make You Pay for It"

The nursing home failed to ensure each resident has the right to voice grievances to the nursing home or to other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal for seven residents in the confidential group interview, one individual interview (resident 1), and six additional residents and/or representatives.

Seven residents reported fearing retaliation from staff if they reported care concerns, regardless of who they reported it to. The failure could place the residents at risk of being fearful of voicing grievances and a decreased quality of life.

During a Confidential Group Interview, seven residents stated if the residents questioned a staff member or tried to tell them how they wanted something done, the staff member would shut down and leave. The residents said if that happened, the staff would make the residents wait longer.

One resident said, "No matter what you say, they will make you pay for it." All the residents present at the meeting agreed with the statement. The residents initially said there was no staff they felt safe with, and later identified one.

When the surveyor pointed out that the residents did not voice these concerns in the survey, the residents stated, "It got smooth because we got tired of [OBSCENITY]ing, they won't talk to us, so we clammed up."

Grievance/Complaint Reports documented: Resident 12's family reported the family asked a CNA why the resident had not been showered, had his teeth brushed, or had his brief changed (the brief was soiled). The aide did not have a clear response as to why, but she had an attitude toward the family. The aide made the comment, "You better not call state (regulatory services) or it will be worse for the residents."

Review of the nursing home's policy indicated,

"Residents, family, and resident representatives have the right to voice or file grievances without discrimination or reprisal in any form, and without fear of discrimination or reprisal of any form."

Name of Nursing Home	Focused Care at Hogan Park / Provider ID: 675910
Address	3203 Sage Street, Midland, Texas
Date investigation completed	May 11, 2022
Type of deficiency issued	F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/675910/health/complaint?date=2022-05-11

Staff "Would Get Back at Them"

The nursing home failed to have grievance forms accessible for all residents and educate residents and review the grievance policy and procedures on how to file a grievance, for 15 sampled residents attending the Resident Council Group Interview Meeting, conducted as part of the survey process.

During a Resident Council Interview, the group of residents stated:

- Residents could not anonymously get a grievance form
- Residents were concerned about staff members knowing they were getting a grievance form
- Grievance forms were at the nurses' station and they are too high up for the residents to reach
- Residents did not know how to file a grievance
- Residents did not know if there was a grievance official

Twelve of the 15 residents present did not feel a resident or family group could complain about care without worrying that someone would get back at them.

Residents said retaliation included not getting ice water, not getting medication timely, not getting call light response in a timely manner, and not getting the help needed.

During the Resident Council Interview, resident 2 said that he/she observed a staff member being mean to another resident and reported the incident. The staff member asked the resident if he/she reported the incident and the resident responded, saying that they reported the incident.

The staff member would no longer respond to the resident's request and would not provide ice water or anything. Supervisory staff removed that staff member from caring for him/her.

During the same Resident Council Interview, resident 109 said he/she asked a staff member for a washcloth. The staff member was doing something on his/her phone and did not respond. The resident stated he/she was too afraid of what would happen if he/she reported the incident.

Name of Nursing Home	Polaris Health & Wellness of Carmel Hills / Provider ID: 265727 [Alternative name I: Redwood of Carmel Hills; *In CMS archive] [Alternative name II: Carmel Hills Wellness & Rehabilitation; *Duplicate investigation report]
Address	810 East Walnut, Independence, Missouri
Date investigation completed	March 9, 2020
Type of deficiency issued	F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/265727/health/standard?date=2020-03-09

"Put Through Hell" for Reporting Medication Error

The nursing home failed to thoroughly investigate a potential allegation of abuse of resident 24 by an agency nurse.

Resident 24 was cognitively intact (BIMS score of 15 out of 15) and legally blind.

During an interview, resident 24 said that there was an issue with a nurse about a month or a month and a half ago. The resident said that the nurse only brought the resident one blood pressure pill but that they should receive three of that specific medication. Resident 24 said that they told the nurse this was not correct dosage and when the nurse didn't respond, the resident told another nurse the next day. That nurse told Unit Manager 1, who notified the nurse that the resident gets three of that medication.

The resident said that after reporting the medication concern, the nurse put them through hell. The resident said the nurse accused the resident of being racist and said she would bring in a witness when administering medications. The resident said that when asking about blood sugar levels, the nurse would tell them to read it from the screen, but the resident had difficulty reading due to being legally blind. The resident said that these concerns were reported to the Activity Director, who filled out a grievance. Resident 24 said that the nurse no longer provides care to him/her.

The Director of Nursing (DON) confirmed the nurse was reassigned to different units after the incident.

The Activities Director confirmed that the resident told her about these allegations. She stated that she filled out a grievance form and gave it to Social Worker 1. She also reported it to the DON.

Review of a grievance/concern form completed by the Activities Director indicated that the resident has reported that they were accused by the nurse of being racist towards her. The resident stated since the nurse's accusation, the nurse has brought a witness into the resident's room when she gives the care and has refused to give the resident the results of the resident's blood pressure, blood sugar, or temperature.

The nurse denied the resident's allegations.

Name of Nursing Home	Country Center for Health & Rehabilitation / Provider ID: 225332
Address	180 Low Street, Newburyport, Massachusetts
Date investigation completed	August 25, 2022
Type of deficiency issued	F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225332/health/standard?date=2022-08-25

The Silent Treatment

The nursing home failed to ensure each resident has the right to voice grievances to the nursing home or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal, for nine residents in the confidential group interview.

Nine residents reported fearing retaliation from staff if they reported care concerns, regardless of who they reported it to. Five residents in the group reported experiencing retaliation by the staff ignoring them, giving them the silent treatment, not giving them pain or other medication, or calling them a liar.

During the confidential group interview, nine residents said the aides went to help on another hall for an hour or longer, deliberately ignoring their own assigned hall. The residents said if they complained, the staff would leave us alone because the staff knew who complained.

One resident attending the confidential group interview said she took a picture of a staff member ignoring her for a personal phone call so the administrative staff would not call her a liar. She said later that night, the nurse intentionally completely ignored her and the next day the picture was gone.

Another resident said a medication aide was rarely on time and "they got your meds when you get your meds." The resident said if they complained they won't get my meds, "I won't get my meds today."

The residents unanimously said not receiving or being late with medications was the worst on the 2:00 PM to 10:00 PM shift. The residents said that if they complain about it, the aides would not answer their call lights, save you for last, ignore the resident, or give the resident the silent treatment.

Staff A stated that some of the delays with medications was because of being short staffed and some was deliberate. Staff A added, the residents are afraid to say anything because of how Administration dealt with complaints.

Staff A said that the residents feel they can't complain about someone because the administration will go straight to that person. Staff B said complaints about staff should be done in a manner the aide does not know who complained but it was probably not done that way. In contrast, the Director of Nursing (DON) said they did not tell staff who complained about them. Staff C said, "If there is a complaint against an aide, the administrative staff would just say 'a resident said' and what the complaint was." Staff C said, "The staff were not stupid and could figure it out."

The DON and Staff B stated that the residents had not brought concerns of retaliation to them.

The Administrator and the Area Director stated, "Retaliation is not allowed and we just don't tolerate it."

Name of Nursing Home	Big Spring Center for Skilled Care / Provider ID: 676380
Address	3701 Wasson Road, Big Spring, Texas
Date investigation completed	September 13, 2018
Type of deficiency issued	F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 2	

Investigation report: No longer available on *Care Compare* website.

"If I Do Speak Up, She Will Retaliate Against Me"

The nursing home failed to protect and ensure residents were free of mistreatment for two residents.

Resident 39 had "intact cognition," vision impairment (observed to be blind), and required moderate care from staff. The resident was Spanish speaking.

During an interview, resident 39 stated he had been at the nursing home about two years but calls it jail. The resident stated he's in jail because of the way he has been treated. The resident added, "I am afraid to say anything because if I do speak up, she will retaliate against me like she did last time." When asked who he referred to, he stated CNA 1. He said she yells at me and calls me names (ungrateful); that he needs to be spoon fed and taken care of and he doesn't appreciate anything that was being done for him. Resident 39 expressed he agreed with CNA 1 and stated, "She was right, I don't deserve anything."

The resident stated he spoke to the social worker around five months ago and notified her about the ongoing abuse from CNA 1. The resident recounted that within the same week, CNA 1 retaliated against him. The resident stated, "She yelled at me and told me I needed to stop telling on her."

During a subsequent interview, resident 39 stated he was not happy with the care received from CNA 1 during the last five months, including CNA 1 yelling at and calling him names during this period. Resident 24 was "alert" and required extensive assistance with care from staff. The resident reported CNA 1 called him derogatory names such as Malagradecido (ungrateful), not assisting him with activities of daily living.

During an interview, resident 24 stated, "I don't have issues with the care I get, unless I get assigned CNA 1." The resident stated that he was having too many problems with CNA 1 because "she's just too mean." When asked for examples, the resident stated, "I asked CNA 1 for hot water for my tea around dinner time the other night, CNA 1 yelled at me saying, I don't deserve it and said she didn't have time to be running around to do that. She never brought me the water for my tea. The resident added that one evening he pressed the call light at 9:00 PM to ask for a blanket and she didn't show up until 10:00 PM and was upset yelling at me asking why I was calling and to stop bothering her, that she didn't have time for that. The resident said that CNA 1 also did not empty his foley catheter bag despite multiple requests one whole shift. He said, "the bag was about to burst" with over 2,000 mL urine out of 2,000 mL and "I was afraid to get an infection because of it." He stated that CNA 1 ended up coming only in the morning. The resident showed a picture of the catheter bag on his cell phone which was time stamped for 6:33 AM.

The resident stated he asked the scheduler not to assign CNA 1 to him again and added, "I am alert and know what's going on. CNA 1 was not going to abuse me like she does others. CNA 1 is too mean." The resident said CNA 1 treated other residents worse, especially resident 39.

Name of Nursing Home	York Healthcare & Wellness Centre / Provider ID: 055664
Address	6071 York Blvd. Los Angeles, California
Date investigation completed	March 11, 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: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/055664/health/standard?date=2022-03-11

"Total Terrors"

The nursing home failed to: a. ensure that grievances were thoroughly investigated according to the nursing home's policy for residents 1 and 4 and failed to ensure efforts were promptly made to effectively resolve concerns identified for all residents; b. prevent ongoing physical and mental abuse, isolation, and neglect for residents 4, 16, and 22; c. ensure that reports of alleged abuse and/or neglect were reported to the Department of Public Health within two hours as required; d. conduct thorough investigations of alleged incidents of abuse and neglect; e. protect residents from accused staff following abuse allegations.

The Grievance Log was reviewed. The residents said that they were not apprised of the investigation, action plan, and resolution to their complaints. The residents felt the staff's treatment of residents was disrespectful and intimidating. Residents said that staff yelled at them for using their call lights and threatened them against reporting complaints. The residents said the administration disregarded their complaints and that the staff (especially agency staff) made up rules as they went along and did not allow them to report complaints.

During an interview, resident 4 stated that filing grievances was pointless. The resident added that staff back each other up when asked about a situation and then become total terrors (toward the resident).
The resident stated that CNA 5 pushed his/her wheelchair into the wall of the elevator and whispered into his/her ear that she wanted to push resident 4 down the stairs and that she could do whatever she wanted to resident 4 and no one would ever know, or words to that effect. The resident stated that staff had threatened the resident and his/her roommate if they complained to the survey team and said that once the Surveyors were gone, things would go back to the way they were. The resident added, "Staff acted like we were non-people" and "they don't even acknowledge that we are human."

Resident 1 told the Surveyor that staff were miserable, mean, rude, and had made everything he/she did an issue. The resident had a list of concerns and complaints that he/she had tried to address with the nursing home but had given up because the staff make him/her feel that he/she is the problem and this increases his/her anxiety and had made him/her feel trapped, hopeless, and depressed.

The resident said he/she had complained about: 1. call bells not being answered and was afraid if something happened to him, no one would come; 2. A nurse saying that if the resident wanted to go to the hospital, the resident would have to call an ambulance himself/herself; 3. Seeing a resident dragged by their arms and feet down the hall; 4. Hearing a CNA slap resident 1's roommate. The resident expressed fear of reporting concerns because of staff intimidation. Resident 1's family reported their concerns to the nursing home and outside agencies but felt that had made it worse.

