“Nobody Spoke Up”

Staff Fear of Retaliation in America’s Nursing Homes

June 2026

STATE INVESTIGATION REPORT

“I might lose my job for telling the truth”

[redacted]

- **100** Nursing Homes
- **35** States
- **160** Employees Impacted
- **172** Residents Impacted

By Eilon Caspi, PhD

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Quotes

"*Nobody spoke up or intervened because nobody wanted to offend another nurse aide or nurse because it would make it difficult to work together again*" – Nurse Aide after another Nurse Aide exposed her buttocks to a man living with Schizophrenia and passed gas on him

"*You did not see anything*" – CNA told Laundry Aide after the latter witnessed unlawful physical restraint of a person living with dementia

"*You didn't see anything*" – Medication Technician told a CNA after the latter witnessed the former forcing medication into the mouth of a person living with dementia

"*I do want this complaint to remain anonymous due to fear of retaliation*" – Anonymous email to the corporate organization about unsafe and hazardous practices at the nursing home

An LPN's hit the face of a person with paraplegia. A CNA who witnessed it changed her statement during the nursing home's internal investigation because she was afraid of retaliation by the nursing home for telling the truth. When in the presence of the state Surveyor the Director of Nursing asked the CNA: "*Which one is your statement? You keep changing your statement*," the CNA said: "*You see, this is the intimidation I am talking about, and I might lose my job for telling the truth*."

A CNA was "*in trouble only because she advocated for the resident*"

"I am a whistleblower and I am being retaliated against. I have had problems with [Nurse's name] because she is stealing narcotics" – Staff member

An LPN stated "*it took so long* ["a few weeks"] *to come forward because they felt they would be retaliated against*" after witnessing an employee's ongoing verbal abuse of residents

"*There was some nepotism going on*" and she did not want retaliation – Reason why an LPN did not report on another LPN who did not provide tracheal suctioning for a man with a history of respiratory failure

"*Many other staff feel the same way but are afraid to say anything for fear of retaliation"* – A Nurse while reporting to state Surveyor on poor staffing levels

"*Staff said they feared for their jobs and felt powerless to protect residents from abuse*" – State Surveyor

CNA 1 witnessed CNA 2 choke hold a man with Alzheimer's disease but didn't intervene or report the abuse Because "*She was a big girl and could beat me up*" / CNA 1 felt if she reported it to administrative staff, the nursing home would retaliate against her, and her employment would be terminated

An LPN was "*hesitant to say anything as management does not do anything and tends to retaliate against reporters"* – The LPN witnessed an RN consume medications but didn't report it until the next day

A Confidential employee told a state Surveyor they are scared to say anything to the Director of Care Services about the poor staffing levels "*because she will retaliate and fire you if you voice a concern*"

"*I did not know staff were afraid to speak up*." – Administrator of a nursing home where there were numerous allegations of abuse and neglect by residents

"*Everyone in the facility was terrified of retaliation by the Administrator if they spoke to anyone about the issues in the building*" – Anonymous complainant

CNA: "*All the staff are scared, terrified, and intimidated by the Administrator"* / She added "*she knows she would lose her job if they talk with the state surveyors*"

Explaining why she didn't report on administrative staff abuse of a resident, a CNA said she feared losing her job. She said "*she could not be without work as she had family to support*" / "*Staff said they feared for their jobs and felt powerless to protect residents from abuse*"

"*The Administrator and Director of Nursing failed to operate the nursing home in a manner to allow the nursing home staff to voice allegations of abuse without fear of retaliation*" – State Surveyor

"*There is a culture of retaliation in the facility*" – CNA in a nursing home with poor staffing levels

Concerns by an anonymous employee about an LPN overmedicating residents or misusing their controlled medications "*were swept under the rug with no repercussions other than* [the nurse] *retaliating against those she felt turned her in*"

"*Retaliation would come in the forms of being given the cold shoulder, yelled at in front of their peers, and/or labeled a troublemaker to the point you either got fired or quit*" – Five Nursing Assistants

A CNA witnessed an LPN verbally abuse a woman with cognitive impairment, but she didn't report it for two weeks. She explained: "*A lot of CNAs on the floor will say they are afraid to report abuse because when you do, they are the ones that end up getting fired instead of the abuser*"

"*If they wanted a paycheck, they better not say anything bad*" to state Surveyors

"*Nobody spoke up*" – Staff Fear of Retaliation in America's Nursing Homes

Abstract

Staff fear of co-workers, supervisors, and managers' retaliation when witnessing right violations, abuse, and neglect of individuals living in nursing homes is a major barrier to reporting, investigation (internal and external), protecting residents and staff, and holding perpetrators and care providers accountable. Despite decades of concern about this problem and known harm, it has not been examined in an in-depth manner to date.

The data for the project consisted of 101 state investigation reports (completed between Dec 21, 2017 and November 10, 2025) from 100 nursing homes (80% for profit) located in 35 states (65% in urban and 35% in rural areas). The project examined the circumstances surrounding 160 staff members' *lived experiences* of fear of retaliation (in their own words) when witnessing right violations and mistreatment (primarily abuse and neglect) of 172 individuals (70% with cognitive impairment) and considering whether or not to report it.

Insights from the project could inform care practice and policy efforts to ensure that direct care staff and all other employees will realize their right to report resident right violations, care concerns, and mistreatment without fear of retaliation and without threats of and actual retaliation against them. This, in turn, could assist in holding mistreatment perpetrators and nursing homes accountable, prevent further harm, and increase the likelihood that vulnerable individuals living in nursing homes will receive dignified and safe care.

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Acronyms

BIMS. Brief Interview for Mental Status

DON. Director of Nursing

LPN. Licensed Practical Nurse / LVN. Licensed Vocational Nurse

MDS. Minimum Data Set

PHI (Formerly Paraprofessional Healthcare Institute)

RN. Registered Nurse

STNA. State Tested Nursing Assistant

Definitions
Fear "An unpleasant often strong emotion caused by anticipation or awareness of danger" * **Fear of Retaliation** "A concern or feeling of vulnerability that one's actions may cause retaliation by another" ** **Retaliation** "An actual or perceived negative reaction of a person as a result of another person's action or behavior" **
* Merriam-Webster Dictionary ** Voices Speak Out Against Retaliation Instructor's Guide

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Disclaimer. In all cases, compliance with all applicable federal and state laws and regulations must take precedence over any suggestion, interpretation, or recommendation contained in this report. This includes any changes made in the future in these laws and regulations.

Chapter 1 – Introduction

Despite federal regulations that set the standards of care in over 15,000 nursing homes nationwide, evidence of widespread and serious mistreatment of individuals living in these care settings is well documented (Castle et al. 2015; Harrington et al. 2020; Hirt et al. 2022). For example, a systematic review and meta-analysis (Yon et al. 2019) found that more than half of staff members admitted that they committed acts of mistreatment against individuals living in various types of long-term care (LTC) settings (psychological abuse, 33%, physical abuse, 14%, neglect, 12%, and sexual abuse, 2%).

In addition, a significant portion of abuse and neglect incidents are not reported by nursing homes to State Survey Agencies as required in federal nursing home regulations (Hirt et al. 2022; U.S. Office of Inspector General, 2019). This is a longstanding problem (U.S. General Accounting Office, 2002).

The nursing home complaint process is considered "the front-line system" for addressing residents and families' concerns (U.S. Office of Inspector General, 2006) and "a critical safeguard to protect vulnerable residents" (U.S. Office of Inspector General, 2017). The importance of resident and family mistreatment complaints in nursing homes has been demonstrated in a study titled *Complaints Matter* (Liu et al. 2022).

A major barrier for reporting right violations, care concerns, abuse, and neglect in nursing homes has to do with residents' fear of staff retaliation. As one Ombudsman explained: "*When you're complaining about someone who is responsible to care for you, it puts them in a vulnerable situation*."

Residents' fear of retaliation has been found in an early study to be common in nursing homes (Robison et al. 2007; 2011). Specifically, 23% of the residents surveyed in Connecticut nursing homes reported worrying about retaliation if they were to report a concern or complaint. An earlier survey conducted by the Atlanta Long-Term Care Ombudsman Program (2000) found that 44% of residents who had seen abuse of other residents did not report it. Half of them did not report it due to fear of retaliation.

In addition, as can be seen below, numerous Ombudsman representatives reported recently that residents' fear of retaliation is common in long-term care homes (Caspi, 2024).

Quotes Illustrating Prevalence of Residents' Fear of Retaliation
"It's real, it's prevalent, and it harms residents."
"It is I think probably at the foremost thoughts of many residents and families…truly."
"We do see it almost every day when we are in the field."
"It happens all the time."
"There is fear with a lot of people and facilities."
"I deal with it almost every visit that I do."
"It very much exists. We hear it very often when we're in facilities and when we're getting calls in the intake line. I feel like it's prevalent."
"I know this phenomenon is widespread. It's all over the place."
"It runs pretty rampant."
"It's a pervasive problem."
"…how often we see it…it really is shocking."
"I think it is an epidemic."
Source: Caspi (2024)

Quote
"We constantly hear about retaliation fears and actual harm to residents, families and staff. This is a rapidly escalating problem that results in inconceivable suffering and it must be stopped" – Kristine Sundberg, Elder Voice Advocates, 3.25.23

In addition, a qualitative study demonstrated the far-reaching negative impact of residents' fear of retaliation on these individuals in nursing homes nationwide (Caspi, 2024; Long Term Care Community Coalition, 2023). It has also been described in another report titled *Silenced* on resident fear of retaliation in 40 Illinois nursing homes (Caspi, 2024) and in a new educational video titled *Breaking the Silence: The Fear of Retaliation* (Connecticut and Colorado Long-Term Care Ombudsman Programs, 2025).

In a quality improvement project, 50 Ombudsman representatives from 32 states described the varied strategies they use to address residents' fear of retaliation in LTC homes (Caspi, 2024). In addition, a comprehensive educational resource on this issue has recently been developed for individuals receiving LTC services and supports, family members, care teams, and educators (*Connecticut and Colorado Long-Term Care Ombudsman Programs and Caspi, 2026)*.

Many family members of people living in LTC homes also fear retaliation when considering whether to report right violations, care concerns, and mistreatment of their relatives (Lawrence, 2024). In recent interviews (Caspi, 2024), one Ombudsman representative reported (about residents' fear of retaliation): "*I hold Family Councils where this topic comes up a lot for family members*." Another Ombudsman said: "*It's a real fear. It is natural for a lot of families to bring that up to me whether they want to open a case because they're fearful that with their loved ones, will it make the situation worse*." Still another said: "*I have a lot of cases where the families are more scared of retaliation than the residents are*."

Research studies are urgently needed to examine the issue of family fear of retaliation in nursing homes and assisted living residences (to my knowledge, no study has been published on it in English to date).

While care employees' fear of retaliation has been well documented and studied in other healthcare settings (Elsehrawy et al. 2025), staff fear of retaliation has also been found in research studies to be a strong barrier for reporting abuse and neglect of individuals in nursing homes (McCool et al. 2009; Winsvold Prang and Jelsness-Jorgensen, 2014; Moore, 2017a). In addition, government reports (U.S. Office of Inspector General, 1990; U.S. General Accounting Office, 2002) and media reports (Brady-Lunny & Swiech, 2017; Khimm, 2020; Magan, 2023) show that staff members' fear of retaliation when witnessing right violations and mistreatment of residents in nursing homes is a longstanding problem.

For example, an early report by the U.S. Office of Inspector General (1990) examined resolution of abuse complaints in nursing homes nationwide. It relied on 232 interviews with individuals working in state, national, and federal organizations that are "involved with receiving, investigating, and/or resolving abuse complaints in nursing homes" and/or "knowledgeable and concerned about nursing home or elder issues." One of the report's findings was that "abuse often goes unreported by nursing home staff."

When asked how often abuse is reported by nursing home staff, half of the respondents (51%) said that they believe abuse is only sometimes or rarely reported by staff. Respondents believed that the primary reasons staff do not report resident abuse include:

- Basic fear of losing one's job
- The sense of loyalty shared among staff
- Fear of retaliation by the nursing home or peers
- Fear of fines or penalties
- Fear of bad publicity
- Lack of clear or sufficient facts
- Failure to recognize the less blatant forms of abuse

The Centers for Medicare & Medicaid Services (CMS), the federal agency overseeing over 15,000 nursing homes across the country, recognizes the importance of staff fear of retaliation:

"Protection of residents can be compromised or impeded if individuals are fearful of reporting, especially if the alleged abuse has been carried out by a staff member" – CMS
Source: CMS State Operations Manual Guidance to Surveyors for Long-Term Care Facilities – Appendix PP (8.8.24)

Examples of applicable CMS guidance to state Surveyors:

Under state survey deficiency citation F607, nursing homes must develop and implement written policies and procedures that, among others, prohibit and prevent abuse, neglect, and exploitation of residents and the misappropriation of their property, establish policies and procedures to investigate any such allegations, include staff training, ensure reporting of suspicion of a crime, and prohibit and prevent retaliation. Under Reporting/Response, CMS states that the nursing home must have written procedures that must include assuring that reporters of alleged violations "are free from retaliation or reprisal."

Under state survey deficiency citation F609, among other requirements, the nursing home "must report alleged violations related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source and misappropriation of resident property and report the results of all investigations to the proper authorities within prescribed timeframes" (the required reporting timelines are detailed in CMS State Operations Manual – Guidance to Surveyors for Long-Term Care Facilities – Appendix PP).

CMS also states: “To encourage reporting of reasonable suspicions of a crime, facilities should develop and implement policies and procedures that promote a culture of safety and open communication in the work environment. This may be accomplished through prohibiting retaliation against an employee who reports a suspicion of a crime.”

CMS provides examples of actions constituting retaliation against staff members. These include:

“When a facility discharges, demotes, suspends, threatens, harasses, or denies a 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” (CMS, 2024).

The federal agency gives the following example of retaliation against a staff member: “If a staff member, on behalf of or as an agent of the facility, harasses an employee who had reported a reasonable suspicion of a crime.” Another example provided by CMS is: “When a facility files a complaint or a report against a nurse or other employee with the state professional licensing agency because of lawful acts done by the nurse or employee for reporting a reasonable suspicion of a crime to law enforcement.”

Despite the fact that fear of retaliation among staff in nursing homes has been known for decades (U.S. Office of Inspector General, 1990) and despite CMS guidance to State Surveyors for addressing it, to my knowledge, systematic and in-depth examination of this issue has not been conducted to date.

This project takes first steps towards bridging this major gap in knowledge. The report “*Nobody spoke up*” aims to capture *the circumstances surrounding* staff fear of retaliation when witnessing, suspecting or otherwise becoming aware of right violations, abuse, and neglect of individuals living in 100 nursing homes in 35 states. The primary focus of the project is on staff *lived experience* (in their own words) of this fear and the impact it exerts on them and their willingness to report these issues. It also sheds light on various forms of right violations and mistreatment experienced by individuals receiving care without being reported or when reports (internally and externally) are compromised, concealed and/or delayed.

The report is based on an examination of 101 state investigation reports retrieved from Nursing Home Inspect (ProPublica) website (which provides a powerful way to quickly identify investigation reports on various forms of resident rights violations and mistreatment in nursing homes nationwide).

My hope is that the report will improve understanding of this longstanding problem with the goal of informing the development of care practices and policies aimed at encouraging and empowering direct care staff members to speak up about resident right violations and mistreatment while remaining safe.

Chapter 2 – Findings

The examination of the 101 state investigation reports (completed between December 21, 2017 and November 10, 2025) identified 160 staff members who feared retaliation or experienced intimidation or threats of retaliation or actual retaliation when witnessing or otherwise becoming aware of right violations, abuse, neglect, and exploitation of 172 individuals living in 100 nursing homes in 35 states (for breakdown of the states, see **Appendix 1**).

A smaller proportion of these staff members reported experiencing intimidation and threats of retaliation as well as actual retaliation against them when speaking up about or reporting resident mistreatment. Specifically, among the 160 staff members, 126 (79%) reported fearing retaliation while 17 (10.5%) reported experiencing intimidation or threats of retaliation from other employees and another 17 (10.5%) reported experiencing retaliation against them for speaking about mistreatment.

Using the Rural-Urban Commuting Area (RUCA) classification system (in which codes 1-3 represent urban areas and codes 4-10 represent rural areas), 65% of the 100 nursing homes were located in urban areas and 35% were in rural areas (Rural Health Information Hub). For comparison, 39%-40% of CMS-certified nursing homes are considered rural (based on the same RUCA classification system).

Ownership Status. Using CMS archival data, the 100 nursing homes consisted of 80% for profit, 15% not for profit, and 5% government owned (including 3% "Government – City / County / State" and 2% "Government – Hospital District"). For comparison, approximately 70% of CMS-certified nursing homes are for profit, 24% are not for profit, and 6% are government owned.

5-Star Quality Rating System

CMS archival data was used to retrieve Overall Quality Star Rating (i.e., the nursing homes' combined ratings for health inspections, staffing levels, and quality measures) for the 100 nursing homes examined in this project (i.e., two investigation reports pertained to the same nursing home called *Autumn Creek Post Acute* – both were completed around the time when the nursing home had the same overall star rating). Information about the Overall Quality Star Rating was not available for seven nursing homes as the investigation reports were completed in 2017 and 2018 while the look-back period of CMS archival data only went back to 2019. Thus, information was available for 93 out of the 100 nursing homes.

The average Overall Quality rating for those 93 nursing homes (94 investigation reports) was 2.4 (on a 1-5 scale where 1 star represents "much below average," 2 stars represent "below average," 3 stars represent "average," 4 stars represent "above average," and 5 stars represent "much above average" within a state). This means that CMS considers the Overall Quality of these 93 nursing homes as slightly lower than the midpoint between "below average" and "average." In addition, a general downward trend was identified whereby 36 of the 93 nursing homes (39%) were rated with 1 star (the same nursing home was rated twice with 1 star in two separate investigations), 18 were rated with 2 stars (19%), 16 were rated with 3 stars (17%), 14 were rated with 4 stars (15%), and 10 were rated with 5 stars (10%). Research is needed to systematically examine whether staff fear of retaliation when witnessing right violations, abuse, and neglect of residents is more prevalent in nursing homes providing overall lower quality of care.

Staff Positions

Among those 160 staff members fearing retaliation, nearly two-thirds (64%) were CNAs and nurses. Specifically, 82 (51.12%) were CNAs / Nursing Assistants, 21 (13.12%) were nurses (including 10 LPNs / LVNs, 6 RNs (and an additional Hospice RN), and 4 "other nurses" (including 2 unspecified, 1 "Hospice Nurse" and one Director of Nursing). In addition, 4 (2.50%) were housekeepers / laundry aides, 3 (1.87%) were recreation workers, 2 (1.25%) were office managers, and 1 (0.62%) was a social worker. An additional 47 (29.37%) employees were classified as "unspecified / anonymous staff" (that is, no details were included in the investigation reports about their position).

Cognitive Function

Cognitive function data were available for only 111 (64.5%) of the 172 individuals for whom staff stated that they experienced mistreatment. Among these 111 individuals, 78 (70%) were reported to live with some level of cognitive impairment while 33 (30%) individuals were cognitively intact. Sixty out of these 111 individuals (54%) were reported to live with moderate-to-severe cognitive impairment.

Types of Mistreatment Violations

The types of right violations and mistreatment described by the state Surveyors in the 101 investigation reports examined in this project varied significantly. Specifically, the types of incidents witnessed, suspected or otherwise known by employees who were fearful of retaliation included:

Right violations. Examples included an Administrator who demanded that a resident will wear a bra when in a public space; turning off a person's TV against their wish; forcing residents out of their beds against their will; and privacy violations such as when a CNA took an unauthorized live photograph showing a resident standing in the bathroom with feces on their buttocks and legs and then the employee shared it with several employees.

Verbal and mental abuse. Examples included clapping and speaking loudly to a man with a "really bad PTSD" known to be "very sensitive" to noise; yelling at or humiliating residents; and encouraging a woman to bang her head on the corner of a wall.

Physical abuse. Examples included spitting at a resident with dementia; slapping and punching a resident's face; hitting a person with Schizophrenia with a closed fist (causing him to cry and be fearful); kicking the shin of a man with severe cognitive impairment; choke holding a resident; placing a pillow over the head of a man with cognitive impairment for 10 Seconds; pushing the head of a person with severe cognitive impairment on a nightstand; pushing a resident into the wall; causing a resident to hit his/her head into a wall; forcing medication into a person's mouth; while laughing, twisting a woman with Alzheimer's disease around "naked in her wheelchair with her feet up in the air;" throwing cups filled with water on a man during care; and filling a gastrostomy syringe with water and squirting the water at sleeping residents. A threat of physical violence was also identified.

Physical restraints. Multiple abusive incidents of physical restraints were identified.

Sexual abuse. Examples included a nurse aide exposing herself and intentionally passing gas on a man with Schizophrenia and laughing at their expense and an allegation that an LPN gave a woman other residents' medications in return for oral sex.

Neglect. Examples included an injurious transfer against requirements in the person's Care Plan; not providing tracheal suctioning to a man with a history of respiratory failure; infected pressure sores; people in advanced stages of dementia who left the building without supervision; neglect to prevent abusive sexual resident-to-resident incidents; and violations related to pests control (e.g., a widespread mice and rats infestation).

Poor staffing levels. Employees in several nursing homes feared retaliation when they considered whether to report on poor staffing levels (e.g., described by one RN as "*heartbreaking*").

Another nurse, who reported to a state Surveyor on poor staffing levels said: "*The ones who suffer are the residents, they get pressure ulcers, they end up infected*."

Taking personal belongings (e.g., in an effort to pressure a resident to move to a different bedroom).

Stealing residents' opioids pain medications.

State Survey Deficiency Citations (Ftags)

A total of 226 relevant Ftags were issued in the 101 investigation reports examined in this report. These Ftags span across 33 unique Ftag types. For definitions of each of these Ftags, see **Appendix 2**.

As can be seen in **Appendix 3**, further support for the wide range of mistreatment violations identified in this project is based on the fact that the 101 investigation reports examined in it included 33 unique state survey deficiency citations (Ftags) – all relevant to the topic at the center of this project.

The most common Ftags issued by state Surveyors consisted of failures to "Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect of anybody" (F600; 26.99%), failures to "Timely report suspected abuse, neglect or theft and report the results of the investigation to proper authorities" (such as the State Survey Agency) (F609; 22.12%), failures to "Respond appropriately to all alleged violations" (F610; 14.60%), and failures to "Develop and Implement policies and procedures to prevent abuse, neglect, and theft" (F607; 10.61%).

Cumulatively, these four violations accounted for three-quarters (74.3%) of the 226 violations (issued under the 33 unique Ftags) identified in this project.

For details about the number of times each of the 33 Ftags was issued, see **Appendix 3**.

Scope and Severity

With regards to Scope and Severity determinations, among the 226 Ftags, 115 (50.88%) were issued by state Surveyors at the level of "Minimal Harm," 34 (15.04%) were issued at the level of "Actual Harm," and 76 (33.62%) were issued at the "Immediate Jeopardy" level (information regarding the Scope and Severity of an additional Ftag was missing in one investigation report). For details, see **Appendix 4**.

For comparison, in 2017, only one-fifth (20.2%) of 875 abuse citations issued in nursing homes nationwide were determined by state Surveyors to be at the Immediate Jeopardy level (U.S. Government Accountability Office, 2019).

Chapter 3

Brief Summaries of 101 Cases – Staff Fear of Retaliation

This chapter includes brief descriptions of incidents detailed in the 101 investigation reports examined in the project (full summaries of these investigation reports can be found in **Appendix 5)**:

Staff Fear of Retaliation

Because it was their boss and fearing they would be fired, two CNAs did not report witnessing the Administrator verbally and mentally abuse a resident (telling her/him in a public space – where other residents and staff could hear it – s/he needs to wear a bra when in public space) / The Administrator also yelled to CNAs at the nurses' station to make sure the resident wears a bra / These actions made the resident feel upset, humiliated, and embarrassed

A CNA took a live photograph showing a resident in the bathroom with feces on their buttocks and legs. Two CNAs were shown the photograph but did not report it for nearly two weeks because they feared retaliation from the Assistant Director of Nursing (DON) who was present when the photograph was shown by the perpetrator to multiple staff members. They both feared retaliation also because the CNA was related to the Assistant DON. One of them was afraid the Assistant DON would have them fired

Delay in reporting punching a man with Alzheimer's disease, resulting in a black eye

An employee fearful of reporting mice and rats infestation

Scared of the Administrator and losing her job ("She just had a baby"), an RN was forced by the Administrator to alter Cardiopulmonary Resuscitation (CPR) Progress Note

"*I do want this complaint to remain anonymous due to fear of retaliation*" – Anonymous email to the corporate organization about unsafe and hazardous practices at the nursing home

A CNA not intervening when hearing supervising nurse verbally abuse a woman with Huntington's disease

CNAs not reporting on co-worker's verbal and physical abuse of a woman with dementia

A Nurse Aide who witnessed abuse of a man requested to remain anonymous fearing losing her job

A Laundry Aide witnessed restraint of a woman with dementia but didn't report it fearing retaliation

A 9-hour delay in reporting yelling at and kicking a person living with cognitive impairment

Fear of retaliation for speaking up about "chronic" staffing shortages

CNAs not intervening when the Executive Director (described by the Assistant Director of Nursing as a "*Tyrant Ruler*") abused a woman / The woman said that she was "*scared to death*" of the Executive Director / "*Many staff members were intimidated by her and afraid of losing their jobs if they reported her*"

A CNA did not report a Nurse's verbal abuse of 10 residents on a "memory care unit"

A CNA witnessed an LPN's striking a resident with dementia – Pressured by the LPN and fearing retaliation from him, the CNA initially reported a false story about the incident

A CNA witnessed but delayed reporting another CNA's physical abuse (punching the chest at least six times and kicking the leg) of a woman living with dementia

A Nurse witnessed but didn't report a Medication Technician forcing medication into a person's mouth / "*You didn't see anything*"

A CNA witnessed verbal and physical abuse of a woman with dementia but did not report it

Delay in reporting verbal and physical abuse of a man with cognitive impairment (slapping him twice in the face and telling him: "*I'll beat the f_ _ _ out of you. You know you're laying in the bed and can't move*")

Scared of retaliation, CNAs did not report abusive physical restraint (multiple Incidents) by RN / One employee explained why s/he did not report it: "*Who are they going to believe a RN or I*?"

A Nurse Aide was fearful of retaliation for speaking up about an abusive Nurse Aide

"*I did not know staff were afraid to speak up*" – Administrator

A CNA slapped the face of a woman with Alzheimer's disease. Then he intimidated a CNA witness who feared retaliation and delayed reporting it / The perpetrator followed the witnessing CNA around throughout the rest of their shift and asked: "*Are you going to tell on me?*" She said she didn't get a chance to say anything to the nurse with the perpetrator always behind her

An Aide witnessed another Aide abuse two residents but delayed reporting it due to fear of retaliation / The Aide said she didn't say anything to anyone about what she witnessed because she had to take the perpetrator home from work, and she was afraid of what would happen to her

Aides were afraid to report on Administrator's abuse (taking personal belongings) of a resident after s/he refused bedroom transfer/ One Aide explained: "*Other staff have been fired for reporting things*"

Two CNAs did not report on Administrator's abuse of a resident due to fear of losing their jobs

A 10-day delay in reporting CNA's verbal abuse of one resident and physical abuse of another

Delays in reporting on a CNA who abused two residents with severe cognitive impairment

Fearing retaliation, Director of Nursing (DON) and Social Worker did not report on abusive Administrator / The DON feared retaliation and even losing her job if she spoke out against the Administrator

Housekeeper witnessed but due to fear of retaliation delayed reporting Nurses' abuse of a woman with serious mental illness as she banged her head on the wall / An RN told her to bang her head on the corner of the wall and maybe it would knock her brain out and she would kill herself

A CNA witnessed but delayed reporting verbal abuse by Medication Aide who then committed another abuse a week later / The CNA who witnessed the 1st incident did not report it to anyone because she was afraid of the previous administration retaliating against her and she would lose her job

An employee anonymously called the police to report sexual resident-to-resident incidents (e.g., a male resident placed his genitals in a woman's face in an attempt for oral sex in the common area)

Fearing retaliation, an anonymous CNA and LPN reported on a woman with dementia who left the building, crossed a 45 miles-per-hour, moderately-high trafficked road, and found at a gas station / The LPN wished not to give her name as she feared retaliation for speaking up about it

CNAs not reporting verbal and physical abuse of two residents with severe cognitive impairment

Fearful of retaliation, a CNA reported an LPN pushed a resident into the wall causing a nose fracture / The witnessing CNA said the resident hit the wall "*like a basketball*"

CNA 1 delayed reporting witnessing CNA 2 slapping the face of a person with Alzheimer's disease and then covering her/his head with a blanket / "*This is how you calm [resident] down*" / The witnessing CNA was shocked, and scared during the incident, and feared retaliation from CNA 2

A CNA witnessed another CNA choke hold a man with Alzheimer's disease but didn't intervene or report the abuse because "*She was a big girl and could beat me up*"

Director of Nursing to Hospice RN: "*If you don't do something with this fucking patient, I am going to stab her in the neck*" / The Hospice RN stated she did not want any retaliation from the Director of Nursing

A Nurse re-wrote her witness physical abuse statement due to fear of retaliation from the Administrator

A CNA in Training witnessed and reported to the Administrator that another CNA placed a pillow over the head of a man with cognitive impairment for 10 Seconds. Then in the locker room, the CNA perpetrator told the CNA in Training and three other employees that they needed to say that while rolling the resident, his head got pushed up against the pillow. Then when the Director of Nursing asked the CNA in Training if she was sure the incident was not a misunderstanding, she felt uncomfortable and intimidated. In fear of retaliation, she retracted her statement and quit her job 15 minutes after her shift

CNA witnessed another CNA yelling "*[OBSCENITY] you! [OBSCENITY] you! [OBSCENITY] you!*" in the face of a man with severe cognitive impairment because he had a bowel movement at shift change. Fearing retaliation from the CNA perpetrator, the CNA was not comfortable reporting the abuse while the CNA perpetrator was in the building. The CNA reported it the following day

An RN witnessed an LVN physically abuse a man with severe cognitive impairment (the LVN put her/his knee over his abdomen) but due to fear of the LVN's retaliation did not report it until the next day

A CNA witnessed but due to fear of retaliation delayed reporting an RN slapping (twice) the face of a woman with cognitive impairment. She reported staff's actions in the past and her name got out there for reporting them and the staff retaliated against her for speaking up for the resident's safety

Several staff members requested to remain anonymous when speaking with a state Surveyor about low staffing levels and their inability to adequately care for residents

Anonymous staff: "*I am afraid to be identified and say anything, because the Board will retaliate*"

An anonymous complainant stated: "*Everyone in the facility was terrified of retaliation by the Administrator if they spoke to anyone about the issues in the building.*" S/he also stated that the Administrator "*placed magnetic cameras that connected to a phone application he had and allowed him to monitor both audio and video from his phone, so that made most everyone afraid to speak freely about any problems.*" / An anonymous employee said: "*The personal cameras went to his house, and they had audio, so he listened to the staff and retaliated by yelling at them and threatening their jobs*" / Another anonymous employee stated "*Nobody wanted to talk to the State because the Administrator warned them all and threatened them if they do*"

A Recreation Worker intentionally clapped and spoke loudly to a man with a "*really bad PTSD*" known to be "*very sensitive*" to noise – Three Recreation Workers were afraid that he will retaliate against them

A Director of Nursing asked staff to change documentation of witnessed resident-to-resident sexual abuse (both with severe cognitive impairment) / "*Staff are afraid of retaliation and losing their jobs*"

Fear of retaliation from LVN who forces residents out of bed against their wish / "*This has been reported to administration, but nothing was done and the staff fears retaliation, so they do not mention it anymore*"

A CNA stated "she is a mandated reporter, and she would have reported the neglect, but did not out of fear of retaliation from co-workers that worked with the CNA" perpetrator / "*It breaks your heart*"

Fearing being fired from her job, an anonymous staff member felt uncomfortable to refuse the Administrator's directive to help a Hispanic resident over an African American resident

Anonymous staff told state Surveyor they fear management's retaliation for reporting understaffing

A CNA didn't report physical abuse of a woman with severe cognitive impairment for two months / She came forward now because she didn't want what happened to her to happen to others / Remaining silent about what she witnessed bothered and concerned her

An RN became aware of physical restraint of a woman with severe cognitive impairment / She waited to report it until the next fay "*so there would not be any retaliation against her*"

Fearing retaliation, a nurse asked to remain anonymous when speaking with a state Surveyor after the Assistant Director of Nursing told her to falsify documentation of late insulin administration

Due to fear of retaliation from management and the Staffing Coordinator, five employees asked a state Surveyor to remain anonymous about poor staffing levels / Lack of care (described by an RN as "*heartbreaking*"). One resident with severe cognitive impairment was found with ants crawling on her while in bed with ant bites throughout her body causing pain, red welts, and hives

A CNA said: "*All the staff are scared, terrified, and intimidated by the Administrator"* / "She knows she would lose her job if they talk with the state Surveyors"

Explaining why they didn't report on administrative staff abuse of a resident, two CNAs said they feared losing their job. One said "*she could not be without work as she had family to support*"

Two CNAs witnessed an LPN abuse a resident (verbal abuse and causing the resident to sit naked in a Geri-chair in the hallway) / They didn't report it immediately due to fear of retaliation from the LPN

Two CNAs did not report alleged sexual abuse of a woman by an LPN (their supervisor), fearing he'll retaliate / The alleged sexual abuse: Oral sex in return for receiving other residents' medications

A witnessing aide lived in a very close proximity to an LPN and "*truly felt in danger of retaliation*" because she was the only staff member working with the LPN when the abusive acts occurred (the LPN filled a gastrostomy syringe with water and squirted the water at the residents while they were sleeping). Therefore, it would be obvious to the LPN that she had reported the abuse

"*I am a whistleblower and I am being retaliated against. I have had problems with [Nurse' name] because she is stealing narcotics*" – A staff member

Fearing retaliation, an LPN did not report on employee's verbal abuse of residents for a few weeks

Due to fear of retaliation, a nurse delayed reporting on another nurse's physical abuse of a woman with severe cognitive impairment living on a secure dementia care unit

Due to fear of retaliation, a CNA Orientee witnessed but did not report staff abuse of a woman

A weeklong delay in CNA's reporting witnessing an LVN exposing himself to a woman in her bedroom / The CNA was afraid to immediately report the incident fearing retaliation if the LVN lost his job

A CNA witnessed physical abuse of a woman with cognitive impairment but didn't report it immediately, saying "*she liked her job and did not want her co-worker to retaliate or confront her*" / The same CNA also witnessed but was afraid to report the same perpetrator's neglect of another resident with Alzheimer's disease who "*sat in poop and urine for eight hours*"

During care, Aide 1 witnessed Aide 2 cause a resident to hit his head on the wall (causing skin tear to his forehead and broken glasses) but due to fear of retaliation, Aide 1 reported it only the next day / Aide 1 said it was a mistake not to report it the first time Aide 2 was rough with the resident but she was afraid of retaliation because it was a small nursing home and the Aide's mom works there too

LPN 1 didn't report on LPN 2 who didn't provide tracheal suctioning to a man with history of respiratory failure because "*there was some nepotism going on*" and she didn't want retaliation

A CNA Orientee recorded a CNA throwing cups of water on a man during care. She recorded it because she feared retaliation and wanted a proof. She said: "*I am only being a whistleblower*"

Fearing retaliation, Nurse Aides and an RN didn't report on another RN who turned off a person's TV (a baseball game) against their wish, saying (against policy) that TVs must be turned off after 11:30 PM

"*Many other staff feel the same way but are afraid to say anything for fear of retaliation*" – A Nurse reporting to state Surveyor on poor staffing levels / The same Nurse also stated: "*The ones who suffer are the residents, they get pressure ulcers, they end up infected*"

A CNA didn't tell the administration about a CNA who allegedly screamed at a resident with cognitive impairment as "*s/he felt bullied by his/her peers and was fearful of retaliation for reporting*"

Fearing retaliation, a staff member delayed reporting on a staff member who was witnessed kissing (at times on the lips) three residents with severe cognitive impairment

A CNA witnessed a woman with severe cognitive impairment being physically restrained to her wheelchair – for about a year – but didn't report it due to fear of retaliation

A woman with cognitive impairment told Hospice Nurse: "*They hit me*" and was told "*Shut up and turn over*" by an employee but the Nurse did not report it to any staff members due to fear of retaliation

An LVN witnessed a sexually inappropriate incident between two male residents (one cognitively intact and the other severely cognitively impaired) but didn't chart it at the direction of and due to fear of the Director of Nursing's (DON) retaliation / The LVN stated that the DON had "*crossed her before and had multiple shifts taken away from her. She needed the shifts and therefore followed her direction even though she knew it was not right*." / After the DON directed the LVN not to inform the residents' families about the incident, a physician said: "*And that is how you keep state out of your building*"

A confidential employee told state Surveyor they are scared to say anything to the Director of Care Services about the poor staffing levels "*because she will retaliate and fire you if you voice a concern*"

Two Nurse Aides expressed a concern of retaliation by management for talking with state Surveyors about a man with cognitive impairment who left the building unaccompanied for three hours (he was located by law enforcement about half a mile away, in a ditch)

Due to fear of retaliation, Aide 2 did not initially report witnessing Aide 1 physically abuse a person with severe cognitive impairment (pushing her/his head on the nightstand) / Aide 2 stated "*she had verbally told the Director of Nursing that she witnessed the incident, but because she was interviewed in front of [Aide 1], she did not write it on her* statement" / Aide 2 said that Aide 1 "*had been verbally abusive to her in the past and she was afraid of retaliation*"

An LPN witnessed another LPN kick the shin of a man with dementia and severe cognitive impairment but did not report it for about two weeks due to fear of retaliation

A CNA witnessed an RN spitting at a woman with dementia but did not report it for 2 days because she "was afraid of retaliation from RN due to issues in the past, not related to residents"

A CNA witnessed an LPN verbally abuse a woman with cognitive impairment, but she didn't report it for two weeks, explaining: "*A lot of CNAs on the floor will say they are afraid to report abuse because when you do, they are the ones that end up getting fired instead of the abuser*"

CNA 2 witnessed CNA 1 smacking the hand of a person with severe cognitive impairment. CNA 2 also witnessed CNA 3 sexually abusing another resident. Due to fear of retaliation, CNA 2 delayed reporting the former incident and did not report the latter incident

Intimidation / Alleged Threats of Retaliation

CNA N reported feeling "*extremely intimidated*" by CNA M after witnessing an injurious transfer of a woman with severely impaired cognition against her Care Plan / CNA N said that CNA M advised her: "*You are not to tell anyone that this incident happened*"

Two staffers were hesitant to speak to state Surveyor unless away from the Administrative Offices for fear of being seen and retaliation. Four staffers reported that the Administrator and Director of Nursing told staff whenever Surveyors asked staff questions, they needed to respond that everything was fine. / "*If they wanted a paycheck, they better not say anything bad*"

A Behavioral Health Manager intimidated witnessing staff not to report his/her physical abuse of a person with Schizophrenia (hitting him/her with a closed fist, causing him / her to cry and be fearful)

An RN slapped the face of a woman with dementia and then intimidated two witnessing CNAs (telling them not to snitch on her)

An LVN delayed reporting employee's physical abuse of a person with Schizophrenia and severe cognitive impairment after the employee threatened to kidnap the LVN, take her to a secluded place, rape her, dismember her, put chloroform on her face, put her in the trunk, and throw her into the river / He was also reported to pull a knife on the LVN in the staff breakroom a few days later

A Director of Nursing pressured a CNA during interview with state Surveyor when she questioned her witness statements regarding LPN's injurious physical abuse of a person with paraplegia. In response, the CNA said: "*You see, this is the intimidation I am talking about, and I might lose my job for telling the truth*."

Administration's intimidation of Housekeeper who witnessed and audio recorded abuse of a woman with Alzheimer's disease (while laughing, two Night Aides were "*twisting her around naked in her wheelchair with her feet up in the air*"). The Director of Nursing made her delete it out of her phone when she came to report it. The administration told her she was "*too emotionally involved*" for that job and to "*think really hard about what she wanted to do at the nursing home*" and then they had her clock out

"*The Administrator led the facility by fear and retribution*" / A frequent visitor said that "*staff had been told during the current survey there would be consequences for speaking to the state*" / An aide said "*many staff were afraid of retaliation by the nursing home and were not going to say anything*"

A Nurse perpetrator told a CNA about a resident who was found unresponsive: "*We didn't see anything*" / When asked why she didn't tell anyone about the unresponsive resident, the CNA said she "*feared retaliation from her nurse because she has gotten people fired in the past*" / Another Nurse said about their failure to perform CPR: "*You wouldn't even do that to a dog*"

Alleged Retaliation

A CNA refused to help with resident care after an RN reported to the Executive Director that the CNA abused a person living with Multiple Sclerosis

An Office Manager was suspended after confronting the Administrator about the need to report an allegation of sexual abuse of a cognitively intact woman living with lung cancer

A Housekeeper was fired for suggesting a family member to install a camera in their loved one's bedroom "*because she believed he was being mistreated by staff*" / The Housekeeper was reportedly also fired "*for not reporting the abuse allegations to the Administrator*"

A CNA said she reported to management (including the Administrator) concerns about LPN's mistreatment of a person with severe cognitive impairment, and "*as a result became the target of hostile staff*" / Another CNA stated "*most of the staff were hesitant to speak up because the staff they reported would make our [de-identified] tougher*"

An Employee who requested to remain anonymous said that when she spoke up about physical and mental abuse of a woman with cognitive impairment, "*she was bullied and retaliated against*"

An LPN witnessed an RN consume medications, but didn't report it until the next day. She was "*hesitant to say anything as management does not do anything and tends to retaliate against reporters*" / The LPN said: "She and *many other staff have concerns regarding RN, noting others reported him sleeping a lot, smelling like alcohol, acting weird, and making inappropriate comments*" / Another RN said the RN was scheduled to work on the overnight shift and was "*acting off the wall and unsafe with residents*"

Five Nursing Assistants stated: "*Retaliation would come in the forms of being given the cold shoulder, yelled at in front of their peers, and/or labeled a troublemaker to the point you either got fired or quit*"

Concerns by an anonymous employee's about an LPN overmedicating residents or misusing their controlled medications "*were swept under the rug with no repercussions other than* [the nurse] *retaliating against those she felt turned her in*"

A CNA told a state Surveyor she was fearful of retaliation when speaking about short staffing. She added: "*There is a culture of retaliation at the facility*"

Chapter 4 – Discussion

This project is the first to conduct an in-depth examination of staff fear of retaliation when witnessing, suspecting or otherwise becoming aware of right violations and mistreatment of individuals living in U.S. nursing homes. The examination of state Surveyors' rich narratives contained in the investigation reports enabled to capture staff *lived experience* (in their own words) of these fears and their consequences.

Due to fear of retaliation from co-workers, supervisors, or managers, many staff members did not report or delayed reporting witnessing, suspecting or otherwise knowing about right violations, abuse, neglect, and exploitation of residents (delays in reporting varied from a few hours to "about a year"). This often meant that investigations (internal and external) were not conducted or that they were delayed or that inadequate (such as incomplete and limited) investigations were conducted.

Quote
"Thousands of complaints are not investigated so maltreatment continues, and less severe issues may escalate to more serious harm." "If less serious issues [such as falls, abuse by staff, resident-to-resident incidents, unexplained injuries and fractures, medication mismanagement, drug thefts] were addressed early on, individuals might not be seriously harmed in subsequent incidents."
Source: State of Minnesota (2017). 2018-19 Biennial Budget proposal

Study
A study among 49 employees (nursing, administrative, and other staff members) from two nursing homes in Iowa found that "53% of the respondents reported that they have suspected a case of elder abuse" in their nursing home. Of those respondents, 35% indicated that "they did not report all the cases of abuse they have suspected." Interviews with 21 of these employees found that the reasons for the underreporting were: • The feeling that they are not qualified to judge the abusive situation • Fear of retaliation following the report.
Source: McCool et al. (2009) article titled "Multidisciplinary reports of nursing home mistreatment"

Study
A study among 564 Registered Nurses in Nevada found that 34% of them were aware of conditions that may have caused patient harm but had not reported it. The most common reasons identified for failing to report issues were: • Fear of retaliation (44%) • The belief that nothing would prevail from the reports (38%).
Source: Black (2011) article titled "Tragedy into Policy"

The lack of or delayed reporting of mistreatment also meant that many victims were left without assessment of harm and protection as the perpetrators continued to have access to them and other residents. In some cases, it allowed neglect, abuse, and thefts to continue while fearful care employees who witnessed or knew about the mistreatment remained silent. Perpetrators and the nursing homes were often not held accountable or that holding them accountable was significantly delayed.

Staff fear of retaliation is a major factor contributing to underestimation of the scope of abuse and neglect of vulnerable elders living in nursing homes

A significant number of staff members did not report these incidents or delayed reporting them because they feared retaliation from the perpetrator or from others such as managers. One CNA witnessed physical abuse of a woman with cognitive impairment but didn't report it immediately because "*she liked her job and did not want her co-worker to retaliate or confront her.*" Another witnessing aide lived in a very close proximity to the LPN perpetrator and "*truly felt in danger of retaliation*" because she was the only staff member working with the LPN when the abusive acts occurred so it would be obvious to the LPN that she had reported the abuse.

Other staff members did not report mistreatment or delayed reporting fearing they would lose their jobs. Examples of statements made by fearful care employees included: *"She will retaliate and fire you if you voice a concern"* and "*Other staff have been fired for reporting things.*"

One CNA, who witnessed administrative staff abusing a resident, said: "*She could not be without work as she had family to support.*" Another CNA said: "*A lot of CNAs on the floor will say they are afraid to report abuse because when you do, they are the ones that end up getting fired instead of the abuser.*"

In accordance, CMS states: "Anecdotal reports have indicated that failure to report an alleged violation may be due to, but not limited to, staff fear of retaliation, or fear losing his/her job" (CMS, 2024).

CNAs' Fear of Losing Their Jobs

"*She could not be without work as she had family to support*"

Direct care workers' hourly wage in nursing homes

$18.83

Annual Salary

$39,166

"Wages for direct care workers are untenably low and have barely budged over the last 10 years. As a result, direct care workers are often forced into poverty, cannot make ends meet or support their families, and end up leaving this field for other industries, such as fast food and retail" – PHI

Note: Wages applicable to 2024

Source: U.S. Bureau of Labor Statistics, as cited in PHI report

Many fearful staff members felt powerless to protect vulnerable residents who experienced right violations and mistreatment. They experienced anxiety and fear for residents' safety. Some felt hopeless that change is possible and with that sense of helplessness, they discontinued voicing care concerns.

In one case, an LVN repeatedly forced residents to get out of their beds against their wish (an ongoing right violation). A staff member said: "*This has been reported to administration, but nothing was done and the staff fears retaliation, so they do not mention it anymore.*"

In another case, a CNA witnessed her supervising nurse verbally abuse a woman with Huntington's Disease and severe cognitive impairment. Specifically, the CNA said that the woman tried to hit and spit at her and the nurse and that, in response, the nurse told her: "*You keep it up, you will be sorry*."
The CNA said she thought the comment was wrong, but the nurse was her supervisor, and she could not go against her supervisor. She did not tell any other staff members what the nurse said to the resident.

The CNA said that the nurse was known to not be very polite with the staff and residents and that she had told her previous supervisor about the nurse, but nothing was done so she quit telling.

Some staff members said that there is no point reporting resident mistreatment since management ignores complaints and does not do anything about them to improve things. Examples include:

A CNA who stated she could not tell upper management about a CNA who punched a resident with Alzheimer's disease (causing a black eye) because "*I felt it would have been swept under the rug.*"

In another case, concerns expressed by an anonymous employee (allegations that a nurse overmedicated residents or misused their controlled medications) were reportedly *"swept under the rug with no repercussions other than* [the nurse] *retaliating against those she felt turned her in*."

Consistent with these concerns, prior research found that some employees witnessing suspected abuse of individuals in nursing homes stated that "they are not confident that prompt action will be taken once they report abuse" (McCool et al. 2009). In another study, researchers interviewed 13 nurses working in seven nursing homes about barriers for reporting incidents (described as "events or circumstances which could have or did harm to anyone or which resulted in a complaint, loss or damage") (Winsvold Prang and Jelsness-Jorgensen, 2014). Some nurses expressed frustration about the fact that they did not receive information about the consequences of their reports (such as about improvements in care). For example, one nurse said: "We do not know if something really happens with the things we report (...). It is quite frustrating." Another nurse said: "It is difficult to know how to improve quality due to lack of feedback." Importantly, the lack of feedback did not allow these nurses to know how to address comparable incidents in the future. It also led them to be more reserved about reporting incidents.

Nursing homes with a care culture that tends to dismiss, discredit, downplay, and deny allegations of abuse of residents represent a longstanding problem in nursing homes (Stannard, 1973; Caspi, 2024).

In addition, the aforementioned study by Winsvold Prang and Jelsness-Jorgensen (2014) found that "lack of support and a culture of blame had deleterious effects on incident reporting." For example, some nurses reported that prior negative responses to incident reporting (such as conflicts and verbal bullying) had "deleterious effects" on whether an incident was reported (i.e., incidents they would have reported in other circumstances).

Study
An early study in a nursing home found that aides rarely reported inappropriate and abusive actions to the charge nurse. The researcher stated that one reason for the lack of reporting of these incidents was "the solidarity and cohesiveness that obtained among the small group of regular and steady employees, who did not want to harm another aide and be responsible for someone losing their job." He added: "On the side of the lower-level employees, there was the tendency to look the other way when another employee abused a patient."
Source: 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.