Name of Nursing Home	Garden Place Healthcare / Provider ID: 225267
Address	193-195 Pleasant Street, Attleboro, Massachusetts
Date investigation completed	October 19, 2017
Type of deficiency issued	F166 – Right to prompt efforts to resolve grievances F223 – Right to be free from abuse F225 – Report and investigate abuse, neglect or mistreatment F226 – Develop/implement policies prohibiting abuse/neglect/misappropriation/exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225267/health/standard?date=2017-10-19

Moved To the "Slow Answer List"

The nursing home staff failed to provide a private uninterrupted meeting space for the Resident Council meeting. The nursing home also failed to ensure residents felt able to voice grievances without reprisal.

At 9:24 AM, the surveyor explained to the Activity Director that the Resident Council was gathering to meet privately with the surveyor. The Activity Director left the room.

At 9:30 AM, the Resident Council with the surveyor was called to order by the Council President. The surveyor explained the purpose of the meeting.

At 9:35 AM, a resident asked the surveyor to close the door so it would be quieter. After the surveyor closed the door, CNA 1 entered the room and said she was taking notes. The surveyor explained that the Resident Council meeting was intended to allow the residents to meet the surveyor without staff present.
CNA 1 stepped around the surveyor and asked the Resident Council President if it was okay for her to be there. She asked three times, louder with each repetition. The Council President said it was OK after the third time.

At 9:40 AM, the Activity Director returned to the room and CNA 1 said that she was there to observe and learn and asked the Council President if that was okay three times. He agreed after the third time.

The surveyor started asking the residents questions that make up the standard Resident Council interview. When the surveyor asked if residents felt they could file grievances without fear of retaliation, one resident said, "No." CNA 1 corrected the resident saying that was not true. The surveyor asked CNA 1 not to interrupt residents. Residents reported some concerns during the meeting that were relayed to the administration. Because the residents were not allowed to answer the questions about being able to make complaints without retaliation, the surveyor individually interviewed residents from each nursing unit who had or had not attended the Resident Council meeting.

The surveyor assured the residents that their comments would be anonymous. The residents reported a common concern that if they complained about the amount of time it took staff to answer the call bells, that they would be moved to the slow answer list. One resident said he thought he was currently on the 30-minute answer list and was afraid of being moved to the hour answer list. Another resident, after reiterating that the comments must be anonymous, reported not being toileted on the weekend and only receiving incontinence once a shift.

The concerns related to residents' right to meet without staff present were reported to the Administrator and the Director of Nursing.

Name of Nursing Home	Choice Healthcare at Roanoke / Provider ID: 495156 [Alternative name: Cuirs at Roanoke Transitional Care & Rehab Center]
Address	324 King George Ave. SW. Roanoke, Virginia
Date investigation completed	April 26, 2019
Type of deficiency issued	F565 – Resident/Family Group and Response F585 – Grievances
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/495156/health/standard?date=2019-04-26

"You Will Just Have to Wait"

The nursing home failed to: a. implement their abuse and neglect policies to prohibit and prevent abuse for residents 1 and 2; b. report alleged abuse to the proper authorities according to state and federal regulations for resident 1 and 2; and c. respond to an allegation of abuse and neglect for resident 1 and 2.

Resident CR 1 had moderate cognitive impairment (BIMS score of 10 out of 15) and required one person to provide limited assistance with bed mobility, transfers, and dressing. The resident, who uses a wheelchair, is occasionally incontinent of bladder and frequently incontinent of bowel.

During a confidential group interview at 10:00 AM, CR 1, tearful, stated that she is afraid of CNA A and afraid to report care concerns about CNA A. CR 1 stated that she was afraid CNA A would retaliate against her and that she told her roommate's son that staff were being rough with his mother. CR 1 said her roommate's son complained to the nursing home about it. She said she felt that CNA A treated her differently after that incident by mocking her, refusing to assist her with care, and delaying care.

CR 1 stated she asked CNA A to help her get up from her bed. CR 1 stated she can get to her wheelchair on her own but needed assistance getting up. CR 1 stated CNA A said, "I can't lift you." CR 1 said she told CNA A she was not asking to be lifted but just needed assistance to stand. CNA A did not assist her. CR 1 said she told CNA A to get out of her bedroom and as CNA A left the bedroom, CNA A waved and said, "Bye, bye." CR 1 felt that CNA A was condescending and mocking her. She said she did not report it because she was afraid of CNA A. CR 1 said she cried at the time of the incident.

Resident CR 2 was cognitively intact (BIMS score of 15 out of 15) and required a one-person limited assistance with bed mobility, transfers, and personal hygiene. The resident required extensive one-person assistance with dressing, limited range of motion upper right extremity, and utilizes a wheelchair.

At 10:35 AM, CR 2 entered the confidential group meeting and stated she was late because CNA A did not help her get ready on time for the meeting. In an interview, CR 2 revealed she requested assistance getting ready by 9:00 AM to ensure she could attend the 10:00 AM group meeting. CR 2 stated CNA A told her, "You will just have to wait." CR 2 stated she had not reported this to staff and was afraid of CNA A. CR 2 also stated she was afraid CNA A would retaliate if she found out that she complained. In an interview a couple of hours later, CR 2 revealed she feared retaliation if she identified the CNA whom had told her she had to wait to get dressed on the same day in the AM. CR 2 became teary eyed stating she feared CNA A because she had reported CNA A to the previous Administrator of being sarcastic, rude, and hateful with her when she had asked her for help standing up. CR 2 stated from that time the CNA will delay her care telling her she has to wait. She was scared to report CNA A because she feared she feared CNA A would retaliate.

Name of Nursing Home	Prestonwood Rehabilitation & Nursing Center Inc / Provider ID: 676156
Address	2460 March LN, Plano, Texas
Date investigation completed	October 3, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/676156/health/standard?date=2021-10-03

Uncomfortable Speaking Up

The nursing home failed to ensure residents were able to voice concerns and grievances without fear of retaliation.

During a resident group meeting, 10 out of the 14 residents attending expressed that they feel uncomfortable speaking up and making complaints/grievances to staff due to fear of retaliation.

The 10 residents who expressed fear of retaliation stated that they felt that they had experienced retaliation after bringing up concerns about staff to management.

Examples of the alleged retaliation that were provided by the residents:

- Staff turning off call lights without providing the requested care
- Staff taking longer to answer call lights
- Staff not bringing in linen needed for bathing tasks
- Staff's attitude changed towards them (e.g., not being as friendly; being short with responses)

In addition, the 10 residents said grievances/complaints are often not resolved and feel the nursing home does not take the complaints seriously.

During an interview, the Director of Nursing (DON) said she was unaware that residents were fearful of voicing concerns/grievances. The DON said she was unaware of any concerns with staff retaliating or treating residents differently after having voiced concerns/grievances and that any form of retaliation by staff was unacceptable and should be taken seriously.

The nursing home's policy titled Grievances/Concerns – Resident/Family indicated:

- No resident will be subject to retaliation by any member of the Center's staff as a result of the submittal of a concern or recommendation for change.
- All formal concerns will be investigated and responded to within five days.

Name of Nursing Home	Medford Rehabilitation and Nursing Center / Provider ID: 225339
Address	300 Winthrop Street, Medford, Massachusetts
Date investigation completed	April 27, 2021
Type of deficiency issued	F585 – Grievances
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/225339/health/standard?date=2021-04-27

Residents "Get Chewed At"

The nursing home failed to: a. treat resident 29 and resident 45 with dignity and respect; b. resolve grievances in a timely manner; c. prevent abuse of five residents; d. implement their abuse policy for four residents; and e. report allegations of abuse for four residents.

During a confidential group meeting, eight residents said they are not treated with dignity. They reported staff frequently refuse to provide care or assistance. They make comments like, "Do it yourself." They expressed fear of retaliation and when they report, things get worse. They said care refused included using bed pans, getting towels for morning care, and getting clean briefs. When asked how it makes them feel, one resident said, "Retarded." Another said, "Upset." They were all very frustrated and upset.

During an interview, resident 45's spouse reported the nursing home is short staffed on weekends. He said that recently his spouse soiled herself in her bed because of an extended call light wait. The spouse reported two other occasions when she laid in wet bed awaiting a call light response. The spouse reported he complained to the Administrator who told him that maybe resident 45 should go to another nursing home.

Confidential resident reported, "I try to stay isolated because of disrespectful treatment by staff." She added she has witnessed other residents "get chewed" [*sic*] at when a concern was voiced. She said she knows not to say anything against staff because she will get spoken to. She reported she was afraid of staff retaliation and added, "I am nervous now that I said something" (to the surveyor). She declined to be identified to have her concerns addressed stating, "They will come at me."

The nursing home also failed to support resident choices for resident 15 and eight residents, resulting in residents being restricted from social interactions with other residents outside scheduled group activities.

During a confidential group meeting, residents said they were not allowed in the dining room from 9:00 PM to 7:30 AM. They said they did not want to discuss these concerns with the Administrator and the Director of Nursing because they feared retaliation. Resident 15 said, "The residents just want to use the main dining room as a place to just sit and relax." Resident 8 said they had nowhere to go outside their bedrooms during those hours other than the halls.

During the meeting, the residents said the nursing home did not resolve their grievances. They gave the example of a resident who would wander into their bedrooms and take their belongings. The resident yells and swears at the men and they are afraid of him. The residents said they didn't want to discuss these issues with management because management responds to concerns with retaliation against residents.

Name of Nursing Home	Medilodge of Midland / Provider ID: 235284
Address	4900 Hedgewood Dr. Midland, Michigan
Date investigation completed	March 12, 2020
Type of deficiency issued	F550 – Resident Rights; F561 – Self-determination F565 – Resident/Family Group and Response F600 – Freedom from Abuse, Neglect, and Exploitation 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: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235284/health/standard?date=2020-03-12

Fearing the Administrator

The nursing home failed to ensure: a. residents who were not a safety or elopement risk were allowed to go outside unsupervised for six residents (B, C, D, E, F and G); b. seven residents (B, C, D, E, F, G, H) were able to communicate with the Administrator without being verbally degraded and threatened with discharge, which resulted in the residents being fearful and feeling like they live in a prison.

The change in Smoking Policy indicated: "All residents who smoke will be on supervised smoking. There will no longer be individual times for any residents." A written statement from the Administrator indicated, "In good conscious, I cannot allow residents to keep lighters on their person and smoke where they like, as this may put all residents' safety at risk."

The following descriptions pertain to a select number of residents – all assessed to not be at risk of wandering and elopement – who expressed concerns regarding the change in the smoking policy:

Resident F who was cognitively intact (based on BIMS assessment) indicated that she used to be able to go outside to the secured patio/garden area whenever she wished to smoke, get fresh air, enjoy the garden, and look at the sky. She has done nothing to cause the loss of her independent access to the patio/garden area, and there was a camera and alert button if she needed assistance. This made her feel her independence, rights, and dignity were being demeaned and made her feel more hopeless about her life.

Resident G who had moderate cognitive impairment (based on BIMS assessment) stated that the new policy made him feel "like he was a child being punished for something," that the nursing home was run like a prison, and that the one independent thing he really enjoyed was taken away from him.

Resident C who was cognitively intact (based on BIMS assessment) stated, the resident spent time in prison and, "I don't think I should be made to feel like I am in jail again." He/she said, "I've tried to talk to her [Administrator] about my concerns and she has threatened to kick me out seven or eight times."

The Social Services Director indicated that she knew of no safety reasons that would prevent residents B, C, D, E, F and G from being able to have unsupervised access to the patio/garden area. These residents have been assessed to be non-risk for smoking and non-risk for elopement.

During confidential interviews, the residents stated that they were afraid of retaliation from the Administrator if they speak out. In addition, staff reported that they are not able to honestly tell the corporate staff their concerns out of fear of retaliation. During an interview, the Interim Administrator indicated his investigation was completed and the Administrator's employment was terminated.

Name of Nursing Home	Core of Bedford / Provider ID: 155388
Address	514 E. 16th Street, Bedford, Indiana
Date investigation completed	May 5, 2019
Type of deficiency issued	*F561 – Self Determination **F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	*Minimal Harm or Potential for Actual Harm **Actual Harm
Overall Quality Star Rating: 3; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/155388/health/standard?date=2019-05-05

Call Light Out of Reach

The nursing home failed to ensure that: a. resident 1 was free from verbal abuse or punishment by staff. CNA 1 admitted to and was witnessed yelling at resident 1. In addition, resident 1 reported that staff, including CNA 1, removed his/her call light from within reach because they said he/she used the call light too often; b. staff consistently implemented interventions identified in his/her Care Plan to provide resident 1 with the call light, which included to make sure the call light was kept within his/her reach.

Resident 1 (cognitively intact based on MDS) required staff assistance with all activities of daily living.

During an interview, resident 1 stated that when CNA 1 came to assist him/her sometime after the start of the night shift, CNA 1 yelled at him loud enough that staff heard CNA 1 at the nurses' station. The resident said that CNA 1 accused him/her in a nasty tone of voice of treating her like his/her personal aide and said that CNA 1 said she hated coming to help him/her. The resident said he/she did not report how poorly CNA 1 treated him/her because he/she was fearful of not having his/her care needs met.

Nurse 1 said that prior to the incident, resident 1 was yelling for help so she/he asked CNA 1 to go and check on resident 1. CNA 1 said she was not going to go to resident 1's bedroom again but did finally get up and go. Nurse 1 said that CNA 1 stood at resident 1's doorway and told resident 1 (in an irritated and angry tone), "What do you need now? I am not changing you again!"

Nurse 1 stated that she checked on resident 1 after CNA 1 left the bedroom. Resident 1 reported CNA 1 was mean to him/her, and that CNA 1 hated him/her. Nurse 1 said resident 1 reported similar allegations on multiple prior occasions. Nurse 1 said she had also expressed concerns about CNA 1 being burned out, that CNA 1 worked approximately 80 hours per week between different jobs, had expressed hatred of the nursing home, that CNA 1 did not have any respect for staff or residents, and that she was a bully. CNA 1 didn't respond to attempts by the Director of Nursing to interview her by phone, but she did respond by texts stating that there was nothing to investigate, that she yelled at resident 1 for taking off his/her diaper and for making a mess of the bed.

Resident 1 said that during the incident, CNA 1 removed his/her call light from within reach because CNA 1 said he/she used the call light too much. The resident said CNA 1 has done it on prior occasions, and when CNA 1 did that, he/she would have to yell for help. Resident 1 said he/she did not report staff taking away his/her call light because he/she was fearful of not having his/her care needs met as a result. Nurse 1 said that during the incident, she/her heard CNA 1 say words to the effect of, "I am not giving you the bed remote. You can get up and get it yourself." After CNA 1 left the bedroom, Nurse 1 observed the remote control of resident 1's bed on the floor and his/her call light not within reach. Nurse 1 stated that resident 1 was not functionally able to get out of bed and/or able to pick something up from the floor without staff assistance.

Name of Nursing Home	St Francis Rehabilitation & Nursing Center / Provider ID: 225438
Address	101 Plantation Street, Worcester, Massachusetts
Date investigation completed	April 7, 2021
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F656 – Comprehensive Care Plans
Severity level	*Actual Harm; **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225438/health/complaint?date=2021-04-07

Life After Reversal of Inappropriate Discharge

The nursing home failed to ensure residents could exercise their rights without interference, coercion, discrimination, or reprisal from the nursing home for resident 1. The nursing home placed resident 1 on continuous one on one (1:1) supervision without justification when he readmitted to the nursing home after winning his appeal against inappropriate discharge by the nursing home. The nursing home failed to inform resident 1 why he was placed on 1:1 supervision, how long the supervision was meant to last, and what steps were to be taken to remove that level of supervision. It also failed to allow the resident personal privacy and privacy with visitors and phone calls.

The failure resulted in resident 1 experiencing increased emotional distress and decreased quality of life by feeling like his home and feeling of security were in jeopardy. Resident 1 was a young man with "no cognitive delays" and "no short or long-term memory problems." He needed extensive assistance of one to two staff for bed mobility, transfers, toilet use, bathing, and personal hygiene. The MDS assessment indicated that he had verbal behavioral symptoms directed toward others, but the behaviors did not put residents at risk for injury or intrude on the privacy of others.

The resident received an immediate discharge letter stating the safety of individuals in the nursing home was endangered due to aggressive behaviors with residents, family members, and staff to include verbal threats to cause physical harm to residents and a staff member. The nursing home did not have documented evidence that the resident was harmful or had the potential to be dangerous to other residents.
The resident went to the hospital for acute catheter care and was not allowed back to the nursing home.

With the assistance of the Ombudsman, the resident appealed the discharge which was reversed. The nursing home was ordered to immediately re-admit the resident, but the nursing home refused. Corporate made it re-admit the resident when penalties started accruing for deficiencies related to resident 1.

Resident 1 was re-admitted with a physician order, "Resident to be on 1:1 for aggressive behaviors" despite no Care Plan discussing the 1:1 monitoring, the behavior that caused it to be used, and how the monitoring would be titrated. He was placed under constant 24/7 staff supervision." If he smoked, spoke on the phone, used the toilet, slept, or had private time with his girlfriend, staff monitored him. Someone followed him everywhere he went and documented all his movements. This made him upset and angry as he felt like being in a prison. He said, "I am not a monkey in a zoo" and "This is an invasion of privacy!"

When the resident refused an X-Ray, a change in bowel regime, and psychiatric evaluation, the medical director told him that their physician-patient relation will be terminated, which could mean discharge.
The resident thought the nursing home was harassing him and retaliating against him for challenging his discharge and winning his fair hearing. The Ombudsman stated that what the nursing home was doing to the resident was considered profiling and that the 1:1 monitoring violates his rights.

Name of Nursing Home	Heritage at Turner Park Health & Rehab / Provider ID: 455733
Address	820 Small Street, Grand Prairie, Texas
Date investigation completed	November 26, 2019
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights F583 – Personal Privacy / Confidentiality of Records
Severity level	Actual harm
Overall Quality Star Rating: 2; Staffing Rating: 1	

Investigation report: No longer available on *Care Compare* website.

Locked Up

The nursing home failed to protect resident 1's rights to be free of involuntary seclusion. Resident 1 was placed on the secure/locked unit without clinical justification. The resident was accused of inappropriately touching resident 2 who slapped resident 1's face. The nursing home gave resident 1 an ultimatum to either be placed on the secure unit or be discharged. The failure could place residents at risk of retaliation feeling isolated, low self-esteem, and depression.

Resident 1 had moderate cognitive impairment and required supervision with ADLs. The resident rejected care, but he had no physical, verbal or other behaviors directed towards others. Resident 2 had moderate cognitive impairment and required supervision with all ADLs. The resident had repetitive behaviors with male residents in which she led male residents to believe she was interested in them sexually and then when she became upset over anything, she accused them of inappropriate behaviors directed towards her.

A Care Plan indicated the Director of Nursing (DON) informed resident 1 of resident 2's allegation of him slapping her on her bottom without her consent. The note indicated the resident was given a choice of either move to the secure unit or be discharged to another nursing home. Resident 1 stated, "I didn't do anything." RN B stated it would have been impossible for resident 1 to have touched resident 2 at that time because he sat about 8-10 feet away from her. Psychiatric evaluation indicated staff witnessed resident 2 slap resident 1 but did not witness resident 1's supposed sexually inappropriate behavior that led to the slap.

During an interview with the surveyor, resident 1 said that while he was sitting in his wheelchair, resident 2 walked up and slapped him on the face for no reason. He said he and resident 2 were good friends and had never had any type of sexual relationship. He said he had not touched resident 2. He said the social worker and the DON told him he had to stay on the secure unit, or they would send him to another facility. He said he was locked up for no reason and he was being punished for something he did not do. He said he liked being at the nursing home and did not want to leave. He felt he did not have a choice about being locked in the secured unit if he wanted to stay at the nursing home. He said that since he was moved to the secured unit, he felt down, depressed, and did not want to be on the secured unit because he felt like a prisoner. The resident told the surveyor, "I really hope you can help me. I don't want to be locked up."

Two CNAs were not aware of any past behaviors by resident 1. The Social Worker stated resident 1 had not displayed any inappropriate sexual behaviors or other behaviors since she started working in 2017. She added that resident 2 had behaviors of attention seeking and having sex with other male residents.

The Administrator said it was her policy to place a resident on the secure unit to protect another resident if an allegation of sexual aggression was made. She stated that she felt that was the only way to keep resident 1 away from resident 2. She said it did not matter if the allegation could not be proven.

Name of Nursing Home	Overton Healthcare Center / Provider ID: 675408
Address	1110 Hwy 135 S. Overton, Texas
Date investigation completed	August 3, 2020
Type of deficiency issued	F550 – Resident Rights F603 – Free from Involuntary Seclusion
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/675408/health/complaint?date=2020-08-03

"Done With the Abuse"

The nursing home failed to ensure staff treated six residents in a dignified and respectful manner. This failure placed the residents at risk of experiencing a high level of frustration, embarrassment, and the need to constantly advocate for their care.

Due to scope consideration, the following summary focuses on Resident 221 who was cognitively intact.

During an interview, resident 221 stated they were discharging home the next day. The resident shared that there was no home health service availability but that was okay because they can leave this abuse.

Resident 221 stated Staff B – an LPN – was very verbal with her. She expressed concerns that the LPN waited until late at night to do their dressing change. She added that Staff B "was tired as hell and shouldn't have been here. They were on their second shift, and it was very busy, but I am also a patient too. I just needed a little help, that's all." She added, "Staff B was not organized for dressing changes and would leave their stomach exposed three times while going out to retrieve forgotten supplies."

Resident 221 stated, "After this Staff B won't be caring for me. I think this should be investigated. There are people here that need not be neglected."

Resident 221 shared that she reported this complaint to another nurse and added that they told Staff B they were going to report them for mistreatment.

The resident said Staff B was very rude now after they complained about them. Resident 221's roommate interjected saying, "Yes, very rude." Resident 221 added that Staff B came in today and slammed their pills down and rudely said "Take them." The resident said there was no reason Staff B should act like that. Maybe it was because they got in trouble when I reported them. The resident said they did not want to make a bigger fuss, just done with the abuse and can go home now to avoid it.

In a joint interview with resident 221 and her roommate resident 178. Resident 221 had told the Administrator that Staff B was completely rude to them and said, "Take your pills" while they were in the middle of sewing. They told Staff B, "Wait, I just have four more stitches, or I will lose my needle." The resident added, "I didn't want to lose the needle in my bed." Staff B said, "Take your pills, I need to watch you." Resident 221 added, "There is no reason to act that way."

Resident 221 was worried Staff B was retaliating against them since they reported them to management.

Administrator: "This may have been avoided had Staff B been reassigned from resident 221's care.

Name of Nursing Home	Everett Center / Provider ID: 505491
Address	1919 112th Street Southwest, Everett, Washington
Date investigation completed	September 21, 2021
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/505491/health/standard?date=2021-09-21

Mocked for Physical Disability

The nursing home failed to report an alleged violation of abuse to the administrator and the State survey and certification agency in accordance with State law affecting resident 14.

The nursing home failed to timely and thoroughly investigate allegations of abuse involving resident 14.

Resident 14 who was younger than 30 years old was cognitively intact (BIMS score 15 out of 15), "totally dependent," and two-person assistance for activities of daily living.

During an interview, resident 14 was very upset and angry while he explained how CNA 12 mocked him for being disabled. He said CNA 12 held her arms up and imitated his arm contractures.

He said he felt helpless because he could not defend himself due to his disability and he felt like he was retaliated against because of his anger towards staff.

He added that he was already depressed about being disabled and this made him feel more embarrassed and depressed about his inability to care for himself.

He said that he reported it to a staff member, but then nobody ever talked to him about it.

Name of Nursing Home	Park Forest Care Center, Inc. / Provider ID: 06A172
Address	7045 Stuart Street, Westminster, Colorado
Date investigation completed	August 3, 2020
Type of deficiency issued	F609 – Reporting of Alleged Violations F610 – Investigate/Prevent/Correct Alleged Violation
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/06A172/health/infection-control?date=2020-08-03

Retaliation for Advocating

The nursing home failed to protect a resident's right to be free from mistreatment after notifying the Ombudsman of not getting showers. The nursing home also failed to: a. immediately report the allegation of abuse to the Administrator; b. report the allegation of abuse to the state survey agency within two hours of the Director of Nursing (DON) being notified; and c. failed to conduct a thorough investigation.

The resident was "cognitively aware" (based on MDS assessment) and required total dependence with two staff physical assistance with bed mobility, transfers, and bathing.