In one case identified in the current report, witnessing staff stated they thought no one was going to believe them if they reported that their supervisor committed the abuse or neglect of a resident. They said: "*Who are they going to believe a RN or I?*"

Fearing retaliation from co-workers and supervisors, some staffers did not intervene during abusive and neglectful incidents they witnessed. One staff member witnessed a CNA choke hold a man with Alzheimer's disease. He/she did not report it, explaining: "*She was a big girl and could beat me up.*"

A nurse interviewed for the aforementioned study on barriers for reporting incidents in nursing homes said: "If nobody intervenes and everyone keeps doing things in whatever way it suits them, we can still continue to make the same mistakes over and over again (…). Probably even with higher confidence" (Winsvold Prang and Jelsness-Jorgensen, 2014).

Quote
"Staff members need to remember what their role is…that they are there for residents and that they need to be that resident voice and be there to protect the residents. And they are mandated reporters." "If they hear something, they need to intervene and if they notice one of their peers getting to a breaking point,…they need to be saying "It looks like you're getting to a place, some of the things I see you've done or some of the tone you're taking is not okay. I am going to step in at this point. I think you need to go take a minute." And then you're showing the resident that you're identifying it's not okay, that you're making a safe space, you're letting that staff member peer know that you've seen it, it's not okay. You're not going to allow it, and you also letting them go cool down and come back in a head space that is better." – State Long-Term Care Ombudsman
Source: Caspi E. (2024). A bridge over scary water: Ombudsman program strategies and barriers in addressing residents' fear of retaliation in long-term care homes

Some employees find it difficult to report a colleague who they witnessed mistreating residents. For example, the study by Winsvold Prang and Jelsness-Jorgensen (2014) found that "most nurses reported that they had experienced conflicts related to reporting incidents. These conflicts were particularly difficult if the incident involved a colleague." One nurse said: "I don't know if it is worth the price (…). I mean, if I report, it will put me in a very difficult situation." Another nurse said: "I believe it is important to report, but I sometimes wonder – is it worth it? I mean, it is difficult when it is a colleague." Another nurse said: "I mean, we are not only colleagues, we are friends. That makes it difficult."

In addition, a study by Lund et al. (2023) among nursing staff in 17 nursing homes found that "although there was an agreement that reporting incidents of neglect is a way to raise awareness and possibly improve poor practices, this is not easy to execute." Specifically, reporting neglectful practices made nursing staff feel that they are turning their colleagues in, leaving an extremely unpleasant feeling. It made nursing staff feel disloyal as if they were betraying their colleagues when revealing neglectful practices to managers and other colleagues." One LPN said: "You're kind of together 'by the bedside.' A bit like that, should I snitch on someone?" An RN said: "There are people you work together with many days a week. So, you're a bit afraid creating a bad atmosphere…[laughs], yes. Also, you probably have such good faith in people that they don't do this intentionally. So it's hard to bring it up."

Quote
"In nursing homes, you only see a piece of what is going on and lots goes on behind closed doors that is never reported – you know, in bedrooms, bathrooms, and toilets. I've seen it happen and it's not being reported [...] I've not reported it, no. I've got to work with these people you know." – Nurse "Abuse often isn't reported. If you report stuff like that, you are in trouble, aren't you? You've still got to work with the same people." – Care staff member
Source: Moore (2017b)

The report "*Nobody spoke up*" found that several staff members reported experiencing intimidation and threats of retaliation after witnessing staff abuse and neglect of residents. One CNA injured a woman with severe cognitive impairment during a transfer done against requirements in her Care Plan. The CNA then told another CNA who witnessed it: "*You are not to tell anyone that this incident happened.*" In another nursing home, an RN slapped the face of a woman with dementia and then told two witnessing CNAs not to "*snitch*" on her. In another case, administration told staff members that "*If they wanted a paycheck, they better not say anything bad*" to state Surveyors.

LPN's License at Risk
An LPN found a woman trapped between the mattress and bedrails in her nursing home. She died. The Director of Nursing (DON) told the LPN not to record the entrapment in the rails. After speaking with the Administrator, the DON warned the LPN that her license was at risk if she did not chart as directed. After the LPN refused to tell the family that the woman died in her sleep, she overheard the Charge Nurse tell her daughter that she died peacefully. The Charge Nurse told the aides not to discuss this accident with other staff members. The daughter called back to ask about the unexpected death and was again told that her mother had simply stopped breathing. The police received anonymous tip that the woman suffocated or strangled. As the family assembled for the funeral, the Medical Examiner demanded the body for an autopsy. It confirmed death by asphyxiation (suffocation). The family sued the nursing home.
Source: Miles, H.S. (2002). Concealing accidental nursing home deaths. *HEC Forum, 14(3)*, 224-234.

In a number of cases, perpetrators actively intimidated staff members who witnessed them abusing or neglecting residents (e.g., "*Are you going to tell on me?*" and "*This bitch snitched on me*"). In other cases, managers and Administrators engaged in acts that intimidated the witnessing staff members (e.g., "*Everyone in the facility was terrified of retaliation by the Administrator if they spoke to anyone about the issues in the building*" and "*All the staff are scared, terrified, and intimidated by the Administrator"*).

In one case, the Director of Nursing pressured a CNA during an interview with a state Surveyor when she questioned her witness statements regarding an LPN's injurious physical abuse of a person living with paraplegia. In response, the CNA said: "*You see, this is the intimidation I am talking about, and I might lose my job for telling the truth*." In accordance, a nurse interviewed for the aforementioned study on barriers for reporting incidents in nursing homes said: "Some time ago, my head nurse questioned me in public about the necessity of reporting an incident (...). I have been reluctant to report ever since" (Winsvold Prang and Jelsness-Jorgensen, 2014).

In another case, *staff had been told during the current survey that "there would be consequences for speaking to the state."* One aide in this nursing home said: "*Many staff were afraid of retaliation by the nursing home and were not going to say anything*."

Quote
"The nurse in charge and the owner called me into the office [after I had reported abuse] and the owner asked me if I had a mortgage. I said I did, and he said, 'if you don't shut up about what happened, I'll have your house off you.' I was scared he might, so I said nothing."
Source: Moore (2017b)

These threats add to baseline reluctance among a subgroup of care employees when it comes to reporting suspected resident abuse to the State Survey Agency. For example, a study by McCool et al. (2009) found that many staff members do not feel comfortable communicating with the State Survey Agency regarding suspected abuse of residents.

In another case, a night CNA found a resident unresponsive in their bedroom. The nurse told the CNA about the resident: "*We didn't see anything.*" The CNA said she didn't report the incident because she "*feared retaliation from her nurse because she has gotten people fired in the* past."

In an extreme and disturbing case, a perpetrator of physical abuse of a person with serious mental illness and severe cognitive impairment threatened a nurse with deadly violence (to kidnap and kill her).

Fearing retaliation, some staffers gave false stories about witnessed physical abuse of residents while others altered their witness statements and documentation of incidents. In several cases, managers allegedly instructed fearful staff to falsify records pertaining to witnessed abuse and neglect of residents. Other employees were so fearful that they retracted their abuse witness statements altogether.

In one case, an employee was pressured to falsify insulin records. The employee, who wished to remain anonymous for fear of retribution and retaliation by the nursing home, told a state Surveyor that she was told by the Assistant Director of Nursing that if staff were to give insulin late, they have to go into the e-records, falsify documentation, and change the time the insulin was given to reflect what the order indicates (to avoid non-compliance). She stated she won't falsify documentation and risk her nursing license. She added that the nursing staff just follow along with the instruction.

In another case, a housekeeper witnessed and recorded two night aides physically abuse a woman with Alzheimer's disease (while laughing, they were "twisting her around naked in her wheelchair with her feet up in the air"). When she came to report it, the Director of Nursing made her delete it out of her phone. The Administration told her she was "*too emotionally involved*" for that job and to "*think really hard about what she wanted to do at the nursing home"* and then they had her clock out.

Concealment of abusive incidents – including methods used to conceal abuse – in nursing homes has been identified in prior research (Moore, 2017a; 2017b). In addition, the concealment of accidental deaths in nursing homes was examined in a case series by Miles (2002). Reflecting on it, the author observed: "These situations are extremely difficult for nurse aides and front-line nurses. They are often intimidated, fired, and disparaged. Resolution of these events should also address the needs of these victimized staff." He added, however, that "the complexity of the effort to alter records and the essential intimidation to secure silence of the frontline clinical staff create the evidence and forces by which an attempt to conceal a lethal accident is discovered."

Furthermore, a study titled "*Making Neglect Invisible*" by Lund et al. (2023) among nursing staff in 17 nursing homes found that neglect is sometimes invisible due to a combination of personal and organizational factors. For example, staff members may minimize "missed care" (e.g., repeatedly missing showers or mouth care) and not consider it neglect, and therefore it is not reported. They may also be

reluctant to acknowledge or reveal their own or colleagues' neglectful practices. The researchers concluded their study by stating: "Our core finding is that there is a reporting practice and culture that renders neglect invisible in nursing homes."

In the current report "*Nobody spoke up*," many staff members asked to remain anonymous when speaking with state Surveyors. For example, this happened in one nursing home after a resident with severe cognitive impairment was found with ants crawling on her while in bed with ant bites throughout her body causing pain, red welts, and hives.

In another case, an employee – describing herself/himself as "a concerned medical worker" – anonymously wrote the State Survey Agency about extensive and ongoing mice infestation in the nursing home. S/he stated: "*The facility is infested with mice & rats!!"* The worker stated that the mice are in residents' bedrooms, hallways, dining rooms, and kitchen ("*Running wild in the kitchen!*"). S/he added: "*This has been an issue since before I was made aware of it at least 2 months ago and it's only gotten worse not better*." S/he also said: "*All CNAs are aware and nurses especially the ones that work the evening and night shift. They['ve] been complaining and nothing is being done*."

In one case, an employee anonymously called the police to report on a male resident who placed his genitals in a woman's face in an attempt for oral sex with her in the common area of the nursing home.

In another case, an employee wrote an anonymous email to the corporate office of the nursing home. In it, the employee stated, among others: "*I no longer feel I or any of my other direct care coworkers can safely and confidently provide the care and services our special resident[s] deserve*." The employee went on to describe "*unsafe and hazardous practices*" and concluded their email with these words: "*I have reached as far as I can to try and resolve this issue with no results*."

It is important to recognize that sometimes the identity of "anonymous" employees reporting resident mistreatment can be revealed. Examples include but are not limited to a complaint made in a small nursing home or care unit (where only a limited number of individuals live) and/or when the nature of the complaint is unique to a particular resident such as in the context of distressing behavioral expressions among individuals in advanced stages of dementia (e.g., repeated vocal expressions resulting in staff angrily yelling at the person to stop, rejection of undignified care during showers resulting in staff "reflexive retaliation" against the person or neglect to prevent unique and harmful sexual behavioral expressions exhibited by a resident towards another).

Other examples may include complaints related to the mistreatment of a resident who is the only one using a power wheelchair, a resident with a unique neurological condition that causes distinct physical manifestations (e.g., hand tremor due to Huntington's disease), a resident receiving a rare type of medication (serious medication error) or when a resident with cognitive impairment is the only one receiving dialysis treatment and the resident was harmed on the way to the dialysis center due to not being accompanied by a staff member. Since the identity of the direct care employees assigned to care for residents is known, the identity of the individual care employee alleged perpetrator could often be narrowed down (with the caveat that other and non-direct care staff may also mistreat residents).

In one nursing home, staff member A said that complaints about staff should be done in a manner the aide does not know who complained but added that "it was probably not done that way." While the Director of Nursing said that they did not tell staff who complained about them, staff member B said: "If there is a complaint against an aide, the administrative staff would just say 'a resident said' and what the complaint was." Staff member B added: "*The staff were not stupid and could figure it out*" (Long Term Care Community Coalition, 2023).

Study
"The anonymity of employees who reported was not always well protected, leading to increased worry about being identified in public."
Study by Winsvold Prang and Jelsness-Jorgensen (2014) among nurses in nursing homes

Alleged acts of retaliation against staff members were also identified in the "*Nobody spoke up*" report. Examples include: An Office Manager was suspended for confronting the Administrator about the need to report an allegation of sexual abuse of a woman. In another nursing home, a housekeeper was fired for suggesting a family to Install a camera in their loved one's bedroom "*because she believed he was being mistreated by staff*." A CNA in another nursing home reported to management her concerns about an LPN's mistreatment of a person with severe cognitive impairment. "*As a result, [she] became the target of hostile staff*." A staff member in another nursing home was being "*bullied and retaliated against*" for speaking about physical and mental abuse of a woman with cognitive impairment. In another nursing home, five staff members said that they were "*given the cold shoulder, yelled at in front of their peers, and/or labeled a troublemaker to the point you either got fired or quit*."

Practical Implications

The report "*Nobody spoke up*" could be used to raise awareness to the longstanding problem of staff fear of retaliation when witnessing or otherwise becoming aware of abuse and neglect of residents in nursing homes. Insights identified in this report could be used to educate various stakeholders about these fears, their negative consequences on staff and residents, and the ways to prevent and address them.

Within the nursing home, these groups include, among others, individuals receiving care, their family members and friends, direct care staff members, indirect care staff members (e.g., dietary aides, housekeeping staff, maintenance workers), nurses, social workers, recreation therapists, managers, Directors of Nursing, Administrators, and importantly, the owners of the care setting.

Outside the nursing home, these groups may include, among others, the Long-Term Care Ombudsman Program, CMS and State Survey Agencies, law enforcement agencies, Adult Protective Services (in states where the agency has authority to investigate resident mistreatment in nursing homes), Medicaid Fraud Control Units, Coroners and Medical Examiners, and elder abuse attorneys.

Elder care advocacy organizations such as the National Consumer Voice for Quality Long-Term Care, the Long-Term Care Community Coalition, Elder Voice Advocates, California Advocates for Nursing Home Reform, Delaware Elder Care Advocacy Coalition, and Journey to Justice, but also the National Center on Elder Abuse could use this report to educate the public, policy makers, and legislators about this issue.

Long-term care trade associations (e.g., the American Health Care Association, LeadingAge, and Argentum) and other organizations dedicated to improving the quality of direct care workers' jobs such as PHI (formerly Paraprofessional Healthcare Institute) could use the report to strengthen their efforts to address this issue.

Unions representing direct care workers (e.g., Service Employees International Union [SEIU]) should have a special interest in this report given their role in improving the working conditions and protecting the rights and safety of these care employees.

To assist these organizations in raising awareness to this issue, fact sheets, infographics, and an educational film need to be funded, developed, and disseminated among stakeholders nationwide.

All employees (direct and indirect care staff) need to be regularly educated about their right to speak up – to report right violations, care concerns, abuse, neglect, and financial exploitation of individuals receiving care – without being retaliated against. All employees must also be educated about their responsibility and regulatory and legal requirements to report suspected mistreatment of residents. They must know exactly what constitutes abuse, neglect, and financial exploitation and what must be reported, when, and to whom. This includes temporary agency CNAs and nurses and all other contracted employees.

Abuse, Neglect, and Exploitation Training

State Survey Deficiency Citation F943

Nursing homes "must provide training to their staff that at a minimum educates staff on activities that constitute abuse, neglect, exploitation, and misappropriation of resident property…"

The staff training must address the above forms of mistreatment but also "dementia management."

Such training would include, but is not limited to the nursing home's "procedures and Federal and State requirements for reporting abuse, neglect, exploitation, and misappropriation of resident property, including injuries of unknown sources, timeframes for reporting, and to whom staff and others must report their knowledge related to any alleged violation without fear of retaliation."

Source: CMS State Operations Manual Guidance to Surveyors (8.8.24)

Quote

"I was auditing a nursing home that was considered outstanding. We came early in the morning and saw how the residents were woken up, which was awful. They were taken out of their beds, with the same clothes on, without washing their faces, without brushing their teeth, then taken to the dining room where they had their face wiped with wet wipes, their hair was brushed with the same hairbrush. After the meal, some of the residents were bathed, because most of them are bathed every other day, and they were all washed in the same shower so as not to get other showers dirty…They did it in front of me. I did not hide my presence – I stood there openly…It was routine for them, and it did not even seem strange to them. They just did what they were used to, and I was deeply shocked."

– Surveyor reflecting on an inspection they conducted in a nursing home

"A staff member cursed a resident in my presence. It seemed that she was so used to it that she just did it automatically even though she knew I spoke the same language…, and then she said an unpleasant word out loud." – Surveyor reflecting on an inspection they conducted in a nursing home
Source: Lev at al. (2022)

This is important because prior research among employees of two nursing homes found – in the context of suspected abuse incidents – that some of these employees reported having difficulty making judgments about whether the situation needs to be reported on (McCool et al. 2009). In accordance Lafton and Fagerstrom (2011) stated that lack of knowledge pertaining to what should be reported in nursing homes represents an important driver of underreporting.

Another study among nurses working in nursing homes found that "there were diverse opinions among nurses as to what sort of incidents needed to be reported and their seriousness" (Winsvold Prang and Jelsness-Jorgensen, 2014). One nurse said: "It is not clear to me what I am expected to report on or not."

Another study by Lund et al. (2023) among nursing staff in 17 nursing homes found that lack of knowledge and ambiguity regarding what constitutes neglect and what needs to be reported (including different views regarding severity of consequences of incidents) had implications for detecting and reporting.

Related to it, state surveyors report that during investigations, some staff members have stated that they were aware, or had knowledge, that the incident had occurred, but did not report it because they did not think it met the definition of abuse, neglect, mistreatment, exploitation, or misappropriation of resident property or a reasonable suspicion of a crime (CMS, 2024).

In accordance, prior research found that abuse may be perceived as ambiguous (i.e., "unthinkable" and "unacceptable" and yet often tolerated and not reported), that it is considered a serious misconduct that is difficult to talk about (considered as a "*highly sensitive*" topic), that the conceptualization of abuse is often limited to intentional physical abuse and sexual abuse, and that knowledge gaps exist related to the understanding of neglect of residents in nursing homes (Hirt et al. 2022).

Quote
"Staff identification of resident harm is critical to the success of resident safety efforts giving them the opportunity to correct problems and reduce harm as well as to report problems contributing to events."
Source: U.S. Office of Inspector General (2014)

Owners and Administrators of nursing homes need to take the following measures to ensure a care culture and environment that is free from staff fear of retaliation when employees witness, suspect or otherwise become aware of resident right violations and mistreatment:

The culture of care must be based on the premise that when care employees are regularly empowered and encouraged by supervisors and managers to voice care concerns and wrongdoing, it places the nursing home in a better position to identify care-related problems and mistreatment (generally and timely), immediately and thoroughly investigate these care concerns, and ultimately be better able to provide dignified and safe care to residents (the quality of care can often improve when co-workers, supervisors, and managers listen to and act upon staff concerns). Open and honest communication and continuous feedback are key to effective implementation of this care culture.

Study
Prior research in seven nursing homes has shown that nurses view the role of the Administrator (e.g. Head Nurse) as being very important in the process of incident reporting.
Source: Winsvold Prang and Jelsness-Jorgensen (2014)

Owners and Administrators of nursing homes need to create and maintain a care environment where employees strongly agree with the following questions (adopted directly from *The Warmth Survey* of the Eden Alternative, 2017):

"My immediate manager / supervisor listens to me and takes my opinions seriously"

"I am free to ask questions"

"I can voice my concerns without risking my job"

Quote
"Culture starts with vision, leadership, training, and relentless accountability WITHOUT SHAME AND BLAME. That avoiding shame and blame is key with our fragile and traumatized workforce…they have been dealing with this all their life……and it's really hard to create an environment where traumatized people feel safe." – Dustin Lee, Owner & CEO, Prairie Cottages
Source: Email communication (2.26.26)

Research studies provide support for these statements. A review of six studies identified a series of factors that may influence a nurse's decision to speak up about unsafe practices and unethical behavior in healthcare settings (Elsehrawy et al. 2025). These factors include, among others, a culture of trust (a high level of organizational trust), a culture of responsibility, honesty, and integrity, a culture of accountability, an ethical climate (nursing ethics encouraging ethical conduct), upholding moral and professional standards (cultivating and supporting moral courage), a culture of psychological safety, open communication, a culture of transparency, a supportive environment encouraging reporting (with a clear obligation to report unsafe or bad practices), respect, peer support, and teamwork.

A study titled "*The Courage to Speak Out*" on fear of retaliation among RNs in hospitals found that "Nursing leadership's ability to facilitate a culture of safety by proactively addressing unsafe practices fosters a level of comfort for patient advocacy and willingness to report issues" (Cole et al. 2019). The researchers stated: "Organizations need to create supportive workplace environment whereby, through collective input and leadership, reporting protocols are in place that empower RNs to report unsafe conditions." In contrast, an anonymous survey among 527 staff members (nurses, nurse aides, physicians, and others) in hospitals found that higher levels of staff fear of retaliation was related to lower overall patient safety (Layne et al. 2019).

Studies have also shown that leadership style makes a difference. A study among 4,000 Administrators and Directors of Nursing in nursing homes examined the role of consensus managers (i.e., "Leaders who solicit, and act upon, the most input from their staff") and found that this leadership style had a strong association with better quality of care (Castle & Decker, 2011).

In addition, a survey among 2,900 Administrators of nursing homes found that being an Administrator who is a "consensus manager" was associated with the lowest turnover levels (44% for nurse aides, 7% for RNs, and 3% for LPNs) while being a "Shareholder manager" (i.e., "Leaders who neither solicit input when making a decision nor provide their staffs with relevant information for making decisions on their own") was associated with the highest turnover levels (168% for nurse aides, 32% for RNs, 56% for LPNs) (Donaghue and Castle, 2009).

Quote
"*We want to be listened to and taken seriously about our concerns. We want to be worked with on solutions to make it a better place for staff to work in, so these residents have a better place to live in*" – An aide in a nursing home with poor staffing levels

Another study among directors and care managers of 21 nursing homes found that a culture of openness, learning through feedback, reflection for shared understanding, and a blame-free culture were some of the ways in which these leaders aspired to respond to elder abuse allegations and how they try to prevent abuse from reoccurring (Myhre et al. 2020). This is consistent with the importance of a "safe reporting culture" and "critical case reviews" identified in studies on abuse in nursing homes (Hirt et al. 2022).

Quote
"Learning from previous incidents is important to improving safety culture."
Source: Winsvold Prang and Jelsness-Jorgensen (2014)

CMS (2022) reinforced the above messages when it stated that supervisors and managers in nursing homes should routinely ask direct and in-direct care staff members the following question:

"Do you feel safe reporting care concerns? Are you reluctant or afraid to report abuse and neglect?"

CMS encourages supervisors and managers to "ask staff if they are confident in reporting compliance matters without fear of retaliation."

Quote
"The need to create a psychologically safe reporting culture in nursing homes to lower the threshold of incident reporting is very important"
Source: Winsvold Prang and Jelsness-Jorgensen (2014)

When Individuals Receiving Care and Care Partners Raise Issues
• Listen carefully and patiently and avoid defensiveness • Focus on solutions, not on blame • Communicate clearly about next steps • Keep them informed until concerns are resolved
Source: *Connecticut Long-Term Care Ombudsman Program, Colorado Long-Term Care Ombudsman Program, & Caspi, E. (2026). Breaking the Silence: Fear of Retaliation – A Comprehensive Educational Training Program Addressing Concerns and Promoting a Safe Environment When Receiving Long-Term Services and Supports*

Direct care staff provide the vast majority of the hands-on care to residents. They therefore often hold critically important and nuanced information about them, their disabilities, care needs, preferences, and care concerns. Owners, Administrators, and all managers would be wise to listen and learn from them.

Quote
"CNAs are the foundation of the caregiving industry. I use the word foundation because just like putting up a building, first you have a strong foundation or else the building will not stand up. The CNAs are the backbone of the organization because, as caregivers, we are with the residents 24 hours a day, seven days a week, from the time they [are] awake to the time they go to sleep. We know each and every one of our residents intimately." The CNA added: "We love working with the residents, it gives us joy that we can assist them in the evening of their lives. We truly care for the residents and that honest care shows in the work we do." She concluded: "In closing, while we do not hold a MD or PhD, CNAs are equally important because we are the foundation and bridge between the residents, family, and management." – An experienced and skilled CNA
Source: Presentation titled "CNAs: The Foundation" delivered during Massachusetts Alzheimer's Association Annual Meeting on 5.14.08

Owners and Administrators need to routinely make it clear to all employees that they are required to report any concerns they may have regarding residents' right violations, abuse, neglect, and financial exploitation. They need to know what types of concerns must be reported, to whom, how, and when – per requirements in federal and state nursing home laws and regulations. These requirements need to be clearly described in the nursing home's policies and procedures, and all employees must read them and sign that they read and understand them (signed attestation forms must be kept in employees' files).

As part of this effort, all employees must be educated about their state's requirements for mandatory reporting of abuse and neglect of individuals in nursing homes (they should also know their rights and protections under these laws). As part of a "zero tolerance policy," all employees should also know that their employment may be terminated if they witnessed or otherwise were aware of abuse and neglect of residents and did not report it in general or within required timelines.

Quote
A CNA stated "she is a mandated reporter, and she would have reported the neglect, but did not out of fear of retaliation from co-workers that worked with the CNA" perpetrator

Importantly, law professor Nina Kohn and colleagues (2025) state that the value of the mandatory reporting system "ultimately depends on the efficacy of the systems that respond to reports…"

F609
Timely and Accurate Reporting of Alleged Violations

In response to allegations of abuse, neglect, exploitation, or mistreatment, the nursing home must:

1. Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported within strict timeframes:

- Immediately (but no later than 2 hours if the alleged violation involves abuse or results in serious bodily injury) or
- Within 24 hours if the alleged violation involves neglect, exploitation, mistreatment, or misappropriation of resident property; and does not result in serious bodily injury (§483.12(c)(1)).

2. 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 (§483.12(c)(4)).

Source: CMS State Operations Manual (8.8.24)

Serious Bodily Injury

The term "serious bodily injury" is defined as an injury:

- Involving extreme physical pain
- Involving substantial risk of death
- Involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty
- Requiring medical intervention such as surgery, hospitalization, or physical rehabilitation.

In the case of "criminal sexual abuse" which is defined as serious bodily injury / harm shall be considered to have occurred if the conduct causing the injury is conduct described in section 2241 (relating to aggravated sexual abuse) or section 2242 (relating to sexual abuse) of Title 18, United States Code, or any similar offense under State law.

Source: Section 2011(19) (A and B) of the Affordable Care Act

Remember
When abuse, neglect, or retaliation is suspected, you have a legal and ethical duty to report it
Steps to take: • Ensure immediate safety of the resident. Provide reassurance. • Report concerns promptly to your supervisor or Administrator and to police as required • Notify the Long-Term Care Ombudsman and/or State Survey Agency and/or Police as required • Document all details objectively
Source: *Connecticut and Colorado Long-Term Care Ombudsman Programs, & Caspi, E. (2026). Breaking the Silence: Fear of Retaliation – A Comprehensive Educational Training Program Addressing Concerns and Promoting a Safe Environment When Receiving Long-Term Services and Supports*

Quote
"*If you as a human being can be sitting here right now working in this facility and see abuse and do not feel in your soul to report that, you need to get up and walk out that door because you do not belong in healthcare*." – Lynn Fiedler, founder, *Journey to Justice*, a nonprofit dedicated to protecting older adults who can't protect themselves from abuse, neglect, and exploitation
Source: Bolger (2026)

The nursing home is required to have written procedures that must include "assuring that reporters are free from retaliation or reprisal."

Remember
"In nursing homes, retaliation against employees for lawful reporting of mistreatment is against federal law and can result in serious consequences"
Source: *Connecticut and Colorado Long-Term Care Ombudsman Programs, & Caspi, E. (2026). Breaking the Silence: Fear of Retaliation – A Comprehensive Educational Training Program Addressing Concerns and Promoting a Safe Environment When Receiving Long-Term Services and Supports*

To encourage reporting of a reasonable suspicions of a crime against a resident, nursing homes "should develop and implement policies and procedures that promote a culture of safety and open communication in the work environment. This may be accomplished through prohibiting retaliation against an employee who reports a suspicion of a crime" (CMS State Operations Manual Guidance to Surveyors, 10.21.22).

State Survey Deficiency Citation F608 Requires
"The facility may not retaliate against an individual who lawfully reports a reasonable suspicion of a crime under section 1150B of the Social Security Act."

All employees must know and follow the requirements as stated in federal law (provision called Elder Justice Act under the Affordable Care Act under Section 1150B of the Social Security Act) regarding reporting reasonable suspicion of a crime against people living in nursing homes. This includes, among others, what constitutes a "reasonable suspicion of a crime" and that they must report events that cause reasonable suspicion resulting in serious bodily injury immediately after forming the suspicion but not later than two hours after forming the suspicion. Otherwise, the report must be made no later than 24 hours after forming the suspicion. Whether or not the events that cause the reasonable suspicion result in serious bodily injury, they must report it to the State Survey Agency and local law enforcement agency.

All "covered individuals" (including owner, operator, employee, manager, agent, or contractor of the nursing home) must follow these reporting requirements but also know that this law includes strong protections for whistleblowers. For important details regarding the requirements related to reporting reasonable suspicion of a crime in nursing homes, consult with CMS Memorandum (2012).

Whistleblowing – Definitions
"Whistleblowing is the reporting of misconduct, unsafe or inappropriate practices, or other forms of wrongdoing within the organization (typically by a current or former member) to individuals or organizations that may have the ability to take appropriate corrective action." *
"An act of the international nursing ethical ideal of advocacy." **
* Mannion et al. (2018) as cited in Elsehrawy et al. (2025) ** Davis & Konishi (2007)

Concern and Recommendation About Whistleblowers' Policies
"Whistleblowing policies are failing to protect nursing home residents who experience abuse, as it is either not reported, or reported internally but ignored or stifled." "Ensure whistleblowing policies are clear, accessible and include guidance on how to report directly to external agencies." – Steve Moore
Source: Moore (2017b)

CMS requires nursing homes to annually notify all "covered individuals" (described earlier) of their reporting obligations and the nursing home must "conspicuously post, in an appropriate location, a notice for its employees specifying the employees' rights, including the right to file a complaint under this statute." The notice "must include a statement that an employee may file a complaint with the State Agency against a long-term care facility that retaliates against an employee as specified above, as well as include information with respect to the manner of filing such a complaint" (CMS Memo 2012).

The notice must include employee rights as a mandated reporter, as reporters of a crime against a resident / The Elder Justice Act (part of Patient Protection and Affordable Care Act), the right to be free from retaliation and reprisal when reporting abuse, and employee rights under the National Labor Relations Act.

Examples of Locations where the notice should be posted include staff break rooms, the hallway by the HR Office, and on a bulletin board in the front lobby. It should be displayed using these size and type requirements: "No less than the minimum required for any other required employment-related signs."

One state investigation report (completed on September 21, 2023) describes how a Colorado nursing home did not post in central locations employees' right to report abuse, neglect, and crimes against a resident without retaliation against them. Specifically, the state Surveyor determined that the nursing home failed to: 1. Implement policies and procedures to inform staff of their responsibility to report abuse and neglect and the right to not be retaliated against for reporting allegations of abuse and neglect. 2. Assure that reporters were free from retaliation or reprisal by posting a conspicuous notice of

employee rights, including the right to file a complaint with the State Survey Agency if they believed the nursing home had retaliated against an employee or individual who reported a suspected crime with details of how to file such a complaint.

An anonymous staff (AS) member who wished to remain anonymous was interviewed on September 18, 2023. The AS asked about their rights to not be retaliated against when reporting a crime. The AS was fearful that the nursing home was going to proceed with termination if the AS proceeded to call the State Agency office to report resident abuse/neglect. The AS was curious to know an employee's rights as a reporter and said the nursing home had not provided specific education on mandated reporting rights and that the nursing home had not posted such Elder Justice Act information for staff resources.

The nursing home was issued two deficiency citations (F607 "Develop and Implement policies and procedures to prevent abuse, neglect, and theft" and F609 "Timely report suspected abuse, neglect or theft and report the results of the investigation to proper authorities") for these violations pertaining to allegations of staff abuse of three residents.

CMS states that nursing homes "are also subject to civil money penalty and exclusion sanctions for retaliating against any employee who makes a lawful report, causes a lawful report to be made, or for taking steps in furtherance of making a lawful report pursuant to the statute."

Vulnerability of Individuals Living with Cognitive Impairment

The examination of the investigation reports revealed that 70% of the alleged victims of mistreatment (e.g., abuse and neglect) lived with some level of cognitive impairment (i.e., out of 111 individuals for whom data were available to determine it). In addition, over half (54%) of these 111 individuals lived with moderate-to-severe cognitive impairment. While preliminary, these findings may suggest that individuals with cognitive disabilities are at enhanced risk of mistreatment (a fact established in prior research by Mileski et al. 2019; Sun et al. 2023) that is not being reported or that the reporting is delayed due to fear of retaliation among care employees who witness these incidents or otherwise become aware of them.

Preventing and adequately responding to allegations of right violations and abuse and neglect of residents with dementia therefore warrants greater attention in care practices, policies, regulatory oversight, and enforcement – in general and in the specific context of staff fear of retaliation.

Role of Social Workers

Given their professional training, responsibilities, and role in nursing homes (Miller et al. 2020), social workers should routinely work to instill a culture of open communication where staff members feel comfortable and safe speaking up about right violations and mistreatment of residents. Psychologically supporting direct care workers in their physically and emotionally demanding jobs (such as through regular one-on-one and group supportive sessions) and working hard to build and nurture trusting working relationships with them is key to this effort. However, the only way social workers' efforts on this front could bring about lasting positive effects – for all care employees and residents – is if owners, Administrators, and managers will fully support it in action.

Role of Long-Term Care Ombudsman Program

Long-Term Care Ombudsman representatives can play a significant role in addressing not only resident fear of retaliation (Caspi, 2024) but also staff fear of retaliation when staff witness right violations and mistreatment of people living in nursing homes and considering whether or not to report these incidents.

Quote
"Without our eyes and ears in these facilities, residents are at risk of abuse, neglect, and exploitation, and any number of rights violations" – Mairead Painter, Connecticut State Long-Term Care Ombudsman
Source: Testimony at House Appropriations Subcommittee on Labor, Health and Human Services, Education, and Related Agencies

I have reached out to experienced and highly regarded leaders in various Long-Term Care Ombudsman Programs and sought out their views about Ombudsman representatives' role in addressing staff fear of retaliation in nursing homes. What follows is what they shared with me:

Mairead Painter, Connecticut Long-Term Care Ombudsman and President of the National Association of State Long-Term Care Ombudsman Program:

"The fear of retaliation in nursing homes, whether among residents, families, or staff can lead to abuse and neglect going unreported. This creates a culture of silence and puts everyone at greater risk. When staff are just as afraid to speak up as residents and families, problems remain hidden and trust in the facility breaks down. Leadership must make it clear that retaliation is not tolerated and act quickly when concerns arise. Talking openly about retaliation and encouraging people to report problems without fear

can help make nursing homes safer. Regular training and conversations are important to reduce fear and ensure that anyone who experiences or worries about retaliation gets the support they need.

The Long Term Care Ombudsman is available to provide education, resources, and support for anyone concerned about retaliation in nursing homes. Contact your Ombudsman to learn more about how to address these issues and create a safer environment for everyone."

Richard Danford with decades of experience as an Ombudsman and advocate who has served as a Local Program Coordinator for Long-Term Care Ombudsman Programs in four States. He currently serves as a Member of the Board of Directors of the National Association of Local Long-term Care Ombudsman (NALLTCO). He is the author of *Be Aware of That Nursing Home: How We Got Here and What to Know*:

"Staff in nursing homes are legally required to report resident abuse. In most states, however, Ombudsmen are not mandated reporters. This difference affects how Ombudsmen respond when staff report concerns. Ethically, Ombudsmen must protect resident confidentiality and generally need resident consent before reporting abuse or neglect to outside authorities.

Because of this, reporting concerns to an Ombudsman does not fulfill a staff member's legal duty to report. Staff must understand these limits. Training on this issue varies widely, and many facilities, especially those without regular Ombudsman presence may not receive it. This is particularly important where staff fear retaliation; they need to know that telling an Ombudsman alone does not meet their reporting obligation.

When staff report abuse to an Ombudsman, it may signal deeper cultural and legal problems within the facility, especially if fear of retaliation is a factor. Such situations should be elevated to the Local Ombudsman Program Coordinator and, when appropriate, the State Ombudsman, who has broader authority when it comes to abuse reporting. Unfortunately, it is easy to see how these kinds of situations likely contribute significantly to the numerous abuses and neglect that go unreported. At the same time, Ombudsmen must assess what additional steps beyond reporting are needed to protect residents while staying within their ethical standards."

Patricia Hunter, Washington State Long-Term Care Ombudsman and Past President of the National Association of State Long-Term Care Ombudsman Program:

"Our absolute priority is resident protection. We actively investigate institutional gaps and use every tool at our disposal—from surveillance to systemic advocacy—to ensure no incident of abuse and neglect is ignored. Because Ombudsmen recognize that frontline nursing staff often fear retaliation from coworkers, supervisors and employers, we provide important education and support on mandated reporter laws, encouraging transparency and enforcing systemic accountability."

Amity Overall-Laib, Director, National Ombudsman Resource Center: "When Ombudsman representatives provide training to nursing home staff abuse, neglect, and exploitation, it is common for them to remind staff of their role as mandatory reporters of resident mistreatment."

Role of Unions Representing Direct Care Workers

Given that half of the employees identified in this project (51%) reported being fearful of retaliation when witnessing abuse and neglect of residents were direct care workers (CNAs and Nurse Aides) while an additional 13% were nurses, unions representing these workers (such as Service Employees International Union [SEIU], the National Nurses United, and the American Federation of State, County, and Municipal Employees [AFSCME]) should fund, develop, and launch educational and advocacy initiatives aimed at protecting the rights, psychological well-being, job satisfaction, and safety of these care employees in the specific context of retaliation fears.

Suing to Hold Nursing Homes Accountable

Elder abuse attorneys can sue nursing homes that retaliate against employees who fulfill their duty to report on mistreatment of residents and/or other unlawful practices. In one case in Illinois, a nurse was fired from the nursing homes after she refused to follow the Director of Nursing's orders to double dose anti-anxiety meds for residents described as "agitated" and to delete records of suspicious injuries (Brady-Lunny & Swiech, 2017). The Jury awarded her 5.2 million dollars.

Multiple other lawsuits related to alleged retaliation against employees who spoke up about resident mistreatment and other violations were reported over the years (such as in Michigan, Illinois, and Texas).

In a recent case, one Iowa nursing home chain was reported to face several separate whistleblower claims from former employees (an RN, a CNA, a "caregiver," and a Director of Nursing).

Quote
“Keep your mouth shut and keep your opinions to yourself” – Administrator’s text to a CNA along with instructions that she should not communicate about a night incident with the family of an 87-year-old man with a tracheostomy who needed regular suctioning. The text was sent after a temp-agency night shift nurse who allegedly, despite multiple requests by the CNA, “would not suction the resident, nor did she attempt to use the suction machine,” the lawsuit claims. He died around 2:25 AM.
Source: Kauffman (2025)

Policy Recommendations

Oversight and Enforcement

CMS and State Survey Agencies need to strengthen their oversight and enforcement of federal and state regulations and laws pertaining to staff fear of retaliation, threats of retaliation, and actual retaliation against employees who witness, suspect or otherwise become aware of right violations and mistreatment of residents but remain silent due to those fears and retaliation against them.

Quotes
In one nursing home, "s*taff had been told during the current survey there would be consequences for speaking to the state*." One nurse aide said: "*Many staff were afraid of retaliation by the nursing home and were not going to say anything.*" ~~~ In another nursing home, the Administrator and the Director of Nursing told four staff members that whenever state Surveyors asked staff questions, they needed to respond that everything was fine. They also told them that "*if they wanted a paycheck, they better not say anything bad*."

A recent report titled *Uninspected and Neglected* has shown that many State Survey Agencies struggle to fulfill their mission to protect vulnerable nursing home residents due to longstanding factors, including, among others, underfunding, understaffing, burnout, low salaries, high turnover rates, inexperienced surveyors, and challenges related to surveyors' training (U.S. Senate Special Committee on Aging, 2023).

The aforementioned recommendation will likely remain largely meaningless without Congress and states' substantial investment (funding) in robust nursing home oversight and enforcement.

In addition, calls for increased involvement of nurse aides in the state inspection process have been identified in a research study (Chung, 2012). Specifically, the researchers recommended CMS and State Survey Agencies to consider ways to increase opportunities for direct care employees to "vocalize their views about the care that they provide" and "the process of organizational policy implementation." This, in general, and by utilizing different strategies to keep these employees safe while they speak up with Surveyors about care concerns during annual inspections and complaint investigations (i.e., strategies that go beyond telling Surveyors to "maintain the confidentiality of witnesses and the person who

reported the allegation (e.g., change the order of the interviews, location or time), to the extent possible"). The same recommendations should be implemented during mistreatment complaint investigations.

As the study by Chung (2012) has shown, state Surveyors should routinely try to find out from direct and non-direct care staff members whether the care and safety practices as well as staffing levels provided during annual surveys reflect the scope and quality of these care and safety practices and staffing levels during routine care periods. While the length of annual surveys may vary significantly (See bar chart in Figure A.1. in Chen and Dillender, July 2025; revised February 2026), according to one estimate, "Standard surveys are typically conducted over three to five days depending on the size of the facility being surveyed" (U.S. Senate Special Committee on Aging, 2023). The question becomes: To what extent the quality of care and staffing levels provided to residents during the relatively brief annual survey period reliably reflect those provided during the rest of the of the year (approximately 360 days)?

For example, a NY Times investigation found that in 2019 about 70% of nursing homes increased their staffing levels on the days the inspectors were in the building, compared with their typical staffing levels on that day of the week (Silver-Greenberg & Gebeloff, 2021). In addition, an earlier study demonstrated that staffing levels (i.e., Nurse Aides, LPNs, and RNs) increased a week prior to the state Survey, peaked during the state Survey week, and then returned to baseline a week after the survey (Geng et al. 2019). Furthermore, a recent study in nursing homes nationwide (using 2014 to 2019 data) found that nursing staffing levels increase during health inspections but that then "the increases disappear immediately after inspection" (Chen and Dillender, July 2025; revised February 2026). The authors concluded: "Nursing homes show strategic responses to health inspections in multiple care dimensions." The concern is that nursing homes that know when to expect the annual survey to be held may engage in "window dressing" practices (Chen and Dillender, July 2025; revised February 2026).

Taken together, these studies warrant a closer look at CMS implementation of what it describes as "unannounced" annual inspections in nursing homes. It is important to note that CMS regulations require standard annual inspections ("surveys") to be unannounced (i.e., "All standard surveys must be unannounced" including standard surveys, complaint investigations, and onsite revisit surveys; CMS guidance also states that states must keep surveys "unannounced and their timing unpredictable").

Quote
"All surveys must be unannounced" "The policy lessens, to the extent possible, the predictability of the surveys and increases the probability that the surveys will observe conditions and care processes that are typically present." – CMS
Source: CMS Memorandum titled Policy Regarding Unannounced Surveys (6.5.09)

The federal regulations state: "The survey agency must conduct a standard survey of each Skilled Nursing Facility and Nursing Facility not later than 15 months after the last day of the previous standard survey…[and] the statewide average interval between standard surveys must be 12 months or less."

While the actual number of days between adjacent annual surveys varies (the bulk of the annual surveys take place between 330 and 470 days from the previous annual survey with an average of 390 days (see bar chart in Figure A.3 in Chen and Dillender, July 2025; revised February 2026), the inspection dates "may not be completely hidden from nursing homes" (Thomas, 2014; Rau, 2018). Nursing homes may know the approximate "survey window" (a rough sense) based on prior inspection cycles but they are not supposed to receive the date or time in advance. Some do.

The NY Times reporters Silver-Greenberg and Gebeloff (2021) stated: "Data suggest that at least some nursing homes know in advance about what are supposed to be surprise inspections." There could be other ways in which the nursing may become aware that an annual survey is about to take place. For example, when the survey team settles in a hotel in a small rural town (where "everybody knows everybody") a day prior to the scheduled survey and the nursing home "gets wind of" it (is tipped off) from a hotel employee who is a family relative or friend of a manager or a CNA working at the nursing home.

Even when the nursing home does not know ahead of time when the annual survey will take place, the somewhat gradual start of the survey process (see pages 11-12 in the *Uninspected and Neglected* report of the U.S. Senate Special Committee on Aging, 2023) with the "entrance conference" (a brief meeting with the Administrator or a nursing manager) could in some cases trigger a response resulting in care conditions and staffing levels that are improved when compared to the pre-survey period (say, for example, when the entrance conference takes place on a Monday morning and the nursing home then bolsters its staffing levels for the evening shift and during the remaining days of the annual survey).

Related to it, nursing assistants interviewed for the study by Chung (2012) reported that "their supervisors and Administrator treat them better when state Surveyors are around." One nursing assistant said: "This is when we are at our best. We go beyond the call of duty. We get treated better by our supervisors where the surveyors are there." Another nursing assistant said: "It is a good time for all CNAs because it is the time when we really give good care to the residents because it's time when everybody is helping CNAs. They are afraid of survey and help us a lot." Another nursing assistant said that they "fake" their activities during the survey because they excel only when state surveyors are present. S/he gave these examples: "They will use more new linens than usual, or they will answer call lights much faster than they usually do." The researcher stated: "This kind of temporary change is also encouraged by nurses and Administrators. When the surveyors leave, everything goes back to the previous state."

Quotes
"When the surveyors leave, everything goes back to the previous state." – Gawon Chung ~~~ "We are taught to be fake. Why can't we pretend the state is here every day? It will run so much better for all of us." – Nursing Assistant
Source: Study by Chung (2012)

Collectively, these studies' findings regarding nursing homes that "staff up" during annual surveys and those reported in the study by Chung (2012) raise the question of whether in some important ways the annual survey time may put direct care staff at a disadvantage with regards to their ability to report care concerns, right violation, and mistreatment of residents. For example, unusually more staff members, care professionals, managers, Director of Nursing, and Administrator on the floor during the annual surveys could make direct care staff members feel less comfortable and safe speaking with surveyors about issues of concern that have taken place during the months, weeks, and days prior to the survey.

Related to it, a U.S. Government Accountability Office report (2008) cite federal comparative surveys finding that a substantial portion of deficiencies are missed during states' annual surveys. Specifically: "Undetected care problems at this level are a concern because they could become more serious if nursing homes are not required to take corrective action."

As importantly, state Surveyors should increase their efforts to verify – directly with direct care staff members – that state survey deficiency citations and plans of corrections requiring meaningful and sustainable improvements are actually being adequately implemented post annual surveys and

complaint investigations. Some nursing assistants doubt whether plans of corrections will actually take place after state Surveyors complete their survey and leave because, as they said, these are "underlying problems." A number of nursing assistants interviewed for the study by Chung (2012) hinted that the "yearly inspection does not change anything fundamentally in terms of quality of care." In accordance, Harrington et al. (2004) reported that "even though many nursing homes have been found with serious deficiencies, the actual follow-up enforcement action and sanctions are lacking" (cited in Chung 2012).

Targeted Surveys and Complaint Investigations

Given that four out of the 33 unique Ftags (12%) issued in the 101 investigation reports examined in the current project on staff fear of retaliation accounted for three-quarters (74%) of the total 226 citations issued, CMS and State Survey Agencies need to pay special attention to overseeing these more common violations and strongly enforcing applicable resident and staff rights. These violations consisted of:

- The failure to protect residents from abuse, neglect, and exploitation (F600)
- The failure to timely report suspected abuse, neglect, and theft and to report the results of the investigation to the State Survey Agency (F609)
- The failure to appropriately respond to alleged violations (F610)
- The failure to develop and implement policies and procedures to prevent abuse, neglect, and theft (F607).

Of course, other violations identified in the current report deserve adequate attention by state Surveyors even if they may occur less frequently in the specific context of staff fear of retaliation.

Need for CMS Memorandum to State Survey Agencies

As demonstrated in the current report, staff fear of retaliation when witnessing, suspecting or otherwise becoming aware of violations of residents' rights and their mistreatment (e.g., abuse and neglect) can often result in far-reaching negative consequences on residents' well-being and safety (such as when due to these fears, alleged violations are not reported or that such reports are delayed, investigations are not conducted or they are delayed, and alleged perpetrators continue to have access to alleged victims). It often also results in harmful consequences for fearful staff members (e.g., emotional distress, anxiety, being intimidated and retaliated against, threats to personal safety, and fear of losing their jobs).

While staff fear of retaliation is a longstanding problem in nursing homes, the broad spectrum and varied types of related resident mistreatment and their severity identified in this report (see Chapter 2 under the heading *Types of Mistreatment Violations*) warrant special attention by CMS and State Survey Agencies.

Call for Action
CMS needs to develop a Memorandum on the issue of staff fear of retaliation when witnessing, suspecting or otherwise becoming aware of resident abuse, neglect, and financial exploitation.

The long overdue Memorandum will equip state Surveyors with a toolkit for navigating, tackling, and ultimately alleviating this common problem (current CMS Memoranda address staff fear of retaliation significantly less than resident fear of retaliation). It will also send a signal to the nursing home sector (about 70% for-profit) that CMS and state surveyors take this issue seriously and address it in a more targeted way than was done to date. Without a Memorandum, the longstanding problem of staff fear of retaliation will remain a major blind spot in CMS ability to effectively oversee and enforce federal nursing home regulations and laws pertaining to the well-being, health, and safety of vulnerable residents.

One of the reasons CMS publishes new Memorandums to the directors of State Survey Agencies overseeing care and safety in nursing homes is when a patten of serious harm is identified nationally (such as in the case of social media abuse where staff take unauthorized photos and videos of residents – often with demeaning and humiliating content – and then they post them on social media platforms).