The Assistant DON arranged with the Ombudsman to make sure the resident received a weekly shower on Mondays, but with only one aide available that Monday, the resident would receive a shower on Tuesday.

During an interview, the resident reported on a Tuesday at 1:30 PM three aides came into her bedroom yelling and were mad because it was near the end of their shift, and they had to give her a shower. One of them reportedly stated, "We have to give you a shower because you went and called the Ombudsman!"

The resident added that the aides transferred her from her bed to the shower bed with a mechanical lift in a rushed and rough manner. The resident asked them to get her body wash, shampoo, and cream rinse but was told, "You won't need that!" When she requested the cream rinse, she was told, "You're getting a shower, that's all you're entitled to. Be grateful." During the shower, the resident told them that the water temperature was scalding, and was told, "You're getting a shower. Be quiet." One of the aides turned the water temperature down. The resident felt the nurse aides were being mean to her because she had called the Ombudsman about not getting showers and they were retaliating against her.

The resident added that after the shower, she was placed in the dining room to eat lunch and was left in the shower chair with wet hair. The resident usually eats in her bedroom. She stated she felt the aides brought her to the dining room instead of back to her room because they were punishing her for calling the Ombudsman. Eventually, around 3:00 PM the Wound Treatment Nurse (WTN) came and put her to bed. The resident stated that she had a horrible day, and she was very upset about the aides' behavior. The WTN stated the resident, who was genuinely upset when she saw her, told her she asked to be taken back to her bedroom on several occasions, but no one answered her. She requested her glasses so she could see what she was eating but was told "Shut up." Eventually, an aide brought her glasses.

The three aides denied the resident's complaints. The Administrator and the DON did not feel the resident was abused. The Administrator shared that the Ombudsman told her there should be criminal charges against the nursing home for what had happened to the resident.

Name of Nursing Home	Brunswick Cove Nursing Center / Provider ID: 345318
Address	1478 River Road, Winnabow, North Carolina
Date investigation completed	May 12, 2021
Type of deficiency issued	*F600 – Free from Abuse and Neglect **F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	*Actual Harm **Minimal harm or potential for actual harm
Overall Quality Star Rating: 3; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/345318/health/complaint?date=2021-05-12

"She Was Out for Blood"

The nursing home did not thoroughly investigate an allegation of abuse involving a staff member.

The resident was cognitively intact (BIMS score of 15 out of 15) and used a wheelchair for mobility.

The resident notified the Administrator that she had a bowel movement and then left in incontinence for two hours by CNA C during the late evening hours. CNA C was suspended pending the investigation.

Camera footage revealed CNA C entered the resident's bedroom at 8:25 PM and then again at 10:12 PM.

An RN stated she had received a telephone call around 10:00 PM from the resident requesting help. The RN sent CNA C to assist the resident. According to CNA C's statement, CNA C responded to the resident's bedroom at around 8:00 PM to answer her call light but the resident was unable to state what she needed assistance with, so CNA C exited the bedroom. Upon being notified later by the RN at around 10:00 PM, CNA C went back to the resident's bedroom and assisted her with her bowel incontinence.

The nursing home unsubstantiated the resident's allegation due to lack of evidence. CNA C returned to work 10 days after the resident's allegation was originally reported to the Administrator. The next day, staff reported that CNA C and the resident had a verbal altercation. The nursing home suspended CNA C immediately.

Multiple staff stated, through witness statements, CNA C pursued the resident near the dining room after the resident had originally approached CNA C. These staff members stated that CNA C had made these statements to the resident, "You're a liar and you're messy" and "You're not going to whoop me." A Medication Aide who witnessed it described CNA C's behavior: "It was like she was out for blood."

The nursing home concluded the investigation by substantiating verbal abuse because CNA C's actions were deemed inappropriate and caused the resident to become fearful of retaliation. CNA C's employment was terminated.

Surveyors interviewed the resident who stated she had heard from other people that CNA C was telling other staff and residents that "she is going to lay in it" (referring to the resident's bowel incontinence). When the resident saw CNA C, she approached CNA C and questioned CNA C as to why she (CNA C) would let her lay in it. The resident stated that the two began to argue loudly and, at one point, CNA C stated the resident was "messy" and "Nobody is going to whoop me." The resident reported to the surveyor that she wasn't afraid CNA C would physically hit or hurt her but was afraid CNA C would purposely not provide care for her or not tend to her needs out of spite.

Name of Nursing Home	Bay at Belmont Health and Rehabilitation Center / Provider ID: 525074 [Alternative name: Belmont Health and Rehabilitation Center]
Address	110 Belmont Road, Madison, Wisconsin
Date investigation completed	August 11, 2021
Type of deficiency issued	F610 – Investigate/Prevent/Correct Alleged Violation.
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/525074/health/complaint?date=2021-08-11

Demeaning, Demoralizing, and Belittling

The nursing home failed to ensure two residents were free from abuse. Specifically, the nursing home failed to protect resident 22 and resident 34 from verbal and mental abuse from the Dietary Manager (DM) after voicing food related concerns. The nursing home also failed to have evidence that a timely, thorough, and complete investigation was conducted for abuse allegations related to these two residents.

A small group interview was conducted with members of the Resident Council. The members expressed concerns with the DM. They said they have expressed their concerns related to the quality of food using the appropriate channels but have felt retaliation from the DM. Four residents said the DM showed disrespect in the way she handled herself and addressed grievances with food. They said the DM would frequently call them "the troublemakers" because of their concerns regarding the quality of the food.

Two of the council members said the DM wrote a letter to the council members to humiliate and retaliate against them after they submitted a food-related grievance. It made them feel fear and humiliation. The Social Services Director thought the letter was "demeaning, demoralizing, and belittling." The nursing home investigation substantiated the letter as "verbal and physical abuse."

The council said the DM was later ordered to write an apology letter to them (acknowledging she was "unkind, inappropriate, and unprofessional") but it was impersonal and did not resolve their frustrations.

The following concerns were voiced by residents attending a Resident Council meeting held several months earlier. The grievance card described concerns of food that was over and undercooked, tough to chew, and overall concern with palatability. The residents felt upset, poorly treated, unimportant, and not cared for. Words such as "dumb" and "idiot" were also used in the way they felt treated.

During an interview, resident 22 shared that the DM called him a "troublemaker," "bastard," "son of a (expletive)," and made him feel small when he complained about the food. He said that he told the SSD he felt intimidated and scared of DM because she handled his food. While crying, he said that the DM might poison his food. He felt fearful for himself and others who took a stand against her. He added that the DM told him that if the nursing home got rid of him, the problem would go away. He said that he was told an investigation would be conducted but never received a follow up to his report. Resident 34 also felt that DM retaliated against him in response to their food concerns.

The residents felt they were "fighting a losing battle," concerns were thrown back in their lap, their intelligence was attacked, they were bullied, and they felt they were treated as the lowest form of life. Several residents retracted their food related concerns when they were individually approached by the DM. They felt they could not voice their concerns because the DM did not take the concerns well.

Name of Nursing Home	Colorado State Veterans Nursing Home – Rifle / Provider ID: 065386
Address	851 E. 5th Street, Rifle, Colorado
Date investigation completed	October 27, 2020
Type of deficiency issued	F600 – Free from Abuse and Neglect F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/065386/health/standard?date=2020-10-27

*"You're Too Old for This S***"*

The nursing home failed to ensure three residents (26, 25, 30) were free of verbal abuse by CNA 23. It also failed to ensure that two other residents (29, 53) were free from physical abuse from CNA 23.

This summary focuses on resident 26 who was moderately cognitively impaired (BIMS score 11 of 15).

During an interview, resident 39 stated that over the holiday weekend, CNA 23 went off on resident 26 again. Resident 26 had an incontinence accident and CNA 23 kept going up and down the hall and in and out of his bedroom while getting him cleaned up screaming things like, "G****** it man! You're too old for this s***! I can't believe you s*** yourself again, you're a f***** baby man! I should be up at the track the way you've got me running around like this!" Resident 39 reported that this went on for at least 10 minutes. She/he added that resident 26 was so angry, was visibly shaking, and asked resident 39 to go with him to report it to management. Monday was holiday and no management was at the nursing home so first thing Tuesday morning the two residents reported it to the Social Services Director who notified the Administrator and the Director of Nursing. Resident 39 stated that CNA 23 was suspended again "but it wouldn't do any good since this was like his third suspension."

During an interview, resident 26 indicated he did not like CNA 23 at all. He stated that CNA 23 screamed and yelled at him all the time because he would have accidents on himself. It embarrassed him because the whole hall could hear it. Resident 26 said that he wanted to get the hell out of this place if he was going to be treated like that. He said that CNA 23 yelled at him before as well and that he is "fed up with it" and wanted out of the building.

During an interview, resident 29 indicated, "We've been warning y'all about him," referring to CNA 23. The resident indicated that he heard CNA 23 yell up and down the hall, especially at resident 26 things like, "I can't believe you f***** s*** on yourself! Man, I don't get paid enough to keep wiping you're a** like this!" It seemed to resident 29 as though CNA 23 "was just burnt out, he had a really short fuse, and you did not want to be on the wrong side when it went off."

The nursing home investigated and substantiated the verbal abuse allegation. CNA 23's employment was terminated, and he was reported to the Attorney General's Office.

A family member of resident 26 indicated that the resident seemed more depressed lately when she talked with him on the phone. The last conversation they had, there was an increased sense of urgency in the resident's voice when he told her he wanted to move out of the nursing home because of a recent incident between him and a staff member.

Name of Nursing Home	Alpha Home – A Waters Community / Provider ID: 155717
Address	2640 Cold Spring Road, Indianapolis, Indiana
Date investigation completed	April 13, 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/155717/health/standard?date=2022-04-13

"A Lapse in Judgment"

The nursing home failed to ensure resident 1 was treated with respect and dignity, when CNA 1 responded to resident 1's complaints by dumping out resident 1's drink, twice.

Resident 1's cognitive patterns were intact (based on MDS documentation).

During an interview, resident 1 said that CNA 1 dumped out his/her drink. The resident said that when CNA 1 delivered his roommate's (resident 2) dinner tray, resident 1 said he/she told CNA 1 that resident 2 could not have milk. Resident 1 said that CNA 1 told him/her resident 2 could have the milk and that CNA 1 told him/her to mind her/his own business. Resident 1 said when CNA 1 did not remove the milk from resident 2's tray, he/she (resident 1) went and took the milk from the tray and threw it in the trash. Resident 1 said CNA 1 took a glass of water from his/her (resident 1's) over the bed table and dumped it in the sink before leaving the bedroom.

Resident 1 said that after dinner, he/she told CNA 1 several times that resident 2 could not have milk and said that CNA 1 was incompetent and called her it. Resident 1 said that at some point that same evening, CNA 1 came into his/her bedroom and dumped out his/her cup of water again.

During an interview, CNA 1 said that she dumped out resident 1's drink. CNA 1 said that it was a lapse in judgment and said she should not have done that. CNA 1 said that resident 1 dumped out resident 2's milk from his/her dinner tray.

CNA 1 said she did not think that resident 1 was being fair to resident 2 because resident 2's meal instructions indicated that he/she could have the milk on his/her dinner tray.

During an interview, Nurse 1 said that during dinner resident 1 came to the nurses' station and asked for a drink. Nurse 1 said that CNA 1 dumped out his/her water. Nurse 1 said that after dinner, resident 1 reported that CNA 1 threw out his/her water a second time and that resident 1 wanted to report CNA 1. Nurse 1 said that when she realized that resident 1 was complaining that CNA 1 intentionally threw his/her water, she reported resident 1's allegation to the supervisor and CNA 1 was sent home.

The nursing home provided the Surveyor with a plan of correction which addressed the concern with a series of measures including, among others:

a. Termination of CNA 1's employment.
b. The Director of Nurses initiated an all staff retraining related to abuse prohibition, resident rights, and retaliation (the majority of staff were trained).

Name of Nursing Home	Chapin Center / Provider ID: 225291
Address	200 Kendall Street, Springfield, Massachusetts
Date investigation completed	February 3, 2020
Type of deficiency issued	F557 – Respect and Dignity
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225291/health/complaint?date=2020-02-03

Ice Water on the Head

The nursing home failed to prevent staff from retaliating against resident 12. The failure resulted in V9 pouring a cup of ice water over resident 12's head.