The current report goes beyond anecdotal evidence and isolated media reports about staff fear of retaliation reported to date. Together with prior research showing that nearly one-quarter of nursing home residents reporting worrying about retaliation if they were to report a concern or complaint (Robison, 2007 / 2011), it suggests "a pattern of serious harm nationally." Of note is the fact that the very issue at the center of this report – staff fear of retaliation – serves as a strong barrier for knowing the extent of this fear (i.e., when due to this fear, staff do not file complaints about it) and the resulting witnessed or suspected resident mistreatment that is often not reported to the State Survey Agency. The current report aimed to capture staff lived experience of fear of retaliation (in their own words), not to identify the

prevalence or incidents of this issue. What has been discovered is disturbing enough to warrant the attention of CMS, State Survey Agencies, and lawmakers but also care advocacy organizations, the Long-Term Care Ombudsman Program, and unions representing direct care staff.

It is important to recognize that resident abuse in nursing homes is often not reported to State Survey Agencies (U.S. Government Accountability Office, 2019; U.S. Office of Inspector General, 2019). While research is needed to confirm it. the same can be reasonably assumed when it comes to staff fear of retaliation, threats of retaliation, and actual retaliation against them when witnessing or otherwise suspecting resident abuse and neglect.

The need to shine a light on the longstanding problem of staff fear of retaliation in nursing homes through the development of a CMS Memorandum stems also from the facts that:

- A substantial portion of nursing home residents live with dementia (Mukamel et al. 2023). A subgroup of these individuals, especially those in the later stages of dementia, may have difficulty or inability recalling key details from abuse and neglect incidents and/or reporting them to trusted others, family members, the Long-Term Care Ombudsman Program, the State Survey Agency, and law enforcement agencies.
- A significant number of residents experience social isolation (Autschbach et al. 2024). Being isolated in a nursing home may reduce the likelihood that a resident will report mistreatment.
- While many nursing home residents are regularly visited by family members and friends, a significant minority of residents have minimal or absent family involvement (Gaugler, 2005).
- Resident mistreatment often occurs inside victims' bedrooms and bathrooms (Moore, 2017b) often behind closed doors (short of having a camera installed in the bedroom, co-workers and other employees may be the only witnesses of abuse, neglect, and exploitation of residents).
- Many residents are fearful of retaliation when voicing right violations, care concerns, and mistreatment (Caspi, 2024, Long Term Care Community Coalition, 2023). Many family members and friends of residents are also fearful of retaliation when considering voicing care concerns.
- A substantial portion of states' Long-Term Care Ombudsman Programs do not have an adequate number of Ombudsmen staff to meet the 1995 Institute of Medicine's recommended 1:2,000 ratio of Ombudsman per long-term care beds (U.S. Senate Special Committee on Aging, 2024), thus decreasing their ability to educate residents about their rights and advocate to realize these rights.

- Many State Survey Agencies struggle to fulfill their mission to oversee resident care, mistreatment, and safety in nursing homes and to enforce the federal nursing home regulations and laws (U.S. Senate Special Committee on Aging, 2023)

The need for a new Memorandum is further supported by a review conducted for this report. Specifically, a review of CMS State Operations Manual Guidance to Surveyors – Appendix PP (8.8.24) reveals that while it does provide some guidance to Surveyors on staff fear of retaliation, overall, the attention to this critical issue is limited in scope and it is scattered across different parts of it.

For example, it includes guidance and investigative protocols on specific areas of focus during Surveyors' interviews with staff members (e.g., F602 – Misappropriation of resident property and exploitation; F603 – Right to be free from involuntary seclusion; F607 – The nursing home must develop and implement policies and procedures). The guidance primarily focuses on Surveyors' efforts *to identify* whether staff feel fearful of retaliation from the nursing home, whether they feel that they were retaliated against, and if so, what retaliatory actions were taken against them for reporting allegations of resident mistreatment.

In addition, CMS "Abuse Critical Element Pathway" (2017) guidance to Surveyors when investigating alleged violation of abuse of residents also focuses primarily on *the identification* of staff fear of retaliation when reporting alleged abuse and the ways in which retaliatory actions may have taken place.

However, both CMS State Operations Manual Guidance to Surveyors *and* the Abuse Critical Element Pathway do not seem to provide guidance to surveyors on *what to do* when they identify that a staff member is fearful of retaliation or has experienced retaliation for reporting alleged abuse of a resident (that is, what specific strategies they should consider using to try and overcome this fear and encourage employees to speak up with them about the alleged abuse while keeping the employee safe as possible).

Related to it, the extent and quality to which state Surveyors' training *systematically and meaningfully* addresses the issue of staff fear of retaliation (including reluctancy to speak with state Surveyors and being evasive with them) and the ways in which Surveyors can work to address it is unclear (that is, not only to identify it but to work through it in ways that will increase the likelihood that staff will feel comfortable and safe speaking up with Surveyors about resident right violations and mistreatment).

Specifically, if it does not exist in adequate scope and quality, CMS must develop and provide Surveyors with more robust training, guidance, and tools to navigate the common and complex issue of staff fear of

retaliation in nursing homes (one state Surveyor wrote me recently about staff fear of retaliation, saying that it can “make or break” the mistreatment investigation).

Specifically, all state Surveyors need to have the knowledge and skills to be able to:

- Recognize signs that a staff member is fearful of retaliation when being interviewed.
- Create conditions that reduce a staff member's fear before, during, and after an interview.
- Conduct staff interviews privately and away from supervisory and co-workers oversight (in general but especially away from co-workers, other employees, and managers who the staffer believes have perpetrated abuse and neglect of residents in the past and those with a known history of using threats of retaliation and retaliatory practices).
- Follow up when a staff member appears reluctant or abruptly changes their account.
- Document or act on situations where staff fear appears to be suppressing information.

In addition, this guidance is included in CMS State Operation Manual Guidance to Surveyors – Appendix PP (under F562 – “The facility must provide immediate access to any resident”): “If facility staff attempt to interfere with the survey process and restrict a surveyor’s ability to gather necessary information to determine compliance with requirements, surveyors should consult with the CMS location.” The term “CMS location” refers to CMS Regional Office responsible for overseeing the State Survey Agency in that geographical area (CMS is organized into 10 Regional Offices across the country, each responsible for a specific group of states). When CMS guidance states that the Surveyor “should consult with the CMS location,” it means the Surveyor should contact the State Survey Agency’s Regional Office for guidance on how to handle the interference situation. What this means is that when a nursing home attempts to interfere with a survey, the guidance does not authorize the surveyor to independently issue a deficiency for the interference itself or take immediate punitive action. Instead, the Surveyor is directed to: 1. Stop and report the situation upward to their CMS Regional Office. 2. Await guidance on how to proceed.

The practical meaning of this guidance is that interference with a survey process, which is a serious matter, triggers a consultation step rather than an immediate, clearly defined enforcement response. This is a clear weakness in the survey process since it gives nursing homes a window in which interference may go unaddressed while the surveyor waits for guidance from the Regional Office.

While interference with the survey process can take different forms, the scenario where ahead of or during a survey the nursing home attempts to silence an employee who witnessed abuse or neglect of a resident represents a major concern which is directly relevant to the topic of this report.

For example, an employee plans to tell the Surveyors about a witnessed abuse while the Surveyors are in the building. As the employee is about to approach the surveyors, s/he receives a text from the Administrator instructing her/him to immediately go to the Administrator's office. While there, the Administrator tells the employee that if s/he will report the abuse to the Surveyors, s/he can start looking for another job. Terrified of losing her/his job, the employee does not report the abuse to the surveyors.

This type of interference represents a major barrier to surveyors' ability to obtain critical information during annual surveys and complaint investigations. CMS needs to address it in a more structured and meaningful way (with a comprehensive protocol) than it has done to date. Otherwise, staff fear of retaliation, threats of retaliation, and actual retaliation against them will continue to suppress the scope, quality, and accuracy of information surveyors are able to gather, ultimately undermining the integrity of the survey and complaint investigation processes.

The new CMS Memorandum needs to address a series of issues (these are described in **Appendix 6)**.

Investigations by U.S. Office of Inspector General and U.S. Government Accountability Office

In light of the fact that staff fear of retaliation has been shown in the current report to be a strong barrier for reporting right violations, abuse, and neglect of nursing home residents, the U.S. Office of Inspector General and the U.S. Government Accountability Office need to conduct investigations of this issue and make recommendations to CMS for addressing it.

Need for a New State Survey Deficiency Citation (Ftag) Under New Federal and State Regulation

A new "stand alone" state survey deficiency citation (Ftag) is urgently needed in nursing homes. The new Ftag should consist of employees' right to voice and report resident right violations, care concerns, and mistreatment (internally and externally) without being intimidated, without being threatened with retaliation, and without being retaliated or discriminated against. As importantly, the Ftag should also address staff right to voice and report resident right violations, care concerns and mistreatment without *fear of* retaliation and discrimination (as is the case with residents' right in federal regulations [42 CFR § 483.10(g)(1)]: "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").

Signaling to the nursing home sector that violations of this right will be taken seriously by CMS and State Survey Agencies and that such violations will not be tolerated is critically important for two reasons: 1. The critical need to respect care employees (the bedrock of care) and their voice. 2. The negative consequences on residents' well-being, health, and safety when employees witness or suspect resident right violations and mistreatment but are too afraid to report on them.

Since usually there must already be an underlying regulatory authority (existing federal requirement) supporting the issuance of a deficiency citation and its enforcement, Congress will likely need to pass a new federal regulation to bridge this major gap in the federal oversight of residents' care and safety.

This recommendation is based on the premise that doing justice in consistently and effectively addressing this longstanding, common, harmful but often overlooked problem may not be fully realized only with CMS reorganizing, renumbering, splitting, consolidating, interpreting, or revising guidance to existing Ftags or with a new or revised Interpretive Guidance to State Survey Agencies.

That said, states should not wait for a new federal regulation. With applicable state legislation or licensure regulations (existing or those that will be passed in the future), State Survey Agencies would be able to cite state-only deficiencies outside the federal Ftag system.

Need for Legislation Requiring In-Service Training

States should consider passing legislation requiring annual in-service training on staff fear of retaliation, intimidation and threats of retaliation, and actual retaliation against them and all other employees (addressing issues including, but not limited to, staff applicable rights and nursing home's responsibilities for preventing, detecting, investigating, reporting, and addressing it as well as meaningful enforcement actions when violations are identified). Similar legislation exists in Connecticut nursing homes (effective October 1, 2013) and assisted living residences (effective October 1, 2026) and in Illinois nursing homes (effective January 1, 2026) in the context of residents' fear of retaliation.

Need for Broad Protective Legislation

An expert panel should be appointed to review all applicable federal and state laws and regulations pertaining to nursing homes to identify gaps related to anti-retaliation protections for employees when they witness, suspect or otherwise become aware of resident right violations and mistreatment. That is, when employees consider reporting these or actually have reported these allegations internally within the nursing home and/or extremally to the State Survey Agency, Adult Protective Services (in states where

the agency has authority to investigate mistreatment in nursing homes), the Long-Term Care Ombudsman Program, and law enforcement agencies.

While mandatory reporting laws and other state laws include anti-retaliation protections for these employees, these state laws vary greatly (Kohn et al. 2025). Other state laws include anti-retaliation protections, but such protections may not exist, or they may be inadequate or weak in other states. Federal and state labor laws will also need to be reviewed by the experts' panel.

Even states with anti-retaliation laws that are generally considered meaningful may consist of substantial gaps. For example, the Minnesota Vulnerable Adults Act provides some meaningful protections related to employer retaliation against employees who "in good faith" report on maltreatment of vulnerable adults in nursing homes, assisted living residences, among other care settings. The law also provides some significant remedies. However, it also consists of a series of important gaps. These include, among others, those related to government enforcement, co-worker retaliation, informal and subtle retaliation, narrowly defined internal reporting protections, vulnerabilities and challenges related to the "in good faith" requirements (despite being a standard protection), reactive remedies (as opposed to proactive protections), and major barriers related to awareness and practical access.

Importantly, having a law "on the books" does not guarantee that it will be implemented or that it will be adequately implemented or that it will be implemented in time to protect employees and residents.

Quote
"Our protections in law are only as good as the enforcement capabilities." – Jan Malcom, Former Minnesota Health Commissioner
Source: Minnesota Department of Health Assisted Living Licensure Work Group held on 11.5 .18

The experts' panel should therefore also examine the extent to which federal and state laws include strong enforcement mechanisms to protect ethical and brave employees from threats of retaliation and actual retaliation for good faith reporting of violations of residents' rights and mistreatment.

Call for Research

Research studies are urgently needed to examine:

- The prevalence of staff fear of retaliation when witnessing, suspecting or otherwise becoming aware of residents' right violations and mistreatment in nursing homes. Studies should also examine the extent to which staff members experience intimidation, threats of retaliation, and retaliation when witnessing, suspecting or otherwise becoming aware of residents' right violations and mistreatment in nursing homes. Similar research is needed in assisted living residences.

Attempt to Silence Physical Abuse in Assisted living
A woman lived with dementia in an "Assisted Living with Dementia Care" (a "memory care unit) in Minnesota. Aide1 and Aide 1 witnessed an employee "*strike the resident in the face during a struggle for a blanket*." The aides said that during the struggle, the resident became agitated and hit the employee and that the employee then "*balled up her fist and struck the resident on the left side of her face*." The resident then said: "*Sheesh, okay then*," and went to sit in a chair. Aide 1 noticed a red mark on the resident's left cheek. Due to her cognitive status, she was unable to verbalize what happened. Aide 1 told the employee "*You know I saw that, right?*" and the employee answered, laughing: "*You saw her hit me*." Aide 2 said that when Aide 1 told the employee she saw the employee hit the resident, the employee responded: "***You didn't see anything, it's he said/she said***." Aide 1 reported the incident to leadership, who sent the employee home pending the results of the investigation. The employee "was charged with gross misdemeanor (disorderly conduct) against a vulnerable adult."
Source: Minnesota Department of Health's investigation report substantiated as Abuse (investigation completed on 7.2.24)

- Facilitators and barriers for care employees' willingness to speak with state Surveyors about residents' right violations and mistreatment during annual inspections and complaint investigations. Related to it, research should examine what strategies are used by state Surveyors when facing staff members who have witnessed, suspected or otherwise know about resident mistreatment but do not report it to the Surveyors due to fear of retaliation from the nursing home.
- Direct care staff perspectives regarding reporting to the Long-Term Care Ombudsman Program residents' right violations and mistreatment in nursing homes. What circumstances and factors contribute to staff members' willingness versus unwillingness to report these allegations to Ombudsman representatives.
- Family members' fear of retaliation when witnessing, suspecting or otherwise becoming aware of right violations and mistreatment of their relatives (e.g. prevalence, risk and protective factors, and facilitators and barriers for reporting) in nursing homes and assisted living residences.

In Closing

Discussions about care provided to people living in nursing homes often revolve around the need to protect their safety and preserve their dignity. Dignity is defined as "The quality or state of being worthy of honor and respect" (Merrian Webster dictionary).

The report "*Nobody spoke up*" can now be used to inform care practice and policy efforts aimed at creating the conditions that will enable direct care staff members and all other employees to feel that their voice and care concerns matter and that they are always honored and respected.

Quote
"If the leadership first respects their staff, then their staff respects their residents." – Ombudsman representative
Source: Report titled A Bridge Over Scary Water (Caspi, 2024)

When direct care employees are treated by owners, administrators, and managers of the nursing home in disrespectful and undignified ways (or "*being treated like dirt*" as one Ombudsman representative said recently), the likelihood that individuals receiving care will suffer right violations, undignified care, and mistreatment increases. One is and has always been directly tied to the other.

The current project has generated extensive and disturbing evidence showing that a subgroup of direct care staff members are victimized when they are made to fear retaliation, when they are intimidated and threatened with retaliation, and when they are retaliated against for trying to do the right thing and report on right violations and mistreatment of a vulnerable people living and receiving care in nursing homes.

Dr. Stephen Miles's words, in the context of his review of nursing homes' attempts to conceal accidental deaths of residents (i.e., bedrails entrapments and physical restraints resulting in fatal asphyxiation) and the concealment itself, are worth reiterating: "These situations are extremely difficult for nurse aides and front-line nurses. They are often intimidated, fired, and disparaged. Resolution of these events should also address the needs of these victimized staff."

Quote
"I've always said that in a sense, the staff, particularly the CNAs but to an extent the nursing staff, they are victims of the same system that the residents are. This profits over people system that we keep seeing, that causes all these bad things to happen" – Personal Injury Attorney Evan W. Jones
Source: Nursing Home Abuse Podcast interview # 215 on a common form of neglect: Harmful resident-to-resident incidents

My hope is that the report will contribute to de-stigmatizing and breaking the silence related to staff fear of retaliation in America's nursing homes. That is, if we want the word "*heroes*" to have a real meaning.

Recommendation for Practice
"Encourage a culture of openness, in which reporting abuse is viewed as an opportunity for improvement." – Steve Moore, Commissioner of Care and Nursing Home Services, Dudley Metropolitan Borough Council, England
Source: Moore (2017b)

Quote
"When the person receiving care, families, friends, and care partners feel safe speaking up, everyone benefits."
Source: *Connecticut and Colorado Long-Term Care Ombudsman Programs, & Caspi, E. (2026). Breaking the Silence: Fear of Retaliation – A Comprehensive Educational Training Program Addressing Concerns and Promoting a Safe Environment When Receiving Long-Term Services and Supports*

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Appendix 1

Breakdown of States (n=35)

State	Number of Investigation Reports
Texas	21
California	8
Iowa	6
Florida	6
Illinois	5
Ohio	4
Michigan	4
Washington State	4
New York	4
Pennsylvania	3
Kansas	3
Kentucky	3
South Dakota	2
Wisconsin	2
Oklahoma	2
Indiana	2
Missouri	2
Connecticut	2
Colorado	2
North Carolina	1
Nebraska	1
Mississippi	1
North Dakota	1
Idaho	1
New Mexico	1
Minnesota	1
New Jersey	1
Alabama	1
Maine	1
Georgia	1
Arizona	1
Montana	1
Tennessee	1
Oregon	1
Massachusetts	1
Total	
35	**101 Investigation Reports (from 100 Nursing Homes)**

Appendix 2

State Survey Deficiency Citations (Ftags) Issued – Definitions

F550 – Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.

F559 – Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made.

F580 – Immediately tell the resident, the resident's doctor, and a family member of situations (injury, decline, room, etc.) that affect the resident.

F600 – Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect of anybody.

F602 – Protect each resident from the wrongful use of the resident's belongings or money.

F603 – Protect each resident from separation (from other residents, his/her room, or confinement to his/her room).

F604 – Ensure each resident is free from the use of physical restraints, unless needed for medical treatment.

F607 – Develop and Implement policies and procedures to prevent abuse, neglect, and theft.

F608 – Develop and implement policies and procedures to ensure (1) employees report any suspicion of a crime against any resident, according to timelines (2) post the notice of employee rights (3) prohibit and prevent retaliation for reporting.

F609 – Timely report suspected abuse, neglect or theft and report the results of the investigation to proper authorities.

F610 – Respond appropriately to all alleged violations.

F622 – Not transfer or discharge a resident without adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.

F656 – Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured.

F658 – Ensure services provided by the nursing facility meet professional standards of quality

F660 – Plan the resident's discharge to meet the resident's goals and needs.

F678 – Provide basic lie support, including CPR, prior to arrival of emergency medical personnel, subject to physician orders and the resident's advance directives.

F684 – Provide appropriate treatment and care according to orders, resident's preferences and goals.

F689 – Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.

F695 – Provide safe and appropriate respiratory care for a resident when needed.

F697 – Provide safe, appropriate pain management for a resident who requires such services.

F725 – Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift.

F755 – Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.

F757 – Ensure each resident's drug regimen must be free from unnecessary drugs.

F760 – Ensure that residents are free from significant medication errors

F761 – Each drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.

F835 – Administer the facility in a manner that enables it to use its resources effectively and efficiently.

F836 – Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards.

F837 – Establish a governing body that is legally responsible for establishing and implementing polices for managing and operating the facility and appoints a property licensed administrator responsible for managing the facility.

F842 – Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards

F867 – Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.

F895 – Have a Compliance and Ethics Program.

F925 – Make sure there is a pest control program to prevent / deal with mice, insects, or other pests.

F943 – Give their staff education on dementia care, and what abuse, neglect, and exploitation are; and how to report abuse, neglect, and exploitation.

Appendix 3

Ftags by Type by Frequency (n=33 Ftags)			%
1	F600	61	26.99%
2	F609	50	22.12%
3	F610	33	14.60%
4	F607	24	10.61%
5	F725	8	3.53%
6	F835	8	3.53%
7	F550	4	1.77%
8	F608	3	1.32%
9	F602	2	0.88%
10	F604	2	0.88%
11	F622	2	0.88%
12	F658	2	0.88%
13	F678	2	0.88%
14	F684	2	0.88%
15	F689	2	0.88%
16	F755	2	0.88%
17	F761	2	0.88%
18	F837	2	0.88%
19	F559	1	0.44%
20	F580	1	0.44%
21	F603	1	0.44%
22	F656	1	0.44%
23	F660	1	0.44%
24	F695	1	0.44%
25	F697	1	0.44%
26	F757	1	0.44%
27	F760	1	0.44%
28	F836	1	0.44%
29	F842	1	0.44%
30	F867	1	0.44%
31	F895	1	0.44%
32	F925	1	0.44%
33	F943	1	0.44%
Total		**226**	**100%**

Appendix 4

Scope and Severity Determinations	Frequency	%
Minimal Harm or Potential for Actual Harm	115	51.11
Actual Harm	34	15.11
Immediate Jeopardy	76	33.77
Total	225	100%

Notes

1. Missing data (n=1)

2. These findings need to be interpreted with caution because a significant portion of the scope and severity determinations were not issued directly related to staff fear of retaliation or threats of retaliation and actual retaliation against them.

Appendix 5

Full Summaries of 101 Investigation Reports

Fear of Retaliation

Because It Was Their Boss and Fearing They Would Be Fired, Two CNAs Did Not Report Witnessing the Administrator Verbally and Mentally Abuse a Resident (Telling Her/Him in a Public Space – Where Other Residents and Staff Could Hear It – S/he Needs to Wear a Bra When in a Public Space) / The Administrator Also Yelled to CNAs at the Nurses' Station to Make Sure the Resident Wears a Bra / These Actions Made the Resident Feel Upset, Humiliated, and Embarrassed

The nursing home staff failed to ensure Resident 19 was free from verbal and mental abuse. Specifically, Resident 19 was told to wear a bra in a common area by the Administrator, and it resulted in mental anguish and psychological distress.

The nursing home failed to ensure staff implemented their abuse policy for Resident 19. Specifically, the nursing home failed to identify, report, and investigate Resident 19's abuse allegation.

The nursing home failed to report an allegation of abuse for Resident 19.

The nursing home failed to investigate an allegation of abuse for Resident 19.

Resident 19 had diagnoses of Asthma and Heart Failure.

Cognitive Function. Resident 19 was **cognitively intact** (BIMS score of 15 out of 15).

Activities of Daily Living. Not Reported.

Due to scope considerations and relevance to the topic of staff fear of retaliation, this summary focuses primarily on violations related to Resident 19 (not on violations pertaining to other residents).

During an interview on April 18, 2024, Resident 19 said when he/she was in the day room a few months ago, with other residents and staff present, the Administrator approached him/her and said he/she needed to go back to his/her room and put on a bra because he/she was dressed inappropriately. Resident 19 said he/she told the Administrator he/she did not want to wear a bra because it is uncomfortable and the Administrator responded saying he/she needed to buy comfortable bras. Resident 19 said the Administrator said he/she needed to be wearing a bra when in common areas. Resident 19 said the Administrator left the room and yelled at all the staff members sitting at the desk, which is next to the day room, to make sure he/she wears a bra because he/she is dressed inappropriately. Resident 19 said he/she felt humiliated by this, still feels humiliated by it, and doesn't feel comfortable when the Administrator is near him/her because he/she fears humiliation again. Resident 19 said sometimes when he/she goes out for special events, he/she will wear a bra, but does not usually wish to wear a bra in the common areas because it's his/her home.

During a Resident Council meeting held on April 17, 2024, Resident 19 said that the Administrator is very rude and disrespectful. Resident 19 said that he/she felt humiliated and embarrassed when the Administrator addressed him/her not wearing a bra in public, where everyone, including other residents and nurses could overhear.

During an interview on April 17, 2024, CNA 1 said about two months ago the Administrator told Resident 19 that he/she needed to wear a bra, while he/she was with other residents.

CNA 1 said after the Administrator went to the desk and told all the CNAs and nurses they needed to make sure Resident 19 was wearing a bra when other people are around. CNA 1 said the way the Administrator discussed this was inappropriate and embarrassed the resident. CNA 1 said Resident 19 does not usually want to wear a bra and that his/her breasts were covered, but the shirt was low cut.

During an interview on April 17, 2024, CNA 2 said she was at the nurses' station when the Administrator told the staff that Resident 19 had to wear a bra because he/she was dressed inappropriately. CNA 2 said Resident 19 has a large bust and the shirt was a little low cut, but the shirt was not inappropriate.

During an interview on April 17, 2024, CNA 3 said she was at the nurses' station when the Administrator told the staff that Resident 19 had to wear a bra because he/she was dressed inappropriately. CNA 3 said staff need to respect Resident 19 wishes to not wear a bra because it is his/her right to decide what he/she wants to wear, so the Administrator should not have told staff he/she needed to wear one.

During an interview on April 18, 2024, CNA 4 said it is Resident 19's choice to not wear a bra. CNA 4 said Resident 19 told her he/she was embarrassed the Administrator told him/her that he/she needed to wear a bra when in common areas after the encounter that day. CNA 4 said the Administrator was yelling when informing staff that Resident 19 needed to wear a bra and it was inappropriate because other residents and people nearby could hear him yelling. CNA 4 said she heard Resident 19 tell the Administrator that he/she was upset and felt disrespected, and heard the Administrator respond by saying "Here's the phone, why don't you call and report me?"

During an interview on April 18, 2024, CNA 4 and CNA 5 said they did not report the incident. Both CNA 4 and CNA 5 said the Administrator was inappropriate but did not report abuse. **CNA 4 and CNA 5 said they would have reported it but did not because it was their boss and feared they would be fired**. CNA 5 said she did not know where else she could report, and that the sign on the unit with the Abuse Reporting Hotline was just placed on the wall two days ago when the survey began.

During the interview, CNA 4 and CNA 5 showed the surveyor a form titled Nurses and CNA Inservice [sic] Continued, dated April 15, 2024, indicating: Conversations regarding dignity need to be had in private at all times. If you notice a resident exposed or dress [sic] inappropriately, please calmly and discreetly remove them from the situation, and speak with them in private as well as get assistance to help you. Conversations like this should never occur in a public area as they can embarrass the resident.

During an interview on April 18, 2024, the Director of Nursing (DON) said the Inservice form referenced by the CNAs was written by her and was dispersed to all staff because she observed staff needing education on resident privacy. The DON said she gave this Inservice to the Administrator, who had begun dispersing this education on Monday April 15, 2024.

Review of Investigation Statement from the Administrator, dated April 18, 2024, indicated, but was not limited to: "I was conducting my unit rounds, and I noticed Resident 19 was not dressed appropriately. The patient's [sic] breasts were hanging out. I went to the nurse's station and spoke to aide as discreetly as possible to alert her of this dignity concern. I anticipated the aide would remove him/her from the day room and speak with him/her in private about this concern. I did notify the Activities Director to assist with offering to get him/her appropriate attire."

During an interview on April 22, 2024, the Administrator said that two months ago, he had just rounded the floor and noticed the resident was not dressed appropriately. The Administrator could not define appropriately dressed to the Surveyor. The Administrator said he told a CNA to address the inappropriate dressing. The Administrator said he emailed the Activities Director to follow up on assisting Resident 19 in ordering any clothing he/she needs. The Administrator said residents have the right to preference and choice on how they dress.

On April 18, 2024, the Surveyor reported the allegation to the DON. The DON said this is a report of abuse and needs to be reported and investigated. **The DON said she and the governing body were not aware of this allegation and should have been notified when it occurred**.

During an interview on April 18, 2024, Corporate Nurse 1 said Resident 19 does not have to wear a bra if he/she does not want to and the Administrator should never have done that and will be suspended immediately.

Name of Nursing Home	Highland Park Rehabilitation and Healthcare Center
Provider ID	225557
Address [RUCA Code: 1] [% County Population Rural: 0.01]	255 Central Avenue, Chelsea, Massachusetts, 02150
Day Investigation Completed	April 22, 2024
Type of Deficiency Issued	*F600 **F607 ***F609 ****F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm **** Minimal Harm or Potential for Actual Harm

A CNA Took a Live Photograph Showing a Resident in the Bathroom with Feces on Their Buttocks and Legs. Two CNAs Were Shown the Photograph but Did Not Report It for Nearly Two Weeks Because They Feared Retaliation from the Assistant Director of Nursing (DON) Who Was Present When the Photograph was Shown by the Perpetrator to Multiple Staff Members. They Both Feared Retaliation Also Because the CNA Was Related to the Assistant DON. One of Them Was Afraid the Assistant DON Would Have Them Fired

The nursing home failed to protect Resident 1 from abuse by staff. Specifically, on November 12, 2024, CNA 5 shared with co-workers a live photograph (a feature on a cell phone that captures 1.5 to 3 second video with sound that allows a photo to come to life) that was taken on their personal cell phone of Resident 1 during incontinence care with their buttocks exposed and without the resident's consent.

Using CMS Reasonable Person Concept, it was determined that psychosocial harm occurred for Resident 1.

The nursing home did not ensure that all alleged violations involving abuse and mistreatment are reported immediately, but no later than two hours after the allegation is made, if the events that cause the allegation involve abuse, to other officials (including the State Survey Agency) for Resident 1. Specifically, allegations of resident abuse identified by multiple staff members on November 12, 2024 were not reported to the Administrator until November 25, 2024 (a total of thirteen days). The allegation was not reported to the New York Department of Health within two hours, which resulted in psychosocial harm for Resident 1.

Resident 1 had diagnoses of **dementia**, major depression disorder, and anxiety disorder. The resident's Care Plan indicated that the resident had a mood problem related to Bipolar disorder and a history of traumatic events of abuse when they were younger.

Cognitive Function Level. Resident 1 was **severely cognitively impaired** though was always understood and usually understands others (based on MDS documentation).

The nursing home investigation summary dated November 25 2024 documented Resident 1 was found to be grossly incontinent. CNA 2 went to provide care and became overwhelmed by odor and asked CNA 1 assist them. CNA 2 began to cough and gag in Resident 1's room while CNA 1 was attempting clean Resident 1. CNA 1 became overwhelmed by odor ad began to gag and began telling CNA 2 "I quit, I quit." CNA 5, who was down the hallway, heard CNA 1 and went to the room. When CNA 5 arrived at the room, they observed CNA 1 and CNA 2 gagging and laughing at each other while attempting to provide care and took a video/photograph (live photo) of the incident as they thought the staff's reactions were funny.

During an interview on November 6, 2025, CNA 3 stated that in November of 2024 (could not recall exact date), they saw a video on CNA 5's cellphone that showed CNA 1 and CNA 2 in Resident 1's room gagging. They stated in the background they could clearly see Resident 1 standing in the bathroom with feces on their buttocks and legs. They stated CNA 5 kept showing it to staff members who were standing on the porch of the nursing home at the change of shift. They stated the staff who were on the porch included CNA 1, CNA 4, CNA 7, LPN 2, and the Assistant Director of Nursing. CNA 3 stated it was a violation of Resident 1's rights and humiliating for them.

This incident occurred at the end of August or the beginning of September 2024. On November 12, 2024, CNA 5 showed the video / photograph (live photo) to multiple staff, laughing at CNA 1's reaction. LPN 2 said in the photo, Resident 1 was in the background and their buttocks was visible. They stated taking photographs of residents was a form of abuse and would have been embarrassing for Resident 1.

During a telephone interview, LPN 2 stated, in November of 2024 (could not recall exact date), they were standing on the porch of the nursing home with the Assistant Director of Nursing when CNA 5 was sharing the live photograph with other staff members. They stated they could not recall everyone that was there, but everyone was talking and laughing. LPN 2 stated CNA 3 was standing next to them and CNA 5 was showing them a live photograph on their phone.

CNA 1 stated if Resident 1 was alert and oriented and had found out about the live photograph, they would have felt exposed and could have felt degraded.

Resident 1's Responsible Party stated when they received the telephone call from the nursing home about the incident, they were told that an individual at the nursing home had taken a video of Resident 1 after Resident 1 had a bowel movement. They stated when Resident 1 was younger, they had experienced similar trauma. If Resident 1 knew about that video, they would have felt embarrassed, upset, degraded, and may have relived some of their past trauma.

During a telephone interview, the Medical Director stated they were made aware of the incident. Referring to the live photo of Resident 1, the Medical Director stated: "Talk about a HIPAA violation! The whole situation should have never happened."

During a telephone interview, CNA 5 stated they had taken a live photograph of CNA 1 who had a nightgown around their neck. They stated they had thought it was a funny picture and there were no residents in the background. The stated they should have never taken the photograph.

During a telephone interview, the Assistant Director of Nursing (no longer employed at the nursing home) denied seeing or having any knowledge of a live photograph / video on CNA 5's cellphone. However, multiple staffers reported that the Assistant Director of Nursing was present when CNA 5 had shown the video / photograph of Resident 1, so they did not report the incident because they were aware of supervisor knowledge.

LPN 1 stated CNA 3 told them they had viewed a photo exposing Resident 1's buttocks. LPN1 stated they never saw the video but had told CNA 3 to report it to the supervisor, Director of Nursing, and Administrator immediately. They stated **CNA 3 had expressed to them that they were intimidated by the Assistant Director of Nursing and were afraid of retaliation from them if they reported it**. CNA 3 stated **they wanted to report the video to someone but feared retaliation from the Assistant Director of Nursing because they were close with CNA 5**.

During a telephone interview, CNA 4 stated they had remembered seeing the photograph on CNA 5's cellphone. They stated they were able to see Resident 1's bare buttocks. **CNA 4 stated they did not report the video because CNA 5 was related to the Assistant Director of Nursing and were afraid that the Assistant Director of Nursing would have had them fired**.

During a telephone interview, the Director of Quality Assurance stated it was their expectation to never see any staff members on their cellphones in resident care areas. They stated the incident that occurred with Resident 1 was an invasion of privacy and a form of abuse.

Name of Nursing Home	Fiddlers Green Manor Rehab and Nursing Center
Provider ID	335457
Address [RUCA Code: 10] [% County Population Rural: 10.31]	168 West Main Street, Springville, New York, 14141
Day Investigation Completed	November 10, 2025
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Actual Harm **Actual Harm

CNA Not Intervening When Hearing Supervising Nurse Verbally Abuse a Woman with Huntington's Disease

The nursing home failed to protect the residents from verbal abuse from Licensed Nurse (LN) G. On the morning of August 26, 2023, CNA M heard LN G threaten to hit Resident 2 and CNA N heard LN G threaten Resident 2 if she hit her again, she would be sorry. CNA N failed to report the verbal abuse and CNA M reported the abuse to LN H. LN H failed to notify Administrative Nurse D. LN G worked three shifts after the verbal abuse until Administrative Nurse D was made aware of the occurrence on August 31, 2023.

Resident 2 had a diagnosis of **Huntington's disease** (a rare abnormal hereditary condition characterized by progressive mental deterioration a disabling central nervous system movement disorder).

Cognitive Function. The resident was assessed to have **severe cognitive impairment** (BIMS score of 7 out of 15).

Activities of Daily Living. The resident required extensive assistance of one to two staff for her activities of daily living (ADLs), and required staff support to maintain her balance.

During a telephone interview, CNA M revealed the verbal incident with LN G to Resident 2 occurred the last weekend she worked before she quit, which was the weekend of August 26-27, 2023. CNA M stated Resident 2 had been very agitated, was walking and crawling out of her bedroom, and hitting at staff. CNA M stated she was outside Resident 2's bedroom in case CNA N and LN G needed help with Resident 2 when in her bedroom trying to calm her down and keep her in bed. CNA M stated she heard LN G say "[Specific name], if you hit me, I will hit you right back." **CNA M** stated she **did not enter the bedroom and intervene at that time as LN G intimidated her and she was scared of what LN G might say or snap back at her, as she had done that before** when she tried to ask LN G something. CNA M stated she told the day shift agency charge nurse (could not recall her name) who told her she would contact Administrative Nurse D or the scheduler who worked under Administrative Nurse D.

During an interview, CNA N stated Resident 2 was trying to hit and spit at her and LN G and LN G stated to Resident 2: "You keep it up, you will be sorry." **CNA N** stated she **thought the comment was wrong, but LN G was her supervisor, and she could not go against her supervisor.** CNA N stated **she did not tell any other staff what LN G stated to Resident 2**. CNA N stated LN G was known to not be very polite with the staff and residents and she had told the previous supervisor about LN G, which was no longer at the facility, and nothing was done so she quit telling.

During an interview, LN G denied stating to Resident 2 she would hit her and denied saying to Resident 2 if she hits her again, you'll be sorry.

The nursing home's investigation found the verbal abuse allegations to be unsubstantiated. However, it terminated the employment of LN G on September 7, 2023 for being high risk due to poor communication skills.

Name of Nursing Home	Wheat State Manor
Provider ID	175451
Address [RUCA Code: 2] [% County Population Rural: 46.10]	601 S. Main St, Whitewater, Kansas, 67154
Day Investigation Completed	September 13, 2023
Type of Deficiency Issued	*F600 **F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Immediate Jeopardy

A Delay in Reporting Punching a Man with Alzheimer's Disease Resulting in a Black Eye

The nursing home failed to report and thoroughly investigate an allegation of abuse for Resident 31.

Resident 31 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. The resident had a **cognitive communication deficit** (based on admission records).

Activities of Daily Living. The resident was dependent for eating, toileting, hygiene, shower/bathe, dressing upper and lower body, and personal hygiene. The resident was dependent for mobility to roll left to right or from sit to lying in bed.

CNA (Staff N) stated that CNA (Staff R) came into Resident 31's bedroom as she was placing linen onto Resident 31's roommate's bed. CNA (Staff N) stated CNA (Staff R) walked into the room behind her and stated: "Did you see his face?" When CNA (Staff N) looked to see Resident 31's face, she saw a left black eye with a gash over his left eyebrow. CNA (Staff N) stated she did not receive report about concerns to the resident's face. CNA (Staff N) stated she thought he had a fall, but CNA (Staff R) stated she punched the resident because he had her fingers bent backwards and would not let go of her. CNA (Staff N) stated she had no idea why CNA (Staff R) divulged this information to her. CNA (Staff N) stated CNA (Staff R) did this a few days ago on a Tuesday or Wednesday.

CNA (Staff N) stated CNA (Staff R) stated she put on a pair of gloves and rubbed it into the resident's bloodied face and then took the bloodied glove and wiped it on the inside of the left side rail. CNA (Staff N) stated Resident 31 tends to navigate to his left side naturally. CNA (Staff N) stated CNA (Staff R) stated to her she went out to notify the nurse the resident hit the side of the rail when she was rolling him.

CNA (Staff N) stated she did not report it the day she was told but stated: "It did not sit right with me." CNA (Staff N) stated she could not tell upper management because "I felt it would have been swept under the rug." CNA (Staff N) stated the next day she tried calling LPN Supervisor (Staff M) on her personal cell phone, but she (Staff M) stated she was busy and stated she would call her back, but she did not return her call. **CNA (Staff N) stated she eventually called LPN Supervisor (Staff M) a week to a week and a half after her first attempt** and explained the whole situation to her. CNA (Staff N) stated LPN Supervisor (Staff M) told her to immediately call the Director of Nursing (DON) and report this allegation of abuse. Both CNA (Staff N) stated LPN Supervisor (Staff M) stated because she was told this information, she now will report to the DON as well. The DON called CNA (Staff N) to discuss the allegations of abuse with CNA (Staff N).

The DON stated she had a telephone conversation with CNA (Staff N) after her brief phone call from LPN (Staff M) informing her of an alleged abuse to resident 31. The DON stated she talked to CNA (Staff N) and took her statement. CNA (Staff N) told the DON she received report from CNA (Staff R) and noticed a scrape [on] Resident 31's nose and asked CNA (Staff R) if the resident had a fall. CNA (Staff N) said CNA (Staff R) stated to her she hit the resident because he would not let go of her.

The DON asked CNA (Staff N) if she had reported this allegation to anyone at time and **CNA (Staff N) stated she had not**. **The DON asked CNA (Staff N) why she had not reported this allegation and CNA (Staff N) stated she was in fear of retribution from CNA (Staff R).** The DON stated there was a connection of Staff N's child to Staff R's family.

The DON stated that CNA (Staff R) denied any inappropriate physical acts towards Resident 31. CNA (Staff R) stated Resident 31 was not combative with her. CNA (Staff R) told the DON an incident occurred approximately two weeks ago when she provided care for Resident 31 and he hit his face on the side rails and sustained an injury. CNA (Staff R) stated Resident 31 sustained a skin tear to the bridge of his nose and immediately reported to the nurse supervisor, which the DON stated would have been LPN Supervisor (Staff E). The DON stated CNA (Staff R) was suspended pending the investigation.

The DON stated CNA (Staff R) was adamant she did not hit Resident 31 and her story matched with the events documented in the resident's medical records. The nursing home decided to move CNA (Staff R) to the first floor and **terminated the employment of CNA (Staff N) for failure to report the abuse in a timely manner per policy.**

Name of Nursing Home	Harbourwood Post-Acute and Rehabilitation Center
Provider ID	106041
Address [RUCA Code: 1] [% of County Population Rural: 0.19]	549 Sky Harbor Dr., Clearwater, Florida, 33759
Day Investigation Completed	January 16, 2025
Type of Deficiency Issued	F610
Scope Severity Level	Minimal Harm or Potential for Actual Harm

An Employee Fearful of Reporting Mice and Rats Infestation

The nursing home failed to maintain an effective pest control program so that the nursing home was free of pests in the Main Kitchen and on three nursing units.

Cognitive Function and Activities of Daily Living. Not Reported for all residents affected.

Anonymous complaint: "All staff is aware!! All staff has witnessed!! The facility is infested with mice & rats!! They are by the dozens in the kitchen when the nurses and aides entered at night to get snacks when the kitchen forgot to deliver them to the floors for the diabetics!! They had to fight off the rodents to get to the snacks and juice for the residents. They are on every floor in residents rooms, they scream at night about them running around the rooms the ones that are alert enough to yell out and able to see them! It's approx. 10/15 rooms on each floor except floor 7 is closed from residents but I was told they are running wild up there due to nobody being on that level it's empty not being used. They are in the hallways in the dining rooms. All CNAs (nurse aides) are aware and nurses especially the ones that work the evening and night shift. They['ve] been complaining and nothing is being done. Sticky paper traps put down that are not catching anything. Upper management aware, maintenance is the one placing the traps. They are coming in from the door located by the dumpsters right under the door. It hasn't been fixed. The residents should not have to live in these conditions with rodents running around their rooms. Not to mention there had to be feces from these rodents all through the kitchen, where they are preparing their food! That's just foul! This has been an issue since before I was made aware of it at least 2 months ago and it's only gotten worse not better. A CNA witnessed more than 10 during an 8 hour shift on the 5th floor the other night I was told! Something has to be done, they should not be permitted to take new residents until the problem is controlled. They should be shut down or the residents moved out [of] there. What if one gets bit by a rat! They are not seen as much during the day shift due to the amount of movement of people around the facility! As soon as it quiets down around eightish pm they start coming out of the woodwork literally! After the kitchen workers leave the kitchen, they are like scavengers, running wild in the kitchen! Please do something on these residents behalf's as well as the staff that has to work under these conditions because they need their job! I lasted one shift there, but **my best friend endures this daily and had been afraid to file a claim in fear of retaliation**. This needs to be a priority. Mice and rats carry disease and infection and they [are] around these people and around their food on a daily basis, and have them for some time! And it's not just one or two in the building! If I would have to guesstimate, I would say there's at least 200 + in that building. And that is not an exaggeration!! We watched 22 of them enter the building under that door in the side with the dumpsters the 1st day I worked when we were out there at night smoking! 22 in approximately 15 minutes! They multiply very quickly, so 200 was being nice about it! The facility is more worried about filling the beds than getting rid of the rodents! Thank you, A concerned medical worker!"

During an interview, **three nurse aides confidentially stated** they all have seen mice on multiple occasions. Every day, every night, every floor. During an interview, Dialysis Employee E2 stated she observed two mouse droppings on Resident 93's dialysis port dressing. During an interview, Therapy Director Employee E26 stated: "I have seen dropping on the counter in the kitchen area."

Review of the nursing home's Pest Control Records revealed, among others: "Talking with staff and found droppings on the 6th Floor and kitchen and dish storage area."

During an interview, Resident 11 stated: "The mice are terrible. The traps aren't working. One of the girls screamed when she came in my room. She was afraid of the mouse."

During an interview, Resident 15 stated he had mouse traps in his room, and personal food items such as chips bags that had mice chewed through them. He said that "they destroy my snacks" and "they even eaten through his plastic Jello containers." He said that to prevent them from eating his food: "I keep moving things higher and higher." During a follow up interview, Resident 15 stated he still has mice in his room and he's sick of it.

During an interview, Resident 110 stated: "I've seen two of them yesterday. That's why I am leaving."

During a confidential resident group interview, four residents stated that they have had mice in their rooms.

During an observation on the 5th floor dining room, mouse droppings were observed in several corners of the room. During an observation held on the following day at 8:10 PM, "Two mice were observed in the Main Kitchen, in the area of the tray line. At 8:42 PM, mouse was observed running across the floor in Resident 11's bedroom.

During an observation on the 4th Floor Nursing Unit, mouse droppings were present by the whirlpool bath and dead gnats were observed in the bathtub.

During an interview, Maintenance Employee E28 stated: "There is a mouse issue still going on floors 4, 5, and 6. Also, a roach issue is less but still in the kitchen. I inspected and treated the kitchen for roaches, applying residual pest control solution to all perimeters and under machinery and pipes. Staff stating roaches are in the walls and behind the floor board trim. I treated entire area and dining room. I then was shown rooms on floors 4, 5, and 6. 6th Floor – 3 room traps and glueboards placed. 5th Floor 3 rooms traps and glueboards spied 4th Floor 1 room. Maintenance Employee E28 stating they are catching about 2 per week on glueboards. I will return next week to continue trapping and applying solutions for roaches."

During an interview, the Administrator confirmed the nursing home failed to maintain an effective pest control program.

Name of Nursing Home	Squirrel Hill Wellness and Rehabilitation Center
Provider ID	395028
Address [RUCA Code: 1] [% county population Rural: 2.41]	2025 Wightman Street, Pittsburgh, Pennsylvania, 15217
Day Investigation Completed	February 12, 2024
Type of Deficiency Issued	F925
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Scared of the Administrator and Losing Her Job ("*She just had a baby*"), an RN was Forced by the Administrator to Alter a CPR Progress Note

The nursing home failed to immediately initiate Basic Life Support (BLS) including (Cardiopulmonary Resuscitation (CPR – an emergency lifesaving procedures performed when the heart stops beating) when Resident 1 who was Full Code and had Physician Orders for Life-Sustaining Treatment (POLST) was found unresponsive and without a pulse in his bed, and staff took 10 minutes to start CPR on the resident.

The nursing home failed to comply with applicable Federal, State, and local laws, regulations, and with accepted professional standards and principles for Resident 1 when the Administrator:

Requested RN D to reword her progress note; Directed Licensed Nurse (LN) B to change LN A's progress note; Directed LN A to redraft his progress note, because the time on the note was showing the delay of the care.

Resident 1 diagnoses included dysphagia (difficulty swallowing) following **cerebral infarction** (ischemic stroke – the blood supply to part of the brain is blocked or reduced).

Cognitive Function. Not Reported (No BIMS score noted).

Activities of Daily Living. The resident had "abnormalities of gait and mobility" and was in "need for assistance with personal care."

One evening at 5:45 PM LN A found Resident 1 unresponsive and pulseless; CPR was not initiated. LN A went out the room and asked a nurse to go inside Resident 1's room because Resident 1 had passed away. Both LN A and the nurse did not initiate CPR. LN A then went to check Resident 1's code status and found Resident 1 was Full Code (the type of emergent treatment a person would or would not receive if their heart or breathing were to stop). LN A then had another nurse call for Registered Nurse. At 5:55 PM, LN A started chest compression 10 minutes after LN A initially found Resident 1 was unresponsive and pulseless. At 6:00 PM, Code Blue (generally used to indicate a patient requiring resuscitation or otherwise in need of immediate medical attention) call was placed over the intercom. At 6:01 PM, the nurse called Emergency Medical Services (EMS) for emergency assistance. At 6:07 PM, EMS arrived and took over CPR. EMS continued life sustaining treatment for Resident 1. At 6:30 PM, EMS stopped CPR. At 6:35 PM, Resident 1 was pronounced dead.

During an interview, the Director of Nursing (DON) stated the expectation for the nursing staff is to initiate CPR immediately. During an interview, LN A confirmed that CPR was not started timely as it should have. LN A added that he wished he would have known Resident 1 code status on top of his head, so he could initiate the CPR immediately.

LN B stated the nursing home just had BLS In-Service: "In the BLS class, we learned that everyone should know the code status of all your residents. If you came into a room and you find someone had no pulse, no breathing, you should start CPR immediately and then you yelled for someone like go check the code status, called a code blue. You were not supposed to leave the [resident]."

LN B stated that LN A grabbed the Director of Staff Development (DSD) to check on Resident 1, and the DSD did not know that she needed to start CPR. LN B: "Like nobody knew that they needed to start CPR. It's like there's literally this many people did not know that they need to start CPR if you found someone without a pulse and respiration, there's something wrong."