The nursing home also failed to follow their abuse policy by not immediately reporting an allegation of abuse to the Administrator / Abuse Coordinator for resident 12.

It was reported to the Administrator that resident 12 threw a cup of water on V9 and V9 threw a cup of water on resident 12. Social Worker (V10) said she heard a shout from V9 and saw V9 get up and then heard V9 say, "How do you like it" or "How does it feel."

The final abuse investigation documented that V9 admitted to pouring water/ice on resident 12 in an impulse reaction towards resident 12.

An interview with V9 documented that Social Worker (V10) explained to V9 that it was abuse.

V9 acknowledged that her action of throwing a cup of water on the resident was abuse. V9 was remorseful and understood that her action was unprofessional.

The Director of Nursing stated, "Retaliation is abuse. The incident with V9 and resident 12 was abuse." Due to the findings, V9 was relieved from her duties.

Social Worker (V10) is no longer working at the nursing home due to failure to immediately report an incident to Abuse Coordinator.

The incident has taken place on a Sunday afternoon while the documents under Preliminary 24-hour Abuse Investigation Report indicated that the abuse allegation of the ice water incident was reported to the Administrator only on the following day (Monday) at approximately 9:50 AM.

The nursing home's Abuse Reporting and Prevention Policy stated, "Employees are required to report any incident, allegation or suspicion of potential abuse they observe, hear about or suspect to the administrator immediately or to an immediate supervisor who must report to the administrator immediately."

Name of Nursing Home	Aperion Care Chicago Heights / Provider ID: 145180
Address	490 West 16th Place, Chicago Heights, Illinois
Date investigation completed	February 28, 2020
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F609 – Reporting of Alleged Violations
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 3; Staffing Rating: Missing data	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145180/health/complaint?date=2020-02-28

Wash Basin with Urine in Bedside Drawer

The nursing home failed to support residents' right to file grievances anonymously. This had the potential to affect all residents in the nursing home. The failure increased the risk of diminished quality of life as residents were not allowed to freely voice their concerns.

During a Resident Council interview with seven residents, resident 63 stated he had filed a grievance but was also interested to know if he could file a grievance anonymously. When asked if residents felt they could file grievances without fear of retaliation or that staff would get back at them, resident 55 shook her head and said, "I feel like I am retaliated against when I complain. I still say what I have to say but I feel they won't come to check on my room when my lights are on."

Resident 42 stated he also felt staff retaliates when he complains and said, "a while back I had to poop on myself because there was a wash basin with urine in it sitting on my toilet. I had to urgently poop but first had to urgently move the basin filled with urine and it took too long and I ended up pooping on myself. I had to clean it all up. It was 2:00 AM. When I was done, I took the urine filled basin and placed it on the desk at the nursing station and when staff asked why I did that, I told them why. Well, a couple of days later, I was smelling urine for like two days and looked all over the place. I finally opened my bedside drawer and found the same basin that had the urine in it in that drawer. Can you believe that?" He asked for the official paper to write the complaint and was given a blank piece of paper instead. He said, "I want the official paper to complain on." He wanted to know how to file grievances anonymously.

During an interview, Social Services Director (SSD) stated she oversaw grievances and that she would help residents with grievances complete the grievance form. The SSD stated the grievance forms were also available at the nurses' station by asking the nurse or from the front desk. The SSD stated there is no pamphlet or written information given to residents upon admission specifically related to grievances. She added that no process was available for residents to file grievances anonymously.

Review of the nursing home's Grievances Policy stated, "A resident has a right to voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment." The document did not include language consistent with the federal requirement that residents had the right to file grievances anonymously.

Name of Nursing Home	Miracle Mile Healthcare Center, LLC / Provider ID: 555139 [Alternative name: Beverly West Healthcare]
Address	1020 South Fairfax Ave. Los Angeles, California
Date investigation completed	February 15, 2019
Type of deficiency issued	F585 – Grievances
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/555139/health/standard?date=2019-02-15

Shower Scalding

The nursing home failed to protect resident 15 to be free from mistreatment. It also failed to report an allegation of mistreatment in a timely manner.

Resident 15 had severe cognitive impairment and dementia and required extensive one-staff assistance with personal hygiene.

A Reportable Event identified abuse allegations involving nurse aide 7. During the nursing home investigation, nurse aide 4 reported that yesterday at approximately 10:00 PM, nurse aide 7 threw resident 15 onto the bed from the wheelchair and removed the resident's clothing aggressively. Resident 15 became physical and hit nurse aide 7. Nurse aide 7 then struck resident 15 back in retaliation.

The second allegation came when the nursing home was conducting interviews related to the allegation of mistreatment. Nurse aide 6 alleged that nurse aide 7 verbalized to nurse aide 6 that she intentionally scalded resident 15 in the shower in retaliation after nurse aide 7 saw resident 15 throw coffee on another resident. Nurse aide 6 also alleged that nurse aide 7 told the resident that he/she is rude and "that's why your family doesn't visit."

During an interview, nurse aide 7 denied all the allegations that were presented against her. Nurse aide 7 stated that the Director of Nursing Services had no evidence to prove the allegations against herself.

During an interview, nurse aide 4 stated nurse aide 7's attitude would reflect on the care she gave to the residents. Nurse aide 4 reported that resident 15 was brought back to his/her bedroom by nurse aide 7 and nurse aide 4. Once in the bedroom, nurse aide 7 tossed resident 15 from the wheelchair to bed. The nurse aide identified it was done in such a way that it caused resident 15 to bounce up and down on the bed from the force. Nurse aide 7 then threw a shirt at resident 15 because she saw the resident put on a shirt before and stated he/she can do it again. Resident 15 refused to place the shirt on, at which point nurse aide 7 removed the resident's clothes roughly and aggressively. Resident 15 began to call nurse aide 7 names and become resistive to care. When nurse aide left the bedroom to retrieve additional supplies, she heard a slap sound. Nurse aide 4 immediately went into resident 15's bedroom but was not able to visualize anything. Nurse aide 4 alleges the body position of nurse aide 7 and resident 15 suggested something may have occurred, but nurse aide 4 was unable to positively identify if a slap happened.

RN 2 stated the nursing home was unable to substantiate the allegations against nurse aide 7 due to too many mitigating circumstances to confirm what happened or to substantiate abuse. Nurse aide 7 was terminated from her position.

Name of Nursing Home	Cheshire House Health Care Fac / Provider ID: 075373
Address	3396 E. Main Street, Waterbury, Connecticut
Date investigation completed	May 27, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/075373/health/standard?date=2021-05-27

Be Quiet About What Happened…

The nursing home failed to a. develop and implement written policies and procedures that prohibit and prevent neglect of resident 1, resident 2, and resident 3; b. report allegations of abuse/neglect and continued to allow perpetrators access to fearful residents. The failures placed residents who experienced abuse/neglect at risk of further abuse/neglect, physical and emotional harm, and decreased quality of life.

Resident 1 had moderately impaired cognition (BIMS score 10 out of 15) and required extensive assistance with bed mobility, dressing, personal hygiene, and total dependence with 1 staff for toilet use.

During an interview, resident 1 stated CNA F (agency staff) put a towel with resident 1's feces on it in her face. The resident said that CNA F got mad at her because she did not want her to use paper towels to clean her but wanted her to use a towel. She said that CNA F was mad at her and touched her nose with the towel with feces on it. She stated that after that CNA F threw the towel on the floor because a big hunk of feces came out. The resident reported the incident to the Infection Control Specialist.

Resident 1 said when CNA F touched her nose with feces, she was upset, and it made her feel neglected. She said, "You should not treat anybody that way." Resident 1 stated she believed CNA F did it on purpose and it was retaliation. She tried not to think about it anymore because it made her upset.

The resident said that CNA C asked her if she feared retaliation and the resident told her sometimes resident 1 thinks the nursing home might put her out (discharge her from the nursing home).

When speaking with the Infection Control Specialist, CNA F denied resident 1's allegations.

Resident 3 had severe cognitive impairment (BIMS score of 3 out of 15) and required extensive assistance of one staff for bed mobility, dressing, eating, toilet use, and personal hygiene.

During an interview, Housekeeper 1 said that while cleaning resident 2 and 3's bedroom, resident 2 told her that he heard CNA B slap resident 3. Housekeeper 1 spoke with resident 3 who told her to be quiet about what happened. The resident said he did not want to say anything. While his speech was impaired, he was able to speak a few words and illustrate to the surveyor where on his head he was hit by CNA B. The resident added that he was afraid, and that CNA B was bigger than him.

Resident 2 stated that since his allegations regarding resident 3 being slapped, he was fearful of retaliation. He was afraid that staff will spit in his food and stated that once he receives his last vaccination, he desires to leave the nursing home. He added that resident 3 is so afraid of being reported to the nursing home that he picks through his food to make sure nothing is in it. CNA B denied hitting resident 3.

Name of Nursing Home	Afton Oaks Nursing Center / Provider ID: 455682
Address	7514 Kingsley Street, Houston, Texas
Date investigation completed	January 19, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/455682/health/complaint?date=2021-01-19

Fear of Reporting

The nursing home did not ensure that resident 1 was free from staff abuse. Specifically, resident 1 reported that CNA 1 hit him/her with a metal tray on the right side of the face.

Resident 1 was cognitively intact (BIMS score of 15 out of 15) and required extensive assistance with activities of daily living and supervision with eating.

Review of Accident/Incident Report and nursing home investigation included the following: Resident 1's recollection that someone allegedly caused an injury to the resident's right side of the face was consistent. The resident stated that the incident took place at dinner time. Resident 1 was presented with pictures of the staff and resident 1 identified CNA 1. CNA 1 stated that resident 1 was upset and threw meal items from the meal tray. The food and utensils ricochet onto resident 1's bedding and onto resident 1. CNA 1 reported that he/she noticed that resident 1 had redness beneath the right eye immediately following the behavior. CNA 1 called the nurse to evaluate. While resident 1 was consistent and unwavering, CNA 1 adamantly denied the allegation. The size, shape, and characteristics of the injury were consistent with pressing the tray to resident 1's face. The nursing home's investigation concluded that abuse did occur.

Social Work's Note made a day after the incident revealed resident 1 made an accusation that a staff member hit him/her face with a meal tray. The resident admitted to throwing the meal tray at the staff member because he/she was annoyed. The food was all over the bed and on the floor.

During an interview, CNA 1 stated she/he brought dinner to resident 1 who said, "It's about time." CNA 1 stated that she/he opened the carton of milk that was on resident 1's tray and resident 1 stated that the milk was spoiled. CNA 1 stated that the LPN put the medication in the milk and the resident saw the residue and thought that the milk was spoiled. Resident 1 began throwing everything off the tray onto the floor. CNA 1 stated that she/he ran for safety behind the curtains of the bed next to the door. CNA 1 stated that she/he was unable to get close to resident 1 as the resident was throwing the contents of the tray. CNA 1 stated that she/he left the bedroom and immediately reported the incident to LPN 1. CNA 1 stated that she/he also notified LPN 1 that resident 1 had a slight swelling at the corner of the right eye.

The Director of Nursing Services (DNS) stated that resident 1 was consistent and was unwavering of how CNA 1 hit his/her right eye with the tray that CNA 1 picked up from the floor. Resident 1 stated that CNA 1 stood on resident 1's left side, reached across to and pressed the tray against the side of resident 1's face. The DNS stated that the bruise mark on resident 1's face was consistent with the tray. The DNS stated that resident 1 said that he/she did not say anything when the incident happened because he/she feared retaliation from CNA 1 who was still on duty.

Name of Nursing Home	Triboro Center for Rehabilitation and Nursing / Provider ID: 335445
Address	1160 Teller Ave. Bronx, New York
Date investigation completed	January 12, 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: 4; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/335445/health/complaint?date=2022-01-12

"Honey, They Almost Broke Me in Half"

The nursing home failed to prevent physical and verbal abuse of three residents (701, 703, and 704) and one discharged resident 1. This deficient practice resulted in an Immediate Jeopardy, hospitalization related to physical injury, unnecessary pain, and psychosocial distress.

Resident 701 had moderate cognitive impairment (BIMS score of 10 out of 15) and required extensive to total assistance with activities of daily living. The resident had "hard time swallowing pills."

During an interview with Witness B who worked at the hospital where resident 701 had been transferred following an incident, witness B stated that resident 701 said they had been abused ("handed like a doll") at the nursing home when a worker got mad after they spilled their medications. The witness stated that the resident was hospitalized due to an injury (X-ray showed c-2 displacement) because of the assault.

During an interview held after resident 701 returned to the nursing home, the resident was asked why they were in the hospital and stated, "RN A picked me up by the legs and the back of the neck. I don't want to talk about it. It was scary." The resident said that RN A hurt their neck when they grabbed them, and added, "RN A yelled at me. Called me names. I don't want to talk about it anymore."

During an interview, Nursing Assistant (NA) E stated that resident 701 "called me into their room because RN A left their pills on the bedside table for resident 701 to take themselves" (despite knowing she wouldn't take them). Resident 701 then stated, "Honey, I think I dropped some of my pills and I can't find them." They searched the bed and floor but couldn't find them. NA E stated, "I went and told RN A and RN A went ballistic." RN A was swearing at resident 701 and called them, "Fuc*ing idiot" and "Are you fuc*ing stupid" and "I am going to be in trouble." RN A then yanked the blankets off resident 701 and grabbed resident 701's neck and bent them forward. NA E said that RN forcefully pulled the resident forward by their neck towards their feet. NA E stated that resident 701 cried out, "OW, OOW, OW, Stop. You're hurting me." NA E yelled loudly, "RN A, WHAT THE HELL ARE YOU DOING?" RN A then slammed resident 70's back down in the bed, threw the blankets at the resident, and stormed out the bedroom. NA E said resident 701 was "so upset," looked at me with terror in their face, and said, "Honey, they almost broke me in half." NA E stated they stayed with the resident for 10-15 minutes to provide emotional support and promised the resident they would take care of it.

An hour later, RN A asked NA E, "Was resident 701 really upset? NA E told RN A: "Yes, you were so cruel." RN A then said, "I better go in there and smooth things over so resident 701 doesn't report me."

Resident 701 instructed her spouse not to speak to anyone about it because they were afraid of retaliation.

The Administrator revealed that mistreatment allegation was substantiated, and RN A was fired.

Name of Nursing Home	Medilodge of Richmond / Provider ID: 235486
Address	34901 Division Road, Richmond, Michigan
Date investigation completed	August 13, 2020
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/235486/health/complaint?date=2020-08-13

"Never Saw Such Evil"

The nursing home failed to treat residents 191, 22, and 192 with respect and dignity.

The following summary focuses only on resident 191.

Resident 191 lived with "severe cognitive deficit" (BIMS score of 3 out of 15) and required extensive 2-person assistance for transfers, walking, dressing, and toilet use and he frequently rejected care. He had "physical behaviors towards others such as hitting, kicking, pushing, scratching, and grabbing firmly."

Staff F's Letter of Suspension signed by the Administrator was reviewed. It stated that Staff E was assisting CNA Staff F to change the bedding and clothing of resident 191. While providing care, the resident became agitated and struck Staff F in the face.

According to Staff E, Staff F became angry and retaliated against the resident by prying his clenched hand open, grabbing his pinky finger, and bending it back toward his wrist until he screamed. Staff E later shared that Staff F pulled back his pinky finger so far that resident 191 started to scream. Staff E reported that staff F then said that she wanted to beat the s**t out of him. Staff F continued to tell the resident that he was an "a** hole" and "a pain in the a**."

When Staff E reported the incident, they told the Administrator they "never saw such evil."

Staff F was suspended without pay until the completion of the investigation.

Staff H, Registered Nurse (RN) reported that she was the interim Director of Nursing during the time of the incident. She said that she worked with Staff F on other occasions, and that she saw Staff F get verbally harsh and impatient with resident 191.

The Exit Interview revealed that the nursing home was "not willing to bring Staff F back as an employee due to the severity of the abuse case."

Name of Nursing Home	Thomas Rest Haven / Provider ID: 165358
Address	217 Main Street, Coon Rapids, Iowa
Date investigation completed	April 6, 2022
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/165358/health/standard?date=2022-04-06

Struck Out

The nursing home failed to ensure resident 1 remained free from physical abuse when Staff A, after being struck by resident 1, retaliated by striking the resident in the face.

Review of resident 1's Care Plan revealed that the resident was identified as "exhibiting or has potential to exhibit physical aggressive behaviors – hitting at staff and throwing objects. Resists care from staff and is verbally abusive and also wanders into others' bedrooms and not easily redirected at times due to cognitive loss / Dementia."

Video surveillance documented that at approximately 9:00 PM, resident 1 was walking in the hallway and took an item off Staff A's medication cart. Staff A approached the resident from behind, reached over the top of resident 1, and grabbed the item from the resident. The resident then struck Staff A. Staff A then took a step back and struck resident 1 in the face.

Review of the nursing home's investigation of the incident indicated that another staff member reported there was a spot of blood on the floor, and resident 1's nose was bleeding.

Witness statement included resident 1 was "doubled over." The witness stated, "I went to resident 1 who had a bloody nose and was saying, 'I didn't mean to.'"

Skin checks showed slight bruising to the peri right eye, and redness has spread to most of the right eye."

The nursing home's investigation concluded that there is sufficient evidence to support abuse, and during the interview, the Director of Nursing stated that it was "definitely a situation of abuse."

Staff A was immediately suspended and subsequently terminated.

Name of Nursing Home	Springfield Health & Rehab / Provider ID: 475025
Address	105 Chester Road, Springfield, Vermont
Date investigation completed	August 19, 2020
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 2; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/475025/health/complaint?date=2020-08-19

"Reflexive" Hitting

The nursing home did not ensure that resident 1 was free from physical abuse. Specifically, resident 1 slapped LPN 1 and the LPN retaliated by striking the resident. The incident was captured on surveillance video recording.

Resident 1 had moderately impaired cognition and physical and behavioral symptoms directed towards others such as hitting, kicking, pushing, screaming, and threatening others.

The nursing home investigation documented "there was no indication that there was any intent to harm resident 1. Although, it is reasonable to conclude that LPN 1's actions provoked resident 1 to the extent that resident 1 became physically aggressive and hit LPN 1. Final review of the video footage was done, allowing the camera to run past an incident between resident 1 and another resident. LPN 1 was observed on the surveillance camera aggressively approaching resident 1. LPN 1 was in face-to-face proximity with the resident in an intimidating manner waving his arms instructing the resident to leave the area. Resident 1 was seen slapping LPN 1 with an open right hand to his/her left cheek. Resident 1 started to run away, and LPN 1 ran after the resident. LPN 1 reacted and was seen grabbing the resident's left hand and pushing the resident against the wall. LPN 1 was acting in an aggressive manner by raising her right hand to strike the resident. Both CNA 1 and CNA 2 witnessed the incident and separated LPN 1 from resident 1.

During an interview, the Chief Nursing Officer (CNO) stated that he/she reviewed the resident-to-resident incident on the surveillance camera and allowed the video recording to run past the resident-to-resident incident and that was when he/she observed the incident between LPN 1 and resident 1. The CNO stated that resident 1 suddenly hit LPN 1 and LPN 1 hit resident 1 back. The CNO stated that he/she immediately started an investigation.

On the day of the incident, resident 1 was transferred to the hospital via New York Police Department for aggressive behavior and the resident was admitted to inpatient psych and will be re-evaluated.

During an interview held nearly four months later, LPN 1 stated that he/she was at the far end of the hallway when he/she heard a resident-to-resident altercation that involved resident 1. LPN 1 stated that after the residents were separated, LPN 1 spoke to resident 1 to try and redirect resident 1 back to his/her bedroom. LPN 1 stated resident 1 slapped him/her on the left side of the face and that his/her (LPN 1) reflex came in back at the resident. CNA 1 pushed LPN 1 into another resident's bedroom stating, "Remember your job, remember your job." LPN 1 discontinued the phone interview by hanging up the phone. Two additional attempts to contact LPN 1 via phone call were unsuccessful.

Name of Nursing Home	Highland Care Center / Provider ID: 335505
Address	91-31 175th Street, Jamaica, New York
Date investigation completed	November 19, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/335505/health/complaint?date=2021-11-19

Punched in the Face

The nursing home failed to ensure that: a. resident 24 was free from abuse; and b. policies and procedures prevented abuse of resident 24.

Resident 24's medical record indicated that the resident had no cognitive score due to her/his inability to complete the questions related to dementia.

An Incident Report indicated that CNA 4 punched resident 24 in the face. The incident was witnessed by CNA orientee 1 and immediately reported to the Administrator and Director of Nursing (DON).

Review of the nursing home's investigation of the incident revealed that on a Friday at 3:05 PM, CNA 4 and CNA orientee 1 were in resident 24's bedroom providing care. Resident 24 became combative and hit CNA 4 in the face. CNA 4 then punched resident 24 twice in the face, causing a bloody nose and mouth. CNA 4 initially called CNA 5 to the bedroom and stated resident 24 hit his head on the bed, but then admitted to hitting resident 24. CNA orientee 1 left the room and went to alert the nurse to resident 24's injury and CNA 4 clocked out and left the nursing home. CNA orientee 1 went to the Administrator and DON to inform them of the incident. At 3:44 PM, the nursing home contacted local law enforcement, reported the incident, and sent resident 24 to the hospital for evaluation.

CNA 4 was asked to return to the building to be questioned related to the incident. CNA 4 appeared to be under the influence of some substance, and a urine test was administered, but the urine specimen provided did not have high enough temperature to be utilized.

The local police initially declined to take the case, stating CNA 4 acted in self-defense. The Administrator contacted the local Sherriff on the same day (Friday) and further explained the situation. The Sherriff was informed that all staff, including CNAs, were trained to walk away and not retaliate when residents become combative. The Sherriff stated that the situation had been handled incorrectly by the police and a warrant should have been obtained for the CNA's arrest, but it would likely be Monday as it was the weekend. The Administrator stated that after an initial police refusal to pursue legal action against CNA 4, the police did become involved, and charges were sought against CNA 4 for striking resident 24.

At 8:00 PM on the same day of the incident, CNA 4 had been hospitalized after a car wreck in which CNA 4 was driving and tested positive for alcohol and an unknown substance. CNA 4 did not return a call to discuss the incident and her/his employment was terminated. CNA orientee 1 left the employment with the nursing home and did not respond to attempted phone calls.

Name of Nursing Home	Dundee Manor, LCC / Provider ID: 425118
Address	710 15-401 Bypass, West, Bennettsville, South Carolina
Date investigation completed	September 19, 2019
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/425118/health/standard?date=2019-09-19

Cursed and Slapped

The nursing home did not ensure resident 3 was free from abuse. Specifically, the nursing home did not ensure resident 3, who had severe cognitive impairment, was free from verbal and physical abuse when CNA 4 used profanity and slapped the resident.

Resident 3 had severely impaired cognition (based on MDS assessment) but could usually make herself understood and could usually understand others.

An Accident/Incident Report documented the resident received an open hand slap on the cheek.

The investigation completed by the Director of Nursing (DON) documented CNA 4 was assisting CNA 2 with care for resident 3. Resident 3 was verbally and physically uncooperative, which was common for the resident. After deciding to stop and return later, CNA 4 suggested trying once more. CNA 2 thought that was an acceptable plan. CNA 4 placed their hand on the resident's left arm and encouraged them to stand. The resident mumbled something., and CNA 4 replied, "Don't tell me what the @%&$ to do." The resident then struck CNA 4 in the right temple with their left hand. CNA 4 reacted by slapping the resident on the cheek with an open hand using enough force to cause the head to move. CNA 4 immediately left the room and reported their action to the RN.

During an interview, the RN Educator stated that CNA 4 reacted to the resident verbally and physically. Staff are told they cannot retaliate against a resident, and that CNA 4 knew the resident had behaviors and should have reapproached the resident.

During an interview, the DON stated CNA 4 did not think at the time of the incident, and just reacted, then afterwards they realized what they had done.

CNA 4 was escorted out of the nursing home, suspended pending the outcome of the investigation.

Name of Nursing Home	Aurelia Osborn Fox Memorial Hospital / Provider ID: 335204
Address	One Norton Avenue, Oneonta, New York
Date investigation completed	October 29, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/335204/health/complaint?date=2021-10-29

"Please God Help Me"

The nursing home failed to ensure staff followed and implemented abuse and neglect policies and procedures for reporting, investigation, and protection for residents 60, 115, and 104. Additionally, the nursing home failed to investigate and protect residents from retaliation and further abuse and neglect after reporting concerns to the Resident Council.