Resident 1's Progress Note by RN D indicated that RN D made a strikethrough mark on her original note and created another note below. One of the sentences in the original note was: "Went to the resident's room with the Responsible Party (RP) to check Resident 1's well-being and the RP instructed the CNA in charge at that time to sit Resident 1 on semi-Fowler's (Semi-Fowler position is a position in which the individual lies on their back on a bed with the head of the bed elevated at 30-45 degrees) so to prevent asphyxiation (deprivation of oxygen that can result in unconsciousness and often death) was noticed to change to: "Went to the resident's room with the Responsible Party (RP) to check Resident 1's well-being and the RP instructed the CNA in charge at that time to sit Resident 1 on semi-Fowler's for reposition. The reason for changing it was incorrect documentation."

LN B stated that she was called into the nursing home's conference room and the Administrator asked LN B to edit an Interdisciplinary Team (IDT) Progress Note for Resident 1 for the unexpected death. The Administrator said to LN B: "Because you wrote good notes." LN B told the Administrator that she was not there when it happened, and she wouldn't know the details. The Administrator told LN B: "Just write it." While LN B was writing the note, the Administrator asked LN B to retype the note the way the Administrator described LN B to write.

LN B stated that while she was editing the IDT note, the Administrator asked LN B to alter LN A's progress note. **LN B refused and said to the Administrator: "No, I could not do that, not only was it illegal**, the PointClickCare (PCC – is a cloud-based Electronic Health Record software platform tailored for long-term care providers, including skilled nursing facilities) won't let you do it."

LN A was requested to report to the nursing home and met with the Administrator. LN A stated: "The Administrator wanted me to redraft my note, she said the time on my note was showing the delay of the care. She handed me a piece of paper and asked me to follow exactly what she wrote on the paper, basically she took away the time. I told her that is not right. I read it, I said OK, but then, I changed my mind, it does not feel right." LN A stated the document reviewed was the one the Administrator handed to him, and the document did not show when the CPR was initiated and when EMS was contacted.

RN D stated that the Administrator texted her to go to the conference room. While RN D met with the Administrator in the conference room, the Administrator asked RN D to change Resident 1's progress note that she wrote. The Administrator told RN D to remove asphyxiation from her note, the Administrator said to RN D: "Because I don't want them to think like that's the reason why he died."

RN D appeared to be tearing and distraught. **RN D stated**: "I said, **"What's wrong with my note, it's correct."** At least I was there with the Responsible Party and then we saw that he was crouched. So, we tried to elevate him to prevent asphyxiation. **RN D stated that she could not say no to the ADMIN** because the ADMIN made her sign the agreement (see details below). **RN D stated that she was scared of the ADMIN, and she just had a baby, she could not lose her job.**

During an interview, the ADMIN confirmed that she made RN D change her note. The ADMIN stated that she would ask the staff to clarify and reword the note if she thinks there's not enough information.

During an interview with RN D, a signed Job Description for RN D was reviewed. RN D stated that after she came back from maternity leave, she lost her old position as a Minimum Data Set (MDS) nurse (a nurse assessment coordinator, collects and assesses information for the health and well-being of residents in Medicare- or Medicaid-certified nursing homes). While she was attempting to get her old job title back, the Administrator made her sign a new job description/agreement, on the paper, there were three handwritten sentences with both the Administrator and RN D's signatures. One of the sentences indicated that RN D had to do anything what Administrator may have requested.

Name of Nursing Home	Autumn Creek Post Acute [*There is another investigation report from this nursing home]
Provider ID	056074
Address [RUCA Code: 1] [% county population Rural: 21.02]	587 Rio Lindo Avenue, Chico, California, 95926
Day Investigation Completed	June 11, 2024
Type of Deficiency Issued	*F678 **F836
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm

"I do want this complaint to remain anonymous due to fear of retaliation"

The nursing home failed to store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys for one resident.

The nursing home failed to store Resident 52's medications which were kept at her bedside which resulted in an incident on November 22, 2023 when she was hospitalized (with a chief complaint of loss of consciousness) and diagnosed with overdose related to self-medication with Diphenhydramine (an antihistamine; used for relief from symptoms related to hay fever, upper respiratory allergy, or cold symptoms) and Hydrocodone (narcotic analgesic agent for the treatment of moderate to moderately severe pain).

Resident 52 lived with the diagnoses of **depression** and **cirrhosis of the liver**.

Cognitive Function: The resident had "**Severe mental cognition impairment**" (BIMS score of 6 out of 15).

An anonymous email to the corporate organization for this nursing home, provided by Confidential Staff Member AF and dated August 7, 2023:

"The reason why I am writing is because I no longer feel I or any of my other direct care coworkers can safely and confidently provide the care and services our special resident[s] deserve. Our company has allowed agency but due to the cost, they have began cutting back on caregivers. The extent of cutting back is exceeding to the point of promoting unsafe and hazardous practices. I have expressed my concerns to management, I have written letters signed by other staff, **I have reached as far as I can to try and resolve this issue with no results**. Management is aware of this issue, and I have personally witnessed them cover things up to try to consolidate the results of an unreported incident to an already open incident. We have reported unsupervised smoking and consumption of alcohol to management multiple times due to intoxication resulting in falls and cigarette burns to residents who fall asleep smoking. A plan was put into place and an alarm was placed on the doorway to alert staff if someone is going out, however the alarm is constantly disarmed therefore allowing incidents to continue happening. I cannot help but feel as though management does not care. Please help me. I want my residents to be safe, feel safe, and trust they are always being cared for by people who truly care. I don't know what else to do. **I do want this complaint to remain anonymous due to fear of retaliation.**"

Name of Nursing Home	Town and Country Nursing and Rehabilitation Center
Provider ID	455796
Address [RUCA code: 4] [% county populations Rural: 56.80]	625 N Main St., Boeme, Texas, 78006
Day Investigation Completed	March 31, 2024
Type of Deficiency Issued	F761
Scope Severity Level	Immediate Jeopardy

CNAs Not Reporting on Co-worker's Verbal and Physical Abuse of a Woman with Dementia

The nursing home failed to prevent and protect a resident with a diagnosis of dementia from physical and verbal abuse by staff. This affected Resident 2.

The failure resulted in Resident 2 being yanked and tugged by CNA (V4) and V4 telling Resident 2: "I am not doing this with you, you're getting on my f****** nerves." Using the Reasonable Person Concept may have resulted in Resident 2 being fearful and displaying anxiety around staff. The nursing home also failed to follow their abuse policy by not immediately reporting an allegation of abuse for Resident 2.

Resident 2 had a diagnosis of **dementia**.

Cognitive function. The resident had a BIMS score of zero, "which indicates resident is **never/rarely understood**."

Activities of Daily Living. Not reported.

CNA (V9) said she was assisting Resident 2 back to her bedroom from the dining room with CNA (V8) and CNA (V4). Resident 2 has dementia and did not want to get out of the chair. V4 said to Resident 2: "You're going to bed." CNA (V9) said CNA (V4) "began to forcefully yank Resident 2's clothing off." CNA (V9) said CNA (V4) told Resident 2: "I am not doing this with you, you are getting on my f****** nerves!" CNA (V9) said CNA (V4) was treating Resident 2 "like a ragdoll." CNA (V9) said CNA (V4) transferred Resident 2 in the bed by "giving her a bear hug and flung her on the bed."

CNA (V8) said Resident 2 was refusing and yelling and pushing at CNA (V4). CNA (V8) said Resident 2 told CNA (V4): "You are not going to do me like that." CNA (V8) said CNA (V4) stopped for a minute to collect herself but then continued to take off Resident 2's shirt as Resident 2 was resisting. CNA (V8) said CNA (V4) was pulling and tugging on Resident 2. CNA (V8) said CNA (V4) picked Resident 2 up by grabbing Resident 2's upper arms and threw Resident 2 into the bed. Resident 2 was still refusing when CNA (V4) provided incontinence care. CNA (V8) said: "It was abusive and if that was her family member, she would not want them to be treated in that way."

Resident 3 (Resident 2's roommate) who was alert and oriented said that CNA (V4) will say things to Resident 2 like: "Oh my God" and "You're the hardest one I have to put to bed." Resident 3 said that CNA (V4) is the only staff that seems to have a problem with Resident 2. Resident 3 said that no other staff have that problem when they are in the room with Resident 2. Resident 3 said CNA (V4) moves too fast and does not have patience with Resident 2.

Nursing home reportable documents dated January 9, 2024: Surveyor reports that during investigation that someone alleged physical abuse toward Resident 2 by CNA (V4).

CNA (V9) said **V9 did not feel comfortable telling on staff about the incident on January 5, 2024 because CNA (V4) has been working there so long**.

CNA (V8) was asked why she did not report the incident immediately to supervisor on January 5, 2024. V8 said she did not want to get in trouble because V4 had worked at the nursing home a long time. V8 said **she did not want to seem like she was snitching on staff.**

During an interview, the Administrator said she did not have or received any allegations of abuse prior to the Surveyor reporting abuse. The Administrator said: "Staff should immediately report any allegations of abuse to me immediately. Staff are given my card upon hire with my cell number to call if any concerns. Staff are trained on abuse upon hire, every six months and as needed."

Name of Nursing Home	Aperion Care Midlothian
Provider ID	145947
Address [RUCA Code: 1] [% county population Rural: 0.05]	3249 West 147th Street, Midlothian, Illinois, 60445
Day Investigation Completed	January 17, 2024
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm

An Aide Who Witnessed Abuse of a Man Requested to Remain Anonymous Fearing Losing Her Job

The nursing home failed to provide services with dignity and respect for Resident 3 and Resident 1.

A reasonable person would be traumatized by having a nurse aide expose herself, intentionally passing gas nearby, and laugh at their expense.

Resident 3 lived with diagnoses of **Schizophrenia** and **Major Depressive Disorder**.

Cognitive Function. Resident 3 had **severely impaired cognition**.

Activities of Daily Living. Resident 3 was evaluated as dependent on staff for personal hygiene and required substantial assistance from staff for transfers.

During an interview, Resident 1 (who was assessed to be cognitively intact) revealed the following events as happening at the change of shift at approximately 11:00 PM on January 15, 2025. Resident 1 heard from her room Resident 3 repeatedly saying "Leave me alone, leave me alone" and cursing loudly. From her room, Resident 1 could see Resident 3 was sitting in his wheelchair near the nursing desk outside of her room. Approximately six nurse aides were dancing around the nursing desk laughing because Nurse Aide (NA) 3 was dancing around Resident 3 in front of him with her pants pulled down sticking her buttocks in his face. Resident 1 grabbed her pitcher, got in her wheelchair, and went into the hallway to see what was happening to Resident 3. Resident 3 kept hollering out "Leave me alone, leave me alone." NA 3 then turned around and pulled her pants down in the front exposing herself to Resident 3 putting her body right up to his face. Resident 1 stated all the nursing staff were laughing at Resident 3. NA 3 then went around behind Resident 3 pulled down her pants in the back, stuck her buttocks on his back, and passed gas on him. Resident 1 explained that she knew Resident 3 had issues. Resident 1 thought she needed to distract NA 3 to make her leave Resident 3 alone, she asked NA 3 to get her some ice for her water pitcher. NA 3 told her: "I am not getting no [curse] ice, I'm going home." Resident 1 explained the event did not make her feel good and stated: "Nobody should be treated like that." Resident 1 explained the next day she reported the incident during her therapy session.

During an interview, the Rehabilitation Director confirmed that Resident 1 had reported to her during her therapy session on January 16, 2025 the events of the previous evening with Resident 3 and NA 3. The Rehabilitation Director stated she immediately went to inform the Director of Nursing in person of the concerns reported by Resident 1. In addition, the Rehabilitation Director filled out a grievance form on behalf of Resident 1 and emailed it to the Administrator and Social Services Director that same day.

Nurse Aide (NA) 2 stated that on the day and time in question, she saw Resident 3 in the hallway near the nurses' desk cussing and hollering at NA 3. NA 3 turned around and exposed her buttocks and her front perineal area to Resident 3 and then walked away. NA 2 confirmed the nursing staff at the nurses' desk were laughing. NA 2 stated she was not able to recollect accurately which nurse aides and nurses were witnesses to the actions of NA 3, but she thought Nurse 2, NA 4, NA 5 and NA 6 were all witnesses. NA 2 stated that everything was caught on camera in the hallway. **NA 2 requested that her name not be documented for the interview out of fear of losing her job.**

During an interview, NA 4 confirmed she was at the nurses' desk when NA 3 pulled down her pants exposing her buttocks and front perineal area to Resident 3 after he called her a racial slur. NA 4 confirmed that all the staff at the nurses' desk were laughing at NA 3 and Resident 3. NA 4 explained that **nobody spoke up or intervened because nobody wanted to offend another nurse aide or nurse because it would make it difficult to work together again if someone corrected NA 3**.

During an interview, NA 5 revealed she observed NA 3 attempting to put Resident 3 to bed, but he wanted to go smoke. NA 5 indicated Resident 3 was calling NA 3 derogatory names, but the screaming and hollering was too much for her nerves, so she went down the hallway without witnessing anything else.

Requests to interview NA 3, NA 6, and Nurse 2 were not responded to.

During an interview, the Administrator stated NA 3 was suspended and then terminated for her lack of customer service and inappropriate behavior. The Administrator stated there were no six witnesses to the incident. During an interview the following day, the Administrator stated that as a company directive, there were no cameras in the building and no camera footage. The Administrator added that the nursing home was trying to get rid of Resident 3 because he was racist and vulgar to staff.

Name of Nursing Home	Camellia Gardens Center for Nursing and Rehab
Provider ID	345344
Address [RUCA Code: 4] [% county population Rural: 53.28]	280 South Beckford Drive, Henderson, North Carolina, 27536
Day Investigation Completed	February 19, 2025
Type of Deficiency Issued	F550
Scope Severity Level	Actual Harm

Laundry Aide Witnessed Restraint of Woman with Dementia But Didn't Report It Fearing Retaliation

The nursing home failed to ensure staff timely reported alleged resident abuse of Residents 1 and Resident 2. The nursing home also failed to conduct timely and thorough investigations into allegations of abuse of Resident 1 and Resident 2.

Resident 1 lived with the diagnoses of **dementia** and metabolic encephalopathy.

Cognitive Function. Resident 1 had **moderately cognitively impaired** (BIMS score of 9 out of 15).

Activities of Daily Living. Resident 1 utilized a wheelchair and walker for ambulation and required extensive staff assistance for activities of daily living, including ambulation and transfers.

A review of nursing documentation dated January 30, 2023 revealed that the nursing staff noted that Resident 1 is anxious, angry, negative statements, flat affect, fidgety. Resident 1 is frequently standing from her wheelchair by herself with attempts to self-ambulate without assistance. She becomes very angry, agitated, and combative with staff when attempting to redirect resident to chair. Resident ambulating in dining room / activities area with two nurse aides. Very difficult to redirect.

Employee 2 (Laundry Aide) stated that she came into work on Monday January 30, 2023, at 4:40 AM. She was going down the hallway and at the nurses' station he saw a female resident (Resident 1) tied to her wheelchair with a sheet tied around her. Employee 2 (Laundry Aide) stated there were three nurse aides present, and Employee 2 (Laundry Aide) told the nurse aides: "You can not tie her up like this, this is an unlawful restraint," to which one of the nurse aides told her: "**You did not see anything**." **Employee 2 (Laundry Aide) stated that she did not come forward until Wednesday February 1, 2023, because she felt threatened by the nurse aide that stated: "You did not see anything," and was scared of (other staff) judgement and repercussions if she did report it** (the unlawful restraint of Resident 1).

Upon relaying her report of the incident to the Administrator, Employee 2 (Laundry Aide) stated that this incident with Resident 1 was not the first time she witnessed a resident being tied up with a sheet. Employee 2 stated that about a week prior, another resident (Resident 2) was tied up with bed sheet to restrain the resident in a geriatric chair. She stated that the resident was an unstable male, who was a fall risk. The same day she saw the male resident restrained, he was discharged from the nursing home.

Resident 2 had a diagnosis of dementia and his nursing documentation on January 27, 2023 indicated that he will not stay in his wheelchair. His behaviors include rolling on the floor. Unable to redirect resident.

There was no documented evidence that Resident 2 was investigated by the nursing home as of the time of the State Survey ending on February 7, 2023.

A review of the nursing home's investigation report revealed that on February 1, 2023, Employee 1 (Housekeeping Manager) called the Administrator to make the Administrator aware that one of the housekeeping employees reported to Employee 1 that she had witnessed Resident 1 being unlawfully restrained, tied to her wheelchair with a bed sheet.

The employee, Employee 2 (Laundry Aide) reported to Employee 1 that she had witnessed this restraining of Resident 1 on Monday January 30, 2023, at approximately 4:30 AM. Employee 2 stated that she told three nurse aides on duty at that time that they were not allowed to retrain residents and the nurse aides reportedly replied to Employee 2 by stating: "You see nothing." Employee 2 reported the incident to Employee 1 (Housekeeping Manager) on February 1, 2023, at approximately 11:30 AM.

Employee 2 failed to immediately report the alleged abuse of Resident 1 she reportedly had witnessed on January 30, 2023. Employee 2 was suspended for not reporting the incident in a timely manner.

The nursing home's investigation on February 1, 2023 indicated that the alleged abuse of Resident 1 and Resident 2 has been unsubstantiated and **Employee 2 (Laundry Aide) was terminated on February 1, 2023 for not timely reporting an allegation of abuse**, **stating that she made a false allegation against employees** at the nursing home.

Name of Nursing Home	Manor at St Luke Village, the
Provider ID	395636
Address [RUCA Code: 1] [% county population Rural: 22.22]	1711 East Broad Street, Hazelton, Pennsylvania, 18201
Day Investigation Completed	February 7, 2023
Type of Deficiency Issued	*F609 **F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm

A 9-Hour Delay in Reporting Yelling at and Kicking a Person with Cognitive Impairment

The nursing home failed to implement their abuse policy by immediately reporting abuse of Resident 2.

Resident 2 had a diagnosis of **depression**.

Cognitive Function. The resident had a **cognitive communication deficit**.

On April 1, 2024, the Administrator stated that on March 18, 2024 at approximately 5:30 AM, CNA 1 witnessed and videotaped CNA 2 yelling and kicking Resident 2.

The incident was reported to the Administrator at 2:30 PM on March 18, 2024. The Administrator stated they immediately reported the incident to the State Survey Agency, began investigation, and terminated CNA 2. They stated **CNA 1 did not report it immediately because she was afraid of CNA 2**. The Administrator stated that CNA 1 should have stopped the abuse and reported it immediately.

Name of Nursing Home	Montereau, Inc
Provider ID	375460
Address [RUCA Code: 1] [% county population Rural: 5.13]	6800 South Granite Avenue, Tulsa, Oklahoma
Day Investigation Completed	April 1, 2024
Type of Deficiency Issued	F607
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Fear of Retaliation for Speaking Up About "*Chronic*" Staffing Shortages

The nursing home failed to provide services by sufficient numbers of nurse aides and licensed nurses on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans for 6 shifts.

The nursing home failed to schedule nurse aides and licensed nurses in numbers consistent with the posted nurse staffing during six shifts.

The failure placed residents at risk of not having their needs for assistance with activities of daily living and their medical needs met.

Cognitive Function and Activities of Daily Living. Not Reported

During an interview, the DOR stated there was a staffing problem at the nursing home that was well known. She stated the problem was scheduled staff calling in and not working. She stated that the understanding was that the schedules were made to include sufficient numbers of nursing staff, but people called in. The DOR stated she and the therapy staff had to help provide incontinent care and transfers sometimes to ensure people were ready for their therapy sessions. She stated the team worked together to meet the needs of residents, and the staff who came to work did a great job, but the nursing home did not pay very well, and they were having a hard time keeping staff or hiring new staff.

During a confidential interview, an anonymous resident (1) stated the staff did not answer call lights quickly or provide help quickly. They stated the staff treated them well, but there were not enough staff to provide care in a timely manner. They stated that there had been no negative impact and nothing negative had occurred that they were aware of beyond the inconvenience of waiting.

During a confidential interview, an anonymous resident (2) stated the nursing home hardly had any help. They stated everyone had quit. They stated new nursing staff stayed two weeks and then quit because they were overworked. They stated they had to stay all day sometimes because there was not enough staff to get them up. They stated they were not aware of any specific negative impact on residents or anything negative that had occurred to them as a result of the short staffing.

During a confidential interview, an anonymous resident (3) stated there was an ongoing problem with staffing at the nursing home, and they did not know what was causing it. They stated staff they have had working there for years had been quitting, and new staff that were hired were quitting after only a few weeks of work. They stated the other staff told them the delay in call response time was due to people calling in and quitting. They stated they had not heard of any specific negative impact of the staffing problem on residents, but everybody felt the strain. They did not elaborate on precisely what that meant.

During a confidential interview, **an anonymous staff person** stated the nursing home had a problem with sufficient nursing staff that was widely known by everyone who worked there. They stated the Director of Nursing had quit, the Administrator had been terminated this morning, and they did not know exactly who is in charge. They stated they thought the team who worked did a great job and took care of resident needs, but people kept quitting because of the pay and being overworked. They stated the staff were all on a 12-hour shift, and there were a select few who would always show up to work, and those would be

called to work when someone else did not show up to work their shifts. This meant they were always working a lot of extra hours.

The anonymous staff stated there was a notification system for all the facilities in the area owned by the same company, and other buildings sent notifications that aides could receive $250 bonuses for picking up shifts, while this facility would offer $25, $50, or $75 a shift. They stated the staff were aware of the difference, and it meant they were less likely to pick up shifts and the morale at this facility was low. They stated **they were afraid of being quoted in case there was retaliation and they lost their job.**

During a confidential interview, **an anonymous staff person** stated there have been staffing issues at the nursing home the entire time they had worked there. They stated the charge nurses provided ADL care to make up for the absence of aides, but then the nurses were not able to do everything they were supposed to do. They stated the nurses ended up working extra hours and that meant they got burned out more quickly and left to find other places of employment. They stated the same thing happened with the CNAs. They stated everyone who came to work each shift stressed out due to not knowing if they would be fully staffed. They stated they were about ready to quit and find work elsewhere.

During a confidential interview, **an anonymous staff person** stated people were quitting because they were tired of being left at the nursing home with not enough help for more hours than they should have had to work. They stated **they were afraid of retaliation if they spoke openly and allowed their name to be used.** They stated the nursing home had adequate staffing currently because the State Agency was conducting an investigation.

During a confidential interview, **an anonymous staff person** stated the nursing home was "always short staffed."

During an interview, RN A stated the nursing home experienced "chronic short staffing" because everyone who worked there was so overworked they often called in or just did not show up. She stated this includes RNs, LVNs, and CNAs who did not work their shifts. She stated "it would only get worse as people became more and more worn out."

Name of Nursing Home	Navasota Nursing & Rehabilitation
Provider ID	675399
Address [RUCA Code: 2] [% county population Rural: 74.52]	1405 E. Washington, Navasota, Texas, 77868
Day Investigation Completed	April 23, 2025
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

CNAs Not Intervening When an Executive Director (described by the Assistant Director of Nursing as a "*Tyrant Ruler*") Abused a Woman / The Woman Said that She Was "*Scared to death*" of the Executive Director / "*Many staff members were intimidated by her and afraid of losing their jobs if they reported her*"

The nursing home failed to ensure Resident B was free from mental and verbal abuse and intimidation, failed to ensure staff members intervened while a resident was being mentally and verbally abused and intimidated, and failed to provide 72-hour psychosocial follow-up for the resident.

Resident B said while being abused by the Executive Director (ED), she thought she was going to be hit, her personal space was invaded, she was in fear for her life, and following the incident she thought the ED sent an unidentified man into the nursing home to harm her in retaliation for the ED being suspended.

The nursing home failed to ensure the facility-initiated transfer or discharge not in alignment with Resident B's goals for care and preferences did not occur when the resident was told to leave the nursing home by the ED.

Resident B had diagnoses of **Generalized Anxiety Disorder** and **Chronic Kidney Disease** (**Stage 3)**.

Cognitive Function. **Mild Cognitive Impairment** (BIMS score of 11 out of 15 on August 24, 2023). The resident also had a Mini Mental State Examination score of 28 out of 30, which indicated **no cognitive impairment** (progress note on September 18, 2023).

The State Survey Agency Report System indicated that on September 20, 2023, at 9:15 AM during a meeting between the previous ED and Resident B, Resident B indicated the previous ED took her walker out of her hands and was rude to her. After a thorough investigation, the five-day follow-up indicated the previous ED acted in an unprofessional manner leading Resident B to believe she had to discharge from the nursing home. When the Interim ED spoke to Resident B, he offered her to return to the nursing home.

During an interview, the Interim ED indicated he had spoken (verbal counseling) to the previous ED within the past few weeks for how she was treating the managers and staff in general. She had treated some of the managers mean and staff members rudely and mean. **Many staff members were intimidated by her and afraid of losing their jobs if they reported her, so they would not report her to him when he came to visit the nursing home. He discovered the intimidation and fear of retaliation of staff members' jobs by the previous ED after he terminated her.**

During an interview, Resident B indicated that on September 20, 2023, she was getting dressed to go home to see her dogs when the ED busted in the door of her bedroom. Breakfast had just been served onto her bedside table in front of her. She was sitting in her recliner with her bedside table across the front of her chair with her breakfast on it. She had just started eating her toast. Her ex-husband was sitting on her bed. The previous ED asked Resident B why her ex-husband was at the nursing home. The resident indicated that he was at the nursing home because he took care of her and her animals. The previous ED indicated to the resident that he had to leave the nursing home. The resident indicated to the previous ED that if he had to leave, then she had to leave also, since he was her caregiver. The previous ED indicated she did not have to leave but her ex-husband had to leave because he was not allowed to stay the night at the nursing home with her. Resident B indicated that if he left, then she would leave also

because he was her caregiver, since there were not enough staff at the nursing home to care for her in a timely manner. The previous ED then indicated that the resident was to leave also. The previous ED jerked the bedside table out from in front of her and came at her "like an angry bull." She invaded Resident B's personal space with her face up close to the resident's face and her arms pulled back and her chest puffed out indicating she was to leave the nursing home now. Resident B indicated to the previous ED that she was invading her personal space and told her to step back, which she did step back out of her face. The resident indicated at that time she was "scared to death" of the previous ED. She thought the previous ED was going to hit her when she was invading her personal space. The previous ED left the bedroom, but five minutes later she came back to the bedroom with three to four nurses and boxes to pack her belongings. Resident B had already begun to pack her belongings, and the previous ED asked Resident B what she was doing, and the resident indicated she was leaving as the previous ED had told her to do. The previous ED indicated to her she never told her to leave.

Resident B stated that the Maintenance Director got her ex-husband a nice chair to sleep in, since he was with her every night providing care to her. He took care of her because there was not enough staff to care for her in a timely manner. She left with her belongings the day of the incident and went back home with her ex-husband.

Resident B indicated after the previous ED was asked to leave the nursing home and she had returned as a resident, one evening she observed a tall male walking down the hallway towards her. She thought the previous ED hired this man as a hit man to come and kill me in retaliation for her being sent home.

The nursing home's bus picked her up at her house and brought her back to the nursing home. She was anxious to come out of her bedroom when the previous ED was in the nursing home, but after she was terminated, Resident B started going out to activities. She used to be very social when she lived at home.

During an interview, Resident B's ex-husband said that he was "in shock" when the previous ED was yelling at his ex-wife. He said that he did not even know what to do because he was not believing what he was witnessing.

During an interview, CNA 7 stated that she heard the previous ED yelling at Resident B during the incident. When asked if 0 was quiet and 10 was extremely loud, CNA 7 indicated the previous ED was yelling at a level 10 at the resident. **When asked why she did not intervene when the previous ED was yelling at the resident, CNA 7 indicated she was intimidated by the previous ED and was afraid of her**. She went on to describe another situation that went on the day prior in which she felt the previous ED was bullying her. **She said she was scared to break up the interaction between the previous ED and Resident B because of her being screamed at the day before.**

During an interview, **CNA 8** stated she **did not intervene during the screaming at the resident because she was shocked it was happening and she was intimidated by the previous ED.**

During an interview, the **Assistant Director of Nursing** stated that **the previous ED ran the nursing home like a Tyrant ruler by staff working under fear and intimidation.**

Name of Nursing Home	Aperion Care Kokomo
Provider ID	155064
Address [RUCA Code: 1] [% county population Rural: 25.66]	3518 S. Lafountain St., Kokomo, Indiana, 46902
Day Investigation Completed	September 29, 2023
Type of Deficiency Issued	*F600 **F622
Scope Severity Level	*Actual Harm ** Minimal Harm or Potential for Actual Harm

A CNA Not Reporting on a Nurse's Verbal Abuse of 10 Residents on a "Memory Care Unit"

The nursing home failed to ensure 10 residents had the right to be free from abuse on the memory care unit. The nursing home failed to ensure a safe environment free from verbal abuse for residents on the memory care unit when LVN C was yelling at Residents 1-10 in the common room on February 18, 2024.

Cognitive Function. Not Reported. Activities of Daily Living. Not Reported.

During a phone interview, LVN B stated that LVN C was yelling in the common room on the secured unit, she was not yelling at one resident but in general stating for them to leave her alone and go away. She stated that this agitated the residents.

During a telephone interview on March 6, 2024, **CNA A** stated that LVN C was agitated and yelling at the residents all day on February 28, 2024. She stated this was not the first time she raised her voice at the residents in the memory care unit. **When asked why she did not report this, she stated that she was usually back there with only LVN C and she was afraid of retaliation**.

During an interview, the Administrator stated when he called LVN C to inquire about the events of February 28, 2024, she replied "okay" and made no other comment, when he stated she would be placed on administrative [leave] pending an investigation, her reply was "Okay, thank you" and she ended the phone call. He stated that after interviewing both LVN B and CNA A, and the observations he has made of LVN C since she has been working here, that the incident actually happened. He stated that his plan was to terminate LVN C. Abuse of any kind was not tolerated. He stated that his expectation was that all employees follow policy and procedure and [act] in a professional manner.

Name of Nursing Home	Caraday of Lampasas
Provider ID	676473
Address [RUCA Code: 7] [% county population Rural: 66.13]	1000 E. Ave J, Lampasas, Texas, 76550
Day Investigation Completed	March 6, 2024
Type of Deficiency Issued	F600
Scope Severity Level	Actual Harm

A CNA Witnessed an LPN Striking a Resident with Dementia / Pressured by the LPN and Fearing Retaliation from Him, the CNA Initially Reported a False Story About the Incident

The nursing home failed to ensure residents were protected from physical abuse for Resident 1, Resident 6, and Resident 7. LPN 2 struck Resident 1 with his/her fist resulting in Resident 1 having an injury to his/her right eye. Resident 1 was taken to the emergency room for evaluation and was later admitted.

Resident 6 slapped Resident 7 on the face while waiting to go outside to smoke, then in return, Resident 7 slapped Resident 6 on the face.

Note: Due to scope considerations and relevance to staff fear of retaliation, this resident-to-resident incident is not further described in this summary.

The nursing home failed to ensure an allegation of physical abuse (LPN 2 striking Resident 1 with his fist resulting in an eye injury) was reported to the State Agencies and local law authorities immediately, but no later than 2 hours after the allegation was made for Resident 1. CNA 1 reported to RN 1 that the resident initially head-butted LPN 2; however, later reported to RN 2 that LPN 2 had physically abused Resident 1 by hitting the resident with a fist. The CNA's failure to report timely allowed LPN 2 continued access to Resident 1, to potentially abuse the resident further, and all of the other nursing home's residents, which was the nursing home's failure to ensure the residents were protected from abuse.

The nursing home failed to develop and implement a comprehensive person-centered care plan for three residents (Resident 1, Resident 6, and Resident 7) that included measurable objectives and time frames to meet the resident's medical, nursing, and mental and psychosocial needs.

Resident 1 was combative during care and LPN 2 struck Resident 1 with his fist resulting in Resident 1 having an injury to his/her right eye. Review of the resident's care plan revealed staff should have backed away from the resident when he/she becomes combative to let him/her calm down. However, the staff member failed to implement the resident's Person-Centered Comprehensive Care Plan when the resident became combative during care.

Resident 1 has a diagnosis of **dementia**.

Cognitive Function. **Cognitively impaired** (BIMS score 99).

The nursing home failure to have an effective system in place to ensure residents were free from abuse has caused or is likely to cause serious injury, harm, impairment or death of a resident.

Review of interview statement with CNA 1 revealed CNA 1 had asked LPN 2 to assist her in the shower room with Resident 1. CNA 1 stated the resident was calm until they attempted to remove Resident 1's shirt. When the shirt was being removed, Resident 1 hit LPN 2, then LPN 2 hit Resident 1 in the face/eye area with his fist causing a cut under Resident 1's right eye. CNA 1 stated **LPN 2 told her she would have to write a statement saying Resident 1 head butted LPN 2, which caused Resident 1's face / eye injury**. CNA 1 stated she asked the LPN why and he did not respond. **CNA 1 stated she was scared and intimidated by LPN 2 and that was the reason she did not tell the truth about the incident initially**.

During an interview, the Director of Nursing (DON) stated **CNA 1 stated she was afraid of LPN 2 and that was why she did not tell the truth initially.** The DON stated **CNA 1 reported immediately the false story of Resident 1 head butting LPN 2 but did not report LPN 2 hitting Resident 1** and therefore, did not follow the nursing home's abuse policy.

The nursing home Incident report included the following handwritten statement by RN 2:

"I was called to the shower room by LPN 2 and when entering the room, Resident 1 was bleeding and verbally upset saying to LPN 2 that 'it's not over, I'm going to get you.'" Review of the report revealed a small laceration was noted on the resident's cheek bone, under the resident's eye area to the right eye. Continued review revealed: As the shift was ending, CNA 1 called RN 2 and reported that LPN 2 told her to say Resident 1 head butted him; however, **CNA 1 told RN 2 she had not told the truth about what had occurred**, CNA 1 then stated she saw Resident 1 hit at LPN 2, then LPN 2 hit the resident in the face causing a cut under Resident 1's right eye. LPN 2 then told CNA 1 to say Resident 1 had head-butted LPN 2 causing eye injury.

During an interview, RN 1 stated that after receiving a report about the incident from RN 2, RN 1 looked over Resident 1 and saw his/her right eye was black and bruising way down to his/her cheek and his/her eye was almost swollen shut. RN 1 called the DON and then Resident 1's spouse, informing him/her that the resident is being transferred to the local hospital. After being treated in the hospital, Resident 1 was discharged from the hospital to a long-term care setting in another state to be close to family.

CAN 1 was an agency employee and did not return to the nursing home again (employment terminated).

LPN 2 was suspended and then his employment was terminated. The nursing home reported the LPN 2 to the state's Board of Nursing, and his license had emergency suspension effective [DATE], then indefinite suspension effective.

Police Department Report. LPN 2 was interviewed by law enforcement, was served a criminal arrest warrant, and charged with fourth degree assault.

Name of Nursing Home	Corbin Health and Rehabilitation Center
Provider ID	185366
Address [RUCA Code: 5] [% County Population Rural: 63.66]	270 Bacon Creek Road, Corbin, Kentucky, 40702
Day Investigation Completed	August 11, 2023
Type of Deficiency Issued	*F600 **F609 ***F656
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

A CNA Witnessed but Delayed Reporting Another CNA's Physical Abuse (Punching the Chest At Least Six Times and Kicking the Leg) of a Woman with Dementia

The nursing home failed to ensure Resident 2 was free from abuse. The failure resulted in Resident 2 being physically abused by CNA (V5) on November 2, 2023. Resident 2 complained of leg pain and limping on November 5, 2023. A new order of morphine sulfate every six hours for pain being placed on November 6, 2023 and the resident using a wheelchair for leg pain relief.

The nursing home failed to immediately report to the Abuse Coordinator an allegation of physical abuse of Resident 2. This had the potential to affect all the residents in the nursing home.

Resident 2 had a diagnosis of **dementia**. She was receiving **hospice services**.

Cognitive Function. The nursing home assessment noted Resident 2 had **severe cognitive impairment**.

Activities of Daily Living. Required extensive staff assistance for dressing, toileting, and personal hygiene.

During an interview, CNA (V3) said she worked a double shift on November 2, 2023, from 6:00 AM to 10:00 PM. CNA (V3) said that around 9:00 PM that night she was assisting CNA (V4) with changing Resident 2's clothes and providing nighttime care. CNA (V3) said she asked CNA (V4) about using the cream (topical anti-anxiety cream) for Resident 2 that calms her down before changing. CNA (V3) said CNA (V4) declined using the cream. CNA (V3) said her and CNA (V4) took off Resident 2's shirt and Resident 2 was grabbing onto her clothes when they were taking them off. CNA (V3) said Resident 2 was not being combative. CNA (V3) said CNA (V5) was in the room at the time, charting on a computer and CNA (V4) asked CNA (V5) to help with Resident 2. CNA (V3) said CNA (V5) grabbed Resident 2's hair and started punching Resident 2 in the chest. CNA (V3) said CNA (V5) hit Resident 2 in the chest at least six times, maybe as much as 12 times. CNA (V3) said CNA (V5) then kicked Resident 2 in the leg. CNA (V3) said her and CNA (V4) told CNA (V5) to stop several times. CNA (V3) said she (V3) backed away and CNA (V4) got in between Resident 2 and CNA (V5) to block them. CNA (V3) said it all happened so fast. CNA (V3) said one of the times CNA (V5) hit Resident 2 close to the neck and she heard Resident 2 gasp for air. CNA (V3) said the incident started in the bathroom doorway and ended up in the corner of the bathroom. CNA (V3) said she did not see Resident 2 do anything to make CNA (V5) do that. CNA (V3) said Resident 2 was not combative prior to CNA (V5) hitting her. CNA (V3) said: "Of course Resident 2 was combative after CNA (V5) started hitting her." **CNA (V3) said she did not report the incident until the next morning because she was afraid of retaliation.**

CAN (V4) said that during cares, Resident 2 was being handful so he asked CNA (V3) to help him. CNA (V4) said he asked CNA (V5) to help and hold Resident 2's hands. CNA (V4) said he did not know if CNA (V5) pulled Resident 2's hair because he was trying to pull Resident 2's pants up. CNA (V4) said when he stood up, both CNA (V5) and Resident 2's hands were swinging, and he could not tell who was hitting who. CNA (V4) said he had to stand between Resident 2 and CNA (V5) to make sure no physical contact continued, because they were both hitting each other. CNA (V4) said he did not report the incident. CNA (V4) said he was baffled by the situation and did not know what to do. CNA (V4) said he had never seen CNA (V5) act like that with any other resident.

Registered Nurse (RN) V9 said that on November 5, 2023 (three days after the incident) staff noticed Resident 2 limping. Resident 2 was assessed and when her leg was squeezed, she would move her leg and had pain. RN (V9) said that Hospice was updated. X-rays were completed and were negative. RN (V9) said she thinks Resident 2's leg pain was a result of the incident on November 2, 2023. RN (V9) said the gel was discontinued and morphine was ordered for the pain. RN (V9) said Resident 2 uses the wheelchair for comfort, to reduce her leg pain. RN (V9) said Resident 2 did not use the wheelchair prior to the incident on November 2, 2023.

CNA (V5) said CNA (V4) and CNA (V3) were taking care of Resident 2 on November 2, 2023. CNA (V5) said CNA (V4) asked her to help with Resident 2. CNA (V5) said she went over to help them and Resident 2 hauled off and kicked her (CNA V5) in her knee. CNA (V5) denied hitting or kicking Resident 2. CNA (V5) said she put her arm out and put her hand on Resident 2's forehead, on her hairline, to stop Resident 2 from kicking her. CNA (V5) said CNA (V4) got between them and took Resident 2 out of the bathroom.

During an interview, the Administrator said Resident 2 tends to be aggressive with care. The Administrator said she was notified of a potential situation related to CNA (V5) being aggressive towards Resident 2. The Administrator said she investigated the allegation. The Administrator (V1) said CNA (V3) told her that she did not see everything, but she thought she saw CNA (V5) kick Resident 2. The Administrator said CNA (V5) denied this. The Administrator said when she took CNA (V4) statement, he said that Resident 2 kicked CNA (V5), and CNA (V5) pushed Resident 2 away from her, then Resident 2 lunged at CNA (V5). The Administrator said when Resident 2 lunged out, CNA (V5) reflexively responded and made contact with Resident 2's chest. The Administrator said CNA (V4) told him that he stepped between them to separate them. The Administrator said CNA (V5) said she did not strike out but put her hand on top of Resident 2's head to calm her. The Administrator was asked why CNA (V5) was terminated, yet the allegation was not substantiated by the nursing home. The Administrator said she terminated CNA (V5) because there was inappropriate behavior, but not abusive behavior. CNA (V5) should be trained enough to know to walk away from a combative resident. The Administrator said that was not the correct way to handle the situation. The Administrator said something physical happened, but it was a reflex reaction, and physical response was not an appropriate response. The Administrator said while interviewing CNA (V4), he did not tell her that he witnessed CNA (V5) hitting Resident 2, and she (the Administrator) can only go by what she is told during the interviews.

CNA (V5) was suspended pending the investigation and was later terminated.

Name of Nursing Home	Aperion Care Wilmington
Provider ID	145316
Address [RUCA Code: 2] [% County Population Rural: 4.87]	555 West Kahler, Wilmington, Illinois, 60481
Day Investigation Completed	November 21, 2023
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm

A Nurse Witnessed but Did Not Report on Medication Technician Forcing Medications into a Person's Mouth / "*You didn't see anything*"

The nursing home failed to protect Resident 1's right to be free from physical abuse during medication administration, when a staff member held the resident's hands and forced his/her medication in his/her mouth – resulting in the resident sobbing and screaming the staff were devils.

Resident 1 had a diagnosis of **dementia**.

Cognitive function. The resident was **severely cognitively impaired** (based on MDS assessment).

Review of the nursing home's Reported Incident dated October 21, 2024, showed: On October 21, 2024, the Administrator received a handwritten account from CNA C of an incident which occurred on October 19, 2024.

CNA C reported on October 19, 2024 that he/she heard Resident 1 yelling and went to check. CNA C walked upon and observed Certified Medication Technician (CMT) A push Resident 1's head and pinch the resident's nose until the resident opened his/her mouth while LPN B held the resident's wrists. CMT A shoved the medication and yogurt mixture into Resident 1's mouth. CMT A and LPN A released the resident and the resident stumbled into CNA C sobbing with his/her face covered in yogurt screaming the nurse and CMT were devils. CMT A told CNA C: "**You didn't see anything**."

The Administrator immediately began an investigation, terminated all staff involved after receiving written statements and in-serviced all staff on abuse and neglect, reporting timely and techniques and expectations from staff regarding dealing with a confused resident.

During an interview, CMT A said on October 19, 2024 at 4:15 PM he/she attempted to give medications to Resident 1 and the resident refused and spit at him/her. CMT A again attempted to give medications to Resident 1, and the resident attempted to scratch him/her. CMT A called LPN B over to hold the resident's hands while CMT A held the resident's head back and pinched the resident's nose until the resident opened his/her mouth. CMT A gave the resident the medication and yogurt mixture when the resident opened his/her mouth. CMT A said he/she knows he/she should not have administered the medications in that manner. CMT A said he/she was overwhelmed from working too much and the incident should have never happened.

During an interview, LPN B said on October 19, 2024, around 4:15 PM, CMT A yelled for assistance with Resident 1. LPN B said as he/she approached CMT A, he/she observed Resident 1 attempting to scratch CMT A while the CMT was attempting to give the resident his/her medication. LPN B said he/she went over and held Resident 1's wrists so the resident couldn't scratch CMT A. CMT A proceeded to push the resident's head back and pinched the resident's nostrils until the resident opened his/her mouth then shoved the medication and yogurt mixture in. **CMA T told CNA C**, who had observed the medication administration: "**You didn't see anything**" and walked off. LPN B said he/she was caught off guard by CMT A pushing the resident's head back and pinching the resident's nose and it should not have happened.

LPN B said he/she knew it was wrong and should have reported it, but he/she was new to the nursing home and was afraid to say anything. LPN B said he/she should not have held the resident's wrists.

During an interview on October 22, 2024, the Quality Assurance Nurse Consultant (QA Nurse) said if a resident is agitated and refusing medications, he/she would expect staff to attempt to calm and redirect the resident. AQ Nurse said staff should attempt to give the medications again after the resident has calmed down or attempt to have a different staff member give the medications. Residents should never be forced to take their medications.

During an interview on October 22, 2024, the Administrator said he/she would expect staff to honor the wishes of the resident if a resident refuses their medications and document the refusal.

During an interview on October 22, 2024, the Nurse Practitioner said it is unacceptable to hold a resident's nose to attempt to administer medications. Staff should redirect, try again later to administer medications, or have a different staff member administer the medications.

Name of Nursing Home	Potosi Manor
Provider ID	265681
Address [RUCA Code: 2] [% County Population Rural: 100]	307 South Highway 21, Potosi, Missouri, 63664
Day Investigation Completed	October 22, 2024
Type of Deficiency Issued	F600
Scope Severity Level	Immediate Jeopardy

A CNA Witnessed Verbal and Physical Abuse of a Woman with Dementia But Did Not Report It

The nursing home failed to ensure the right to be free from physical and verbal abuse by staff. Resident 45, who resides on the dementia unit, was subjected to physical and verbal abuse by CNA (V13) on three separate occasions. Resident 45's hands and chest were bruised. Resident 45 was fearful showing emotional symptoms following incidents as evidenced by increased behaviors with cares, making more sudden abrupt startled movements when approached by caregivers.

The nursing home failed to follow abuse prohibition policy by failing to report allegations of abuse to the nursing home's Administrator and prevent further resident abuse.

The nursing home failed to report repetitive instances of verbal and physical abuse of Resident 45 by CNA (V13) to the Administrator. These failures resulted in CNA (V13) having continued access to Resident 45 in which CNA (V13) provided direct cares and in the further instances of verbal and physical abuse of Resident 45 by CNA (V13). As a result of this abuse, Resident 45's hands and chest were bruised and Resident 45 displayed emotional symptoms of residual harm as evidenced by flinching (making sudden startled movements) and increased behaviors with cares.

Nursing Home failures were also identified related to two other residents engaged in a resident-to-resident incident. Due to scope considerations, these failures are not detailed in this summary.

Resident 45 had a diagnosis of **dementia**.

Cognitive Function. Not Reported.

Activities of Daily Living. Not Reported.

The Nursing Home's Allegation / Summary conclusion dated March 19, 2024 documents on March 13, 2024 at approximately 1:45 PM during a team meeting, CNA (V16) made the comment to the group that CNA (V13) was mean to Resident 45 and suggested that a bruise seen on Resident 45's hand was from where CNA (V13) was holding her down. CNA (V7) then added she witnessed an incident the week prior where CNA (V13) threatened Resident 45 after Resident 45 became aggressive during care.

On April 2, 2024, CNA (V7) stated that on March 6, 2024, at 5:30 PM, CNA (V13) and I went to Resident 45's room. CNA (V7) stated they were transferring her to bed and changing her. CNA (V7) stated they were talking to Resident 45 and we were trying to get Resident 45's shirt off but it wasn't working and she was tensed up. CNA (V7) stated CNA (V13) then tried to force her to take the shirt off without saying anything. CNA (V7) stated this caused Resident 45 to try to fight her and Resident 45 began to punch and scratch CNA (V13). CNA (V7) stated CNA (V13) then grabbed both of Resident 45's wrists and pinned them against her chest and got face to face to Resident 45 and was touching nose to nose and said: "I will snap your wrists if you won't let us get you to bed. I will snap your legs." CNA (V7) stated they then hooked her up to the mechanical lift and got Resident 45 in the bed. CNA (V7) stated CNA (V7) took Resident 45's pants off. CNA (V7) stated that as they were trying to change Resident 45, CNA (V13) kept pinning Resident 45's arms to her chest. CNA (V7) stated once they were done, CNA (V13) took a blanket and threw it on Resident 45.

On April 3, 2024, CNA (V7) stated that after the March 6, 2024 incident with CNA (V13), Resident 45 was scared. CNA (V7) stated during the incident Resident 45 appeared scared, her eyes were great big. CNA (V7) stated after that, during cares Resident 45 would flinch (making sudden startled movements) and she still does. CNA (V7) stated: "I really feel like she still remembers and is now more combative."

CAN (V7) stated that she did not report the physical and verbal abuse of Resident 45 to the Administrator.

On April 3, 2024, CNA (V9) stated CNA's (V13) was very aggressive with the residents. A couple of months ago, on January 9, 2024, "I was giving Resident 45 a shower. Resident 45 was becoming combative, so I asked CNA (V13) for help. Resident 45 made a noise and then said: "Oh poo."" CNA (V9) stated "CNA (V13) then got in Resident 45's face and meanly said: "Oh Poo!" back to Resident 45 and then hissed like a snake in Resident 45's face very aggressively." CNA (V9) stated she did not report it to the Administrator.

Review of CNA's (V16) undated witness statement indicated that on March 12, 2023, **CNA (V16) witnessed** CNA (V13) abuse Resident 45 (pinning Resident 45 arms to her chest and telling her: "Stop hitting or I will break your arms"). This statement documents **CNA (V16) was afraid to say anything about the abuse CNA (V16) witnessed**. **CNA (V16) did not report it to the Administrator.**

CNA (V13) Employee Termination Form dated March 19, 2024, documents: On March 6 2024, CNA (V13) verbally abused Resident 45 by using profanity and physically threatening her during care. And on March 13 2024, CNA (V13) held the same resident's hands down hard enough to bruise her hand and wrist as well as leaving a small bruise on the resident's chest. She also cursed and threatened the resident during this incident.

The Administrator stated CNA (V9), CNA (V7), and CNA (V16) did not report the verbal and physical abuse of Resident 45 inflicted by CNA (V13) on January 9, 2024, March 6, 2024, and March 12, 2024.

The Administrator stated CNA (V13) was terminated for the physical and verbal abuse. The Administrator stated Resident 45 did have bruising as a result of this abuse.

Name of Nursing Home	Piatt County Nursing Home
Provider ID	145883
Address [RUCA Code: 2] [% County Population Rural: 64.10]	1111 N State St., Monticello, Illinois, 61856
Day Investigation Completed	April 9, 2024
Type of Deficiency Issued	*F600 **F607 ***F609
Scope Severity Level	*Immediate Jeopardy ** Minimal Harm or Potential for Actual Harm ***Immediate Jeopardy

Delay in Reporting Verbal and Physical Abuse of a Man with Cognitive Impairment (Slapping Him in the Face Twice and Telling Him: "*I'll beat the f_ _ _ out of you. You know you're laying in the bed and can't move*")

The nursing home failed to ensure Resident 1 was free from physical abuse. The nursing home failed to prevent physical abuse of Resident 1 witnessed by **Hospitality Aide (HA**) to have been hit on the head by Employee I A during incontinence care on February 27, 2024 at approximately 3:00 AM.

The nursing home failed to implement policies and procedures that prohibit and prevent abuse, neglect, and exploitation of Resident 1. The nursing home failed to prevent physical abuse of Resident 1 who was hit on the head by Employee I A on February 27, 2024. The nursing home failed to ensure Employee I A was not allowed to work after the allegation of abuse had been reported.

The nursing home failed to ensure that all alleged violations involving abuse or mistreatment were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse, to the Administrator of the nursing home and to other officials (including the State Survey Agency where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures for Resident 1. The nursing home failed to report physical abuse of Resident 1 to the Administrator immediately following HA witnessing Employee I A hit Resident 1 on the head during incontinent care on February 27, 2024 at approximately 3:00 PM.

Cognitive Function. Resident 1 had **moderate cognitive impairment** (BIMS score of 12 out of 15).

Activities of Daily Living. Not Reported.

During a phone interview on March 27, 2024, Employee I C said: "The HA that worked at night came in and said: "I need to talk to you." She said: "I don't know what to do [Employee I A] slapped the resident in the face twice." I said you should have reported it to the charge nurse." Employee I C said "**HA told her she was scared and afraid Employee I A would retaliate on her if she reported the incident**." Employee I C said she knew [she] should have reported it then, but she did not report it until the next day to her Director of Nursing (DON) because she had told HA to report it.

Review of Incident Statement dated February 28, 2024, signed by HA, revealed: **HA stated** that on Tuesday morning at 3:00 PM during incontinent rounds, she and Employee I A went into Resident 1's room. When they first went into Resident 1's room, he drew his fist back. HA stated she tried to talk him down because usually this will work. They began performing care and rolled him over toward her, but he started hitting her in the stomach. Employee I A then rolled him back over and slapped him more than once on the forehead. HA stated that Employee I A said: "I'll beat the f_ _ _ out of you. You know you're laying in the bed and can't move." They finished the care and put a brief on him and left the room. After this, HA said she went outside because she was upset. She said she thought about leaving but didn't, she came back inside to complete her shift. **She didn't go to the charge nurse at that time** and stated **she was afraid she would be in trouble as well**. This was the last round of the evening so nothing else occurred with other residents and Employee I A. **HA stated she knows she should have said something but that she had never seen anything like this and it just scared her**.

Review of Incident Statement dated February 28, 2024, signed by the Administrator, revealed:

Informed by Employee I C that HA had informed her that she had witnessed abuse by Employee I A. Called HA to confirm statement. HA stated she was in Resident 1's room with Employee I A during incontinent care and the resident punched her [HA] in the stomach, and she stepped back away from him. Then Employee I A rolled the resident over to his back and hollered "Motherfucker, do not do that again" while slapping him in the forehead several times. The resident then swung at Employee I A. **When asked why HA did not report to supervisor immediately, she stated because she was scared of Employee I A and that she had a look when she turned to look at her** and she was upset about everything.

During an interview, Employee I A said: "I did not hit him." The Administrator asked Employee I A about the curse words that were alleged and asked her if she used the f-word. Employee I A stated she did not curse the resident. Maybe the worst she said was damn don't do this. The Administrator asked about the allegation that she slapped on the forehead several times and she said: "Well, yes she did do that just to get him to stop hitting." The Administrator asked her to demonstrate, and she slapped her forehead several times with her fingers, palm down in front of nose. The Administrator asked about why she didn't back away when he was combative as this could be one approach – she stated they just had to get the job done.

Review of Disciplinary Memorandums dated February 28, 2024 revealed Employee I A, HA, and Employee I C were suspended pending investigation. Employee I C and HA were reinstated and received training on abuse. Employee I C received formal written disciplinary action for failing to report abuse. Supervisors comments revealed Employee I C was aware of reporting guidelines, understands not to wait if she believed anything had occurred, and states she told employee to report to the Director of Nursing (DON) or Administrator. Employee I A was discharged effective March 5, 2024 due to employee confirming allegation of incident that warrants termination.

Name of Nursing Home	Whitehall Rehab & Nursing
Provider ID	675624
Address [RUCA Code: 7] [% County Population Rural: 73:10]	1116 E Loop 304, Crocket, Texas, 75835
Day Investigation Completed	March 27, 2024
Type of Deficiency Issued	*F600 **F607 ***F609
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

Scared of Retaliation, CNAs Did Not Report Abusive Physical Restraint (Multiple Incidents) by RN / One Employee Explained Why S/he Did Not Report It: "*Who are they going to believe a RN or I*?"

The nursing home failed to immediately inform Resident 1's physician, and notify, consistent with his or her authority the resident representative when there was a change in condition reviewed for restraint and abuse, in that: The nursing home failed to ensure Resident 1's physician and Responsible Party were notified when it was discovered on March 1, 2024 that Resident 1 had been restrained by RN A.

The nursing home failed to ensure Resident 1 was free from physical abuse when RN A and Nurse Aide (NA) A restrained him using a gait belt wrapped around his abdomen from October 8, 2023 to March 1, 2024 and secured to his wheelchair behind the resident to prevent the resident from standing, used furniture to prevent Resident 1's movement in his wheelchair and emotional abuse by RN A.

The nursing home failed to ensure Resident 1 and Resident 5 were free from verbal abuse when RN A used derogatory language and profanity at the residents.

The nursing home failed to ensure Resident 1 was free from restraint when RN A and Nurse Aide (NA) H tied Resident 1 to a wheelchair with a gait belt wrapped around his abdomen and secured behind the resident out of reach and by using furniture to block his movement while in the wheelchair on multiple occasions from October 8, 2023 to March 1, 2024.

The nursing home failed to develop and implement an abuse policy that clearly defines restraint as abuse and ensure staff had the knowledge of how and where to report allegations of restraint and abuse.

Due to scope considerations, details about violations related to Resident 5 are not included in this summary.

Resident 1 had a diagnosis of **dementia**. Cognitive Function. A BIMS score could not be assessed because the resident was **rarely or never understood**.

Activities of Daily Living. The resident required moderate assistance to go from sitting to standing, moderate assistance to walk and was totally dependent on staff for ADL care.

Review of Resident 1's medical record for consents revealed there were no consents for physical restraints. Review of Resident 1's physician's orders history revealed there were no orders for restraints.

During an interview, the Director of Nursing (DON) stated Resident 1 had a fall history. The DON stated there was no pattern of time for these falls because they happened on every shift. She stated the falls were not happening with one particular staff person. She stated she had terminated RN A on night shift for restraining Resident 1 in his wheelchair with a gait belt on March 1, 2024. The DON stated she did not know how many days the resident was restrained. The DON stated RN A admitted to restraining the Resident 2 to 3 times, but she was very vague and would not give a time frame or an exact date.

The DON also stated she had run out of new interventions to try. She stated after every fall, she updated the resident Care Plan. She stated the most effective intervention was to keep Resident 1 within eyesight. She said that she did have enough staff to care for him. She added that he was so unsteady on his feet that by the time the staff saw him stand up, it was too late. The DON stated she asked staff about the restraints and how often they were used with Resident 1 but did not get a good answer. She said that **staff said they did not report the restraints earlier because they were scared of retaliation.**

The DON stated they presented the possibility of restraining Resident 1 to their legal team, and it did not pass through. She stated: "Legal said: "Absolutely not.""

Resident 1's family member stated he suggested to the nursing home they use something to keep Resident 1 from falling. He stated he was talking about a wheelchair seat belt or bed rails for his bed. He stated he had not been notified the resident had been restrained with a gait belt by a staff member.

Multiple employees and practitioners (LVN J, Medical Director, Clinical Psych Counselor, the Psych Nurse Practitioner, and the Nurse Practitioner for Resident 1's physician) stated they were not been made aware of Resident 1's restraints.

Review of a handwritten document dated March 1, 2024 and signed by the DON revealed Agency I B called the DON and told her RN A on the night shift was using a gait belt to restrain Resident 1 in his wheelchair at night. The document indicated the Agency I B could not give specific dates and times.

Review of a handwritten document dated March 4, 2024 and signed by the DON revealed Employee I D stated she had witnessed RN A use a gait belt to restrain Resident 1 in his wheelchair. The document indicated that Employee I D could not remember exact dates and times and stated **Employee I D did not report it because she was scared of retaliation from RN A**.

Review of a handwritten document dated March 4, 2024 and signed by the DON revealed **Employee I N** stated she had witnessed RN A use a gait belt to restrain Resident 1 at night. She stated she **did not report it because she was afraid of retaliation** and could not remember exact dates and times.

Employee I N also described an incident in which Resident 1 tried to stand up in the main living room so RN A instructed her to tie a gait belt on Resident 1 and that she refused to do it, saying: "No." When the RN A yanked the gait belt out of her hand and stated she was going to do it herself, Employee I N stated she again told RN A "No" and told her she would sit with Resident 1 so he would not need a restraint. Employee I N stated RN A tried to put the gait belt around Resident 1, but she (Employee I N) put he hands out and stopped RN A from wrapping it around him. Employee I A stated she believes if she had not been there to stop her, RN A would have strapped Resident 1 down with the gait belt.

During an interview, the Assistant DON (ADON) stated **Employee I D told her she did see RN A strap Resident 1 to a chair with a gait belt but because RN A was a Registered Nurse, she did not report it because "Who are they going to believe a RN or I?"** The ADON added: "Restraint was abuse."

During an interview, Employee I B stated that RN A would get the big couch in the main living area and block the entrance to prevent Resident 1 from coming out of the room (she did it because Resident 1 was going into other residents' bedrooms). Employee I B stated she knew that was also a restraint. During an interview, Employee I F confirmed witnessing RN A doing it.

Employee I B said that one day Resident 1 was having a good day and was in a good mood. He looked at RN A and stated: "I love you" and RN A looked right at him and stated: "I hate you." Employee I B said it really broke her heart. She stated she told RN A "Wow" and just walked off.

Name of Nursing Home	Pleasanton North Nursing and Rehabilitation
Provider ID	675502
Address [RUCA Code: 4.1] [% County Population Rural: 71.45]	404 Goodwin St, Pleasanton, Texas, 78064
Day Investigation Completed	April 24, 2024
Type of Deficiency Issued	*F580 **F600 ***F604 ****F607
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Immediate Jeopardy ***Immediate Jeopardy ****Immediate Jeopardy

A Nurse Aide Fearful of Retaliation for Speaking Up About an Abusive Nurse Aide

The nursing home failed to protect residents' right to be free from verbal abuse by Nurse Aide (NA) G. This had the potential to affect all residents residing in the nursing home.

Cognitive Function Levels and Activities of Daily Living: Not Reported.

In confidential interviews, residents reported the following:

NA G was unkind, had yelled at them, and had made them cry on more than one occasion. **They were fearful of retaliation if they reported NA G's actions to administration**. They sometimes felt unsafe living at the nursing home due to NA G's behavior.

NA G was abrupt and scared them when they first arrived at the nursing home.

NA G yelled at them in front of a bunch of people for asking for help, including other residents and staff. They felt embarrassed and sad.

NA G scolded them for using the call light for assistance. N A G is unkind and aggressive at times. They had witnessed NA G yelling at other residents. They had voiced their concerns to the Director of Nursing (DON).

Scared of a staff member that yells at them and is unkind. Fearful to disclose a staff member's name, but reported they were working that day.

The DON described the following complaint made by a CNA: **Met with CNA privately in my office**. CNA tells me that s/he is concerned because there is a staff member who screams, yells, and belittles (both staff and residents) and makes others feel terrible. States NA G is terrible. States that CNA and other new staff have talked of quitting due to his behavior. States that residents have complained to CNA and staff about this behavior. Feels that **residents and staff are afraid of retaliation if they complain.**

The CNA states that they heard the nursing home had a high turnover in staff. CNA states that CNA feels that NA G's negative behavior has been one reason for the high turnover. CNA states CNA has known people who have worked here previously and reports that one past employee told CNA that they would not step in the building for a million dollars.

CNA reports after the recent death of a female resident, NA G told the reporting CNA: "The bitch died." Per CNA's report, this was said in the community room in front of other residents. CNA reports CNA observed three new staff members crying after an interaction with NA G. CNA has heard both staff and residents say they are thinking of calling the state about his behavior. In CNA's words, CNA feels that this behavior is elder abuse.

During an interview, the DON reported a nurse aide had come to them and reported allegations of verbal abuse involving Nurse Aide (NA) G on [DATE]. The DON C further reported **the nurse aide had requested confidentiality**, but had reported observing NA G use profane language, scolding residents for using their call lights, and being verbally abusive to residents. The DON stated they had taken the weekend to mull it over and then reported the allegations to Interim DON and the LTC Manager on [DATE]. The DON stated

they were instructed at that time to get more information from the nurse aide who confidentially reported the abuse allegations. The DON stated they visited again with the nurse aide on [DATE] and **the nurse aide expressed fear of retaliation for themselves and residents for speaking up.** The DON stated they had not worked any further on the investigation since that time. The DON stated Interim DON and Long-Term Care (LTC) Manager had not been involved in the investigation and had put it back on the DON to do.

During an interview, the Administrator stated the allegations of verbal abuse should have been reported to them immediately on [DATE]. The Administrator confirmed the DON and LTC Manager should have suspended NA G and immediately started an investigation into the alleged verbal abuse after it was reported to them on [DATE] and [DATE] in accordance with the nursing home's Abuse and Neglect Policy and Procedure.

A review of the nursing home investigation dated [DATE] revealed the nursing home had initiated the process to terminate NA G's employment after allegations of verbal abuse were substantiated as evidenced by findings in resident interviews completed by the nursing home on [DATE].

Name of Nursing Home	Good Samaritan Society – St Luke's Village
Provider ID	285192
Address [RUCA Code: 4] [% County Population Rural: 31.06]	2201 East 32nd Street, Kearney, Nebraska, 68847
Day Investigation Completed	November 29, 2022
Type of Deficiency Issued	F600
Scope Severity Level	Immediate Jeopardy

***"I did not know staff were afraid to speak up"* – Administrator**

The nursing home failed to utilize the Quality Assurance and Performance Improvement (QAPI) process to investigate, develop, and implement effective Performance Improvement Plan (PIP) to ensure the nursing home was free from abuse and neglect.

During a survey conducted on January 8 2024 to January 12 2024, non-compliance was found for nine residents reviewed for abuse and neglect. The incidents/allegations included resident-to-resident physical / sexual abuse (Residents 32, 90, 100), staff-to-resident physical abuse (Residents 6 and 164), staff-to-resident verbal abuse (Resident 36), neglect resulting in worsening of wounds (Residents 308 and 106) and failure to investigate a fracture of unknown origin (Resident 12).

Review of records, interviews with staff, family members, and the Medical Director revealed concerns with the nursing home's reporting, investigation, protection, and implementation of safety / corrective processes to prevent further abuse and neglect from occurring.

The nursing home placed all current residents (census: 112) at risk of serious injury and/or death due to the systemic failure to identify patterns of occurring abuse and neglect incidents / allegations and not initiating a PIP to address the on-going concerns, resulting in the determination of Immediate Jeopardy which began on September 19, 2023 and was ongoing at the time of the survey exit on January 12, 2024.

Resident 164 reported CNA (Staff R) poisoned his coffee on September 19, 2023. The resident had a diagnosis of **dementia**. Cognitive Function: **Severe cognitive impairment** (BIMS score of 7 out of 15).

Resident 32 reported allegations of sexual abuse by another resident on November 18, 2023. The resident had a diagnosis of **Schizoaffective Disorder**. Cognitive Function: **Intact Cognition** (BIMS score 15/15).

Resident 90 was identified to be involved in in a resident-to-resident abuse incident. The resident had a diagnosis of **hemiplegia**. Cognitive Function: **Cognitively intact** (BIMS score of 15 out of 15).

Resident 6 reported allegations of physical abuse by CNA (Staff W) on December 15, 2023. Cognitive Function: **Cognitively intact** (BIMS score of 15 out of 15).

Resident 100 was involved in a resident-to-resident sexual abuse incident on December 16, 2023. Diagnosis of **hemiplegia**. Cognitive Function: **Severe cognitive impairment** (BIMS score of 3 out of 15).

Resident 36 was involved in a verbal abuse incident by a staff member on December 23, 2023. The resident had a diagnosis of **Bipolar Disorder**. Cognitive Function: **Intact cognition** (BIMS score of 13/15).

Resident 308 failed to receive goods and services resulting in worsening of wounds identified on November 29, 2023. The resident had a diagnosis of **Encephalopathy**. Cognitive Function: **Unable to complete cognitive interview** (BIMS score of 99).

Resident 106 was involved in an allegation of neglect related to wound care on October 24, 2023. This resident had a **partial amputation**. Cognitive Function: **Not Reported**.

Resident 12 was involved in an allegation of possible neglect related to a failure to complete a full investigation following a possible fall with a fracture on December 4, 2023. The resident was **legally blind** and had a diagnosis of **end stage renal disease**. Cognitive Function: **Not Reported**.

Activities of Daily Living. Not Reported for all 9 residents.

During an interview, the Administrator stated: "We do not have a PIP on abuse and neglect. We had not identified a pattern. We did not see it as so and the residents have not voiced any fear."

The Administrator added residents sometimes change their stories during an investigation. She said: "It has not been a red flag. **I did not know staff were afraid to speak up.** We have considered team-building a community with staff and residents. I have not discussed concerns related to resident-to-resident or staff abuse allegations with Resident Council. I will now."

Name of Nursing Home	Groves Center
Provider ID	105269
Address [RUCA Code: 1] [% County Population Rural: 10.88]	512 11th St, Lake Wales, Florida, 33853
Day Investigation Completed	January 12, 2024
Type of Deficiency Issued	F867
Scope Severity Level	Immediate Jeopardy

An Aide Witnessed Another Aide Abuse Two Residents But Delayed Reporting It Fearing Retaliation / The Aide Said She Didn't Say Anything to Anyone About What She Witnessed Because She Had to Take the Perpetrator Home from Work and She Was Afraid of What Would Happen to Her

The nursing home failed to ensure allegations of physical and verbal abuse on February 22, 2023 were reported timely to ensure all residents were protected. **State Tested Nursing Aide (STNA) 374 witnessed** STNA 370 potentially physically and verbally abuse Resident 26 **but failed to report the incident**.

On February 22, 2023, STNA 374 witnessed STNA 370 potentially verbally abuse Resident 36 but failed to immediately report the incident. The lack of timely reporting placed all nursing home residents at risk of physical, verbal, emotional, psychosocial harm as STNA 370 continued to work additional shifts before the incidents were ultimately reported and the STNA was suspended on February 24, 2023.

No information was provided in the state investigation report regarding the Cognitive Function and Activities of Daily Living of Resident 26 and Resident 36.

During an interview on March 1, 2023, STNA 374 revealed that on February 22, 2022, at approximately 1:30 AM, **STNA 374 witnessed** SNTA 370 say disparaging words and hit Resident 26. On February 22, 2023, at approximately 4:45 AM, **STNA 374 witnessed** STNA 370 say disparaging words to Resident 36 during care. **STNA 374 stated she didn't say anything to anyone regarding what she witnessed that day because she had to take STNA 370 home from work, and she was afraid of what would happen to her**. On the night of February 22, 2023, STNA 374 stated she tried to tell LPN 319, who stated: "Oh, you know how [STNA 370] is." STNA 374 felt LPN 319 was not taking it seriously. On February 23, 2023, STNA 374 stated she did not work. On February 24, 2023, STNA 374 reported the incident to RN 395 at the beginning of her shift when she went to work. **STNA 374 confirmed the notification of the observed abuse was not immediate** and any observation of abuse should be reported immediately.

During an interview on March 1, 2023, the Administrator confirmed STNA 374 did not report the observations of abuse timely, and STNA 370 remained on the schedule and provided care to the nursing home residents until she punched out in the morning of February 24, 2023. When the Administrator was notified about the alleged abuse on February 24, 2023 at 10:41 PM, STNA 370 was taken off the schedule until an investigation could be completed. The Administrator confirmed **the notification from STNA 374 was not timely**, and if the abuse had been reported timely by STNA 374, STNA 370 would have been taken off the schedule and not have worked two full shifts after the observation.

On February 24, 2023, the nursing home suspended STNA 370 upon report of staff-to-resident verbal and physical abuse involving Resident 26 and Resident 36. On March 1, 2023, the nursing home terminated STNA 370 – upon determining there was potential that the allegations of verbal and physical abuse occurred – to safeguard the residents affected as well as the other residents in the nursing home.

On March 1, 2023, the nursing home **terminated STNA 374 and LPN 319 for failing to timely report the alleged staff-to-resident verbal and physical abuse** to protect all residents in the nursing home.

Name of Nursing Home	Windsor Medical Center Inc
Provider ID	366456
Address [RUCA Code: 1] [% County Population Rural: 14.76]	1454 East Maple Street, North Canon, Ohio, 44720
Day Investigation Completed	March 14, 2023
Type of Deficiency Issued	F607
Scope Severity Level	Immediate Jeopardy

Aides Afraid to Report on Administrator's Abuse (Taking Personal Belongings) of Resident After S/he Refused Bedroom Transfer/ One Aide Explained: "*Other staff have been fired for reporting things*"

The nursing home failed to protect Resident 6 from abuse and neglect. The nursing home willfully deprived Resident 6 of his/her personal belongings, from February 24, 2022 to February 28, 2022. These belongings were necessary to attain or maintain his/her mental and psychosocial well-being necessary to avoid mental anguish or emotional distress. Resident 6 stated he/she felt this behavior was abuse, as well as staff, who described this behavior as abusive. Staff were aware Resident 6 was upset and cried during this time. However, the resident's belongings were not returned until February 28, 2022.

The nursing home failed to report allegations of abuse and neglect for Resident 6, whose personal belongings were removed from his/her bedroom for four days causing him/her psychosocial harm. Resident 6 cried and was upset from Thursday to Monday. Staff weren't able to provide the necessary care to the resident. The resident asked for his/her belongings to be given back. However, no one would give him/her his/her belongings. Although the resident felt this behavior was abusive and staff thought it was abuse, no one reported this as an allegation of abuse.

Resident 6 had a diagnosis of **dementia**. **This diagnosis contradicts with**: Cognitive Function. The resident was assessed to have **intact cognition** (BIMS score of 15 out of 15).

Activities of Daily Living. Not Reported.

During an interview on March 10, 2022, Resident 6 stated that staff removed his/her belongings, including clothing, grooming/hygiene, and dental supplies on Thursday February 24, 2022, and did not return them until the following Monday February 28, 2022. Resident 6 stated this was done in an attempt to make him/her move to another bedroom. The resident stated he/she was not able to change clothes, to perform personal hygiene, and was unable to perform oral care. Resident 6 stated he/she was very upset and hurt by the nursing home's actions and cried the entire weekend. The resident stated he/she told housekeeping staff not to touch his/her belongings. Resident 6 stated he/she asked repeatedly to speak with the Administrator, as well as asked daily to have his/her personal belongings returned. Resident 6 stated he/she felt this was abuse.

During an interview, LPN 2 stated she worked with Resident 6 on February 24, 2022. LPN 2 stated Resident 6 was very upset about his/her belongings being taken. LPN 2 stated she talked with the Administrator, who stated not to return Resident 6's belongings. LPN 2 stated she informed the Administrator that Resident 6 wanted to speak to her. However, the Administrator never talked to Resident 6 during this time.

During interviews, the following staff members stated that the nursing home's actions (taking the resident's belongings for a few days) were considered abusive: Housekeeping Supervisor**, State Registered Nurse Aide (SRNA) 7**, SRNA 18, SRNA 14, SRNA 11, and LPN 3.

For example, SRNA 7 who worked with Resident 6 during the time the resident did not have his/her personal belongings, **stated** she felt the situation was abuse by taking the resident's personal belongings.

The SRNA stated Resident 6 was very upset and cried repeatedly. **But SNRA 7 stated she was afraid she would have been fired if she reported the abuse.**

SRNA 18 stated she was unable to provide any care to Resident 6, not was she able to help the resident to change clothes since the resident's personal belongings were taken from the resident's bedroom. SRNA 18 stated she felt this was abuse, **but she was afraid to report the abuse**. SRNA 18 stated **other staff have been fired for reporting things**.

SRNA 14 felt it was abusive of the Administrator to remove Resident 6's personal belongings and told staff not to return them. SRNA 14 stated Resident 6 stated it was abuse to take his/her personal belongings and not return them to him/her. **SRNA 14** stated she **was afraid to report the abuse due to being fired.**

During an interview, the Administrator stated she was informed Resident 6 was refusing the room transfer and was going to talk to Resident 6 on February 24, 2022, but she forgot, and when she remembered, on February 28, 2022, she had the resident's belongings returned. The Administrator stated she had meant to go and talk to the resident on Friday, February 25, 2022, and if the resident still refused the transfer, she would have returned the resident's belongings then. When interviewed regarding Resident 6 having to go all weekend without his/her personal belongings, including hygiene and clean clothing, the Administrator then stated it would be considered abuse. When asked why she did not report the abuse, the Administrator stated she did not know.

During an interview with the Regional Director of Operations (RDO) and the Interim Administrator on March 30, 2022 revealed the previous Administrator was terminated on March 20, 2022. The RDO / Interim Administrator provided documentation of his referral to the state's Board of Licensure for Long Term Care Administrators related to the previous Administrator's actions.

Multiple staff members stated that things have improved since the Administrator was terminated. For example, SRNA 8 stated: "Things were going smoother since the Administrator left" and added "The general feeling of staff was less tense."

Maintenance Technician stated: "Things were 100% better since the Administrator left. In the last two weeks, communication was much better for maintenance now, staff seemed much happier and were willing to be at work since the Administrator was gone." Laundry Aide: "Residents and staff seemed in better spirits, staff having a better day helps residents have a better day also." Dietary Aide 3: "The atmosphere was so much better and staff were less on edge." Activities Director: "The mood among the staff and residents was much better, like a burden has been lifted from their shoulders. More residents had been coming to activities recently." SRNA 9: "A weight has been lifted."

Name of Nursing Home	Ridgeway Nursing & Rehabilitation Facility
Provider ID	185254
Address [RUCA Code: 10] [% County Population Rural: 100]	406 Wyoming Road, Owingsville, Kentucky, 40360
Day Investigation Completed	March 31, 2022
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy

A 10-Day Delay in Reporting CNA's Verbal Abuse of One Resident and Physical Abuse of Another

The nursing home failed to ensure residents' right to be free from physical and verbal abuse when CNA 1 was reported by CNA 2 and CNA 3 to have physically abused Resident 1 on March 7, 2025 at 6:45 AM and verbally abused Resident 2 (date/time unknown) and the nursing home did not take immediate protective action for the two residents. Additionally, the Administrator was not informed of the allegation until March 17, at which time CNA 1 was suspended. This left residents vulnerable for 10 days after the abuse was initially witnessed by staff.

The nursing home failed to implement its abuse policy, allowing an abusive act to occur without staff intervening or prompt reporting for Resident 1 and Resident 2. CNA 3 witnessed CNA 1 physically abuse Resident 1 and CNA 2 witnessed CNA 1 verbally abuse Resident 2. Both CNAs did not intervene to prevent the violation of the residents' right to be free from abuse. The nursing home's failure to intervene and immediately report to the Administrator placed Resident 1 and Resident 2 and other residents at risk of similar abuse including the risk of harm, injury, impairment, or death.

The nursing home failed to report abuse within the required 2-hour timeframe (Residents 1 and 2).

Resident 1 had diagnoses of **dementia** and **Parkinson's disease**.

Cognitive Function. Resident 1 had **moderately impaired cognition** (BIMS score of 10 out of 15)

Resident 2 had a diagnosis of **Major Depressive Disorder**.

Cognitive Function. Resident 2 had a **severe cognitive impairment** (BIMS score of 3 out of 15).

Activities of Daily Living. Not Reported for Resident 1 and Resident 2.

A review of the nursing home's investigation dated March 17, 2025 revealed that on March 17, 2025 at 10:44 AM, **the Administrator found two different anonymous pieces of paper in his desk** that stated CNA 1 had been abusing residents. Upon interviews with residents and staff, a witness stated she was changing a resident and heard CNA 1 tell Resident 2 that if she [expletive] out the bed like she did yesterday, she was going to beat her [expletive]. Another witness stated she was assisting CNA 1 with providing care to a combative resident, when she grabbed the resident's nose causing it to leek blood and told the combative resident: "It how you deal with crazy [expletive] like you."

During an interview on April 2, 2025, CNA 3 stated that **on March 7, 2025** at approximately 6:20 AM, she was working the overnight shift (11:00 PM to 7:00 AM). She explained that LPN 1 asked her to assist CNA 1 with providing care to Resident 1 as the resident was reportedly combative. As care began, Resident 1 swung at both CNAs. CNA 3 reported that she held the resident's hands gently and reassured her, telling her everything was okay. The resident then pulled away from the grasp and grabbed CNA 1 by the hair. CNA 3 reported that in response, CNA 1 grabbed the resident's nose and twisted it upwards, which caused the resident's nose to bleed. According to CNA 3, CNA 1 then stated: "This how you deal with crazy [expletive] like you." CNA 3 recalled telling CNA 1: "You can't treat and talk to her like that" and stated she attempted to leave the room to locate the nurse but did not see her nearby. Not wanting to leave the resident alone with CNA 1, CNA 3 returned to the room and offered to finish providing care.

She stated that CNA 1 appeared to ignore her and refused to leave the room. CNA 1 continued providing care, cleaned the blood from the resident's face using the resident's gown, finished dressing her, and transferred her to the chair before exiting the room. **CNA 3** stated that she **did not report the incident to the nurse, Director of Nursing (DON), or the Administrator until March 17, 2025 because she feared retaliation from other staff.** She confirmed that she had previously received training and in-services regarding abuse, neglect, and the requirement to report such incidents.

During an interview on April 2, 2025, CNA 2 stated she was in Resident 2's room providing care to the roommate when she overheard CNA 1 tell Resident 2: "If you [expletive] in the bed like you did yesterday, I am going to beat your [expletive]." CNA 2 stated she immediately told CNA 1 that she could not speak to a resident in that manner, to which CNA 1 replied: "I bet it works." **CNA 2** said she **did not report the incident at the time because she was afraid of retaliation from staff, stating that people had recently been losing their jobs** and there were concerns about false allegations being made through the compliance hotline. CNA 2 confirmed she had received prior training and in-service on abuse, neglect, and reporting requirements.

During an interview on April 2, 2025, CNA 1 denied physically abusing Resident 1 and verbally abusing Resident 2. CNA 1 stated she believed the accusations were fabricated by another CNA because she was not part of the clique among the staff at the nursing home. She further stated she had never worked with CNA 3 on the hall and that CNA 3's primary responsibility was providing showers. CNA 1 confirmed she had received training and in-service education on abuse, neglect, and reporting requirements.

LPN 1 stated she was the nurse assigned to the hall on March 7, 2025. LPN 1 stated she was not made aware of any physical abuse involving the resident and that neither CNA reported any concerns to her.

Social Worker stated she was not made aware of the allegations of physical and verbal abuse until she was informed by the Administrator on March 17, 2025.

During an interview on April 2, 2025, the Administrator stated that after he received the two anonymous letters, CNA 1 was immediately suspended pending an investigation and was terminated on March 18, 2025. He confirmed the abuse allegations were substantiated based on statements from CNA 3 who witnessed physical abuse of Resident 1 and CNA 2 who witnessed verbal abuse directed at Resident 2.

On April 2, 2025, the Quality Assurance Committee met to review, develop, and implement a policy on abuse and neglect with an emphasis on reporting abuse and neglect and to determine the root cause. **The root cause was determined to be: Employees were afraid of retaliation from other employees.**

On April 2, 2025, all staff members were interviewed by the Executive Director, Human Resources, and the Assistant Director of Nursing to ask if they ever witnessed any employee abuse a resident and explained the process of what to do if they ever witness abuse or neglect, with an emphasis on reporting requirements and that failure to do so is a crime.

Name of Nursing Home	The Oaks Rehabilitation and Healthcare Center
Provider ID	255261
Address [RUCA Code: 4] [% County Population Rural: 53.68]	3716 Highway 39 North, Meridian, Mississippi, 39301
Day Investigation Completed	April 4, 2025
Type of Deficiency Issued	*F600 **F607 ***F609
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

Delays in Reporting on a CNA Who Abused Two Residents with Severe Cognitive Impairment

The nursing home failed to: a. Protect Resident 7 and Resident 9's right to be free from physical, mental and verbal abuse by CNA J; b. Notify the required entities of allegations of physical mental, and verbal abuse by CNA J of Resident 7 and Resident 9; c. Thoroughly investigate allegations of physical, mental, and verbal abuse CNA J towards Resident 7 and Resident 9; d. Ensure the nursing home was operated and administered by Executive Director (ED) A and Director of Nursing (DON) B in a manner that ensured the safety and overall well-being of 62 residents. Those areas include: Maintaining and effective abuse and neglect prohibition program that included following policies and procedures related to mandatory reporting and investigations of all allegations of abuse, relating to allegations of physical, verbal, and mental abuse by CNA J toward Resident 7 and Resident 9. In addition, ED A and DON B had not ensured the safe management and overall well-being of residents who lived in the nursing home. This was evidenced by a system's breakdown to ensure they had implemented.

Resident 7 was reported to have **dementia**. Cognitive Function. **Severely cognitively impaired** (BIMS score of 2 out of 15). The resident was described as "**nonverbal**."

Activities of Daily Living. She was dependent on staff for ambulation, bathing, dressing, bed mobility, and eating. She required the use of a stand-lift for transfers.

Resident 9 was reported to have **dementia**. Cognitive Function: **Severely cognitively impaired** (BIMS score of 3 out of 15).

Activities of Daily Living. She used a wheelchair for locomotion, required maximal / substantial assistance with bathing, dressing, bed mobility, and grooming.

The nursing home learned about concerns regarding the care and services a CNA was providing to residents on January 1, 2025 at around 1:30 PM. The provider failed to protect the residents from potential further abuse during the investigation by allowing the CNA to keep working an overnight shift from 10:30 PM on January 1, 2025 to around 7:25 AM on January 2, 2025. The provider failed to get more information from the reporting party to understand the extent of the situation. The provider failed to report the incidents to the necessary entities. The provider conducted an investigation into the allegations including assessing the residents involved for injuries, but nothing was documented.

Primary witness statements from other CNAs who witnessed the alleged perpetrator kick a resident in the shin twice, and a separate incident with a different resident where the alleged perpetrator put a washcloth over a resident's mouth to quiet the resident. Both those residents have dementia. Statements from staff indicate that this has been an ongoing issue and the alleged perpetrator improves their actions for a short while after being talked to by Administration but then slips back into their old ways. These is a serious concern that the alleged perpetrator will potentially re-offend.

Review of the State Survey Agency's (SSA) Complaint Intake Form dated December 31, 2024, revealed: **The SSA received an email** on December 27, 2024 detailing allegations of abuse by CNA J. **They wanted to remain anonymous**. The complainant claimed to have reported CNA J to management previously.

She (CNA J) got talked to and [had her work] hours cut, after getting talked to before, she would be good for a week if that before she continued her verbal and physical abuse.

The complainant described a witnessed incident involving Resident 7 and CNA J. The complainant did not mention a date. Resident 7 was non-verbal. The complainant and CNA J were transferring Resident 7 using a full-body mechanical lift. CNA J slammed a cloth over [Resident 7's] mouth and held it there with her fingertips. The complainant felt as if CNA J did that as a means to quiet the resident.

The complainant described another witnessed incident involving Resident 9 and CNA J. The complainant did not mention a date. Resident 9 had dementia and tended to reach out to people walking by to hold their hand. Resident 9 was sitting in her wheelchair in the hallway next to anonymous staff member N. Resident 9 reached out towards CNA J as she was walking past and said: "Hey, come here quick." CNA J was witnessed to have kicked Resident 9 twice in the shin.

SSA Complaint Intake Form (January 6, 2025): **The SSA received an email on January 3, 2025 from a different anonymous complainant:** "There is a CNA that works here named [CNA J] and she is abusing residents. I have witnessed her kicking, yelling, and calling [them] names, which is mental abuse. I have reported this to the administration to no avail." **The complainant** did not include any dates. They **wished to remain anonymous**.

The SSA team entered the nursing home on January 6, 2025. The Director of Nursing (DON) B denied that any staff had reported allegations of abuse or neglect against any other staff. When asked specifically about the aforementioned allegations, she denied any knowledge of such incidents.

Confidential interview on January 6, 2025 with **anonymous staff member M** revealed: "**They were initially afraid to come forward with the allegations against CNA J due to CNA J's retaliatory nature.** During one incident, anonymous staff member M was assisting CNA J with transferring Resident 7 using the full body mechanical lift. CNA J put a cloth over [Resident 7's] mouth. She held the cloth over the resident's mouth for about a minute. Anonymous Staff M perceived it to be forceful, as a way to quiet Resident 7. During another incident, anonymous Staff M and another staff member witnessed CNA J kick resident 9 in the shin. "I brought Resident 9 into the hallway. Resident 9 reached her hand out to CNA J and CNA J kicked Resident 9 twice in the shin." They confirmed they witnessed this incident happen. Anonymous staff member M could not recall when the kicking incident occurred but guessed it was within the last three to four weeks. They explained the reason why they did not report those incidents immediately was because previously when incidents were reported, CNA J's actions would improve for a short while, but then would return to the abusive behaviors. Anonymous staff member M confirmed that they and another staff member reported the abuse incidents to the ED A.

Anonymous staff member N observed Resident 9 reaching towards CNA J. CNA J kicked Resident 9 twice on the right shin hard enough that Resident 9 made a face about it but not hard enough to leave a bruise. Resident 9 looked sad and shocked. She was not very verbal, so she did not say anything about it.

Anonymous staff member N also overheard CNA J say to Resident 9: "You're an ugly gremlin. I can tell you've had a hard life. I can tell you probably smoked all your life."

Anonymous staff member N did not report that incident to the nurse or to management at that time. The staff member was aware they were required to report incidents like abuse immediately. **The staff member feared retaliation from CNA J**. **Anonymous staff member M and N finally reported their concerns to ED on December 30, 2024 around lunchtime.** Both anonymous staff member M and N were specific when detailing the alleged abuse to ED A and provided the specific incidents. On January 1, 2025, they again reported the alleged abuse to RN F after no improvements were observed in CNA J's behavior towards residents. Anonymous staff member N confirmed they were very specific with details of the alleged abuse when reporting their concerns to RN F.

During an interview, RN F confirmed that two staff members reported CNA J's alleged abuse on January 1, 2025. She denied that they were specific about the abuse allegations. They did not specify exactly what happened that was rough. She confirmed that she called DON B immediately to report the concerns.

During an interview on January 6, 2025, ED A denied that any staff had reported allegations of abuse or neglect against any other staff. However, when asked specific questions about CNA J allegedly having kicked a resident and having held a cloth over another resident's mouth, he confirmed he had been aware of those allegations. He explained that the staff member who brought forward those allegations was nondescript and could not describe specifically what CNA J had done.

An interview with the ED A and DON B on January 6, 2025 revealed that on January 2, 2025, DON B had given CNA J a written warning like "your actions and how you hold yourself can be perceived different [differently] by others." They confirmed there had been no other documented disciplinary actions against CAN J during her employment with the provider.

DON B confirmed she learned about the allegations on January 1, 2025 around 1:30 PM when RN F contacted her about the allegations. RN F had told her that staff had come forward with concerns. RN F did not provide any details about the concerns, and DON B did not ask further questions about the concerns. She did not contact the ED about the allegations until the morning of January 2, 2025. DON B confirmed that CNA J worked from 10:30 PM on January 1, 2025 to 7:30 AM on January 2, 2025 after she learned of the allegations against the CNA. DON B had never before suspended any staff pending an investigation. She had not considered suspending CNA J pending an investigation (CNA J was not suspended). DON B explained that she had been the DON since July 2024. She indicated she had not received a lot of training when she took over the DON position. She was not aware that the above allegations required reporting. She was not aware of the Administrative Rules of the state detailing what type of incidents were required to have been reported. She was not aware of the provider's abuse and neglect prohibition policy when it came to reporting and investigating allegations of abuse and neglect.

CNA J denied harming any residents.

ED A was placed on suspension related to his failure to follow the provider's policy regarding abuse and neglect prevention and prohibition. He was supposed to be acting as the Abuse/Neglect Coordinator.

Name of Nursing Home	Riverview Healthcare Center
Provider ID	435086
Address [RUCA Code: 10] [% County Population Rural: 100]	611 East 2nd Ave, Flandreau, South Dakota, 57028
Day Investigation Completed	January 8, 2025
Type of Deficiency Issued	*F600 **F609 ***F610 ****F835
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy ****Minimal Harm or Potential for Actual Harm

Fearing Retaliation, Director of Nursing and Social Worker Not Reporting on Abusive Administrator / The DON Feared Retaliation and Even Losing Her Job If She Spoke Out Against the Administrator

The nursing home did not ensure residents were free from mental or verbal abuse for Resident 11.

R11 reported to Social Worker (SW) E, SW F, Director of Nursing (DON) B, and Assistant DON that the Administrator yelled at him more than once, slammed the phone down on his family, stormed out of his room, and threatened to drop him off at a homeless shelter causing him to feel intimidated and scared.

R11 reported to DON B that SW E yelled at him, demanded he write checks for money he did not have in his account, made him call the bank to verify how much money he had in his account in front of her, called family members that he did not give permission to receive updates about his care, and caused him to be fearful.

The nursing home did not ensure that all alleged violations involving abuse, neglect, exploitation, and mistreatment are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the appropriate agencies for allegations involving R11.

Staff observed what they perceived as abuse by the Administrator to R11 and did not report this to the Administrator's superiors or to the State Agency.

The nursing home did not ensure that all alleged violations involving abuse are fully investigated and Resident 11 is protected during the investigation in accordance with State law though established procedures. R11 reported allegations of verbal abuse to staff. The nursing home failed to investigate these allegations. Staff observed what they considered abuse and did not complete a thorough investigation of protect R11 from the alleged abuse.

R11 had diagnoses of **hemiplegia** and **Major Depressive Disorder**.

Cognitive Function. The resident was assessed to be **cognitively intact** (BIMS score of 15 out of 15).

Activities of Daily Living. Not Reported.

On April 27, 2022, DON B indicated she witnessed the Administrator abuse Resident 11 verbally and mentally causing him unnecessary fear. **DON B indicated** that **the Administrator has made it clear that no one in the nursing home has the authority to call Human Resources or the county board and she was not sure how to report an abuse allegation against the Administrator**. **DON B** indicated she **feared retaliation and even losing her job if she spoke out against the Administrator**. DON B indicated being an advocate for R11 was high priority, but **there was no way around the Administrator.**

On a date prior to April 7, 2022, DON B and the Administrator went into R11's room together. The Administrator stood over top of R11 while she yelled, telling him he needed to leave and he could not stay any longer. DON B stated that the Administrator's actions were threatening and abusive. **When the surveyor asked if she did anything to separate R11 from the abuse, DON B indicated she had not**.

DON B indicated she tried to get into the system to report abuse to the State's Division of Quality Assurance but the only staff member with access was the Administrator.

The DON B indicated R11 told her he felt scared, threatened, and didn't know what to do. DON B said she felt uncomfortable also, stating that the Administrator's actions were abusive. He was told he may have to go to a homeless shelter.

On April 27, 2022, referring to the Administrator's abusive actions against him (such as when he yelled at him and threatened to drop him off at a homeless shelter), R11 stated: "I feel intimidated and scared." The state Surveyor asked if R11 has reported these concerns to anyone. R11 indicated he has told the ADON C, DON B, SW E, one county board member, and some of the CNAs that care for him,

During an interview on April 26, 2022, the Administrator indicated that she had tried to discharge R11 due to nonpayment and his level of care needs.

During an interview on April 27, 2022, SW E indicated she observed the Administrator verbally and mentally abuse R11. On February 15, 2022, she witnessed the Administrator raising her voice and telling R11 that he will need to go to a homeless shelter because this was not a charity place. She also witnessed the Administrator verbally abuse R11 on April 7, 2022 when she attended a discharge meeting for R11. The Social Worker indicated that the Administrator yelled at R11 saying: "I am not going to go through this again. I have already explained this to you. You are no longer considered skilled nursing care. You need to find a different place. After the meeting, the Social Worker observed the Administrator raising her voice to R11 telling him to wake up as she was talking to him. The social worker said: "This is abuse. Verbal abuse and mental abuse. R11 was intimidated and scared."

The state Surveyor asked if she did anything to intervene and separate the Administrator and R11 in any of these situations. **The Social Worker indicated she did not do anything to intervene because she was also intimidated by the Administrator.** The state Surveyor asked the Social Worker if she reported these allegations of abuse to anyone. The Social Worker indicated she had talked to staff about it, but she didn't know who to report it to, because **the Administrator has told the staff they are not to contact the county board members and they are not to contact the county superintendent, or they will be reprimanded for insubordination**.

Name of Nursing Home	Rock Haven
Provider ID	525390
Address [RUCA Code: 2] [% County Population Rural: 20.4]	3400 N Cty Trk Hwy F, Janesville, Wisconsin, 53547
Day Investigation Completed	April 27, 2022
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm ***Minimal Harm or Potential for Actual Harm

A Housekeeper Witnessed but Due to Fear of Retaliation Delayed Reporting Nurses' Abuse of a Woman with Serious Mental Illness as She Banged Her Head in the Wall / RN Told Her to Bang Her Head on the Corner of the Wall and Maybe It Would Knock Her Brain Out and She Would Kill Herself

The nursing home failed to ensure the right of Resident 45 to be free from abuse. The nursing home failed to protect Resident 45 when an allegation of abuse occurred when on March 20, 2025 RN A told Resident 45 to bang her head on the corner of the wall and maybe it would knock her brain out and she would kill herself. The nursing home failed to protect Resident 45 from abuse when RN A, RN D, and the Director of Nursing (DON) demonstrated to Resident 45 how she should hit her head on the wall to injure herself. The nursing home failed to prevent abuse when RN A, RN D, the DON, Medication Aide (MA) C and Medication Aide (MA) B laughed at Resident 45 for banging her head on the wall, while she was in emotional distress. Note: During interview on March 27, 2025, Housekeeper E said the incident occurred on March 19, 2025.

The nursing home failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of Resident 45. **The nursing home failed to ensure Housekeeper E reported an allegation of abuse immediately to the Abuse Coordinator on March 19, 2025 due to fear of retaliation.** The Abuse Coordinator failed to follow the nursing home's abuse policy when he did not report an allegation of abuse to the State Survey Agency within 2 hours and did not thoroughly investigate when Housekeeper E reported to him on March 30, 2025 about the aforementioned incident.

The Abuse Coordinator failed to follow the nursing home's abuse policy when he did not protect Resident 45 from potential abuse when he took her to MA C and MA B and asked Resident 45 if she had laughed at her. The Abuse Coordinator failed to follow the nursing home's abuse policy when he did not suspend RN A, RN D, the DON, MA C, and MA B after an abuse allegation was made against them on March 20, 2025. The Abuse Coordinator failed to identify an allegation of abuse and acknowledge and act upon it to prevent alleged perpetrators to have continued access to Resident 45 and others.

The nursing home failed to ensure that all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, were reported immediately, but no later than 2 hours after the allegation was made for Resident 45. **The nursing home failed to ensure Housekeeper E reported an allegation of abuse immediately to the Abuse Coordinator on March 19, 2025 due to fear of retaliation**. The Abuse Coordinator failed to identify and report an allegation of abuse of Resident 45 within the required 2 hours.

The nursing home failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, and misappropriation of resident property were thoroughly investigated for Resident 45. The nursing home failed to investigate / protect / correct when an allegation of abuse of Resident 45 allegedly occurred. The nursing home failed to prevent potential abuse of Resident 45. The Abuse Coordinator failed to protect Resident 45 from potential abuse when he took her to MA C and MA B and asked Resident 45 if the former had laughed at her and the latter was mean. The Abuse Coordinator failed to recognize an abuse allegation and acknowledge and act upon it to prevent alleged perpetrators to have continued access to Resident 45 and others.

Resident 45 lived with **hemiplegia and hemiparesis**. Her diagnoses included **Bipolar Disorder** and **Schizoaffective Disorder Bipolar Type**.

Cognitive Function. The resident was **severely cognitively impaired** (BIMS score of 4 out of 15).

Activities of Daily Living. The resident required partial / moderate assistance with showering / bathing self, set up or clean up assistance with oral, toileting, and personal hygiene and dressing.

Care Plan. The resident "had a behavior problem and banged her head against the wall when she got frustrated, called 911 multiple times a shift, and when they arrived, she banged her head on the walls or furniture and demanded to be taken to a psychiatric hospital and 911 refused to take her."