The nursing home's failure to immediately report allegations of abuse and neglect to the state agency as required, failure to initiate immediate investigations, and failure to protect residents after an allegation of abuse/neglect constituted a situation of Immediate Jeopardy. Residents 60 and 104 suffered psychosocial harm in the form of fear, feeling abandonment/neglected and experienced retaliation from staff.

During a Resident Council meeting, residents reported they are afraid/not comfortable reporting individual staff members, when staff does/says something inappropriate to them, ***due to the retaliation they have experienced, have witnessed, or their peers have stated, when they have asked for their preferences to be met, or assistance they needed. They stated that most of the staff members respond to them as if they have no awareness of residents' rights.

The residents were upset that their call lights are not being answered in a timely manner, mostly on the evening and night shifts, and are afraid to say anything about the staff, due to *** above. They reported that staff is rude to them, ignore them, laughs at them, do not take them seriously, accuse them of asking too much of staff, and that even co-worker friends treat them badly when they have spoken up for themselves. Overall, the residents do not feel heard, and supported in their numerous attempts to have their needs and preferences met. The residents stated that Genesis (corporation) does not care about them.

During an interview with two surveyors, resident 60, who had intact cognition and needed two-person assistance with activities of daily living, reported an allegation of neglect. The resident stated that one Sunday ago, around 1:00 PM to 2:00 PM, she called for help as she had a loose bowel movement and needed to be changed. Staff N answered her call light, told her he would be back but never returned. The resident stated she was not changed until 8:00 PM that day. The resident stated, "I felt neglected. I was crying the whole time I was waiting. I said to myself, 'Please God help me and have somebody come.'"

Resident 104 was alert and oriented and able to make her needs known and assessed to be dependent on staff for care, requiring two-person extensive assist for transfers and toileting. During an interview, while visibly upset and crying, the resident stated she used the call light to request assistance to have her incontinence brief changed but "sat in my wet brief for at least an hour to an hour and 15 minutes." Review of Grievances Log included a statement by resident 104 by which grievances given to CNAs result in retaliation. She stated that she is forced to wait more than 2 hours and feels punished.

Name of Nursing Home	Ballard Center / Provider ID: 505042
Address	820 Northwest 95th Street, Seattle, Washington
Date investigation completed	November 7, 2018
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 2; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/505042/health/standard?date=2018-11-07

Threatened to Turn Her Water Off

The nursing home failed to ensure residents were free from staff intimidation when reporting verbal abuse for eight residents. This failure resulted in immediate jeopardy related to psychosocial harm of residents due to fear and intimidation of retaliation by the nursing home in reporting abuse and neglect by staff.

Resident 7 stated staff made her feel degraded and "made me cry" in the last month, the last time was two weeks ago. She said staff talked down to her and acted like she was out of bounds with them.

The resident 7 was asked if she could recall any the name(s) of staff and the resident stated, "It's all the CNAs, on every shift." The resident was asked if she had reported these incidents to the Executive Director. She stated, "No" and added that she wanted to remain anonymous because she was afraid of retaliation from staff after the survey team left." The resident requested the team lead and this surveyor's business card, "just in case." When asked why, the resident added, "Just in case the staff does something to me after you leave."

Residents participating in a Resident Council Meeting were asked collectively if the staff treated them with respect and dignity. Residents 4, 32, 61, and 62 responded, "No." They stated that they were made to feel like an imposition. They reported "being shuffled around like we are furniture."

When the residents were asked if they had reported this to the nursing home, they stated they were very apprehensive about reporting staff incidents. The residents stated they did not feel anyone would do anything, and they did not trust and/or were afraid of the agency staff because they did not know them. Residents 4, 32, 61, and 62 added that staff were "demeaning and disrespectful towards residents."

Resident 333 stated she was afraid to say anything to the staff, because she did not trust them. The resident stated that a CNA threatened to turn her water off, so she could not shower without facility knowledge which made her feel like a child. The resident stated a CNA failed to follow through when she made a request, and she was told, "You can just leave" in a nasty tone of voice by the CNA. When asked who the staff member was, the resident refused to say any more about the incident.

The nursing home's policy Protection of Residents, stated, "Residents have the right to live at ease in a safe environment without the fear of retaliation when allegations are reported."

The investigation report concluded that the policy was not followed.

Name of Nursing Home	Life Care Center of Post Falls / Provider ID: 135135
Address	460 North Garden Plaza Court, Post Falls, Idaho
Date investigation completed	November 8, 2019
Type of deficiency issued	F600 – Free from Abuse and Neglect
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 4; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/135135/health/standard?date=2019-11-08

Epilogue: Breaking the Silence

Several years ago, a *Star Tribune* series on elder abuse, *Left to Suffer*, detailed a disturbing story about an 80-year-old woman recovering from pneumonia at a nursing home in Minnesota.[57] According to the report, the woman felt fluid building up in her lungs and became frightened when the nursing home discontinued giving her antibiotics. When she asked an aide if they could resume her medications, she didn't receive a response. When she asked a nurse to call a doctor to renew her prescription, the nurse came and slammed a phone against her chest so hard that the resident almost passed out.

"I laid there for 20 minutes, too petrified to move," she said.

The woman reported the incident to the Health Department the following day, but no investigator arrived or returned her calls. She was later notified by the Health Department that her case had been delayed until later that year.

The resident, reflecting on her efforts to advocate for herself, "wondered why she bothered to call the state agency instead of 911 or local police." She added, "This is why no one knows about these crimes. It's not because we don't have a voice. It's because people in power deliberately choose not to listen."

It is time to break the silence and end the dangerous normalization of this phenomenon.

We hope this project, **"They Make You Pay,"** starts and continues a conversation about resident fear of staff retaliation in LTC homes by generating the most in-depth examination of this phenomenon to date. Ultimately, we want this project to spark *meaningful* policy, practice, and enforcement actions to address fear of retaliation in U.S. nursing homes. It is time to break the silence and end the dangerous normalization of this phenomenon.

In an interview, Mairead Painter (Connecticut State Long Term Care Ombudsman) offered advice to residents facing fear of retaliation, reminding them that "people are stronger together."[58] Painter raised the following scenario: "Okay, they are afraid to go one-on-one with that. All right, well, let's bring it to the resident council. That way we can bring it together and have the resident council address it as the larger body of us. And using the strength of that peer-to-peer support. And then, if there is a family council, bringing it to the attention of a family council if it is not addressed by the administration."

Painter explained: "Whenever you talk about any type of abuse, there's a power dynamic. The person is using that to isolate. They start to carve the person out. They keep them alone. They keep them in fear. And so, when you align with someone, you break some of that dynamic down. That is what we would really encourage people to do and where the role of the Ombudsman comes in as well."

Systemic progress addressing fear of retaliation, however, requires action beyond the individual level. Though our project does not primarily aim to identify solutions, we hope it will encourage different stakeholders –

---

[57] Serres, C. (November 12, 2017). "Abused, ignored, across Minnesota." [The first in a five-part series "Left to Suffer."], *The Star Tribune*. https://www.startribune.com/senior-home-residents-abused-ignored-across-state/450623913/

[58] Interview with E. Caspi and Mairead Painter held on March 16, 2023. In the interview, Painter spoke about the emotional consequences identified in this project. "It is extremely disturbing," Painter said, "and it just shows we need to do a lot more education and outreach.

including, among others, LTC ombudsmen, providers, federal and state agencies, and care advocacy organizations – to come together to identify and implement solutions.

Importantly, residents and their families **must** be part of any initiative on this front. On that note, we conclude this project with parting wisdom from individuals most directly impacted by the phenomenon of fear of retaliation.

"If you are afraid of anything...I don't care how little or how big it is, you should be able to tell somebody. Whether it be for yourself or for someone else."

– Mary, nursing home resident featured in a 2010 video, Voices Speak Out Against Retaliation

"None of this will happen overnight. You must hold on to your ideas and always have the courage to speak your mind."

– Carol A. Rosenwald (1999), nursing home resident, activist, and driving force behind the first VOICES Forum

Appendix A

Search Strategy and Process

This project used completed and de-identified standard surveys and complaint investigation reports (all public records) called Statement of Deficiencies and Plan of Correction (Referred to as Form CMS-2567 or SOD). This CMS form is the official document on which state surveyors record deficiency citations and document the determination of non-compliance. This record informs the care provider (as well as the public) of its state of non-compliance with the requirements for participation in the Medicaid and Medicare programs.

The search strategy consisted of using the shortened term "retal" (to capture the terms "retaliation" and "retaliated") in standard surveys and complaint investigation reports published on ProPublica's Nursing Home Inspect.[59] An initial pool of 835 standard surveys and complaint investigation reports (Form CMS-2567) were identified from nursing homes across the country. These 835 standard surveys and complaint investigation reports were reviewed between late December 2022 and January 2023 with the goal of identifying 100 investigation reports containing sufficient and compelling detail necessary to meet the project's goals pertaining to identifying: 1. residents' fear of staff retaliation; 2. residents' allegations of staff threats of retaliation; 3. residents' perceived staff retaliation; 4. actual (confirmed) staff retaliation against residents; and 5. the range of emotional consequences of 1-4 (above) on residents.

These 100 standard surveys and complaint investigation reports identified during this process served as the final dataset for this report.

Most of the 835 standard surveys and complaint investigation reports initially identified were excluded from the project's dataset because they pertained to: a. family members' fear of staff retaliation against a loved one (an important phenomenon deserving special attention elsewhere); b. staff fear of retaliation from supervisors, managers, or co-workers (also an important phenomenon deserving special attention elsewhere); c. resident-to-residents acts of retaliation; d. investigation reports containing the term "retaliation" (such as in the nursing home's Abuse Policy or Residents' Rights) that did not contain substantive descriptions relevant to this project; and e. standard surveys and complaint investigation reports that did not contain substantive content.

A digital archive of the investigation reports is available on **nursinghome411.org/retaliation**. Note: Seven standard surveys and investigation reports were no longer electronically available on CMS *Care Compare* website at the time the electronic archive was created.

Caveats: "Type of Deficiency Issued" (F-tag) and "Severity Level"

A deficiency citation issued (e.g., F600 for Abuse) by a state surveyor does not necessarily mean that the deficiency citation was directly related to retaliation. In fact, in most of the cases reviewed for this project, this was not the case. Caution is therefore necessary when interpreting the findings pertaining to deficiency citations (F-tags).

[59] Standard surveys and complaint investigation reports on Nursing Home Inspect (ProPublica) are obtained from the federal CMS *Care Compare* website.

In addition, consider the following when interpreting surveyors' determination of the "severity level": First, the level of harm is not necessarily directly related to the retaliation involved in the report. Second, state surveyors are instructed by CMS to determine a severity level that is a direct result of an identified noncompliance with a regulatory requirement at a specific F-tag. That is, the surveyor's determination of "severity level" may not reflect the level of suffering and harm reported by residents.

The Overall Quality Star rating (i.e., "Overall Rating") and the Staffing Rating of the nursing homes reported on in this project were retrieved from the CMS data archive using the star ratings from the month in which the standard survey or complaint investigation was completed.[60]

This Overall Rating is based on a nursing home's performance in three categories: health inspections, staffing levels, and quality measures. See CMS's Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide for more methodology on constructing ratings.[61]

[60] CMS, Nursing homes including rehab services data archive, https://data.cms.gov/provider-data/archived-data/nursing-homes.