During an interview on March 27, 2025, Housekeeper E said that on March the 20th or 21st, towards the end of her shift, she witnessed DON, RN D, and RN A make fun of Resident 45. Housekeeper E became teary-eyed and started crying. Housekeeper E said she was in the hallway cleaning, and the DON, RN D, and RN A were at the nurses' station. Housekeeper E said Resident 45 was upset and had wheeled up and was banging her head on the wall. Housekeeper E said the DON, RN D, and RN A were telling Resident 45 where to bang her head on the wall to hurt herself. Each one of them was taking turns telling Resident 45 where she should hit her head on the wall. RN A told Resident 45 to bang her head on the corner of the wall and maybe it would knock her brain out and she would kill herself. Housekeeper E said MA B and MA C were watching and laughing. Housekeeper E said Resident 45 often banged her head on the wall and RN A would get irritated with her. Housekeeper E said Resident 45 always talks about killing herself. **Housekeeper E said she did not feel comfortable telling the Administrator because of how he had handled other situations in the past and she feared retaliation**. Housekeeper E said **she did not know who she could trust, and she was scared nobody would believe her**. Housekeeper E said she wished she would have recorded the incident because she did not have any witnesses. Housekeeper E said the next morning she reported the incident to her boss, the Housekeeping / Laundry Supervisor, and she had taken her to the Admissions Coordinator. Housekeeper E said the Admissions Coordinator listened to her and took her to the Assistant DON's office where she reported the incident to the Assistant DON and Administrator.

Review of a Witness Statement signed by **Housekeeper E** dated March 20, 2025 indicated: "To whom it may concern: I [Housekeeper E] witnessed RN A, RN D, and the DON making fun of a resident [Resident 45] on Hall 1. Banging their heads on the wall in the same like manner as the resident because [Resident 45] was angry about something. MA C was laughing and MA B was laughing. I witnessed them making fun of her. As if it was funny but it was wrong for them to behave in that manner. **I did not know who I could trust to talk to**. But I knew that I had to do something. These residents deserve to be treated with utmost respect. And deserve the best care. **I believe in telling the truth**. It is unprofessional to behave the way that they did. Thank you! Housekeeper E."

During an interview on March 27, 2025, RN A denied telling Resident 45 where to hit her head on the wall or to bang her head on the corner of the wall and maybe it would knock her brain out and she would kill herself. RN A said she did not laugh or make fun of Resident 45 for banging her head on the wall. RN A said she could get frustrated that Resident 45 was banging her head on the wall and tell her:

“Can you just stop.” RN A said the Administrator called her and told her an allegation was made against her by Housekeeper E. RN A said she was not suspended and an in-service was done with her on doing teaching and that it could be frustrating when educating residents but she should try as much as she could to do it calmly when she was getting frustrated. RN A said she told the Administrator she did teaching with Resident 45 and told her: “You are going to fracture yourself.” RN A said when the incident occurred, she was giving report to RN D and the DON was also there and a CNA and they were laughing about something different. They were not laughing at Resident 45.

During an interview on March 27, 2025, the DON said the incident took place during a shift change and they were at the nurses’ station. The DON said RN A did not tell Resident 45 to hit her head on the wall. The DON said they were not laughing at Resident 45. The DON said they were talking and laughing, and then Resident 45 pulled over and started banging her head. The DON said she told her to stop banging her head, if she kept banging her head, she was going to hurt herself. The DON said she did not witness RN A frustrated at Resident 45. The DON said she did not laugh at Resident 45. The DON said the Administrator told her he sent Housekeeper E’s Witness Statement to corporate, and they said it was not abuse because they did not laugh. The DON said she was not suspended.

During an interview on March 27, 2025, MA B stated she was not laughing at Resident 45 during the incident. MA B said she was in-serviced but not suspended. During an interview on March 27, 2025, MA C stated she was not laughing at Resident 45 during the incident.

During an attempted interview on March 27, 2025, RN D did not answer the phone.

During an interview on March 27, 2025, the Administrator said that he had spoken with all the staff, and they told him they were having a conversation before Resident 45 pulled up to them. The Administrator said he asked the staff if they were banging their heads on the wall, and they said they were doing it to demonstrate to the resident she could hurt herself. The Administrator said he talked to Resident 45 immediately and the resident said it did not happen. The State Surveyor asked the Administrator if Resident 45 with BIMS score of 4 was a reliable interviewee. The Administrator was silent and did not answer the question. The Executive Director said the Administrator told them the staffers in question were not laughing at the resident.

Name of Nursing Home	Terrell Healthcare Center
Provider ID	675879
Address [RUCA Code: 4] [% County Population Rural: 41.92]	204 W Nash, Terrell, Texas, 75160
Day Investigation Completed	March 29, 2025
Type of Deficiency Issued	*F600 **F607 ***F609 ****F610
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy ****Immediate Jeopardy

A CNA Witnessed but Delayed Reporting Verbal Abuse by Medication Aide Who Committed Another Abuse a Week Later / The CNA Who Witnessed the 1st Incident Did Not Report It to Anyone Because She Was Afraid of the Previous Administration Retaliating Against Her and She Would Lose Her Job

The nursing home failed to ensure Resident 1 was free from abuse. The nursing home failed to protect Resident 1 from continued abuse. Resident 1 was verbally abused twice by Medication Aide (MA) B. MA B told Resident 1: "You need to shut up." CNA A witnessed the incident, did not act, and MA B worked another 7 days and verbally abused Resident 1 again.

The nursing home failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, which included injuries of unknown source and misappropriation of resident property, were reported immediately, but no later than 2 hours after the allegation was made, if the event that caused the allegation involved abuse or resulted in serious bodily injury, or not later than 24 hours to the Administrator or the nursing home and to other officials, which included the State Survey Agency, in accordance with state law through established procedures for Resident 1.

CNA A failed to report to the Abuse Coordinator (Administrator) an observation on May 1, 2023 of verbal abuse involving Resident 1 and MA B, who told Resident 1 "You need to shut up." MA B worked for another 7 days before Resident 1 reported to the Abuse Coordinator on May 12, 2023 that MA B had verbally abused her again.

The Administrator investigated the allegations made by Resident 1 on May 12, 2023, but did not investigate the first allegations of abuse May 1, 2023 provided by Resident 1 at the time she reported the abuse allegation that occurred on May 1, 2023. The Administrator did not discover CNA A had observed the verbal abuse by MA B, allowing MA B to be able to work another 7 days, which provided the potential for further abuse to Resident 1 as well as other residents.

Resident 1 lived with diagnoses of **quadriplegia** and **depression**.

Cognitive Function. The resident was assessed to be "**mildly cognitively impaired**" (BIMS score 12/15).

Activities of Daily Living. The resident required assistance of two staff members to complete ADLs.

During an interview on May 18, 2023, Resident 1 revealed she had reported that she had been verbally abused by MA B. Resident 1 said the first time it happened, on May 1, 2023, she did not report to the Administrator, because she was tired that the previous Administration did not listen to her and the day it happened a new Administrator was supposed to come. During the interview, the resident provided the name of a witness (CNA A) to the incident that occurred and then became upset and did not want to talk anymore.

During an interview on May 18, 2023, CNA A revealed she had been off the day (May 12, 2023) the second time the allegation of abuse was made by Resident 1. CNA A said there had been another time before than on May 1, 2023. CNA A said she was in the hallway right by Resident 1's bedroom around 7:00 AM in the morning and MA B came down the hallway talking loudly. CNA A said she told him to lower his voice, that residents were still sleeping, when Resident 1 said from her bedroom: "You need to be quiet. You are

too loud. I am still trying to sleep." CNA A said MA B said to Resident 1: "You need to shut your door then." CNA A said Resident 1 said: "This is my house and if I want my door open, I can have it."

CNA A said she observed MA B [missing word] to the doorway of Resident 1's bedroom, tell her: "You need to shut up" and then left the bedroom. **The CNA A stated she knew she was supposed to report to the Administrator, but she did not report it to anyone because she was afraid of the previous administration retaliating against her and she would lose her job.** CNA A said the previous administration did not seem to take concerns seriously. CNA A said there was no other staff around and there was no other residents that were awake that said anything at that time.

During an interview on May 18, 2023, Resident 1 stated she was asleep around 7:00 AM, and she heard someone talking loudly. She said she heard CNA A tell the person to lower their voice. I yelled out of my room that I was trying to sleep and be quiet. MA B stood in my doorway and said: "You need to shut your door." Resident 1 stated: "This is my house, and I can have my door open if I want." The resident said MA B came into her room and said: "Then you need to shut up" and her left her room. When the resident was asked who she reported it to, she stated: "I called the state because I got tired of telling the previous administration about my concerns and they never listened." Then when it happened again, [MA B telling me to shut up], I told the new Administrator on the 12th of this month. In a later interview on May 18, 2023, Resident 1 identified the day that the first incident occurred was May 1, 2023. Resident 1 stated that MA B continued to work on her hallway until she was suspended.

During an interview on May 18, 2023, the Administrator said when Resident 1 reported the allegation of abuse on May 12, 2023 of MA B telling her to shut up and MA B told her to shut up the week before, she started an investigation, interviewed the staff members that were at the facility that day and suspending the staff that was alleged to be involved. She said she did not recall if she asked Resident 1 about any witnesses. The Administrator stated she had completed her investigation and was awaiting the state's visit before she decided concerning the staff, which had been suspended. During an interview held three hours later, the Administrator stated she was not aware there was a witness to verbal abuse related to Resident 1's allegation.

During an interview on May 19, 2023, MA B said on May 12, 2023 at 7:30 AM, she was passing medications on the hallway. MA B stated Resident 1 started yelling and screaming at him, some horrible things. They never had any problems with Resident 1, we got along fine, until May 12, 2023 when she started yelling and cursing at me. In fact, she told me she was glad I was working here, it really hurts my feelings the things she said to me. MA B said that was not the first time he had ever had any problems with Resident 1, she had gotten upset with me the week before (MA B could not identify date) saying MA B was too loud, MA B just gave Resident 1 her space and she was fine. MA B stated he knew better than to tell any resident to shut up because that could be considered abuse. MA B said there was no other staff or residents on the hallway when the incident on May 12, 2023 occurred. MA B stated he was suspended on May 12, 2023 after providing a statement to the Administrator and has not returned to work yet.

Immediately on May 18, 2023, **CNA A was suspended for failure to report an allegation of abuse.**

Name of Nursing Home	Duncanville Healthcare and Rehabilitation Center
Provider ID	676178
Address [RUCA Code: 1] [% County Population Rural: 0.58]	419 S Cockrell Hill Rd, Duncanville, Texas, 75116
Day Investigation Completed	May 19, 2023
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Immediate Jeopardy ** Immediate Jeopardy

Employee Anonymously Called Police to Report Sexual Resident-to-Resident Incidents (a Male Resident Placing His Genitals in a Woman's Face in an Attempt for Oral Sex in a Common Area)

The nursing home failed to ensure Resident 3 was free from resident-to-resident sexual abuse. This resulted in Immediate Jeopardy and the potential for serious physical, mental, and/or psychosocial negative outcomes for Resident 3 and Resident 21 when the nursing home failed to recognize and respond to Resident 2's increased sexual behavior.

State Tested Nursing Assistant (STNA) 112 reported on April 20, 2024, Resident 2 had pulled his genitalia out in front of Resident 3. STNA 12 reported the incident to a nurse. On April 26, 2024, Resident 2 was found with Resident 21 with his pants unfastened and was putting away his genitalia. On April 26, 2024, LPN 230 was approached by staff stating Resident 2 had exposed himself to Resident 3 in the dining room. Resident 2's Care Plan was never updated to reflect his increased sexual behaviors towards other residents, nor any new interventions put in place for staff to implement to address these behaviors. The physician was notified and ordered urinalysis, which was not completed due to the resident's refusal and no other interventions were put in place except increased monitoring.

The nursing home failed to incorporate effective interventions to prevent further abuse from happening. On April 29, 2024, Resident 2 was found with his hands down Resident 3's pants. Resident 3 was not physically assessed until six days later when a skin assessment was completed. It did not initiate one-on-one monitoring for Resident 2 until May 6, 2024. Consequently, this continued inappropriate, unwanted sexual behavior/contact resulted in Resident 3 experiencing a change in condition and negative psychosocial outcomes manifested as self-isolation in her room, including eating her meals, expressions of fearfulness, and no longer attending many activities of interest, since these incidents.

Additionally, a reasonable person in the resident's position would potentially have experienced severe psychosocial harm such as dehumanization as a negative outcome resulting from having been treated as an inanimate object or as having no emotions or feelings, and/or humiliation as a result of a feeling of shame due to being embarrassed, disgraced, or depreciated by being subjected to sexual abuse/assault. This affected Resident 3 and Resident 21.

The nursing home failed to report allegations of sexual abuse. This affected Residents 21, 2, and 3.

Resident 21 had a diagnosis of **Bipolar Disorder**. The resident was admitted to **hospice** for terminal diagnosis of malignant neoplasm of breast.

Cognitive Function. Resident 21 had **intact cognition** (based on MDS assessment)

Activities of Daily Living. Resident 21 was not ambulating.

Resident 2 had a diagnosis of **dementia**. Cognitive Function: **Impaired cognition** (MDS assessment).

Activities of Daily Living. Not Reported.

Resident 3 had diagnoses of **Schizoaffective Disorder and Bipolar Disorder**.

Cognitive Function. Resident 3 had **impaired cognition** (MDS assessment). ADLs: Not Reported.

Review of a **police report** revealed on April 20, 2024, at 8:12 PM, **an employee from the nursing home called the police anonymously fearing retaliation from the nursing home**. The anonymous employee reported on April 25, 2024, Resident 2 placed his genitals in Resident 3's face in an attempt for oral sex while in the common area. The anonymous employee revealed no interventions were put in place and Resident 2 resided across the hall from Resident 3. The anonymous employee reported on April 29 2024, Resident 2 was caught by staff with his hand down Resident 3's pants and Resident 3 was anxious and upset. The anonymous employee reported the Director of Nursing was on vacation and the Assistant Director of Nursing called off today due to this incident believing she was attempting to sweep this incident under the rug. Further review of the police report revealed the officer responded to the nursing home and LPN 250 was on duty. LPN 250 advised Resident 2 had displayed his genitals to multiple people at different occasions. LPN 250 reported Resident 3's room had been moved and she appeared upset. Resident 3 confirmed to Officer 77 she had not provided consent for Resident 2 to touch her, but he had placed his hands down her pants but had not penetrated her. Officer 77 also spoke with Resident 2 who was unsure what the officer was talking about. LPN 250 reported to Officer 77 that she believed Resident 2 knew what the officer was talking about.

During an interview on May 6, 2024, Resident 3 stated she had not wanted to talk about the incident with Resident 2. She was scared to come out of her room and had not wanted to go to the dining room. The next day, Resident 3 stated Resident 2 touched her skin under her brief in the private area and she told him to stop. Resident 3 looked fearful as she stated she was upset and scared of Resident 2.

During an interview on May 6, 2024, LPN 250 revealed she worked on April 29, 2024. LPN 250 revealed Resident 2 put his hands down Resident 3's pants. LPN 250 revealed Resident 3 was really upset and shaking and wanted to stay at the nurse's station with the nurse. LPN 250 further stated the following day the resident would not leave her bedroom. LPN 250 revealed she was not aware of the previous incidents with Resident 2 exposing himself to Resident 3 and Resident 21 until she went to put in a nurse's note for Resident 3. LPN 250 confirmed there were no interventions in place for Resident 2 after the incidents.

Resident 3's family member stated it was not Resident 3's normal behavior to stay in her bedroom. They said that the resident liked to go to bible study, play cards, bingo, and be social with other residents.

During an interview on May 7, 2024, STNA 160 stated as a reasonable person, she would feel traumatized, shocked, and humiliated if someone exposed themselves or put their hands down her pants. STNA 161 said as a reasonable person, she would be traumatized and humiliated if a man exposed himself to her or put his hands down her pants. STNA 160 stated Resident 2's behavior shocked her.

Name of Nursing Home	Parkview Care Center
Provider ID	366081
Address [RUCA Code: 4] [% County Population Rural: 43.25]	1406 Oak Harbor Rd, Fermont, Ohio, 43420
Day Investigation Completed	May 20, 2024
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm

Fearing Retaliation, Anonymous CNA and LPN Reported on a Woman with Dementia Who Left the Building, Crossed a 45 miles-per-hour, Moderately-high Trafficked Road, and Found at a Gas Station / The LPN Wished Not to Give Her Name as She Feared Retaliation for Speaking Up About It

The nursing home failed to conduct an accurate and thorough investigation for a potential allegation of neglect related to elopement for Resident 3. The nursing home failure to investigate and determine the root cause of the elopement prevented them from implementing interventions and safeguards to mitigate elopement and prevent other cognitively impaired residents from exiting the nursing home unsupervised.

On October 29, 2024, between 5:00 AM and 6:00 AM, Resident 3, a cognitively impaired woman who resided in the nursing home's west wing exited the nursing home unbeknownst to staff through the east wing door along the front of the nursing home. Resident 3 traversed the nursing home's unevenly paved parking lot and crossed a 45 mile-per-hour, moderately-high trafficked four-lane road in the dark. She was found approximately 30 minutes later by the nursing home's Night Supervisor, sitting on the ground in front of a gas station convenience store approximately 0.3 miles from the nursing home, and ultimately returned to the nursing home. While Resident 3 was out of the nursing home, she had a fall as evidenced by her muddy and wet clothing her daughter found. There was a likelihood Resident 3 could have been seriously injured, lost or hit by a motor vehicle while outside the supervision of the nursing home.

The nursing home's failure to complete a thorough investigation, maintain accurate record of investigation findings, and ensure appropriate corrective actions were in place, placed Resident 3 and other cognitively impaired residents at risk of elopement.

The nursing home failed to appropriately evaluate, monitor, and prevent a cognitively impaired resident from exiting the nursing home unsupervised. It placed the resident at risk for injury, impairment or death.

The nursing home failed to maintain complete and accurate medical records in accordance with professional standards of practice related to missing or omitted information pertaining to an elopement of Resident 3 and Resident 1. Note: Due to scope consideration, this summary focuses on Resident 3.

The nursing home failed to effectively communicate and implement the standards of its compliance and ethics program to promote ethical conduct and failed to adequately enforce those requirements to deter violations, ensure the provision of quality care and promote the highest practicable well-being of Resident 3 and all residents in the nursing home.

Resident 3 had diagnoses of **dementia** and **Parkinson's disease**.

Cognitive Function. The Director of Nursing (DON) said that after the incident, she conducted a BIMS evaluation of Resident 3 which scored 8 out of 15, indicating that she had **cognitive impairment**. Resident 3 required some help with her functional cognition and had impaired safety awareness.

Activities of Daily Living: Not Reported.

Review of a written complaint made to the State Agency on January 13, 2025 by **an anonymous staff member revealed** a male resident eloped out of the front door of the nursing home on January 9, 2025, and the nursing home failed to supervise the resident or intervene when her had exhibited elopement

behaviors. **The anonymous staff member stated** previously a female resident eloped from the nursing home on the night shift and went all the way up the street. The anonymous staff member indicated that the nursing home did not do education or drills after these elopements occurred and did not properly report the incidents.

On January 29, 2025, in a telephone interview, **anonymous LPN N stated she wished not to give her name as she feared retaliation and retribution from the nursing home for speaking up about the elopement**. LPN N stated she worked the 7:00 AM to 3:00 PM shift on October 29, 2024 and was driving to work when she saw resident 3 with the Night Supervisor and police at the [NAME] gas station at approximately 6:30 AM. She said afterwards Resident 3 was assigned a one-to-one sitter and she found it odd for the DON and the Administrator to say that Resident 3 did not elope because they don't put someone on 1:1 just for pushing the bar on the door like the Director of Nursing (DON) documented on her note. She indicated Resident 3 was confused and her hospital transfer form indicated she needed a surrogate. She said staff were told by the Administrator that this was not an elopement because Resident 3 only made it to the parking lot. She was not asked to provide a statement and said staff were concerned that the incident was never reported to the state. She said this was not the first time they had failed to report an incident. She said she found it odd that the Regional [NAME] President of Clinical Services attended the morning staff meeting after the incident and read witness statements to all the department heads which she had never done before. She recalled the statements implied Resident 3 never left the nursing home's parking lot and did not mention how she was found at the gas station. She said "Everything was odd about the way they [the administration] were acting." LPN N stated staff were asked not to document the incident in the nursing home's electronic incident reports and investigation system.

On January 29, 2025, **in a second anonymous telephone interview, CNA O stated she did not want to give her name for fear of retribution from the nursing home.** CNA O stated she worked the 7:00 AM to 3:00 PM shift on October 29, 2024. CNA O said she witnessed the Night Supervisor and Resident 3 with the police at the [NAME] gas station across the street and down the road from the nursing home on her way to work that morning. She said she recognized the supervisor and Resident 3 as she drove by. CNA O was not asked for a witness statement and said this was not the first incident swept under the rug by administration.

On January 28, 2025, the Night Supervisor said that on the night in question, a nurse from the east wing informed her the east wing door had alarmed. The east wing nurse told her she did not see anyone outside, so she closed the door. The Night Supervisor recalled she had staff perform a head count of all residents. The Night Supervisor remembered Resident 3 wandering around her medication cart earlier and realized she was unaccounted for, so she started to search for the resident. She stated she went outside to look for Resident 3 and when she walked toward the road from the parking lot, she saw Resident 3 down the road, across the street, walking towards a gas station. The Night Supervisor explained she went back, got her personal vehicle and drove down toward the gas station where Resident 3 was sitting on the ground near the door of the closed convenience store. The resident was dressed in a pair of pants, short sleeve shirt, and gripper socks but was not wearing shoes. The Night Supervisor recalled Resident 3 was combative and resistant to get in her car to return to the nursing home so the

police officers who were parked nearby assisted her. The Night Supervisor confirmed she had attempted to notify the Administrator and DON when she learned of Resident 3's elopement from the nursing home but was initially unable to reach them. She recalled she was able to reach the Assistant DON first and then eventually spoke with the Administrator while she was at the gas station prior to returning to the nursing home. She explained Resident 3 was returned to the nursing home at approximately 7:00 AM. The Night Supervisor said she was instructed by the DON by phone to complete a head-to-toe assessment, place an electronic wander bracelet on Resident 3 and place her on one-to-one supervision. The Night Supervisor stated she performed the assessment on Resident 3, completed a new elopement risk assessment, placed the electronic wander bracelet and initiated one-to-one supervision to ensure Resident 3 did not attempt to elope again. The Night Supervisor recalled when the DON, Administrator, and Assistant DON arrived, she watched video captured by cameras at the nursing home and was able to see Resident 3 exiting the nursing home via the east wing door on the front of the building (photo evidence was received). She recalled she could see Resident 3 walk across the parking lot toward the road through an area with low tree branches and finally disappear from the camera's view as she left the property. The Night Supervisor described they watched a video that captured the east wing nurse close the door that Resident 3 left from without going outside to look for any residents. She said she sent a written statement about what happened that morning via email to the DON and was interviewed about it on the day of the incident. The Night Supervisor recalled she was told by the DON not to document about the incident in the resident's medical record or the nursing home's internal incident reporting system.

Review of Resident 3's medical record revealed the only documentation related to the incident on October 29, 2024 was an Interdisciplinary Team note entered on October 30, 2024 at 12:30 PM by the DON. The DON documented "Resident 3 ambulated over to the door, pressed on the egress bar, and sounded the alarm." She indicated in her documentation "Staff responded to the resident and redirected her back to her room. She was alert and oriented to person, place, and time and said she just wanted to go for a walk."

During an interview, the DON said she was aware Resident 3 left the nursing home but said she only got to the parking lot, not to the gas station. She said the Night Supervisor said the resident went out to the parking lot, but she immediately went behind her and brought her back inside. The DON said she viewed the camera footage with the Administrator and Assistant DON and confirmed that was what happened. She stated other staff members on duty provided similar statements. The DON said the incident was determined to be a near miss, not an elopement.

During an interview, the Administrator stated she watched the video of Resident 3 leaving the nursing home. The Administrator explained the video was not clear because it was dark outside but saw that when Resident 3 opened the east wing door and stepped out into the parking lot, the nurse was right behind her. She stated staff responded very fast, policies and procedures were followed, and all things were handled appropriately. The Administrator said she was not aware that Resident 3 had walked to the gas station and it was the first time she had heard this.

During a joint interview with the Regional [NAME] Presidents 1 and 2 and the Regional [NAME] President of Clinical Services, the Regional [NAME] President of Clinical Services confirmed they were informed about the elopement on October 29, 2024, were involved with the investigation but had not been told the resident was found at the gas station down the road. She said they followed their process to complete the investigation and Regional [NAME] President 1 said: "You can't blame us because we only know what we are told." They had previously concluded the incident was a near miss based on the version of events they were given; however, they said they had now identified trust issues with the nursing home administration after they reviewed the investigation and spoke with witnesses. Regional [NAME] President 1 expressed they started a new investigation at this time because the information given by the Administrator and DON regarding the incident with Resident 3 conflicted with what staff said happened. He said the differences in what they had been told by the nursing home administration and what they had received from the staff were egregious, so per nursing home policy, the Administrator and DON were suspended pending results of the new investigation.

According to the **nursing home's Code of Conduct and Ethics Policy**, **the organization believed in creating a culture of respect, integrity, and compassion**. They were committed to providing the highest quality of care and expected each team member to utilize legitimate practices that aligned with their mission and values. Employees are to be educated on the Compliance Program upon hire and must acknowledge the I Pledge acknowledgment agreeing to follow corporate values and report unethical behavior. **Honesty,** respect, and care **in performing duties** while dealing with residents should be a standard benchmark of employee conduct. **Employees were to freely report any violations without fear of retaliation**.

Name of Nursing Home	Conway Lakes Health & Rehabilitation Center
Provider ID	105754
Address [RUCA Code: 1] [% County Population Rural: 2.35]	5201 Curry Ford Road, Orlando, Florida, 32812
Day Investigation Completed	February 1, 2025
Type of Deficiency Issued	*F610 **F689 ***F842 ****F895
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Minimal Harm or Potential for Actual Harm ****Minimal Harm or Potential for Actual Harm

CNAs Not Reporting Verbal and Physical Abuse of Two Residents with Severe Cognitive Impairment

The nursing home failed to prevent physical and verbal abuse of Resident 2 and Resident 5. On August 26, 2024, between 5:00 PM and 5:30 PM, a CNA witnessed another CNA physically and verbally abuse Resident 2 and Resident 5. The investigation revealed the same CNA had a history of verbally and physically abusing Resident 2 and Resident 5 without being separated. This failure resulted in residents exposed to the actual abuse and the potential of abuse therefore causing an Immediate Jeopardy to the health, safety, and security of the resident.

The nursing home failed to report an allegation of abuse to the State Survey Agency within 2 hours of an allegation of physical and verbal abuse of Resident 2 and Resident 5.

The nursing home failed to separate an alleged abuser to prevent further verbal and physical abuse of Resident 2 and Resident 5 and failed to complete a comprehensive investigation immediately.

Cognitive Function. Resident 2 had **severe cognitive impairment** (BIMS score of 3 out of 15).

Activities of Daily Living. Not Reported.

Cognitive Function. Resident 5 had **severe cognitive impairment** (BIMS score of 6 out of 15).

Activities of Daily Living. Resident 5 was dependent on staff for dressing and undressing the upper body, lower body, and for toileting.

During an interview on September 7, 2024, **CNA (Staff G**) stated she had heard Staff U speak very verbally abusive to residents. **She felt like Staff U would have retaliated if she told the nurses or administration**. Staff G stated she had seen the three finger bruises and it looked like fingerprint marks on Resident 2. Staff G stated she reported this to Staff V but Staff V did not come down to look at the bruises. Staff G stated she found it right when she got Resident 2 up the morning of August 27, 2024. Staff G stated Staff L stated Staff U had pushed Resident 2 back and down in her wheelchair. **Staff G stated she felt that she should have reported Staff U's behavior towards the residents and she did not**.

Staff G also stated that Resident 5 told Staff U to leave him alone and called her "a f***ing bitch." Staff G stated Staff U said to Resident 5: "You are not going to talk to me like that you f***ing a** hole." Staff G stated one time Staff U was getting Resident 5 up and Staff U took Resident 5's legs and flung his legs in an aggressive manner out of bed. Staff G stated it was done in a manner that if it was done to her, it would have hurt her back. Staff G stated Resident 5 would say he would punch Staff U and Staff U would say she would punch him before he could get her.

CNA (Staff L) stated she reported multiple times to the Administrator about the way Staff U spoke to the residents. Staff L first spoke to the Administrator about Staff U's behavior back in May the first time. **Staff L stated she had worried about retaliation at work**.

Staff D stated that Staff U had pushed Resident 2 back in the wheelchair.

Staff B stated Staff U grabbed Resident 5 by his feet and swung them over the bed and pulled him up by his arms unnecessarily rough.

Staff K stated she had seen Staff U be unnecessarily rough with Resident 2. Staff K stated when Staff U completed personal cares for Resident 2, she would talk down to Resident 2 and tell her that she shouldn't piss her pants. Staff K stated she should have reported the incident. Staff K stated these verbal and physical incidents towards residents had been happening since May (i.e. at least 4 months ago).

The Administrator stated that staff acknowledged that they were probably wrong for not reporting the abuse. The Administrator stated that the nursing home's expectation was that all possible abuse would be reported to management, but the nurse did not see this as abuse. The Administrator stated she thought that the possible verbal and physical aggression to Resident 2 and Resident 5 probably should have been reported to the state agency as an allegation. The Administrator stated the allegations to both Resident 2 and Resident 5 were unreported.

Staff U stated she never cussed at any residents and that she never forced a resident to move if they did not want to. Staff U stated she did not abuse any residents at the nursing home.

Name of Nursing Home	Garden View Care Center
Provider ID	165531
Address [RUCA Code: 7] [% County Population Rural: 33.76]	1200 West Nishna Road, Shenandoah, Iowa, 51601
Day Investigation Completed	September 11, 2024
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

Fearful of Retaliation, a CNA Reported an LPN Pushing a Resident Into a Wall Causing Nose Fracture (Witnessing CNA Said the Resident Hit the Wall "*like a basketball*")

The nursing home failed to protect Resident 1's right to be free from physical abuse. Specifically, Resident 1 was pushed by a staff member into a wall, causing a nosebleed and fractured nose.

Resident 1 had a diagnosis of **Parkinson's Disease**.

Cognitive Function. Resident 1 had **moderate cognitive impairment** (BIMS score of 12 out of 15).

Activities of Daily Living. The resident required supervision or was independent with activities of daily living including transfers and walking, had no falls, and wore wander alert device.

During an interview on December 18, 2024, CNA 3 stated that on December 15, 2024, before dinner, they locked down the hallway and saw LPN 1 push the resident into the wall. They could not hear well what was being said, but when the nurse pushed Resident 1, the resident hit the wall like a basketball. They could see the resident's nose bleeding from down the hallway. They thought they heard LPN 1 say: "I am tired of your [expletive]" and the resident said: "[They] hurt me." CNA 2 and Resident 2 were near the resident. CNA 3 thought the resident slid to the floor but was not sure. **CNA 2 was crying**, and **CNA 3 was initially shocked at what they saw** and did not immediately move. CNA 2 approached CNA 3, very upset, and asked what to do. CNA 3 told CNA 2 they must report it. **CNA 2 was scared** and took the resident with them to get a drink and cookies. When they returned, CNA 2 notified the Director of Nursing (DON). **Both aides were afraid of retaliation** and did not know who the supervisor was or where they were only that they were busy, so CNA 2 called the DON.

CNA 2 stated when Resident 1 approached LPN 1 to ask about anxiety medication, LPN 1 shoved Resident 1 into the wall, the resident's face hit the wall and the resident cried and said they thought they broke their nose. CNA 2 stated hearing Resident 1 saying: "I broke my nose again" and the resident's eyes teared up.

The December 15, 2024 at 7:41 PM DON's Progress Note documented the nursing became aware of an incident on December 15, 2024 at 5:37 PM. It was reported to the DON by CNA 2 that LPN 1 had pushed Resident 1 up against the wall with the resident's face on the wall. The DON directed RN Supervisor 4 to suspend LPN 1 pending investigation and notified the Administrator. RN Supervisor 4 completed an assessment. The resident had dried blood on their nose, the on-call medical provider was notified and ordered an X-Ray. The police were called and the resident's family was notified of what happened.

The December 16, 2024 Medical Director Progress Note documented the resident was seen for a report of being [missed word] against the wall, hitting their face and had a small nosebleed. The on-call provider ordered an X-Ray but did not order to send the resident to the hospital. The X-Ray showed an acute fracture to the tip of the nasal bone. The Medical Director recommended the resident be evaluated at the hospital.

The December 16, 2024 Arrest Report documented LPN 1 was charged with assault in the third degree and endangering the welfare of a vulnerable adult and physically disabled person in the second degree. They were taken to Justice Center and held for arraignment.

During an interview on December 18, 2024, Resident 2 stated they saw LPN 1 abuse Resident 1 on December 15, 2024. The incident occurred at the end of the hallway by Resident 1's bedroom, where the medication cart was. Resident 2 stated they went down that way to get a new oxygen tank before going to the dining room. Resident 1 asked for medications all the time, but on that day, LPN 1 responded angrily and told the resident they did not have the medication. Resident 1 got their oxygen and Resident 1 was still there asking for their medications. The nurse said: "I told you it is not time, and I am sick of this [expletive]." The nurse then grabbed Resident 1 by the shirt and threw them to the wall. Resident 1 hit their head and stated they were hurt. CNA 2 started to cry. The Administrator was there to talk to the residents as well as the police.

Following the notification of abuse, LPN 1 was suspended from their duties and exited the nursing home. Their employment was subsequently terminated.

LPN 1 denied the incident.

Name of Nursing Home	Onondaga Center for Rehabilitation and Nursing
Provider ID	335548
Address [RUCA Code: 1] [% County Population Rural: 14.64]	217 East Avenue, Minoa, New York, 13116
Day Investigation Completed	January 7, 2025
Type of Deficiency Issued	F600
Scope Severity Level	Actual Harm

CNA 1 Delayed Reporting Witnessing CNA 2 Slapping the Face of a Person with Alzheimer's Disease and Then Covering Her/His Head with a Blanket / "*This is how you calm [resident] down*" / Witnessing CNA Was Shocked, and Scared During the Incident, and Feared Retaliation from CNA 2

The nursing home failed to ensure residents remained free from mental and/or physical abuse of Resident 1 who was witnessed receiving physical and verbal abuse. Failure of the staff to immediately report a witnessed incident of staff to resident abuse to the appropriate supervisor delayed the removal of the accused abuser, the start of the nursing home investigation, and assessment of the resident for injury. This delay placed Resident 1 at risk for further abuse, fear, anxiety, and/or psychosocial harm and placed other residents at risk of abuse.

Resident 1 had a diagnosis of **Alzheimer's disease**. Cognitive Function: Not Reported.

Activities of Daily Living. Not Reported.

During an interview on October 15, 2024, CNA 1 stated that while she/he and CNA 3 provided cares to Resident 1 on the evening of October 10, 2024, the resident yelled at the CNA 3 to get out and spit at her. The CNA 1 identified hearing a spitting sound and turned around to see the CNA 3 slap the resident in the face and cover the resident's head with a blanket. The CNA 3 stated: "This is how you calm [resident] down." When the CNA 3 pulled the blanket down, the resident spit, and the CNA slapped the resident again, made faces, and stuck her/his tongue out at the resident. The CNA 1 stated Resident 1 continued to yell at Resident 3. **The CNA 1 reported being shocked, and scared during the abuse incident, and feared retaliation from CNA 3**. The CNA 1 confirmed not reporting the incident immediately on the evening of October 10, 2024 until reported to the evening nurse on October 11, 2024.

Review of the nursing home's initial investigation report, dated October 11, 2024, identified on October 11, 2024 CNA 1 reported to Nurse Manager 2 he/she observed CNA 3 slap and disrespect Resident 1 on October 10, 2024 during evening cares.

During an interview on October 15, 2024, a managerial staff member 4 stated: "Education was given to CNA 1 that CNA 1 should have reported the incident immediately."

Name of Nursing Home	Missouri Slope
Provider ID	355128
Address [RUCA Code: 1] [% County Population Rural: 24.31]	4916 N Washington St, Bismark, North Dakota, 58503
Day Investigation Completed	October 15, 2024
Type of Deficiency Issued	F600
Scope Severity Level	Actual Harm

CNA 1 Witnessed CNA 2 Choke Hold a Man with Alzheimer's Disease But Didn't Intervene or Report the Abuse Because "*She was a big girl and could beat me up*" / CNA 1 Felt If She Reported It to Administrative Staff, the Nursing Home Would Retaliate Against Her, and She Would Be Terminated

The nursing home failed to implement written policies and procedures that prohibit and prevent abuse and neglect for Resident 1. CNA A failed to follow the nursing home's policy to report allegations of abuse when allegedly she observed CNA B hold Resident 1 down in a choke hold on April 24, 2024. The failure could place the residents in the nursing home at risk of abuse and lack of timely reporting of incidents.

The nursing home failed to ensure that all alleged violations involving abuse were reported immediately to the Administrator of the nursing home for Resident 1. CNA A failed to immediately report to the Administrator an allegation of abuse involving CNA B and Resident 1 that allegedly occurred on April 24, 2024. The failure placed residents at risk of not having abuse allegations reported.

Resident 1 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. The resident had a **BIMS score of 00**, indicating he was **not able to complete it**.

Care Plan. Indicated the resident had cognitive function and "**Impaired thought process**."

Activities of Daily Living. The resident required substantial/maximum assistance with toileting. The resident was "always incontinent of bowel and bladder."

Interview on April 27, 2024 with **CNA A revealed** she recently started in the nursing home working in the Memory Care Unit. According to CNA A, she completed training with CNA B. She stated during her training she heard CNA B being verbally aggressive with residents while she provided them with care. CNA A stated when CNA B would say something or give directions to the residents, the residents would jump or act scared when she would tell them to do something. CNA A stated Resident 1 seemed uncomfortable being around CNA B. CNA A stated when Resident 1 refused to be changed on April 24, 2024 between 8:00 PM and 9:00 PM, CNA B grabbed the resident by the back of his neck and held him down in a choke hold saying out loud: "You better get in there, now!" According to CNA A, **she did not intervene**, and she did not say anything to CNA B about being verbally or physically abusive. CNA A stated she did not report what she had witnessed to RN G or the Abuse Coordinator. **CNA A stated she did not intervene because she was scared of CNA B, stating "She was a big girl and could beat me up."** CNA A stated: **"I've seen her speak loudly, aggressively and get up into staff face, and they have not done anything to her. They let her work here."** CNA A stated from the time she started a week ago, she had observed CNA B's behavior and saw that this abuse had been going on before she arrived. CNA A stated by the way CNA B was speaking to residents, she thought to herself this behavior had been going on for a long time and figured no one is doing anything about it. CNA A stated RN G had heard speaking rudely to residents but did nothing to protect the residents. CNA A stated: "**CNA B had friends and family that worked in the nursing home, so she did not know who she could trust in the nursing home**. **CNA A** stated she **felt if she reported the abuse to administrative staff, the nursing home would retaliate against her, and she would be terminated**." CNA A stated she did discuss the allegation with CNA E and Hospitality Aide F; however, it was not clear what day she talked to them.

CNA A stated she **was aware abuse should be reported to the Abuse Coordinator; however, she feared retaliation**. CNA A stated she recently had an In-Service covering abuse and neglect and was aware to report it. CNA A stated not reporting abuse placed residents at risk of harm and endangerment.

During an interview on April 27, 2024, CNA E stated she had not been told about any allegations of abuse, and she denied that CNA A had told her about any allegations of abuse regarding Resident 1 and CNA B. CNA E stated she was aware of signs and symptoms of abuse and to report to the nurse or unit manager.

During an interview on April 27, 2024, Hospitality Aide F reported CNA A did not report alleged abuse by CNA B towards Resident 1.

During an interview on April 27, 2024, the Administrator revealed she had not had any allegations of abuse reported to her. The Administrator was not aware of the alleged incident involving Resident 1 and CNA B.

Interview on April 27, 2024 with CNA B revealed she worked on the Memory Care Unit. CNA B stated she noticed Resident 1's mood had changed. She stated the resident had started eating foreign objects, and she reported this to nursing staff. According to CNA B, she had to stop him from eating foreign objects. She denied being aggressive or physical when interacting with Resident 1. When asked about Resident 1's incontinence care, CNA B stated she had never had any issues with providing care to him. When asked if she had ever held Resident 1 down in a choke hold, she responded: "No." According to CNA B, she did not speak aggressively to residents in the nursing home. She stated she never did anything that would look like abuse to residents. According to CNA B, not reporting abuse would place residents at risk of harm. CNA B stated the last time she in-serviced on abuse and neglect was during the previous week.

During an interview on April 27, 2024, RN G stated it was never reported that CNA B grabbed Resident 1 by the back of his neck and held him down in a choke hold. RN G stated not reporting abuse placed residents at risk of being abused over and over by the same person and causing harm to them. RN G stated all staff were required to report allegations, changes and signs and symptoms to the Administrator.

Interview on April 27, 2024 with Resident 1's Family Member revealed she had not been contacted about anything recently.

Name of Nursing Home	Downtown Health and Rehabilitation Center
Provider ID	455651
Address [RUCA Code: 1] [% County Population Rural: 1.23]	424 S. Adams St., Fort Worth, Texas, 76104
Day Investigation Completed	April 27, 2024
Type of Deficiency Issued	*F607 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm *Minimal Harm or Potential for Actual Harm

DON to Hospice Nurse RN: "*If you don't do something with this fucking patient, I am going to stab her in the neck*" / The Hospice RN Stated She Did Not Want Any Retaliation from the DON

The nursing home failed to ensure Resident 1 was free from abuse. The nursing home failed to ensure Resident 1 was safe from mistreatment and abuse as evidenced by the Director of Nursing (DON) alleging serious life-threatening remarks towards Resident 1. This placed the resident at risk for abuse that could cause diminished quality of life, psychosocial harm, and/or psychosocial harm. The nursing home failed to have evidence that all alleged violations of abuse were thoroughly investigated for Resident 1.

Resident 1 had a diagnosis of **Alzheimer's disease**.

Cognitive Function Level. The resident had **severe cognitive impairment** (BIMS score of 00).

Activities of Daily Living. The resident required substantial assistance with toileting, hygiene, & dressing.

A record review of a Hospice communication note (dated April 3, 2024) reflected the Hospice RN wrote a note for Resident 1 which reflected that when she went to get Resident 1 from the DON, the DON stated: "If you don't do something with this fucking patient, I am going to stab her in the neck."

During an interview on April 16, 2024, **Hospice RN said she did not want any retaliation from the DON**.

During an interview on April 16, 2024, at 9:58 AM, the Hospice RN stated she was at the nursing home on April 3, 2024 for another resident's birthday party. The Hospice RN stated the Dietary Manager told her Resident 1 had fallen so she began to walk from the dining room to the hallway to make a PRN visit since Resident 1 had fallen. The Hospice RN stated the DON had Resident 1 in her wheelchair and said: "If you don't do something about this fucking patient, I am going to stab her in the neck." The Hospice RN stated the DON made a motion with her hand as if she was holding a knife and put her hand up to her own (the DON's) neck. The Hospice RN stated the reason Resident 1 left the nursing home was because she needed a Memory Care Unit and at the time of the incident on April 3, 2024, they were already looking at alternate placement because Resident 1 had fallen 12-15 times since she was admitted. The Hospice Nurse said Resident 1 could not recall what the DON had said because she had **advanced Alzheimer's disease**. The Hospice RN said when she assessed Resident 1, Resident 1 stated: "That's all I wanted, sweetheart." The Hospice RN stated she thought the DON was very frustrated with Resident 1 and that Resident 1 could be a difficult patient, but it was her disease. The Hospice RN stated Resident 1 had a mind of an 18-month-old child, she was regressing and you could tell the DON was irritated or annoyed. **The Hospice RN stated she left the nursing home that day** (April 3, 2024) **in tears** because she trusts these people to take care of her residents. The Hospice RN stated **if something were to happen to Resident 1, she would never forgive herself for not reporting the incident.** The Hospice RN stated the Administrator pulled her into his office and she knew the DON was suspended for 2 days after the incident. The Hospice RN stated she was told there was nothing the nursing home could do because it was a "he said, she said" thing.

During an interview on April 16, 2024, the DON stated Resident 1 was admitted due to having increased falls at home, **her dementia was pretty severe** upon arrival, she was admitted on Hospice and she required extensive to total care when she arrived. The DON stated Resident 1 required a lot of care and

none of it was effective. The DON stated: "This place probably wasn't the best for her and she wasn't a bad patient, she wasn't screaming out all night, but she definitely needed one-on-one care. The DON stated it was a frustrating situation for staff because they did not know how to handle one-on-one care when they had a whole hall. The DON stated: "There was nothing wrong with her except for her falling and needing one-on-one care with extra assistance. The DON stated the Hospice birthday party was on a Wednesday or Thursday and they had a huge gathering in the dining room. The DON stated Resident 1 was roaming all over the place, so we asked Hospice for help. The DON stated Resident 1 had fallen on the 200 Hall, so she picked her up, told the Hospice RN she had a fall and handed off Resident 1 to the Hospice RN so she could do a PRN visit. The DON stated she had a pretty frustrating workload that week because she was on the floor working as a Med Aide and CNA, and she did not have any help. The DON stated: "I do get a little frustrated, don't get me wrong" but said it was not anything she could not handle. The DON stated: "We're always understaffed" and said she was the only nurse manager. The DON stated: "When people call in, it's frustrating because no one can help me do my job." The DON stated: "I honestly couldn't tell you," if she said something out of frustration or by accident that she did not mean to say and stated: "I tried to go back and figure it out." The DON stated: "I am not going to say nothing came out of my mouth." The DON stated sometimes she should say she would stab herself in the neck and maybe staff heard it and it may have been misinterpreted. The DON stated she would never hurt a resident or take any aggression out on a resident. The DON stated: "I am not going to say I didn't because I don't know what I said at the time in question." The DON stated: "Yeah, threatening to stab a resident in the neck would be considered verbal abuse." The DON stated that she did not recall what she said. The DON stated if she said she stabbed herself, she was usually joking, and it was not taken seriously. She said she was suspended until April 9, 2024 and they did all staff abuse education. She said she was taking some courses with the Administrator "but I haven't started it yet." She stated the Administrator told her they would get with Corporate on which courses to take. She added she had been trained on abuse, neglect, and exploitation during orientation. The DON stated if residents were verbally threatened, it could be harsh on them, they could fear their lives, and I could see how it could be hurtful for them.

During an interview on April 16, 2024, the Administrator stated upon learning of the allegation, he joined a group call with Hospice while Hospice notified Resident 1's family and physician. He stated Corporate Office made the decision not to discuss the incident since there was no proof of abuse. He added the incident was a 'he said she said' and ultimately the DON said she didn't do it. The Administrator said he felt like **the Hospice RN feared retaliation**.

During an interview on April 26, 2024, Resident 1's family member stated the nursing home never contacted the family in regard to the incident, but she did hear about it.

Name of Nursing Home	Parkview Nursing and Rehabilitation Center
Provider ID	675458
Address [RUCA Code: 2] [% County Population Rural: 54.59]	1501 S Main St., Lockhart, Texas, 78644
Day Investigation Completed	April 16, 2024
Type of Deficiency Issued	*F600 **F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm

A Nurse Re-wrote Witness Physical Abuse Statement Due to Fear of Retaliation from Administrator

The nursing home failed to keep Resident 1 free from physical abuse when CNA 1 deliberately poked Resident 1 in the right cheek, smacked Resident 1 in the hand, and then forced Resident 1 down in her wheelchair causing her to cry out. The abuse resulted in Resident 1 crying out in pain, hyperventilating (breathing rapidly) and visibly shaking, and had the potential to instill fear in Resident 1 which could result in psychosocial harm. This abuse also had the potential to result in further physical abuse towards Resident 1 and/or other vulnerable residents under CNA 1's care.

The nursing home failed to protect residents in the nursing home from physical abuse when CNA 1 deliberately poked Resident 1 in the right cheek, smacked Resident 1 in the hand, and then forced Resident 1 down in her wheelchair causing Resident 1 to cry out. The nursing home failed to protect 16 residents (Residents 1-16) assigned to CNA 1 from possible physical abuse when the Administrator returned CNA 1 to direct care duty before completion of a thorough abuse investigation, including interviewing all witnesses. CNA 1 was permitted to have access to Resident 1 and continued to work with other vulnerable residents. This failure resulted in Resident 1 crying out in pain, hyperventilating (breathing rapidly) and visibly shaking, and had the potential to result in further physical abuse towards Resident 1 and/or other vulnerable residents under CNA 1's care.

Resident 1 had a diagnosis of **Alzheimer's disease**.

Cognitive Function: BIMS score Not Reported / LVN 1 stated that Resident 1 had **severe dementia**.

Activities of Daily Living. The resident required partial assistance from another person when walking from room to room.

Resident 1 primarily spoke Tagalog (a language spoken by people of Filipino decent) for communication.

During an interview with LVN 1 in the Medication Room on May 14, 2023, LVN 1 stated she was working at Nursing Unit 1 on May 8, 2024 during the PM shift. LVN 1 stated she was doing her medication pass around 6:00 PM, at room [Room Number]. LVN 1 stated CNA 1 was sitting in a chair next to Resident 1, who was sitting in her wheelchair in the hallway outside of room [Room Number]. LVN 1 stated CNA 1 got up to help pass out dinner trays to the Nursing Unit 1 residents. LVN 1 stated Resident 1 then stood up. LVN 1 stated CNA 1 helped Resident 1 sit back down in her wheelchair. LVN 1 said Resident 1 stood up again and CNA 1 yanked Resident 1 down into her wheelchair. LVN 1 stated CNA 1 began yelling at Resident 1 in Tagalog and CNA 1 then poked Resident 1 in the right cheek. LVN 1 stated Resident 1 then swatted CNA 1's hand away from her face. LVN 1 stated CNA 1 then smacked Resident 1 in the hand. LVN 1 stated she also heard the smack to Resident 1's hand. LVN 1 stated Resident 1 stood up again and CNA 1 then grabbed Resident 1 by her pants and slammed her back down in her wheelchair. LVN 1 stated Resident 1 yelped out in pain after being slammed down in her wheelchair by CNA 1. **LVN 1 stated she told CNA 1 to stop because her actions were abusive**. LVN 1 stated she then calmed Resident 1 down and assessed her condition. **LVN 1** stated she **then called Nurse Consultant (NC) and the Administrator to report the abuse she had witnessed**. LVN 1 stated she submitted a written statement to the Administrator about the abuse incident toward Resident 1 that she had witnessed.

LVN 1 stated that the Administrator told her to take out the part where the CNA 1 poked Resident 1 in the cheek and smacked her in the hand because it made CNA 1 look bad. **LVN 1 stated she then re-wrote her statement because she was afraid of being retaliated against by the Administrator**.

During a telephone interview on May 17, 2024, LVN 2 stated she was using the restroom [Room Number] located adjacent to Nursing Unit 1 on May 8, 2024 at approximately 6:00 PM. LVN 2 stated she heard two screams that sounded gut-wrenching, fearful and painful coming from Nursing Unit 1. LVN 2 stated she exited the restroom and ran to Nursing Unit 1. LVN 2 stated Resident 1 was standing in the hallway outside of room [Room Number] hyperventilating (breathing rapidly) and visibly shaking. LVN 2 stated she then asked LVN 1 what had happened. LVN 2 stated LVN 1 told her she witnessed CNA 1 poke Resident 1 in the right cheek, smack Resident 1 in the hand, and slam Resident 1 down into her wheelchair.

During an interview on May 14, 2023, CNA 1 stated that on May 8, 2024, around 6:00 PM, she was sitting next to Resident 1 in the hallway outside of room [Room Number]. CNA 1 stated Resident 1 got up from her wheelchair and attempted to sit in her chair. CNA 1 stated she then helped Resident 1 sit back down in her wheelchair. CNA 1 stated once Resident 1 was seated in her wheelchair, she applied A&D ointment to Resident 1's face because she had dry skin. CNA 1 stated no other physical contact was made with Resident 1 other than apply the A&D ointment to her face.

During an interview on May 13, 2024, the Director of Nursing (DON) stated the alleged abuse towards Resident 1 occurred on May 8, 2024 at approximately 6:00 PM in the hallway outside room [Room Number], which is located at Nursing Unit 1. The DON stated CNA 1 allegedly sat Resident 1 down forcefully in her wheelchair. The DON stated LVN 1 witnessed the incident and felt that CNA 1 handled Resident 1 roughly. The DON stated LVN 1 reported the alleged abuse to the Administrator on May 8, 2024. The DON stated CNA 1 was suspended by the Administrator on May 8, 2024 and returned to duty on May 10, 2024 after the nursing home completed an abuse investigation. The DON stated the abuse allegation towards Resident 1 was unsubstantiated.

During an interview on May 13, 2024, the Administrator stated that CNA 1 told him that during the incident in question, she (CNA 1) helped Resident 1 sit down in her wheelchair because she was falling. The Administrator stated that CNA 1 told him she had applied A&D ointment to Resident 1's face after she was seated in her wheelchair. The Administrator stated CNA 1 was suspended on May 8, 2024 and returned on duty on May 10, 2024, after she completed Resident 1's abuse investigation. The Administrator then stated Resident 1's abuse allegation was unsubstantiated.

Name of Nursing Home	Bay View Rehabilitation Hospital, LLC
Provider ID	056348
Address [RUCA Code: 1] [% County Population Rural: 0.49]	516 Willow Street, Alameda, California, 94501
Day Investigation Completed	May 16, 2024
Type of Deficiency Issued	*F600 **F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Immediate Jeopardy

A CNA in Training Witnessed and Reported to the Administrator that a CNA Placed a Pillow Over the Head of a Man with Cognitive Impairment for 10 Seconds. Then in the Locker Room, the CNA Perpetrator told the CNA in Training and 3 other Employees That They Needed to Say that While Rolling the Resident, His Head Got Pushed Up Against the Pillow. Then When the DON Asked Her If She Was Sure the Incident Was Not a Misunderstanding, She Felt Uncomfortable and Intimidated. In Fear of Retaliation, She Retracted Her Statement and Quit Her Job 15 Minutes After Her Shift

The nursing home failed to prevent physical and verbal abuse for Resident 701, resulting in Resident 701 having a pillow placed over their head and called names and the likelihood of emotional distress and fear, based on the Reasonable Person Concept.

The nursing home failed to report an allegation of abuse for Resident 701, resulting in the allegation not being reported to the State Agency, with potential for continued unreported incidents.

The nursing home failed to thoroughly investigate an allegation of abuse for Resident 701, resulting in the potential for abuse to occur, not be prevented, and not be investigated to ensure resident protection.

Cognitive Function. Resident 701 had **moderate impaired cognition** (BIMS score of 11 out of 15).

Activities of Daily Living. The resident needed extensive assistance with dressing and transfers.

During an interview on January 28, 2021, **Confidential Witness A (CNA F)** explained that she was a new employee at the nursing home training for a Nurse Aide position. On January 14, 2021 and January 15, 2021, Confidential Witness A had been assigned to train with CNA F. According to Confidential Witness A, she had been training with three other new employees (Noncertified Nurse Assistant / NCNA B, D, and E). On her last day of training, the five of them went to complete a brief change for Resident 701. According to Confidential Witness A, Resident 701 did not want to be changed, but was changed anyway. During care, Resident 701 was combative and called CNA F racial names. After the resident was changed, CNA F then held Resident's arm out with one arm and then placed a pillow over the resident's head and face and pushed down on it for about ten seconds. The resident was not able to remove the pillow. While holding the pillow down, CNA F made repeated racial slurs to Resident 701 and then removed the pillow from their face. After the pillow was removed, Resident 701 kept yelling: "You're going to jail!" Confidential Witness A said NCNA B, D, and E were nervously laughing during the incident, but she did not. Confidential Witness A was asked what CNA F did after the incident and said CNA F stated: "Why did I just do that?"

After the incident, they all had gone to lunch. Confidential Witness A explained that she felt uncomfortable with what she had witnessed and had gone to report the incident to Social Worker (SW) C. SW C then referred her to the Administrator. After Confidential Witness A spoke to the Administrator, she then went to the locker room. CNA F, NCNA B, D, and E were also in the locker room. CNA F had addressed all of them and stated that there was an allegation of abuse against her with Resident 701 and that they all needed to collaborate so that they all could have the same story when interviewed. CNA F further explained to them that they needed to say that while rolling the resident, their head got pushed up against the pillow.

Confidential Witness A (CNA F), and NCNA B, D, and E were all brought into the Director of Nursing's (DON) office. During that time, Confidential Witness A (CNA F) stated that they were all just talking about other issues, instead of the incident she reported, and then all the staff were asked to leave the room except for her and CNA F. At that time, **the DON had asked her if she was sure that the incident was not a misunderstanding. Confidential Witness A (CNA F) felt uncomfortable and intimidated**. **In fear of retaliation, she retracted her statement**.

Confidential Witness A then finished her shift out with CNA F, whom according to her, was being unusually nice to her, and then **quit within 15 minutes after her shift ending**. She stated: "I felt it was all handled inappropriately. I was not comfortable working there." Confidential Witness A added: "My sister is a nurse, and I explained to her what happened and she advised me to report it to the State Agency."

During an interview on February 1, 2021, SW C stated that Confidential Witness A had come to her "pretty shaken up" and reported that CNA F had placed a pillow over Resident 701's head during care.

During an interview on February 1, 2021, CNA F was queried by phone about the incident with Resident 701 and the pillow. CNA F did recall the incident. CNA F explained that Resident 701 was a real nice guy and was never combative but cusses and swears. She stated that the resident was not even cussing or swearing at the time but joking around with her. CNA F stated: "When Resident 701 was being rolled to the side (away from her), their face went in a pillow. CNA F was queried on what happened after the incident and explained that she went to lunch and was called in the office with Confidential Witness A, NCNA B, D, and E. She explained that everyone was talking and then the NCNAs were dismissed from the meeting and she was asked what happened and explained that Resident 701 was rolled and their head went in the pillow. CNA F was queried as to why she thought the incident had been reported to the Administrator and DON and stated: "I guess because they were a new CNA and weren't familiar with the job." CNA F was asked if she had given a statement and explained that she was not asked to.

During an interview on February 1, 2021, **the DON explained that Confidential Witness A recanted her story and said it must have been a misunderstanding**. The DON was asked if there had been an investigation in regard to what Confidential Witness A had reported. **The DON stated: "There was nothing to investigate, she recanted her story."** The DON was asked if it was normal procedure to interview the accuser and perpetrator at the same time and stated: "I asked her (Confidential Witness A) if it was okay to bring in CNA F to find out what happened and she said it was fine. The DON was asked if she had interviewed SW C about what was reported to her and stated: "I didn't know she knew anything about it." The DON was asked if she had interviewed Resident 701 and stated: "Did you meet him?" The DON further explained that when the incident was reported to her that she did not know it involved abuse. The DON stated: "We thought it was a clinical issue, like that the aides weren't repositioning correctly. The DON was asked why she felt Confidential Witness A would have felt the urgency to report a clinical issue. The DON stated: "I don't know. She was a new CNA." The DON was asked if she had known the reason for Confidential Witness A to have quit the same day immediately after her shift ended and stated: "I don't know, she was odd."

During an interview, NCNA E was queried in regard to the alleged incident of Resident 701 having a pillow placed over their head by CNA F. NCNA E explained that the resident was combative and that she had helped hold them down during care and that the resident was not turned but the pillow had fell on Resident 701's head. NCNA E further stated: "She (CNA F) was doing the best she could."

During an interview on February 1, 2021, Resident 701 was asked if they recalled an incident with a pillow being placed over their head a few weeks ago. Resident 701 stated: "Of course." Resident 701 was asked if they remembered who did it. The resident just grinned and did not make eye contact. Resident 701 was asked if they ever call the staff members' names, the resident responded: "Yes" and then repeated racial slurs. The resident was asked if staff had called them names and stated: "Yes" and then stated: "They call me [racial] slur." Resident 701 was hesitant during the interview and unable to describe any details of specific incidents.

Name of Nursing Home	Medilodge of Sterling Heights
Provider ID	235263
Address [RUCA Code: 1] [% County Population Rural: 3.21]	14151 E 15 Mile Rd, Sterling Heights, Michigan, 48312
Day Investigation Completed	February 1, 2021
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm ***Minimal Harm or Potential for Actual Harm

A CNA Witnessed a CNA Yelling "*[OBSCENITY] you! [OBSCENITY] you! [OBSCENITY] you!*" in the Face of a Man with Severe Cognitive Impairment Because He Had a Bowel Movement at Shift Change. Fearing Retaliation from the CNA Perpetrator, the CNA Was Not Comfortable Reporting the Abuse While the CNA Perpetrator Was in the Building. The CNA Reported It the Following Day

The nursing home failed to ensure Resident 27 was not subjected to verbal and physical abuse by staff. This resulted in harm to Resident 27 when he experienced verbal and physical abuse by a staff member during cares.

The nursing home failed to ensure physical and verbal abuse was reported to the Administrator and the State Survey Agency within 2 hours. These deficient practices were true for Resident 27 whose abuse investigation was reviewed. This deficient practice placed residents at risk of undetected abuse/neglect.

Resident 27's Cognitive Function: **Severe cognitive impairment** (based on Quarterly MDS assessment).

Activities of Daily Living. The resident required extensive assistance of two staff members with transfers, bed mobility, and toileting. The Care Plan documented staff were to utilize a mechanical lift for transfers.

An I&A Report (dated December 16, 2018) documented Resident 27 sustained two skin tears of unknown source, one on top of his right hand between the 1st and 2nd fingers by the knuckles and one at the base of his thumb. The report documented Resident 27 was self-propelling his wheelchair in the lobby and his hand was bleeding. The report documented Resident 27 had confusion and impaired memory and no witnesses were found.

The Interdisciplinary Team (IDT) follow-up note for the December 16, 2018 skin tears, dated December 26, 2018 (10 days later), documented Resident 27 was transferred incorrectly and sustained two skin tears. The report documented Resident 27 was transferred by a CNA lifting him up and placing him in his wheelchair. Resident 27 was not transferred by the mechanical lift like he should have been. The follow-up note documented abuse was substantiated, and CNA 1's employment was terminated.

An I&A Report dated December 20, 2018 documented: It was discovered that a staff member has caused multiple skin tears to various residents (Resident 27 included) from being rough during cares. CNA 2 witnessed CNA 1 yelling "[OBSCENITY] you! [OBSCENITY] you! [OBSCENITY] you!" in Resident 27's face because he had a bowel movement at the change of shift. The report also documented Resident 27 sustained a skin tear to his front left forearm. The report did not document the size or extent of the skin tear. The report documented Resident 27 was unable to recall the incident.

On January 10, 2019, the Acting Director of Nursing Services (DNS) stated that CNA 2 witnessed CNA 1 verbally abuse Resident 27 on December 20, 2018, but CNA 2 did not report the incident to the Acting DNS or the Administrator Designee until December 21, 2018. The Acting DNS stated **CNA 2 was afraid of CNA 1 and did not want to report him for fear of retaliation by CNA 1**. The Acting DNS stated although CNA 2 did not report the abuse until December 21, 2018, he backed dated the I&A report to December 20, 2018 to reflect the date the abuse occurred.

The IDT follow-up note for the December 20, 2018 verbal abuse and skin tear to the left forearm incident, dated December 20, 2018, also included documentation of Resident 27's two skin tears which were identified on December 16, 2018 and it was discovered that the cause of the skin tears were from CNA 1 handling Resident 27 roughly. The follow up documented CNA 1 was also accused of swearing a profanity in Resident 27's face and transferred him incorrectly and sustained two skin tears on December 16, 2018. The report documented Resident 27 was transferred by CNA 1 by lifting him up and placing him in his wheelchair. Resident 27 was not lifted by the mechanical lift like he should have been. The report documented CNA 1's employment was terminated for verbal and physical abuse.

On January 7, 2019, the Acting DNS and the Administrator Designee stated **CNA 2 was not comfortable reporting the witnessed abuse to the charge nurse at the time of the December 20, 2018 incident while CNA 1 was in the building**.

CNA 2 observed CNA 1 verbally abuse Resident 27 on December 20, 2018, however, did not report the abuse as required by the nursing home's Abuse Policy. The State Survey Agency Reporting Portal was reviewed. The information submitted by the nursing home through the portal documented the abuse incident occurred on December 20, 2018 at 8:00 PM and the nursing home reported the abuse through the portal on December 21, 2018 at 5:10 PM. The December 20, 2018 verbal and physical abuse of Resident 27 was not reported to the Administrator and State Survey Agency within 2 hours of the incident.

The nursing home's Abuse Policy stated, among others: "**Staff members were instructed to report all incidents of abuse immediately to the Executive Director, without fear of retribution**."

Name of Nursing Home	Ivy Court
Provider ID	135053
Address [RUCA Code: 1] [% County Population Rural: 23.51]	2200 Ironwood Place, Coeur D'Alene, Idaho, 83814
Day Investigation Completed	November 9, 2018
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm

RN Witnessed LVN Physically Abuse a Man with Severe Cognitive Impairment (the LVN Put Her/His Knee Over His Abdomen) but Due to Fear of LVN's Retaliation, Did Not Report It Until the Next Day

The nursing home failed to ensure Resident 2 was free from abuse. LVN 1's inappropriate response to resolve an altercation between Resident 2 and Resident 4 caused several skin tears to Resident 2's bilateral arm.

Resident 2 was **severely cognitively impaired** (based on MDS assessment).

Activities of Daily Living. Not reported.

Resident 2's Care Plan showed a care plan problem dated July 22, 2019, with a revision date of October 17, 2019, addressing mood and behavioral problems. The approaches included, if the resident refused or was resistive, leave and try again later, and provide calm, comfortable, and safe environment.

During an interview, RNA 1 stated that on December 17, 2019, in the morning, she heard CNA 1 call for help in Resident 2's bedroom. After RNA 1entered the bedroom, CNA 1 took Resident C out of the bedroom for a shower, and Resident 4 was walking back and forth around his own bed. RNA 1 saw Resident 2 was standing by his bed. LVN 1 grabbed both of Resident 2's forearms and pushed him down to his bed. Then Resident 2 started kicking with his legs. LVN 1 put her knee on Resident 2's abdomen on his bed until Resident 2 stopped kicking. Resident 2 then yelled at LVN 1 that he never wanted to see LVN 1 in his life. When LVN 1 let go of Resident 2, RNA 1 saw blood on LVN 1's hands, and the skin of Resident 2's forearms was torn and bleeding. RNA 1 stated LVN 1 did not ask her to help. LVN 2 came to treat Resident 2's skin tear wounds.

RNA 1 stated she was scared and shaking when she came out of the room. **RNA 1 stated she did not report the incident on December 17, 2019, because she was scared of being retaliated against by LVN 1**. RNA 1 stated on December 18, 2019, in the morning, RNA 1 talked about the incident to her friend who told her she had to report it, so she (RNA 1) reported the incident to LVN 3.

During a telephone interview, CNA 1 stated on December 17, 2019 around 7:30 AM, she was getting ready for a shower. Resident 4 wanted to go to the restroom and she directed Resident 4 to go to the restroom inside his room. Resident 2 asked CNA 1 to get Resident 4 out of his room. CNA 1 explained to Resident 2 that Resident 4 lived in his room. While CNA 1 turned around, she heard something drop. Then CNA 1 saw a jar of water was thrown on Resident 4's bed. Resident 4 did not get injured. CNA 1 pushed the call light to get help in the room so she could leave for Resident C's shower schedule. CNA 1 stated she left when LVN 1 and RNA 1 came in the room. CNA 1 stated both Residents 2 and 4 were calm when she left.

Review of Resident 2's Change in Condition Documentation dated December 17, 2019, documented by LVN 1, showed on December 17, 2019, LVN 1 was called to Resident 2's room for help. Upon entering the room, LVN 1 saw Resident 2 was agitated and combative towards staff. LVN 1's attempt to redirect Resident 2 was unsuccessful. Then a male staff member came in to assist calming Resident 2 down. LVN 1 documented she noted several skin tears to Resident 2's upper extremities.

During a telephone interview, **the Assistant Activity Director** stated that on December 17, 2019, in the morning, the Director of Social Services asked him to help in Resident 2's room. The Assistant Activity Director **saw** LVN 1 was holding Resident 2's forearm and blood was dripping from Resident 2's forearms. **He saw RNA 1 standing at the foot of Resident 2's bed and seemed shocked**. The Assistant Activity Director stated LVN 1 left the room when LVN 2 came in to treat Resident 2's skin tear wounds.

Name of Nursing Home	Extended Care Hospital of Westminster
Provider ID	555211
Address [RUCA Code: 1] [% County Population Rural: 0.25]	206 Hospital Circle, Westminster, California, 92683
Day Investigation Completed	February 11, 2020
Type of Deficiency Issued	F600
Scope Severity Level	Missing Data

A CNA Witnessed but Due to Fear of Retaliation Delayed Reporting RN Twice Slap the Face of a Woman with Cognitive Impairment. She Reported "*staff's actions in the past and her name got out there for reporting them and staff retaliated against her for speaking up for the resident's safety*"

The nursing home failed to prevent abuse of Resident 1. This deficient practice resulted in a staff member yelling at Resident 1, slapping her in the face and grabbing her jaw. Staff report Resident 1 cried and was upset by the event.

The nursing home failed to implement the abuse policy to prevent abuse, thoroughly investigate the incident, provide required staff training, and analyzing the occurrence to determine why abuse of Resident 1 occurred. This deficient practice resulted in Resident 1 being verbally and physically abused and the potential for other residents to be abused after the nursing home failed to identify suspicion of a crime and report it within 24 hours to local law enforcement, the lack of complete investigation, and staff education and training required to properly care for residents with behaviors.

The nursing home failed to report the suspicion of a crime to local law enforcement within 24 hours of forming the suspicion for Resident 1. The deficient practice resulted in a staff member reporting a witnessed event of abuse (yelling at Resident 1, slapping her in the face, and grabbing her jaw) and the nursing home did not notify local law enforcement for 4 days.

The nursing home failed to thoroughly investigate an allegation of abuse for Resident 1. The deficient practice resulted in an incomplete investigation of abuse and the circumstances surrounding and the potential for other events to go under reported and investigated.

The nursing home failed to provide abuse, neglect, exploitation, dementia management and resident abuse prevention training to staff members. This deficient practice resulted in the lack of appropriate education and validated skills through evaluation for staff members to appropriately manage residents with dementia and behavioral symptoms, placing residents at risk for abuse and staff at risk of injury when attempting to manager behaviors.

Cognitive Function: Resident 1 had **moderate cognitive impairment** (BIMS score of 8 out of 15). The resident had a guardian who made medical decisions.

The resident did not reside at the nursing home during the onsite survey.

During a telephone interview on January 27, 2021, CNA D stated that on the morning of December 18, 2020 she was working **on the isolation unit** where Resident 1 resided. CNA D states she was told in report that I need to keep an eye on Resident 1 because she was wandering and rummaging in other residents' rooms. CNA D stated that Resident 1 was wandering in and out of other resident rooms and thinking her belongings were in other peoples' rooms. CNA D stated that Resident 1 had also gotten into the personal protective equipment (PPE) stands outside of the resident rooms in the hallway and needed constant redirection that morning. CNA D stated **at approximately 8:45 AM** she saw Resident 1 enter the room next to hers and talk with that male resident. She could see RN B go into the room behind Resident 1, take ahold of Resident 1 by her shoulders (one hand on each) and yelled at Resident 1 telling her things like she can't go into that room and your things aren't in here. CNA D saw RN B back Resident 1 out of the

room with her hands still on Resident 1's shoulders and when they got back into the hall near Resident 1's doorway, Resident 1 turned towards RN B and started calling her a [OBSCENITY].

Resident 1 and RN B were face to face and both their hands and voices went up. Resident 1 began to hit RN B in the face and then RN B with her left hand struck Resident 1 in the face twice while RN B held Resident 1's left hand down with her (RN B's) right hand. CNA D then saw RN B grasp Resident 1 on the jaw with both of her hands and say with her teeth greeted: "You are not going to treat me that way." CNA D stated that RN B quickly released her hands as CNA D slipped her arm around Resident 1's waist and redirected her into her room and asked for help to fold some laundry. CNA D stated at that point Resident 1 yelled out: "She kicked me." CNA D stated that she did not witness any kicking. When asked if staff should approach Resident 1 from behind with a raised voice, CNA D stated: "No, she has a history of combative behaviors with staff." When asked if Resident 1 had backed RN B up against the wall, CNA D stated: "No, it escalated in the doorway of Resident 1's room." When asked if RN B could have fled and gotten away from Resident 1, CNA D stated: "Yes, she could have let go of her hand and backed away." CNA D stated that she stayed with Resident 1 for a while in her room to console and calm her down. When asked when she reported the incident, **CNA D stated she informed the DON at approximately 10:45 AM**. CNA D stated that she received counseling for not immediately reporting the abuse. When asked why she waited to report the incident, **CNA D stated that she was initially hesitant to report things to the administration for fear of retaliation**. CNA D stated that **she had reported a staff member actions in the past and somehow her name got out there for reporting them and felt that the staff had retaliated against her for speaking up for the resident's safety**.

During an interview on January 26, 2021, Physical Therapist (PT) C stated that she witnessed part of the incident that occurred on December 18, 2020. PT C stated that RN B's approach (coming from behind Resident 1 and placing her hands on the back of the residents' shoulders) "startled" the resident. PT C stated that she saw things going to get heated between the two and that she heard Resident 1 yelling at RN B and RN B yelling back at Resident 1. PT C stated that she didn't see the whole encounter but said that she did see RN B put both of her hands on both sides of Resident 1's face by her jaw. When asked if she immediately reported the observation of RN B yelling at Resident 1 and placing hands on Resident 1's face. PT C stated: "No, I didn't but I was asked about it later." When asked if Resident 1 had backed RN B against the wall, PT C said: "No." When asked if RN B could have fled or gotten away from Resident 1, PT C said: "Yes, oh yes she could have gotten away."

During an interview on January 27, 2021, Nurse Q was asked if she had spoken with CNA D after the incident. Nurse Q stated: "Yes, in the breakroom a couple of hours later." CNA D told Nurse Q that the incident did not happen the way that RN B had told Nurse Q. Nurse Q stated that CNA D reported to her that she saw RN B slap Resident 1 in the face and grab her chin with her hands. **Nurse Q stated: "I told her she had to report this ASAP." CNA D told Nurse Q that she was afraid to because she felt retaliated against after she had reported something previously**. When asked if she had immediately reported that she heard RN B yelling and screaming at Resident 1, Nurse Q stated: "No."

During an interview on January 27 and January 28, 2021, RN B stated that she was assigned to work the Isolation Unit on December 18, 2020. The nursing home places new residents on the unit for 14 days to monitor for signs and symptoms of COVID-19. RN B reported she had been caring for Resident 1 for the past 3 days. RN B stated that over the past 3 days Resident 1 was confused and would wander in and out of other resident rooms, rummaged through their things, and required constant redirection from staff. RN B stated that Resident 1 was difficult to redirect and engage in other activities. RN B stated the administration knew about this and was trying to seek more appropriate placement. RN B stated that this behavior put Resident 1 and other residents on the unit at risk for the potential spread of COVID-19 and she had received many complaints from other residents about this. RN B stated: "They were very upset about this." RN B stated that they did not like her rummaging through their belongings either. RN B stated: "It was stressful."

RN B stated that Resident 1 had entered a male resident's room next to hers, so she followed her, placed both of her hands on the back of Resident 1 shoulders and walked her back out of the room. RN B stated she told Resident 1 that she was not allowed in other people's rooms and Resident responded by turning around (now face to face), yelled at her and struck her in the face. RN B stated she was wearing a mask and a face shield but still sustained a split lip. RN B stated that Resident 1 continued to hit her with a closed fist. RN B stated she put up her right hand as Resident 1 continued to lunge toward her and her face connected with her hand as Resident 1 continued to push toward her. RN B stated that with her other hand she held Resident 1's closed fist down. RN B stated she removed her hand away from Resident 1's face as CNA D arrived and redirected Resident 1 into her room. RN B stated at that point she had no further contact with Resident 1, remained in the hall for a moment to speak with Nurse Q when she approached and then returned to the desk to chart Resident 1's behavioral incident.

When asked if she reported the incident to anyone, RN B stated: "No." When asked if an employee sustained an injury at work, is there a form to complete. RN B stated "There is" but she did not complete one for her split lip. When asked if RN B was in a position to back away from Resident 1's reach, RN B stated: "She had me backed into the wall and could not move away from her. CNA D came and redirected her away from me."

When asked why she was terminated from the nursing home, RN B stated: "Abuse. I was devastated." RN B stated: "I've been a nurse for [Number] years." I feel like they (the nursing home) let me down and wasn't supportive at all. RN B added: "It was frustrating with her (Resident 1) continued behavior, moving items, furniture and trying to leave." When asked how the staff responded to that, RN B stated that staff did the best they could to redirect her. When asked if the nursing home increased supervision for Resident 1, RN B stated: "If you mean one to one, no." RN B stated that the nursing home was even going to staff reduce (send someone home) that day. RN B stated that she was removed from shift at approximately 10:45 AM on December 18, 2020 that day and sent home pending investigation.

According to Employee Disciplinary Record dated December 23, 2020, RN B was terminated for abuse of a resident. The record reflected: "[Name of RN B] was observed making open handed contact with a resident's face. Also, observed grasping a resident's face with her hand. Investigation was initiated. The

incident was reported to the State of Michigan and local police. [Name of RN B] was informed that this would be reported to the Board of Nursing."

During an interview on January 27, 2021, the Director of Nursing agreed that RN B did not follow appropriate dementia training when she was heard raising her voice to Resident 1, approached her from behind, placed her arms on Resident 1's shoulders and physically removed her from the other residents room. The Administrator stated that she was away on leave during the time of the incident.

Review of the police report revealed that the nursing home reported the incident to the police department on December 22, 2020, which is 4 days after the incident occurred on December 18, 2020.

Name of Nursing Home	Laurels of Carson City
Provider ID	235636
Address [RUCA Code: 10] [% County Population Rural: 84.59]	620 North Second Street, Carson City, Michigan, 48811
Day Investigation Completed	January 29, 2021
Type of Deficiency Issued	*F600 **F607 ***F608 ****F610 *****F943
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm ****Minimal Harm or Potential for Actual Harm ***** Minimal Harm or Potential for Actual Harm

Several Staff Members Requested to Remain Anonymous When Speaking with State Surveyor About Low Staffing Levels and Their Inability to Adequately Care for Residents

The nursing home failed to follow their policy and procedure for medication administration and investigate medication error for Resident 1.

The nursing home failed to effectively provide an environment to address patient care needs for up to 114 additional residents, resulting in the likelihood that residents would experience anger and distrust towards staff, the potential for patient care needs and issues with pain to be delayed and/or unmet.

Cognitive Function. Resident 1 was **cognitively intact** (BIMS score of 15 out of 15).

Activities of Daily Living. Resident 1 was described as "two person assist and totally dependent on staff for all Activities of Daily Living."

During an interview on August 4, 2020, Resident 1 stated that on July 27, 2020, she was to receive multiple medications before bedtime between 7:00 AM and 9:00 PM. Resident 1 stated she did not receive her medications as scheduled. At 12:30 AM (past midnight) on July 28, 2020, an Agency Nurse (AN) I woke her to administer her the 8:00 PM medications. AN I was asked to identify the medications and she was unable to do so, according to Resident 1. Resident 1 stated she complained to the Director of Nursing (DON) B who responded to her complaint by saying: "Haven't you ever made a mistake?" Resident 1 said she responded she (Resident 1) had never made a mistake that involved other people's lives. Resident 1 said she was frustrated with the nursing home management because they never fix any of her concerns but sweep them under the rug.

On July 5, 2020, a record review of the nursing home investigation of the med pass error was done. According to the information in the document, the nurse assigned to care for Resident 1 was not able to give Resident 1 her medications as ordered by the physician due to numerous interruptions (other residents required care, doctor's orders required clarifying, etc.) so AN I was asked to assist with medication pass. When AN I attempted to give Resident 1 her medications, Resident 1 became irate and was yelling at AN I. According to the investigation, Resident 1 declined her medications. Both nurses were educated via phone about administering medications timely, notifying the resident's physician when medications were late and to seek assistance from peers as needed in a timely fashion.

During the survey process from August 4, 2020 to August 7, 2020, multiple nursing and facility staff were interviewed onsite in person and by phone. **Statements from several staff members who desired to remain anonymous for fear of retaliation**:

Anonymous Staff (AS N) revealed that "when nursing staff was low, I don't think it is safe at all."

During periods of short staffing, Anonymous Staff O revealed residents would complain of needing assistance, it was not an ideal situation, made them feel bad, and that: "It is not possible the resident is going to get the care that they need."

Per Anonymous Staff P, "when staffing was short, lots of residents would complain of their medications being late. Residents would be in pain and had to wait for nursing staff to return to administer their pain medication, when working multiple units."

Nursing staff also complained of working short, which made it very hard on staff, causing them to feel very stressed while trying to care for the residents.

Several random staffers revealed there would be times when only one nurse and CNA were working on a hall. When the nurse would leave the given unit to go to another unit (they had to work on), it would be left up to the CNA to care for no less than 20 residents by themselves consisting of fall risk residents.

It was revealed that those residents needing 1:1 observation / patient care were not able to receive it.

Name of Nursing Home	Regency at Whitmore Lake
Provider ID	235545
Address [RUCA Code: 1.1] [% county pop Rural: 17.19]	8633 N Main St, Whitmore Lake, Michigan, 48189
Day Investigation Completed	August 7, 2020
Type of Deficiency Issued	F684
Scope Severity Level	Minimal Harm or Potential for Actual Harm

"I am afraid to be identified and say anything, because the Board will retaliate"

Based on interview and record review, the Governing Body / Board of Directors acted with disregard to the well-being of residents of the nursing home by not being effective, taking adequate active and engaged action when the nursing home was in a staffing shortage. This impacted all nursing home residents and contributed to multiple clinical failures at the harm level. Key administrative function positions were vacant and/or staffed by interim personnel which included: Administrator, Director of Nursing Services, Assistant Director of Nursing Services, and Infection Prevention and Control Nurse.

Cognitive Function. Not Reported. Activities of Daily Living. Not Reported.

Staff interviews were conducted which showed **staff were afraid** had distrust **and had job insecurity as a result of the outcome of interactions with a Board Member of the Board of Directors**. These interactions with the Board Member and associated perceptions contributed to staff turnover, lack of continuity of care and failures at Immediate Jeopardy and harm level citations and placed all residents at risk of unsafe environment and unmet needs.

Staff interviews were conducted on July 13, 2022, July 14, 2022, July 15, 2022, July 18, 2022, July 19, 2022, and July 20, 2022, during normal survey hours 8:00 AM to 5:00 PM and showed **staff, who wished to remain anonymous**, had concerns regarding the function of the Board of Directors:

"They are impending the safety and quality of care of the residents."

"The Board doesn't take any suggestions we have into consideration, and it is impacting the safety of the residents."

"I have worked here for many years, and the Board doesn't recognize it's negatively impacting the staff. People are retiring early and quitting."

"I am afraid to be identified and say anything, because the Board will retaliate. We love our residents and the level of stress this is creating is enormous."

"We are kept in the dark and are afraid of the future."

"I cannot work with a person like that" (referring to a specific Board Member).

During an interview on July 26, 2022, Consultant to the Board (Staff QQ) stated that the nursing home's "Board of Directors had not been informed enough to know what was occurring at the nursing home. They are not aware of what is happening in this nursing home for the past [Number] years."

During an interview on July 27, 2022, Collateral Contact (CC) YY stated: "Normally the Board of Directors met on-campus three times per year in August, November, and April. February meetings were held if needed. The Board had been meeting via video conferencing recently due to an issue that had surfaced over a newly assigned Administrator at the nursing home."

CC YY added: “The implementation of policy and procedure was not something the Board assisted the nursing home with and that the [designated Board Member] gets the majority of the information and passes it on to the Board and that although the Board of Directors was aware there has been a lot of turnover, the specifics were not really discussed. I think it would be a good thing for the Board of Directors to be more involved in facility matters.”

Name of Nursing Home	Washington Odd Fellows Home
Provider ID	505421
Address [RUCA Code: 1] [% County Population Rural: 20.25]	534 Boyer Avenue, Walla Walla, Washington State, 99362
Day Investigation Completed	July 27, 2022
Type of Deficiency Issued	F837
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A Recreation Worker Intentionally Clapped and Spoke Loudly to a Man with a "*really bad PTSD*" who is Known to be "*Very Sensitive*" to Noise / Three Recreation Workers Were Afraid of His Retaliation

The nursing home failed to prevent verbal abuse of Resident 64 and Resident 70. If the nursing home is not protecting residents from abuse, then abuse is likely to continue to occur, which could result in an increase of depression, isolation, and emotional distress.

The nursing home also failed to provide services for Resident 83. This deficient practice likely resulted in Resident 83 experiencing a chocking incident without appropriate intervention and his death. The nursing home did not identify that Resident 83 likely swallowed his partial dentures after repeatedly complaining that there was a rock in his throat, when providing treatment and seeking hospital evaluation which likely resulted in his death.

The nursing home failed to thoroughly investigate allegations of abuse and prevent further potential abuse while the investigation was in progress for Resident 64 and Resident 70. If the nursing home is not conducting thorough abuse investigations and ensuring that staff identified in the allegations are not removed from resident interaction, the residents are likely to continue to be at risk of abuse.

Due to relevance to staff fear or retaliation and scope considerations, this summary only focuses on the violation related to the verbal abuse of Resident 64 (not on Resident 83 and Resident 70).

Resident 64 was reported by CNA 6 to be "more alert than some people here [locked unit] but he is **very confused** and has **dementia**." Recreation Worker 2 also stated that the resident has dementia and a "**really bad Post Traumatic Stress Disorder**" (**PTSD**). CNA 6 added that if Resident 64 doesn't like something that is happening, he will voice it right away. The resident can voice it when he is upset by something.

Cognitive Function. Resident 64 was **cognitively impaired** (he had a BIMS score of 6 out of 15, suggesting he was **severely cognitively impaired** and another BIMS score of 12 out of 15 suggesting he was **moderately cognitively impaired**).

Activities of Daily Living. Not Reported.

During an interview, Resident 64 stated "He is very sensitive to loud noises and asked if I [state Surveyor] could speak softly to him." In addition, Resident 64 stated that he did not like to be called Sir.

Record review of the investigative report dated [DATE] revealed: "It was known by staff that Resident 64 does not like to be called Sir."

Record review of Incident Report dated [DATE] revealed: "Resident 64 is very sensitive to sound and always requests that we speak very quietly to him. When Resident 64 asked Recreation Worker (RW) 1 to talk more quietly, RW 1 responded: "I can talk like this or I CAN TALK LIKE THIS!" When he uttered this sentence, RW 1 raised his voice to an almost shouting level. I was shocked into tears. Resident 64 has repeatedly asked all of us to speak softly. It was outrageous that RW 1 would act with such disregard to a very vulnerable resident."

Conclusion of Incident Report: "There is credible evidence to support the allegation of verbal abuse as reported. RW 1 didn't deny making the statement only stated: "Does not recall making the statement." Discipline action will be pursued per State of New Mexico Personnel Rules. The Administrator signed and agreed with the conclusion."

Record review of Resident Incident Report dated [DATE] revealed: "RW 1 went into Resident 64's room I [this writer – RW 3] proceeded to walk in there [into Resident 64's room] and Resident 64 asked me to "Take him out of my room" after talking trying to figure out what happened, RW 1 started clapping and talking loud and Resident 64 stated that RW 1 knows that he [RW 1] being loud. RW 1 proceeded to call him 'Sir.' [Name of Resident 64] fell to bed upset. Incident report further stated: **All three female staff members in Recreation [Department] expressed fear of retaliation from RW 1**."

During a phone interview, Activities Technician 1 stated: "Resident 64 cannot take loud noises and you cannot talk loudly to him." Regarding the [DATE] incident, the Activities Technician stated: "I was sitting next to Resident 64 and RW 1 was standing right above him [Resident 64] and shouted: "Am I talking too loud for you [Name of Resident 64]?" The Activities Technician confirmed that RW 1 was speaking loudly towards Resident 64 on purpose to upset Resident 64.

During a phone interview, RW 2 stated regarding the incident on [DATE]: "[Name of RW 1] went in there [Resident 64's room] clapping his hands and yelling. He [RW 1] does things intentionally." RW 2 confirmed "RW 1 was clapping his hands and yelling at Resident 64 intentionally to upset Resident 64."

During an interview with RW 3, she stated: "He's [RW 1] very loud and very hard to work with. I went to the room [Resident 64's room] to make sure everything is ok. When I walked in, [Name of RW 1] was being loud and [name of Resident 64] told me to get him out of his room. [Name of RW 1] started clapping very loudly and [name of Resident 64] does not like loud noises. [Name of Resident 64] looked visibly upset. RW 3 confirmed that the interaction between RW 1 and Resident 64 was not joking and Resident 64 was visibly upset with RW 1."

Name of Nursing Home	New Mexico State Veterans Home
Provider ID	325092
Address [RUCA Code: 7] [% County Population Rural: 33.37]	992 South Broadway, Truth or Consequence, New Mexico, 87901
Day Investigation Completed	December 18, 2019
Type of Deficiency Issued	*F600 **F610
Scope Severity Level	*Immediate Jeopardy (partially due to the deadly choking violation) **Actual Harm

Director of Nursing Asked Staff to Change Documentation of Witnessed Resident-to-Resident Sexual Abuse (Both with Severe Cognitive Impairment) / "*Staff are afraid of retaliation and losing their jobs*"

The nursing home did not ensure Resident 16 is free from sexual abuse from other residents or the likelihood of future abuse occurring. Resident 9 sexually abused Resident 16 in the dining room. Resident 9's Care Plan: "Resident 9 is not to be allowed to be with female residents unattended." The nursing home failed to prevent future sexual abuse of Resident 16 from occurring. Resident 16's Care Plan was not updated with abuse interventions to protect Resident 16 and other residents from further abuse.

The nursing home did not ensure reasonable suspicion of a crime was reported to law enforcement within 24 hours or the crime occurring to Resident 16. Resident 16 was being inappropriately touched by Resident 9 on March 11, 2021. There is no evidence the police were notified when staff had knowledge of sexual abuse occurring.

The nursing home did not ensure that Resident 9 alleged violations involving abuse were reported to the State Survey Agency. Resident 9 was sexually inappropriate to Resident 16 in the dining room of the nursing home on March 11, 2021 and the nursing home did not ensure the State Survey and Certification Agency was notified.

The nursing home did not have evidence that Resident 9 alleged violations of abuse were thoroughly investigated. Resident 9 was sexually inappropriate with Resident 16 in the dining room of the nursing home. Incident witnessed by Occupational Therapy Assistant (OTA) F and reported to RN C. The nursing home did not complete an investigation of this incident.

The administration was not promoting the highest practicable mental and psychosocial well-being of residents by failing to develop a plan to monitor the whereabouts of a resident with a history of inappropriate sexual behaviors (Resident 9) and by **intimidating staff to limit and suppress the information shared with State Agency Staff**.

Resident 9 has a history of inappropriate sexual behaviors. This was known by the nursing home. The administration did not monitor the whereabouts to maintain well-being of other residents. **The Director of Nursing asked staff members to lie and omit information from the State Survey Team**.

Resident 9 was reported to have **dementia** (based on information included in his Care Plan).

Cognitive Function. Resident 9 had **severe cognitive impairment** (BIMS score of 5 out of 15).

Resident 16 was reported to have **Alzheimer's disease** (based on information included in her Care Plan).

Cognitive function. Resident 16 had **severe cognitive impairment** (BIMS score of 1 out of 15).

Activities of Daily Living. Not Reported for both residents.

On March 22, 2021, state Surveyor interviewed CNA G. The Surveyor asked if Resident 9 had inappropriate interactions with staff or residents. CNA G stated: "No, not that I know of." The Surveyor asked if the CNA heard about any inappropriate behaviors of Resident 9 toward residents or staff. CNA G stated: "No." The Surveyor asked what type of behaviors Resident 9 exhibits are monitored.

CNA G stated there was nothing really, except staff has to make sure he is alone and supervised due to history of behaviors. The Surveyor asked if these behaviors occurred in the facility or elsewhere. CNA G stated: "I am not sure." Surveyor asked if Resident 9 is allowed to be in the same room with other residents. CNA G stated "He can be with other residents, but he has to be supervised." The Surveyor asked if Resident 9 has displayed any odd behaviors. CNA G stated: "No."

On March 23, 2021, CNA G returned to the nursing home to speak with the Surveyor and clarify information given in interview the day prior. CNA G stated: "I was told to lie about [Resident 9] by Director of Nursing" (DON). CNA G added: "I wasn't here that day but heard that he touched another resident. When he is out of his room, he is 1:1. It depends – when asked if there is enough staff here to accomplish 1:1. The Surveyor asked if CNA G is aware of any times Resident 9 is not monitored 1:1 when he should be. CNA G stated she is not aware of any times. The Surveyor asked if CNA G is aware of any incident of inappropriate behavior by Resident 9 prior to or after the incident in question. CNA G stated she was not aware of any. The Surveyor asked if the DON asked her to lie. CNA G stated the DON asked her to lie. The Surveyor asked if the DON threatened her. CNA G stated: "No." CNA G was in tears while talking.

On March 22, 2021, at 4:03 PM, the Surveyor interviewed RN D. The Surveyor asked if Resident 9 has inappropriate behaviors. RN D stated he has had inappropriate behaviors. RN D stated Resident 9 has touched staff, does not know if he has touched residents inappropriately. Surveyor asked what type of touch with the staff does Resident 9 exhibit. RN D stated Resident 9 "will grab female breasts."

On March 22, 2021, at 4:48 PM, RN D returned to the conference room and handed the Surveyor a note. The note stated: "I'm sorry. I withheld information. My [DON] asked me to as I did not witness the incident. [Resident 9] exposed and touched another resident. The resident was [Resident 16]."

On March 23, 2021, at 11:48 AM, the **Surveyor received a phone call from RN D**. RN D told Surveyor that she didn't lie but was untruthful in her interview the day prior. RN D stated **her boss DON, prior to meeting Surveyor yesterday, had her change her documentation in the chart on Resident 9**. RN D stated **the DON asked a CNA to document that Resident 16 raises her shirt up all the time**. **The CNA refused to change the documentation**. **Surveyor asked who the CNA was**. RN D stated **the CNA needs to come forth on their own**. RN D stated: "**Staff are afraid of retaliation and losing their jobs**." RN D stated Resident 16 never has such behavior. RN D stated that the wording she changed in the chart had said: "Resident was sexually inappropriate behaviors towards another female resident in the dining room." RN D said the wording was changed to: "Resident was sexually inappropriate in the dining room."

On March 22, 2021, at 4:56 PM, the Surveyor interviewed CNA H. The Surveyor asked CNA H if Resident 9 exhibited any inappropriate behaviors towards other residents or staff. CNA H stated: "No." The Surveyor asked if CNA H heard of any inappropriate behaviors through other staff. CNA H stated: "No." The Surveyor asked if Resident 9 ever tried to grab her inappropriately and CNA H stated: "No." The Surveyor asked CNA H if she is discouraged to report any incident. CNA H stated: "No."

On March 23, 2021, at 12:16 PM, the Surveyor had a phone interview with CNA H. CNA H stated before she walked in to meet with the Surveyor on March 22, 2021, the DON told her to only state general

behaviors. CNA H stated when she started working at the nursing home, the woman training her told her Resident 9 had sexual behaviors. CNA H has never seen anything but wanted to correct her statement.

On March 23, 2021, at 10:45 AM, the Surveyor interviewed Occupational Therapy Assistant (OTA) F. The Surveyor asked if OTA F ever witnessed any inappropriate behaviors of Resident 9. OTA F stated: "Yes, I have." OTA F stated she witnessed Resident 9 lifting up Resident 16's shirt and touching her breast on March 11, 2021. The OTA F stated Resident 16 was making uncomfortable sounds, such as: "Ah, Ah." OTA F stated she separated the residents and reported to RN C. OTA F stated she took Resident 9 to his room and RN C assessed Resident 16.

On March 24, 2021, at 10:00 AM, the Surveyor interviewed the DON. The Surveyor asked the DON if she was aware of any behavioral incidents of Resident 9 with other residents or staff. The DON stated she was aware of both. The Surveyor asked what behaviors were you aware of. The DON stated sexual inappropriate behaviors like touching. The DON stated if a CNA was with a resident, he would touch their butt or reach across and touch their breasts. The Surveyor asked about any behaviors with other residents. The DON stated there was an incident where Resident 9 touched another female resident's breast. Resident 9 went around by Resident 16 and was seen by therapy with his hand on her breast and her shirt was lifted up. The DON stated the staff moved Resident 9 and made sure Resident 16 was safe. The DON stated the Care Plan was updated for 1:1 supervision of Resident 9 after the incident.

The Surveyor asked if the DON knew of Resident 9's history of sexual behaviors. The DON stated: "Yes." The Surveyor stated such documentation should be part of the medical record of the resident. **The Surveyor stated to the DON that during staff interviews, it was brought forth by the staff that the DON told staff to lie and to state general behaviors of residents when they met with the surveyors**. The DON denied this. The DON stated: "If I were to lie, I wasn't trying to hide it." The Surveyor asked the DON about having an RN change documentation of Resident 9 to remove the words "another female resident" from the sentence "to sexually inappropriate with another resident." The DON stated she was trying to get the RN to document only what she saw or heard and that she did not ask her to change the documentation. The DON stated: "If I wanted documentation changed, I would have changed it myself." The Surveyor asked why the incident was not reported by the nursing home. The DON stated: "According to the flowsheet, it states that those who don't know what they are doing, you don't have to report it."

The Surveyor told the DON the flowsheet states that if the victim can't give a response, consider whether a reasonable person would have experienced psychological distress (and if so, it is reportable). The DON stated her understanding was if the resident didn't know what they were doing, it wasn't reportable.

During an interview on March 24, 2021, the Surveyor asked the Administrator why the nursing home did not report the incident. The Administrator stated the flowsheet indicated it wasn't reportable. The Administrator's understanding is that a crime didn't occur since Resident 9 has dementia.

Name of Nursing Home	Spring Valley Health and Rehab Center
Provider ID	525466
Address [RUCA Code: 3] [% County Population Rural: 69.95]	S830 Westland Drive, Spring Valley, Wisconsin, 54767
Day Investigation Completed	March 24, 2021
Type of Deficiency Issued	*F600 **F608 ***F609 ****F610 *****F835
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm ***Minimal Harm or Potential for Actual Harm ****Minimal Harm or Potential for Actual Harm ***** Minimal Harm or Potential for Actual Harm

Fear of Retaliation from LVN who Forced Residents Out of Bed Against Their Wish / "*This has been reported to administration, but nothing was done and the staff fears retaliation, so they do not mention it anymore*"

The nursing home failed to, in response to allegations of abuse, neglect, exploitation, and mistreatment, have evidence that all alleged violations are thoroughly investigated and prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation in in progress for Residents 15, 21, and 36. It also failed to thoroughly investigate allegations of abuse and neglect for Residents 15, 21, and 36.