[61] CMS, *Design for Care Compare Nursing Home Five-Star Quality Rating System: Technical Users' Guide*, https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcomplianc/downloads/usersguide.pdf

Appendix B

Summary of State Survey Deficiency Citations (F-tags)

New F-tags			Old F-tags			Total
F-tag	**n=**	**Scope**		**n=**	**Scope**	**n=**
F600	43	Free from Abuse and Neglect	F223	1	Abuse. Right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.	44
F585	18	Grievances	F166	1	Right to Prompt Efforts to Resolve Grievances	19
F550	15	Resident Rights / Exercise of Rights	N/A			15
F610	15	Investigate/Prevent/Correct Alleged Violation	N/A			15
F607	14	Develop/Implement Abuse/Neglect, etc. Policies	F226	1	Develop/Implement Policies Prohibiting Abuse/Neglect/Misappropriation/Exploitation	15
F609	14	Reporting of Alleged Violations	N/A			14
F565	7	Resident/Family Group and Response	N/A			7
F557	3	Respect and Dignity	N/A			3
F561	3	Self Determination	N/A			3
F602	3	Free from Misappropriation / Exploitation	N/A			3
F583	2	Personal Privacy / Confidentiality of Records	N/A			2
F656	2	Comprehensive Care Plans	N/A			2
F725	2	Sufficient Nursing Staff	N/A			2
F835	2	Administration	N/A			2
N/A			F225	2	Report and Investigate Any Acts or Reports of Abuse, Neglect or Mistreatment of Residents	2
F603	1	Free from Involuntary Seclusion	N/A			1
F604	1	Right to be Free From Physical Restraints	N/A			1
F675	1	Quality of Life	N/A			1
F677	1	Activities of Daily Living Care Provided for Dependent Residents	N/A			1
F679	1	Activities Meet Interests / Needs of Each Resident	N/A			1
F684	1	Quality of care	N/A			1
F755	1	Pharmacy Services	N/A			1
F812	1	Food Procurement, Store/Prepare/Serve – Sanitary	N/A			1
F919	1	Resident Call System	N/A			1
						157

State Survey Deficiency Citations (F-tags) Identified in Current Project

F-tags used by CMS after November 28, 2017

F550. Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.

F557. Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(c)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

F561. Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

F565. Resident/Family Group and Response. The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

F585. Grievances. The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay. §483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph. §483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident. §483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident.

F600. Freedom from Abuse, Neglect, and Exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

F602. Free from Misappropriation/Exploitation. The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

F603. Free from Involuntary Seclusion. §483.12(a)(1) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

F604. Right to be Free from Physical Restraints. Respect and dignity. The resident has a right to be treated with respect and dignity, including: §483.10(c)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.

F607. Develop/Implement Abuse/Neglect, etc. Policies. §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, §483.12(b)(4) Establish coordination with the QAPI program required under §483.75. §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. §483.12(b)(5)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. §483.12(b)(5)(iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act.

F609. Reporting of Alleged Violations. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12can(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F610. Investigate/Prevent/Correct Alleged Violation. In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment

while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

F656. Comprehensive Care Plans. §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following — (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)— (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

F675. Quality of Life. Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care.

F677. ADL Care Provided for Dependent Residents. A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

F679. Activities Meet Interests / Needs of Each Resident. The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

F684. Quality of Care. Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.

F725. Sufficient Nursing Staff. Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(c).

F755. Pharmacy Services. The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed

personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

Source
State Operations Manual. Appendix PP – Guidance to Surveyors for Long Term Care Facilities (September 30, 2022)

F-tags used by CMS prior to November 28, 2017

F166. Right to Prompt Efforts to Resolve Grievances. A resident has a right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

F223. Abuse. The resident has a right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

F225. Report and Investigate any Acts or Reports of Abuse, Neglect or Mistreatment of Residents. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedure (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is still in progress.

F226 – Develop/implement policies prohibiting abuse/neglect/misappropriation/exploitation. The facility must develop and operationalize polices and procedures for screening and training employees, protection of residents and the prevention, identification, investigation, and reporting of abuse, neglect, mistreatment, and misappropriation of property. The purpose is to assure that the facility is doing all that is within its control to prevent occurrences.

Deficiency Severity Level

A deficiency's "severity level," determined by a state surveyor, represents the extent of harm to the resident(s). The severity levels range from 1-4, though deficiencies in this report range from levels 2-4.

- **Level 1:** No actual harm with potential for minimal harm: A deficiency that has the potential for causing no more than a minor negative impact on the resident(s) or employees.
- **Level 2:** No actual harm with a potential for more than minimal harm that is not immediate jeopardy: Noncompliance with the requirements that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the residents or employees and/or that result in minimal discomfort to the residents or employees of the facility, but has the potential to result in more than minimal harm that is not immediate jeopardy.
- **Level 3:** Actual harm that is not immediate jeopardy: Noncompliance with the requirements that results in actual harm to residents or employees that is not immediate jeopardy.
- **Level 4:** Immediate jeopardy to resident health or safety: Noncompliance with the requirements that results in immediate jeopardy to resident or employee health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident who receives care in a facility or an employee of the facility.

References

American Psychological Association's Dictionary of Psychology: Learned helplessness. Retrieved on March 20, 2023 from https://dictionary.apa.org/learned-helplessness

Broyles, K. (2000). The silenced voice speaks out: a study of abuse and neglect of nursing home residents. A report from the Atlanta Long-Term Care Ombudsman Program and Atlanta Legal Aid Society to the National Citizens Coalition for Nursing Home.

Brod, M., Stewart, A. L., Sands, L., & Walton, P. (1999). Conceptualization and measurement of quality of life in dementia: the dementia quality of life instrument (DQoL). The Gerontologist, 39(1), 25-36. https://academic.oup.com/gerontologist/article/39/1/25/568745

Caspi, E, "Without the Voice of Elders," ChangingAging (February 9, 2021). https://changingaging.org/blog/without-the-voice-of-elders/

Caspi, E, "Life and Death in Assisted Living," *The Gerontologist*, Volume 61, Issue 8 (December 2021). https://doi.org/10.1093/geront/gnab132

Centers for Disease Control and Prevention, "Fast facts: Preventing Elder Abuse." https://www.cdc.gov/violenceprevention/elderabuse/fastfact.html

CMS data archive: Nursing homes including rehab services data archive: https://data.cms.gov/provider-data/archived-data/nursing-homes

CMS, State Operations Manual – Appendix PP – Guidance to Surveyors for LTC Facilities. Available at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/downloads/appendix-pp-state-operations-manual.pdf

CMS: Psychosocial outcomes severity guide. Available at https://www.cms.gov/files/document/psychosocial-outcome-severity-guide.pdf

Conrad, K. J., Iris, M., Ridings, J. W., Rosen, A., Fairman, K. P., & Anetzberger, G. J. (2011). Conceptual model and map of psychological abuse of older adults. *Journal of Elder Abuse & Neglect*, 23(2), 147-168. https://pubmed.ncbi.nlm.nih.gov/21462048/

Goffman, E. (1961). Essays on the Social Situation of Mental Patients and Other Inmates. Anchor Books: Garden City, New York.

Harrington et al. (2016). The need for higher minimum staffing standards in U.S. nursing homes. *Health Services Insights, 9*, 13-19. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4833431/

Harrington et al. (2020). U.S. nursing home violations of international and domestic human rights standards. *International Journal of Health Services, 50(1),* 62-72. https://journals.sagepub.com/doi/10.1177/0020731419886196

Hawes, C. (2003). Elder abuse in residential long-term care settings: what is known and what information is needed?. In Elder mistreatment: Abuse, neglect, and exploitation in an aging America. National Academies Press (US). https://www.ncbi.nlm.nih.gov/books/NBK98786/

Hirt, J., Adlbrecht, L., Heinrich, S., & Zeller, A. (2022). Staff-to-resident abuse in nursing homes: a scoping review. *BMC geriatrics*, 22(1), 563. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9261065/

Liu, P., Caspi, E. Cheng, C-W. (2021). Complaints matter. Seriousness of elder mistreatment citations in nursing homes nationwide. *Journal of Applied Gerontology*, *41(4),* 908-917. https://pubmed.ncbi.nlm.nih.gov/34486438/

Magan, C. (2023). Caregivers allege 'harassment and retaliation' at Hastings veterans home. *The Pioneer Press*. https://www.twincities.com/2023/03/05/caregivers-allege-harassment-and-retaliation-at-hastings-veterans-home/

Minnesota Office of the Legislative Auditor (2005). Evaluation report: Nursing home inspections. https://www.auditor.leg.state.mn.us/ped/pedrep/0505all.pdf

National Long Term Care Ombudsman Resource Center (2018). Responding to allegations of abuse: Role and responsibilities of the LTC Ombudsman Program: https://ltcombudsman.org/uploads/files/issues/ane-no-consent-ref-guide-july_2018.pdf

Resident care assistant. Certified nursing assistants: The Foundation. Presented at the Annual Meeting of the Massachusetts Alzheimer's Association, Marlborough, MA; May 14, 2018.

Robison, J., Gruman, C., Reed, I., Shugrue, N., Kellett, K., Porter, M., Smith, P. Jo, A., Curry, L. (2007). Connecticut long-term care needs assessment: Connecticut Long Term Care Ombudsman Program. University of Connecticut's Health Center.
https://health.uconn.edu/dev-aging/wp-content/uploads/sites/102/2017/03/ombudsman_program.pdf

Robison, J., Shugrue, N., Reed, I., Thompson, N., Smith, P., and Gruman, C. (2011). Community-based versus institutional supportive housing: Perceived quality of care, quality of life, emotional well-being, and social interaction. *Journal of Applied Gerontology, 30(3),* 275-303.
https://journals.sagepub.com/doi/10.1177/0733464810369810

Serres, C. (November 15, 2017). Speak up, and risk eviction. Part 4 in the 5-Part series Left to Suffer.
The Star Tribune. https://www.startribune.com/senior-home-residents-risk-eviction-when-they-speak-up/450626083/

Serres, C. (November 12, 2017). Abused, ignored, across Minnesota. Part 1 in the 5-Part series Left to Suffer. *The Star Tribune*. https://www.startribune.com/senior-home-residents-abused-ignored-across-state/450623913/

Stannard, C.I. Old folks and dirty work: The Social conditions for patient abuse in a nursing home. *Social Problems, 20(3),* 329-342. https://psycnet.apa.org/record/1973-29687-001

State of Connecticut (April 16, 2012). An Act Concerning Fear of Retaliation Training in Nursing Home Facilities. https://www.cga.ct.gov/2012/FC/2012SB-00137-R000419-FC.htm

The National Consumer Voice for Quality Long Term Care (September 8, 2022). High staff turnover: A job quality crisis in nursing homes. https://theconsumervoice.org/news/detail/all/nh-staff-turnover-report

U.S. Government Accountability Office, "Nursing homes: Addressing the factors underlying understatement of serious care problems requiring sustained CMS and state commitment," 2009. https://www.gao.gov/products/gao-10-70

U.S. House of Representatives, "Abuse of Residents is a Major Problem in U.S. Nursing Homes," July 30, 2001. https://www.cbsnews.com/htdocs/pdf/waxman_nursing.pdf

U.S. Office of Inspector General, "Nursing home complaint investigations," 2006. https://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf

U.S. Office of Inspector General, "A few states fell short in timely investigation of the most serious nursing home complaints: 2011–2015," 2017. https://oig.hhs.gov/oei/reports/oei-01-16-00330.pdf

U.S. Office of Inspector General. "Incidents of potential abuse and neglect at skilled nursing facilities were not always reported and investigated," 2017. https://oig.hhs.gov/oas/reports/region1/11600509.pdf

VOICES Forum. Connecticut Long Term Care Ombudsman Program: https://portal.ct.gov/LTCOP/Content/Voices-and-Forums/Voices-Main

Voices Speak Out Against Retaliation training video (2010), produced by the Connecticut Long Term Care Ombudsman Program, the Connecticut Department of Social Services (Office of Organizational and Skill Development), and the University of Connecticut School of Social Work. https://www.youtube.com/watch?v=feoQjlW3_bc

Wright, D., & Tritz, K. (2016, November). Something old, something new: The revised federal nursing home regulations. In *Plenary session at the 40th Annual Conference of the National Consumer Voice for Quality Long-Term Care, Arlington, Virginia.*

Acknowledgements

Eilon Caspi, PhD, conducted the research for this study and is the principal author of this report. For more information on his work, visit https://dementiabehaviorconsulting.com/ and https://chip.uconn.edu/person/eilon-caspi-phd/.

Mairead Painter, Connecticut State Long-Term Care Ombudsman, for sharing key resources for inclusion in the report and for her invaluable insights about this phenomenon during an interview held for this report.

Special thanks to all the state surveyors who work diligently and skillfully to conduct standard surveys and complaint investigations in nursing homes across the country. Without their hard but rarely recognized work, this project would not be possible.

Thanks to the folks at ProPublica for creating the *Nursing Home Inspect* platform that enables the public to identify and retrieve standard inspections and complaint investigation reports in nursing homes nationwide. Without this website and its search features, this project would not have been possible.