The nursing home failed to ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences for Resident 15. It failed to administer PRN pain medication to Resident 15 on October 8, 2021. The failure could result in worsening of pain and injury to the resident.

Cognitive Function. Resident 15 had **severe cognitive impairment** (BIMS score of 5 out of 15).

Cognitive Function. Resident 36 had **moderate cognitive impairment** (BIMS score of 10 out of 15).

Cognitive Function. Resident 21 had **moderate cognitive impairment** (BIMS score of 12 out of 15).

Activities of Daily Living. Not detailed in the investigation report for the three residents.

In an interview on January 12, 2022, Resident 36 revealed that LVN A can be real tacky and several residents don't like her because she was so pushy. She stated that a few months ago, she had a day that she just did not feel well and LVN A told her she had to get out of bed and take a shower because she was on the shower list for the day. She stated LVN A told her that it looked bad to the state when residents don't bathe and she did not have a choice. Resident 36 was not aware that she had the right to refuse. She stated that the situation confused and frustrated her.

In an interview on January 12, 2022, Resident 21 stated LVN A pushes the medical director on her. She stated she was more comfortable keeping her old Primary Care Physician (PCP) because she was aware of all of her medical issues. She stated she was concerned about changing her PCP mostly because of only having one kidney and not wanting a new doctor to mess things up. She explained that LVN A explained to her that she had to change her PCP because the nursing home had to be able to reach someone 24 hours a day if something were to happen. She explained that her son was supposed to be sorting it out for her. She stated LVN A had approached her about her PCP many times. She stated LVN A "was nice, but she wants to be the boss and doesn't like it when a resident disagrees with her." She stated that she was not afraid of LVN A at all and that nothing bad had happened to her in the nursing home.

In an interview on January 12, 2022, **CNA C stated** LVN A tells the direct care staff to make residents get out of bed even when they have refused. She explained that, in her opinion, LVN A believed the residents should not be allowed to make the decision not to get up when they don't want to. Resident 21 seemed to be a target for LVN A to bully. She stated: **"This has been reported to administration, but nothing was done and the staff fears retaliation, so they do not mention it anymore**."

In an interview with **CNA D** on January 12, 2022, she stated that LVN A demands the direct care staff get residents out of bed even when they are begging not to be bothered. She reported Resident 21 and Resident 36 have both voiced concerns to CNA D and the Assistant Director of Nursing (ADON) about LVN A's bullying. **She stated she doesn't report the issue any more for fear of retaliation** and that administration does not follow-up.

In an interview with **CNA D** on February 1, 2022, she stated she and other staff had reported LVN A to the ADON on multiple occasions, but nothing was ever written down. She stated that all the reports that she had made were verbal. She stated she had never filed a grievance with administration. **When she was asked to explain what the staff considers to be retaliation, she stated LVN A makes work more difficult when she was upset about something or at one of the staff**. She stated that the **LVN A "rides you."** She stated **LVN A "pressured the staff to get things done in a hurry when they have the entire shift to do their tasks."** She stated **LVN A "made sarcastic and rude comments to staff when she was upset with them**." She stated there was not fear of physical harm.

In an interview with **CNA E** on January 12, 2022, she reported LVN A pressures residents into using the medical director as their Primary Care Provider. She stated the Medical Director also pressured residents to use her. **She stated the staff was concerned about retaliation and that administration does not investigate their reports, so they don't report these occurrences anymore**.

In an interview with **the ADON** in training on January 12, 2022, she stated that she was aware of LVN A forcing residents to get out of bed when they don't want to. She explained if she saw it happening, she stepped in, **but it does not get reported to her often due to staff concern about retaliation.**

In an interview with LVN A on January 12, 2022, she stated she had never discussed changing PCPs with any residents and that would be admissions who would bring that up. She stated the Medical Director has written orders that all residents must get out of bed daily and she highly encourages they do so due to a risk of aspiration. She denied forcing any resident to get out of bed.

In an interview on February 1, 2022, LVN A stated she does not force residents to get out of bed. She stated she suggests they get out of bed for their well-being. She stated: "Staff do not like doing the extra work and that they do not encourage the residents to get up because it means more work for them." She stated she follows up with the staff on their tasks to make sure the residents are being taken care of.

In an interview with the ADON on January 12, 2022, she stated Resident 21 told her that LVN A was a bully regarding trying to make her change her PCP. She stated that many residents have complained about feeling bullied and pressured by LVN A to do things and so she now does daily rounds to stay on top of it. She stated LVN A came to her and asked if the direct care staff had to obey her when she tells them to get a resident out of bed and that she was told that if it was due to medical reason, then possibly but not if it violates residents' right to choose their schedule. She stated she had addressed LVN A's attitude about forcing residents to do things with her multiple times as had the Administrator.

In an interview on January 12, 2022, the Administrator stated that he was not aware LVN A had been pressuring residents about their PCP or forcing residents to get out of bed.

In a subsequent interview on January 31, 2022, the Administrator stated that the grievance book had been missing for several months. He stated that there had been no reports / allegations / grievances since the book went missing.

In an interview with RN G and the Director of Nursing (DON) on February 1, 2022, they both stated that documentation was a problem in the nursing home. The DON stated that whenever a complaint or allegation is brought to her attention, she investigates but the nursing home does not have a clear policy on documenting the investigation. She stated: "As in the case with LVN A, the nursing home does verbal counseling and does not keep a written record of those sessions." RN G stated: "There is a strong need for better policy on documentation for everything in the nursing home."

In an interview on January 12, 2022, **CNA C** stated that LVN A frequently refused to give residents pain medications. She stated: "The residents will ask LVN A for medication and explain their pain level was high, but LVN A will tell them it isn't and offer over the counter pain medication or nothing at all." She reported an incident on October 8, 2021 in which Resident 15 was supposed to go to an appointment and was crying due to pain related to multiple fractures sustained in a fall prior to admission. LVN A was asked by Resident 15 and staff to give her pain medication and she refused. Resident 15's daughter was present at the time and she also asked LVN A to give the pain medication and was told in front of CNA C, CNA D, CNA E, and LVN B that the crying was a behavior the resident was displaying and she needed to go to the doctor without medication so he could see how much pain the resident was experiencing. She stated **the direct care staff do not officially report when LVN A refused to give medication for fear of retaliation**, but she and others have brought their concerns to the ADON. CNA C also explained direct care staff do not have a place to document when a resident requests pain medications and it was denied. She stated they do not have access to put notes in the charts.

With regards to LVN A's refusal to give residents pain medications, **CNA D stated**: "**Staff does not report LVN A for fear of retaliation**." LVN B **stated: "Direct care staff are afraid to say anything to administration because they fear retaliation from LVN A**." CNA E **stated: "Staff do not report the issue anymore due to retaliation and that administration backs LVN A up**." **CNA F stated that she and other staff no longer report LVN A due to fear of retaliation**.

During an interview on January 12, 2022, LVN A stated the issue regarding the pain medication had been addressed and refused to elaborate. During an interview on February 1, 2022, LVN A stated she did not remember telling Resident 15 or her daughter she could not have pain medication. She stated that does not feel like that was something she would ever do. She stated she does not feel that she withholds pain medication if the residents need it.

Name of Nursing Home	Merkel Nursing Center
Provider ID	676053
Address [RUCA Code: 2] [% County Population Rural: 17.51]	1704 N 1st, Merkel, Texas, 79536
Day Investigation Completed	February 1, 2022
Type of Deficiency Issued	*F610 **F697
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Actual Harm

A CNA stated "*she is a mandated reporter, and she would have reported the neglect, but did not out of fear of retaliation from co-workers that worked with the CNA*" perpetrator / "*It breaks your heart*"

The nursing home failed to implement the ABUSE PREVENTION PROGRAM policy and procedure for 10 residents (Resident 1-10). This failure resulted in the nursing home neglecting personal hygiene care needs of 10 residents (Residents 1-10), which negatively impacted their quality of life and had the potential to negatively impact their emotional well-being.

The nursing home failed to report alleged abuse and neglect for 10 residents (Residents 1-10). This failure resulted in alleged abuse to continue with no nursing home intervention.

No details were included in the investigation report regarding Cognitive Function and Activities of Daily Living for Residents 1-10.

During a review of the nursing home record dated December 24, 2021, the record indicated on December 19, 2021, at approximately 7:30 PM, "I [Director of Nursing – DON] was performing a yearly evaluation with one of my [night shift] nurses. During the process of this evaluation, LVN 1 had stated "there was a problem with CNA 1 leaving her residents in bed soaked with urine." I [DON] asked her to write me a report on the incidence. December 20, 2021 – when I [DON] came to work, I read the report in which LVN 1 wrote. It stated: "During night shift on December 19, 2021, it was brought to my attention that Resident 8's bedding was soaked through the linens. The complaint had come from CNAs on my shift at different times over the last few weeks. The same CNA [CNA 1] has been the one they followed." One of the CNAs that works LVN 1's shift is CNA 2. I called CNA 2 and asked her if she knew of any issues happening with the day shift CNA's daily care. She verbally gave me a report on the phone regarding CNA 1 care especially with Resident 8. After the conversation, I then asked her to write up a statement. I [DON] then assessed ALL residents for rashes, redness or any other skin issues who were incontinent or bowel or bladder. I [DON] found sic total in which I immediately placed on a [every] 2-hour checks and changes. [Resident 1] Redness noted placed on [every] 2 hours checks and changes. [Resident 2] Redness and excoriation [wearing off skin] of scrotum area. [Resident 3] Redness to peri / anal area."

During an interview on January 6, 2022, LVN 1 stated she noticed issues with CNA 1 neglecting her residents a few weeks prior to December 19, 2021, around the end of November or beginning of December 2021. LVN 1 stated she noticed other CNAs complaining that CNA 1's assigned residents would be soaked and wet with urine. LVN 1 stated: "The incidents were occurring more often and increasing in frequency until reported on December 19, 2021." LVN 1 stated some residents under CNA 1's care would have soaked briefs through the linens and through their mattresses. LVN 1 stated: "For weeks I would have CNAs state she's [CNA 1] the worst CNA to follow." LVN 1 stated: "I should have reported it to [DON] because it was neglect on CNA 1's part for not taking care of residents properly." LVN 1 went on to provide details about CNA 1's neglect of Resident 8 and Resident 5. She then stated she should have reported the neglect but did not, saying "It was an error on my part."

CNA 2 stated these incidents with resident neglect by CNA 1 went on for about three to four months. CNA 2 states she spoke with CNA 1 about the care issues, but CNA 1 would state she knew how to do her job. CNA 2 stated the neglect resulted in Resident 10 having severe redness to her buttocks and resulted in distress for Resident 5 because of crying from being left in urine.

CNA 2 stated she is a mandated reporter, and she would have reported the neglect, but did not out of fear of retaliation from co-workers that worked with CNA 1. CNA 2 stated she noticed only CNA 1's residents that were not alert or able to verbalize issues were left uncared for. CNA 2 stated: "When you walk in and see a resident [Resident 5] crying because she was not taken to the restroom, it breaks your heart and makes you angry."

CNA 2 also stated: "Resident 7 had wet feces all the way up her bra line, covering her head and back." Among other concerns about CNA 1, CNA 2 stated that Resident 6 and Resident 1 were left with their Foley catheter bag full of urine from not being emptied throughout CNA 1's shift.

During an interview on June 15, 2022, CNA 7 stated she has worked with CNA 1. CNA 7 stated she would get complaints from residents regarding CNA 1's lack of care. CNA 7 stated Resident 1, Resident 10, and Resident 5, and about three other residents (she could not recall) would complain that CNA 1 was rough and inappropriate when providing care (no specifics given). CNA 7 stated these complaints from the residents about CNA 1 would occur sporadically throughout the time CNA 1 worked at the nursing home. CNA 7 stated she could not recall exact dates. CNA 7 stated she did not report these allegations. CNA 7 stated what the residents told her it should have been reported as an allegation of abuse. CNA 7 stated the residents' complaints were only about CNA 1 and no other staff member.

During an interview on January 6, 2022, the DON stated that she first became aware of CNA 1's abuse and neglect of residents on December 19, 2021. The DON stated despite being informed on December 19, 2021, her investigation uncovered abuse and neglect by CNA 1 had been going on for weeks and that staff were aware. Although the DON was not informed.

Name of Nursing Home	Kern Valley Healthcare District Dpt Snf
Provider ID	555517
Address [RUCA Code: 10.3] [% County Population Rural: 13.35]	6412 Laurel Ave, Lake Isabella, California, 93240
Day Investigation Completed	August 10, 2022
Type of Deficiency Issued	*F600 **F607
Scope Severity Level	*Actual Harm **Actual Harm

Fearing Being Fired from Her Job, Anonymous Staff Felt Uncomfortable to Refuse Administrator's Directive to Help a Hispanic Resident Over an African American Resident

The nursing home failed to investigate and prevent allegations of neglect and mistreatment for seven residents (Residents 43, 53, 87, 6, 56, 71, and 21). The nursing home failed to investigate an allegation of CNA's instructed to neglect residents by not completing care to assist other residents based on race. These failures affected all non-Hispanic origin residents and placed them at risk of neglect and lack of care services provided.

Resident 43 was **African American** woman. Cognitive Function: **Cognitively intact** (BIMS score 15/15).

Resident 53 was Hispanic woman. Cognitive Function: **Severe cognitive impairment** (BIMS score 0/15).

Resident 87 was Hispanic woman. Cognitive Function: **Cognitively intact** (BIMS score 15/15).

Resident 6 was **African American** woman. Cognitive Function: **Cognitively intact** (BIMS score 15/15).

Resident 56 was **African American** woman. Cognitive Function: **Cognitively intact** (BIMS score 15/15).

Resident 71 was **African American** woman. Cognitive Function: **Cognitively intact** (BIMS score 15/15).

Resident 21 was Hispanic woman. Cognitive Function: **Severe cognitive impairment** (BIMS score 0/15).

Review of Shower Tech I's statement (January 16, 2020, signed by the Administrator) revealed: Shower Tech reported to the Administrator she felt she showed "favoritism to residents who were Hispanic."

Interview on January 28, 2020, with the Business Office Manager (BOM). The BOM said Shower Tech I came to her with the concern that the Administrator favored and directed CNAs to stop providing care to African American residents to assist Hispanic residents who needed the same type of care. She said she did not know if it was true, because staff say a lot of things and it could have been gossip. She said there was no investigation done. She said she asked the Administrator about it and he said: "Everything was o.k." She said she should have done a grievance and told the Regional Director. She said a CNA should finish care with one resident before going to another unless it was an emergency. She said neglect is when a resident is not provided care that they needed.

During an interview on January 28, 2020, Shower Tech I said she went to the Administrator and told him of her concerns of him telling staff to stop providing care to one resident and go to assist another resident. She said it had not been an instance where one resident needed care more than another. She said this has happened repeatedly when a Hispanic resident needed assistance. She said the Administrator would tell a CNA to immediately stop helping an African American resident to go to the Hispanic resident. She said she had also told the BOM about her concerns.

During an interview on January 29, 2020, **Anonymous Staff 1 said** any allegation of neglect should be reported to the Administrator and Director of Nursing. Anonymous Staff 1 said the Administrator and Regional RN were aware that Hispanic residents received preferential care. Anonymous Staff 1 said the Administrator goes above and beyond for Hispanic residents because family members would call and demanded care be provided immediately, even if that means stopping care for other residents.

She said it was considered neglect if care is stopped for one resident before finishing to help another when it was not necessary or an emergency.

During an interview on January 29, 2020, **Anonymous Staff 2** said she was directed by the Administrator when providing care with multiple African American residents to stop and assist Hispanic residents at least six times. She said the task had been getting two different residents dressed and priority was always given to Hispanic residents at the direction of the Administrator. **She did not want to give specific names of residents in fear of retaliation from administration.** She said **she felt uncomfortable to refuse the directive from the Administrator to help a Hispanic resident over an African American resident in fear of being fired from her job**.

During an interview on January 30, 2020, CMA H said if a Hispanic resident asked for assistance, then the Administrator would tell you to stop and assist the Hispanic resident no matter what you were doing. She said the Administrator neglects all other races in the nursing home except Hispanic. She said the Administrator was aware that some residents and staff felt he was a racist.

During an interview on January 30, 2020, Resident 6 said there was a partiality toward the Hispanic population from the Administrator. She said that he would leave a Black resident in the middle of conversation and go and see what a Hispanic resident may want. She said she told the Resident Council President (Resident 56) and she thought her concern was given to the Administrator. She said she had not filled out a grievance form. She felt like she was dismissed and put secondary.

During an interview on January 30, 2020, Resident 56 said she has been told by other residents that staff have been pulled away. She said they have recorded the grievance of staff being pulled away in the Resident Council meetings and forwarded it to administrative staff. She said African American residents have complained that they are helped secondary to Hispanic resident. She said the complaint from residents and staff is that the Administrator will instruct staff to do this. She said that most residents are not aware that they are being left to help another resident.

During an interview on January 28, 2020, the Administrator said Shower Tech I did come to him about her concerns that Hispanic residents were favored over African American residents. He said he did talk to Hispanic residents and families more often because he spoke Spanish. He said he had not completed an investigation. He said he was the Abuse Coordinator of the nursing home and did not investigate allegations of neglect. He said he did not do one in this instance because he said he assured Shower Tech I that he was for all races. He said he told Shower Tech I that he respects all residents and thought, everything was ok. He said he did not inform his Regional Director about the allegation.

Name of Nursing Home	Highland Park Care Center
Provider ID	675493
Address [RUCA Code: 1] [% County Population Rural: 1.13]	8861 Fulton St., Houston, Texas, 77022
Day Investigation Completed	January 31, 2020
Type of Deficiency Issued	F610
Scope Severity Level	Actual Harm

Anonymous Staff Told Surveyor They Fear Management's Retaliation for Reporting Understaffing

The nursing home failed to ensure appropriate staffing levels to meet the needs of residents and to ensure residents needs concerns staffing and call light response time was done timely. This affected 13 residents (R42, R29, R39, R7, R6, R40, R9, R8, R18, R35, R243, R5, R1) and had the potential to affect all 37 residents who resided at the nursing home.

Resident 42. Cognitive Function: **Intact cognition** (based on MDS assessment).

Activities of Daily Living. Resident 42 required 1 to 2 staff extensive physical assistance with all ADLs.

Resident 29. Cognitive Function: **Intact cognition** (based on MDS assessment).

Activities of Daily Living. R29 required extensive physical assistance for one to two staff with all ADLs.

Resident 39. Cognitive Function. **Intact cognition** (based on MDS assessment).

Activities of Daily Living. R39 required extensive physical assistance for one to two staff with all ADLs.

Resident 7. Cognitive Function. **Intact cognition** (based on MDS assessment).

Activities of Daily Living. R7 was independent to supervision with ADLs.

Resident 6. Cognitive Function: **Intact cognition** (based on MDS assessment).

Activities of Daily Living. R6 required extensive physical assistance of 1 to 2 staff with all ADLs.

Resident 243. Cognitive Function: **Moderately cognitively impaired** (Based on MDS assessment).

Activities of Daily Living. R243 required extensive assistance from two staff for bed mobility and transfers and extensive assistance from one staff for toileting.

The cognitive function and Activities of Daily Living of the 7 other affected residents were not detailed in the investigation report.

Resident 42 stated on Sunday July 7, 2019 on the 2 PM to 10 PM shift she had the call light on for 50 minutes and before that she had the call light on for over an hour. When asked if there was a particular shift that the call light response time was not good, Resident 42 said "can be any time, a lot of times it depends if the facility was short staffed." Resident 42 stated she would put her call light on when she needed staff to assist to change her dignity pad. Resident 42 stated: "Happens more often than not."

During an interview with Resident 39 on July 8, 2019, when asked if she had to wait for a long time for assistance after putting her call light on, Resident 39 stated she waited for one to two hours for her call light to be answered. Resident 39 stated she had brought the concerns about the call light wait times during monthly Resident Council. Resident 39 further stated: "The staff had a habit of coming into the room, shut the call light off, listen to what she needed help with, then staff would say "hold on" or "we'll take care of it" and then leave. They got a real bad habit of doing that."

During an interview on July 8, 2019, Resident 7 was asked if he had to wait for a long time for assistance after putting the call light on. Resident 7 stated: "They are understaffed. It takes a long time 35 to 60 minutes to answer the call light. It happens all the time. My roommate [Resident 10] when he needs help, he will say my name, and I will go out to find someone."

During an interview on July 10, 2019, Resident 7 stated one thing he had concerns with at the nursing home was there was just not enough help around, especially at night. For example, if his roommate [Resident 10] puts the call light on when for example he had dropped something down. Resident 7 stated he would leave the room to the hallway to get him help, but there was no one in the area. Resident 7 stated he had heard there was a resident in room [Room number] who had a fall and had to wait on the floor for 45 minutes before help arrived and the call light was on at the time.

Review of Grievance / Concern Form identified. On April 4, 2019, Resident 243 reported that at 2:00 AM she put on her call light to have her legs repositioned and a staff member she did not recognize told her she didn't have time to help. Thirty minutes later, R243 was crying out in pain and someone came to help. R243 reported at 8:00 AM staff got her up and cleaned her due to being soiled and as she was being transferred to her chair, she had a bowel movement. Staff laid her back down but told her she could not be cleaned up right away. R243 reported an hour and fifteen minutes later someone came in and there were soiled wipes still in her buttocks.

On April 11, 2019, R243 indicated: "They were giving me hard time again last night." The form indicated R243 reported she had asked to be moved up in bed and staff told her the other staff member was too busy to come and help. R243 said: "It always goes like that, if I ring to be changed or moved and it's not on their schedule, they argue with me." R243 indicated she reported it to the nurse, but it kept happening.

On April 30, 2019, R243 reported that on April 29, 2019 on the overnight shift she was unable to reach her call light and needed to be changed and repositioned. R243 reported no one came to her room the whole night to check on her and she did not receive any repositioning or nursing assistant help and she was left in pain.

A nursing home Progress Report dated April 16, 2019, indicated staff were alerted to an open area on R243's right buttock. Upon assessment, a 0.7 centimeter x 0.8 centimeter pressure injury was observed.

A nursing home Progress Report dated May 12, 2019, indicated R243 continues to ask to be repositioned every hour or every 30 minutes. She was re-educated about being repositioned every two hours.

During interview on July 10, 2019, LPN A stated she had written the Progress Note. LPN A stated R243 had a behavior and would put on her call light every 30 minutes. LPN A stated she told R243 she was programmed for very two hours for repositioning and stated: "We know as staff we do every two hours."

Resident Council meeting. Review of monthly minutes of Resident Council revealed: It was indicated for the months of January through June 2019, call lights being answered timely was an issue that was brought up at each meeting. There were concerns of long waiting times, concern of call lights being answered by staff then residents would be told "You are not my resident" or staff would go in the room to shut off the call light and residents would be told staff was going to help and would not return.

During an interview on July 9, 2019, anonymous staff stated sometimes nurses were mandated to stay from one shift to another or when Trained Medication Assistant (TMA) had called in, the nurses had to do three medication carts between the two nurses, which was heavy. Anonymous staff also indicated it was difficult to get caught up timely with medications and treatments more so when someone like TMA or another nurse called in as staff were not replaced which was difficult to meet the residents' needs timely.

On July 9, 2019, another **anonymous staffer approached the Surveyor and stated there was fear of retaliation from the nursing home management for both residents and staff**. When asked, the staffer stated staffing was not good and sometimes they were mandated to stay, which happened mostly on the evening and night shifts as the shifts are hard to fill in. The staff stated **usually management would threaten staff by saying they would call the State on the basis of abandoning residents**.

The anonymous staff stated at times the medications and treatments were given late when short staffed and there were only two nurses for the entire medication pass which was difficult. In addition, the anonymous staff stated: "There is so much management turnover which is difficult to follow through and the current management does not listen to the staff concerns about staffing."

Name of Nursing Home	The Estates of Fridley LLC
Provider ID	245201
Address [RUCA Code: 1] [% County Population Rural: 15.90]	5700 East River Road, Fridley, Minnesota, 55432
Day Investigation Completed	July 11, 2019
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Didn't Report on Physical Abuse of Woman with Severe Cognitive Impairment for Two Months / She Came Forward Now Because She Didn't Want What Happened to Her to Happen to Others / Remaining Silent About What She Witnessed Bothered and Concerned Her

The nursing home failed to ensure that reported allegations of abuse were reported according to mandated reporting timeframes of 24 hours, when: CNA 1 reported an incident of verbal and physical abuse occurring between Resident 3 and CNA 10, approximately two months after witnessing the event.

The nursing home failed to implement its abuse policy and procedure when residents were not fully protected from staff after a previous abuse allegation on June 27, 2021 occurred. The nursing home did not substantiate an incident of abuse despite CNA 14 witnessing it on June 27, 2021. The nursing home allowed CNA 10 to return to work after being suspended, and reassigned CNA 10 to provide care to residents on the secured unit.

The nursing home failed to ensure Residents 1, 2, and 3 were free from abuse when: CNA 5 became upset with Resident 1 and pushed the resident into the wall. In addition, CNA 5 forced care upon Resident 1 when the resident was refusing care; CNA 10 yelled at Resident 2 and told the resident not to speak up; CNA 10 yelled at Resident 2 and slapped the resident's legs.

The nursing home failed to ensure allegations of abuse were thoroughly investigated for Residents 1, 2, 3.

CNA 1 witnessed CNA 10 yell at Resident 3 and slap the resident's legs. The nursing home investigation did not identify and thoroughly investigate the incident and CNA 10's behavior and treatment.

Resident 3. Cognitive Function: **Severe cognitive impairment** (BIMS score of 0 out of 15).

Resident 2. Cognitive Function: **Cognitively intact** (BIMS score of 13 out of 15).

Resident 1. Cognitive Function: **Severe cognitive impairment** (BIMS score of 2 out of 15).

Due to scope considerations and relevance to the topic of staff fear of retaliation, this summary focuses primarily on Resident 3, to some extent on Resident 2, but not on Resident 1.

A review of the nursing home document titled Report of Suspected Dependent Adult / Elder Abuse completed for Resident 3, dated July 23, 2021, indicated. Suspected Abuse Name of Suspected Abuser: CNA 10. CNA 1 was assisting with care, she states she witnessed CNA 10 allegedly slapped Resident 3. Both CNAs (CNA 10 and CNA 1) were removed from schedule during investigation.

On July 22, 2021, an interview was conducted with CNA 1. CNA 1 stated that **about two months ago** (on or about May 2021) she had assisted CNA 10 with turning and repositioning Resident 3. CNA 1 stated while attempting to turn and reposition Resident 3, CNA 10 became frustrated when Resident 3 could not participate in the turning. CNA 1 stated that CNA 10 yelled at Resident 3 to turn and then slapped her legs hard which made an audible sound when the resident did not move. CNA 1 stated the slap had left a temporary red mark on Resident 3's leg. **CNA 1 stated she did not report the incident at the time it occurred because she was afraid of retaliation**. CNA 1 stated **she came forward now because she did not want what happened to Resident 3 to happen to other residents**. CNA 1 stated **remaining silent about what she witnessed CNA 10 do to Resident 3 had bothered and concerned her**. CNA 1 stated what she witnessed was verbal and physical abuse. CNA 1 stated she had no problems or disagreements with CNA 10. CNA 1 stated she knew failing to report what she witnessed CNA 10 do had been wrong. CNA 1 stated she had not followed her abuse prevention training as a mandated reporter.

During the interview, **CNA 1 stated she did not report the incident at the time it occurred because she was afraid of retaliation as CNA 10 had many friends in the nursing home including management**.

During an interview held on the following day, CNA 1 repeated what she had witnessed occur with CNA 10 and Resident 3, and it was consistent with her previous interview on July 22, 2021. **CNA 1 stated she was concerned her employment would be terminated and that she would receive disciplinary action to include possible revoking of her CNA certificate for failure to report witnessed abuse in a timely manner**. CNA 1 stated that she knew she would be facing disciplinary action and that her statements about what she witnessed happen between CNA 10 and Resident 3 had been accurate.

On July 23, 2021, **a joint interview was conducted with the acting Administrator and the Director of Nursing (DON).** The acting Administrator acknowledged the nursing home was cited in May 2021 for failure to report an allegation of abuse. The DON stated since the citation was issued (in May 2021), the nursing home had conducted extensive trainings and built awareness of recognizing potential signs of abuse and of reporting requirements. The DON stated **there was a nursing home Confidential Compliance Line if staff were worried about retaliation**. The acting Administrator stated **the nursing home had learned from past mistakes and was taking abuse allegations seriously**. The DON stated **it was difficult to learn that CNA 1 failed to report an incident of witnessed abuse that happened approximately two months ago between Resident 3 and CNA 10**. The DON stated CNA 1 should have immediately reported the incident to the DON or the acting Administrator. The DON further stated **CNA 1's failure to report witnessed abuse had potentially allowed an alleged perpetrator of abuse to continue to abuse residents for two months**. The DON stated **the incident on June 27, 2021 that occurred with CNA 10 and Resident 2 could have been prevented had CNA 1 reported the incident immediately**. The DON stated CNA 10 would be suspended again.

The alleged incident between CNA 10 and Resident 2 consisted: CNA 14 stated that when she entered Resident 2's bedroom to help with care on June 27, 2021, she witnessed CNA 10 and Resident 2 arguing. CNA 14 stated Resident 2 told her that CNA 10 was always miserable. CNA 14 stated CNA 10 responded to Resident 2 with a loud and ugly attitude: "Me miserable? At least I have someone [who cares]." CNA 14 stated there was a lot of arguing and she could not understand everything that was said in the argument, adding that it was a loud and inappropriate interaction. CNA 14 stated Resident 2 told her during shower care that she was used to CNA 10 treating her that way. CNA 14 stated that she did not understand why someone would always come to work with an attitude like that. CNA 14 stated the incident was rude, disrespectful, and it was verbal abuse. CNA 14: "I was shocked and reported the incident." CNA 14 stated the next day Resident 2 thanked her for reporting the incident.

On July 22, 2021, an interview was conducted with Resident 2. Resident 2 stated she had an incident on Sunday June 27, 2021 with CNA 10. Resident 2 stated CNA 10 had provided care to her on a regular basis for the last two years. Resident 2 stated CNA 10 frequently would tell her not to speak during the care and that made her feel bad. Resident 2 stated CNA 10 was very controlling, and things have to be done her way. Resident 2 stated CNA 10 would twist her hair up as part of hair care. Resident 2 demonstrated with her hands arranging her hair up into a hairdo. Resident 2 stated there were times she would take her hair down after CNA 10 fixed it up because she wanted her hair to be down. Resident 2 stated CNA 10 would yell at her for taking her hair down. Resident 2 stated she [CNA 10] yells at me when I don't do what she wants. Resident 2 stated CNA 10 could be mean. Resident 2 stated: "I would get a knot in my stomach when she [CNA 10] gets upset with me." Resident 2 stated that if she started talking during care, CNA 10 would throw up her hands and yell: "I can't take it" and walk out of the room. Resident 2 stated CNA 10 was domineering and reminded her of her mother. Resident 2 stated she grew up in an abusive home where her mother would pull her across the floor by her hair, yell at her, and demean her. Resident 2

stated she ran away from home at [AGE] years old to get away from her abusive mother. Resident 2 stated CNA 10's "treatment reminds me of my mother."

Resident 2 added that on June 27, 2021, CNA 10 did not want to do her shower. Resident 2 stated CNA 14 did her shower. Resident 2 stated when CNA 14 was bringing her to the shower room, CNA 10 yelled in the hall: "There's miserable [Resident 2's name]." Resident 2 stated: "I know the residents don't know who [Resident 2] is, but I didn't like that said so everyone could hear." Resident 2 stated it made her feel embarrassed and hurt. Resident 2 stated: "It was then I had enough of her [CNA 10] treatment." Resident 2 stated she had had enough of CNA 10 telling her that she was difficult, and no one wanted to take care of her. Resident 2 stated she talked to CNA 12 and told her she did not want CNA 10 to take care of her anymore. Resident 2 stated it was not abuse because CNA 10 did not hit her. Resident 2 acknowledged there were different types of abuse. Resident 2 stated if how CNA 10 treated her was done to a resident who could not speak for themselves, then that would be abuse. Resident 2 stated again that she did not want CNA 10 to lose her job or get in trouble.

The nursing home undated document titled Investigation Summary: Resident 2 (faxed date July 2, 2021), indicated, on June 27, 2021, CNA 14, a CNA who had just started working on [location omitted] reported that CNA 10 was arguing with Resident 2. The document included this note: "We were unable to substantiate abuse occurred."

On August 27, 2021, a telephone interview was conducted with CNA 10. CNA 10 stated she got along well with her coworkers and did not have any issues or problems with anyone. CNA 10 denied slapping or yelling at Resident 3. CNA 10 stated she had resigned after hearing she had another accusation against her. She stated she was on friendly terms with management and that "management misses me."

On October 12, 2021, a joint interview was conducted with the DON and acting Administrator. The DON stated the incident between CNA 10 and Resident 3 was abuse. The DON stated the incident between CNA 10 and Resident 2 was abuse. The DON stated CNA 10's behavior was a pattern of abuse.

Name of Nursing Home	Avocado Post Acute
Provider ID	555076
Address [RUCA Code: 1] [% County Population Rural: 4.39]	510 E. Washington Avenue, El Cajon, California, 92020
Day Investigation Completed	December 10, 2021
Type of Deficiency Issued	F600, F607, F609, F610
Scope Severity Level	*Actual harm ** Minimal Harm or Potential for Actual Harm *** Actual Harm **** Minimal Harm or Potential for Actual Harm

An RN Became Aware of Physical Restraint of a Woman with Severe Cognitive Impairment / She Waited to Report It Until the Next Day "*so there would not be any retaliation against her*"

The nursing home failed to ensure Resident 1 with severe cognitive impairment was appropriately protected to prevent actual abuse by a staff member.

The nursing home also failed to follow their policy titled: Abuse, Neglect, and Exploitation Policy, to immediately start an investigation and to notify the police for Resident 1.

When on October 13, 2020, CNA 1 tied a resident's hospital gown at the back of the knees and staff members were aware of the abuse and they failed to report it to the supervisor or Administration.

The CNA returned on October 14, 2020, and again tied the resident up with a hospital gown knotted behind the knees which caused actual injury; a skin tear and bruising on both shins. Four staff members observed the resident in bed with the bottom of the gown tied behind the back of the knees on October 14, 2020, they removed the knotted gown and failed to report the incident immediately to the Supervisor or the Administrator until the next day on October 15, 2020, when the RN reported to the Administration.

The deficient practice placed Resident 1, as well as all residents with cognitive impairment, at Immediate Jeopardy (IJ) situation. The IJ ran from October 13, 2020 to October 15, 2020 at 3:00 PM, when the RN reported the incident to the Director of Nursing (DON) and the DON removed the CNA from her assignment and escorted her out of the building. The nursing home provided an acceptable Removal Plan which removed the immediacy on October 15, 2020, when CNA 1 was suspended and escorted out of the building and terminated, and immediate staff in-servicing was initiated.

The nursing home failed to report timely, an allegation of abuse to the New Jersey Department of Health and to the Police for Resident 1. It also failed to follow its policies Abuse and the Reportable Events Form.

The nursing home failed to ensure services were provided to meet professional standards of quality when it failed to show any documentation of any physical assessment or skin assessment completed by the nursing staff on October 14, 2020, after the incident, to verify whether any injury occurred when they found the resident tied up with a hospital gown.

Cognitive Function. Resident 1 had **severe cognitive impairment** (BIMS score of 3 out of 15).

Activities of Daily Living. The resident required extensive assistance for activities of daily living.

Care Plan (dated August 28, 2019). The resident had impaired cognitive function, impaired thought process related to a stroke, and a behavior of hanging the left leg off the side of the bed (the nursing home investigation dated October 15, 2020 noted that "the resident had a habit of kicking the left leg off the side of the bed but does not try to get out of the bed").

Interventions included: "Staff to make frequent rounds to ensure proper position while in bed. Staff to consistently remind the resident to keep the leg in bed for safety and the staff to assist the resident by placing leg back in bed each time the resident hangs it down."

During an interview on October 23, 2020, the DON reported she found out about the incident on October 15, 2020 around 3:00 PM. The RN came to her office at the beginning of her shift. She reported that she wanted to share something that happened the day before around 11:00 PM. The RN overheard a CNA saying a resident was tied up again. According to the DON, **the RN waited until the next day to report the incident because she wanted to remain anonymous and keep it confidential so there would not be any retaliation against her**. Both the RN and the oncoming nurse (LPN) went to the room and found the resident asleep in bed with her hospital gown behind her knees and tied in the back. They assessed the resident and the RN stated she was going to report it. There were two RN supervisors there at the time. Both were interviewed by the DON and reported they were not made aware of the situation on October 14, 2020 (a day before the RN reported the incident to the DON).

The Summary of the nursing home's investigation (based on interviews with staff and Resident 1 on October 15, 2020) revealed: CNA 1 stated that at 10:00 PM, she went into Resident 1 room, sat down near the resident, and told Resident 1 to leave her gown and diaper alone. "I told her "Don't take it off."" CNA 1 reported: Around 10:30 PM she gave Resident 1 a snack while in bed. CNA 1 added: "She was dressed but tried to take off clothes. I told [him/her]: "Don't take it off." I tried to talk to [him/her] to not take off clothes. I did not restrain her in any way."

CNA 2 stated that last night CNA 3 told her that a resident was tied up on Tuesday night (October 13, 2020) in their room, CNA 2 then spoke with the LPN about the resident being tied up on Tuesday. The LPN stated she did not know anything about it. CNA 2 then went and told the LPN to come and see. The RN and the LPN went into the resident's room and saw the resident in restraints. The CNA then stated: "When I loosened the gown on the resident, I noticed the sides of her legs were really red."

During an interview on October 26, 2020, **LPN stated** that she found out about Resident 1 being tied up on October 14, 2020, around 11:00 PM, when CNA 2 reported it to the nurses. She went to the room with the RN and observed the resident in bed with the gown knotted at the back of the knees. She never reported it because the RN indicated she was going to report it. She stated: "**If you see something, don't depend on someone else to report it. Report it yourself. Report it right away and document**."

The nursing home investigation dated October 15, 2020 stated: "CNA 1 was removed immediately after the report of alleged abuse, interviewed then sent home." Conclusion of nursing home investigation: Based on the investigation, it was determined that CNA 1 tied Resident 1 with a Johnny Coat/Gown on two consecutive evenings as witnessed and reported by the staff. CNA 1 was suspended and to be terminated based on the results of the investigation. Disciplinary action and education were provided to any employee who failed to report.

Name of Nursing Home	Canterbury at Cedar Grove
Provider ID	315204
Address [RUCA Code: 1] [% County Population Rural: 0.01]	398 Pompton Avenue, Cedar Grove, New Jersey, 07009
Day Investigation Completed	October 26, 2020
Type of Deficiency Issued	*F600 **F609 ***F658
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm

Fearing Retaliation, a Nurse Asked to Remain Anonymous When Speaking with Surveyor After the Assistant Director of Nursing Told Her to Falsify Documentation of Late Insulin Administration

The nursing home failed to implement procedures to promote accurate narcotic medication records on three medication carts (Unit 200, 400, and North B/C).

The nursing home failed to ensure that Resident C5 and Resident A8 were free from significant medication errors.

The nursing home failed to label multi-dose medications and biologicals in accordance with currently accepted professional principles, including necessary use by/discard dates, on two medications carts and failed to ensure adherence to expiration / use by dates of pharmaceuticals on the medication storage room of one of the three nursing units.

Resident C5 had a diagnosis of **dementia** and type 2 diabetes.

Cognitive Function. Not Reported.

Resident A8 had a diagnosis of [CONDITION(S)] Disorder (**a serious mental illness**)

Cognitive Function. Not Reported.

Activities of Daily Living. No details included in the investigation report about both residents' ADLs.

A review of the nursing home's Statement of Deficiency 2567 from the Survey ending June 29, 2021, revealed that Resident A8's diabetic medications were not given timely. The insulin was late, as it was ordered before breakfast and not given until 11:00 AM, and as a result, the resident became unresponsive and required hospitalization to stabilize her blood sugars.

On August 2, 2021, the [MEDICATION(S)] ordered at 8:00 AM before breakfast was not administered until 10:41 AM, on August 7, 2021 not administered until 9:56 AM, August 9, 2021 not administered until 12:32 PM, September 2, 2021, administered at 10:09 AM and on September 7, 2021, not administered until 12:27 PM.

A review of Resident C6's Medication Administration Audit for September 2021 revealed the resident was prescribed and scheduled to receive the following medications: [MEDICATION(S)] 125 mcg tablet at 8:00 AM however on September 13, 2021, the resident did not receive the [MEDICATION(S)] (a type of medicine called a cardiac glycoside. It's used to control some heart problems, such as irregular heartbeats including [CONDITION(S)]. It can also help manage the symptoms of heart failure). [Note: While it could not be verified, it is possible the Surveyor referred to Resident C5 when noting Resident C6]

A telephone interview on September 23, 2021 with **Employee 7 who wishes to remain anonymous for fear of retribution and retaliation by the nursing home** revealed that this nursing employee stated she was told by the Assistant Director of Nursing (ADON) that if staff were to give insulin late, they have to go into the electronic record, falsify documentation, and change the time he insulin was given to reflect what the order indicates. The employee further stated that the ADON stated that this must be done because the nursing home is out of compliance with giving medications late.

The employee stated that she does not feel comfortable working at the nursing home and risking her nursing license. **The employee stated she will not falsify documentation**, but "the nursing staff just follow along with what they are told by the facility administration and corporate staff."

During an interview on September 21, 2021, the Director of Nursing confirmed that the nursing home failed to ensure the residents were free from significant medication errors.

Name of Nursing Home	Glen Brook Rehabilitation and Healthcare Center
Provider ID	395421
Address [RUCA Code: 4] [% County Population Rural: 44.73]	801 East 16th Street, Berwick, Pennsylvania, 18603
Day Investigation Completed	September 21, 2021
Type of Deficiency Issued	*F755 **F760 ***F761
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm

Due to Fear of Retaliation from Management and the Staffing Coordinator, Five Employees Asked the Surveyor to Remain Anonymous Regarding Poor Staffing Levels / Lack of Care (Described by RN as "*Heartbreaking*"). One Resident with Severe Cognitive Impairment was Found with Ants Crawling on Her While in Bed with Ant Bites Throughout Her Body Causing Pain, Red Welts, and Hives

The nursing home failed to ensure that Resident 1, Resident 2, and Resident 6 received treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, in that:

The nursing home failed to ensure that Resident 1 with physical debilities and severe cognitive impairment was checked throughout the night shift as she was found with active ants crawling on her while she was in bed with ant bites throughout her body causing resident pain, red welts, and hives that required immediate medical intervention and treatment.

The nursing home failed to assist feeding **Resident 2 and Resident 6** who had physical debilities, **cognitive impairments** and who required extensive assistance from staff with eating caused these residents to go without meals for multiple extended days without notifying the residents' physician, dietitian, and administration of the residents' lack of nutrition and possible subsequent health decline.

The failures placed residents at risk of physical harm, pain, mental anguish, emotional distress, weight loss, malnutrition, and decreased quality of life.

The nursing home failed to ensure there was sufficient nursing staff available at all times to provide nursing and related services to meet the residents' needs safely and in a manner that promotes each resident's rights, physical, mental, and psychosocial well-being for Residents 1, 2, 6, and 7.

Resident 1 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. Resident 1 (**non-verbal**) had **severe cognitive impairment** (BIMS score of 99).

Activities of Daily Living. Not reported.

Resident 2 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. Resident 2 had **severe cognitive impairment** (BIMS score of 99).

Activities of Daily Living. Resident 2 had limited mobility with interventions requiring extensive assistance by one staff to eat.

Cognitive Function. Resident 6 had **mild cognitive impairment** (BIMS score of 9 out of 15). [Note: BIMS score of 9 typically represents **moderate cognitive impairment**]

Activities of Daily Living. The resident was "totally dependent on one staff for eating."

Cognitive Function. Resident 7 had **severe cognitive impairment** (BIMS score of 5 out of 15).

Activities of Daily Living. Not reported.

Due to scope considerations, details about the violations related to Residents 2 and 6 are not included in this summary. These could be found in the investigation report.

During an observation on September 7, 2021, at 4:38 AM, CNA A came running out of Resident 1's room yelling that there were ants crawling on Resident 1. RN C and the Surveyor went into the room and observed Resident 1 in her recliner, with ants still on her. RN C knocked off the remaining ants. There were 10-15 ants crawling on Resident 1's mattress and the wall behind her bed. Resident 1 had red ant bites from her right knee to her thigh, and several on her right arm. Resident 1, who was non-verbal, was grimacing with her jaw clenched and her legs were shaking as if she was in pain.

During an interview on September 7, 2021, RN F stated she assessed Resident 1 and told the Surveyor that the ant bites continued from her thigh to her mid-back, and also in her peri area.

Review of Resident 1's Weekly Skin Integrity Review that was completed by nurse, dated September 7, 2021 at 5:37 PM, reflected the following: "Resident with ant bites to bilateral arms and thighs, abdomen, back, inner thighs, and groin area. Rash noted to bilateral thighs and groin area."

During an interview on September 8, 2021, the Director of Nursing stated they did not conduct an internal investigation of the root cause of the ant bit incident.

During an interview on September 7, 2021, CNA A stated she last checked on Resident 1 within the last few hours but could not give a specific time. She added that due to the nursing home always being short-staffed, it was impossible to check on every resident every two hours.

During an interview on September 7, 2021, CNA D stated it was impossible to complete all of their tasks with the number of staff they have on the floor. She stated it was impossible to check on the residents regularly while answering call lights and helping other aides. She added there were residents that fell all the time due to the aides not being able to get them quickly enough.

During an interview on September 7, 2021, RN E stated the lack of care residents are receiving due to being short staffed was heart-breaking. She stated there were a lot of falls, wounds not being treated appropriately, and medications missed. She stated the night nurses also worked as medication aides. She stated it was impossible to pass all medications on time, provide treatments and assessments to the residents, and provide wound care when you were working two halls with not enough aides.

During a confidential interview, Staff S stated that it was often that residents went without showers or incontinent care regularly. She stated if a resident is a two-person assist for transfer, it is difficult to find a CNA to assist with putting them to bed.

During an interview on September 7, 2021, the Administrator stated he believed the staffing was sufficient to be able to care for all of the residents appropriately.

During the **confidential interviews** with **Staff J, K, S, T and Q, they all stated they would like to remain anonymous due to being in fear of retaliation by management and the Staffing Coordinator**.

During an interview, Staff Q stated the staff were treated "horrible" by management and the Staffing Coordinator. Staff Q stated especially the brand-new staff. Staff Q stated they were hardly trained and treated like children. Staff Q stated the management was well aware of the issue and the staff have basically begged for help, but they get no support.

During an interview on September 9, 2021, Medication Assistant A stated: "It was nice having someone from the State here because she was not getting pressured like she normally did." She added: "When someone from the State was in the facility, they have adequate staffing and she was able to focus solely on passing medication." She stated: "Most days, they are so short-staffed that she is constantly answering call lights and assisting residents while trying to pass medications. She admitted that medications were often late and sometimes missed entirely."

During an interview on September 7, 2021, the Administrator stated after he learned of the incident, he had contacted pest control and they had been out earlier to spray inside and outside her room. He stated her room had been deep cleaned by housekeeping staff.

Name of Nursing Home	Brush Country Nursing and Rehabilitation
Provider ID	675118
Address [RUCA Code: 1] [% County Population Rural: 5.11]	6500 Brush Country Road, Austin, Texas, 78749
Day Investigation Completed	September 11, 2021
Type of Deficiency Issued	*F684 **F725
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm

CNA: "*All the staff are scared, terrified, and intimidated by the Administrator*" / She Added: "*She knows she would lose her job if they talk with the State Surveyors*"

The nursing home failed to ensure Resident 1 was not verbally, physically, and mentally abused by Employer Identifier (EI #1), the Director of Nursing (DON) twice on November 3, 2020. On November 3, 2020, at approximately 8:00 AM witnesses reported the DON began hollering and screaming at Resident 1 to get back into the room. The DON was observed to forcefully place Resident 1 back on the bed. Then at approximately 3:30 PM, the DON was again observed hollering at Resident 1, who was wanting to leave and making statements about wanting to harm/kill his/herself. Witnesses reported the DON yelled and told Resident 1 to go ahead and kill him/herself, that the resident sounded stupid. Resident 1 was subsequently transferred to a local hospital for [CONDITION(S)]. The deficient practice placed Resident 1 in Immediate Jeopardy, as this situation was likely to cause serious injury, harm, impairment of death.

The nursing home failed to ensure five components of the Abuse Policy were implemented. On November 3, 2020, the DON was witnessed to verbally, physically, and/or mentally abuse Resident 1 at approximately 8:00 AM and again at approximately 3:30 PM. The Administrator, who is also the Abuse Coordinator, did not identify these incidents as abuse and allowed the DON to continue working with residents until November 9, 2020 (six days after the day of the two incidents), at which time the Administrator confined the DON to her office, submitted an initial report to the State Agency, and began an investigation into the allegations, after receiving a written report from the hospital that documented the alleged abuse.

The Administrator and DON failed to operate the nursing home in a manner to allow the nursing home staff to voice allegations of abuse without fear of retaliation.

Resident # 1 had diagnoses of **Post Traumatic Stress Disorder**, Heart Failure, and Diabetes Mellitus.

Cognitive Function. Resident 1 was **cognitively intact** (BIMS score of 14 out of 15).

In a telephone interview on November 10, 2020, Resident 1 stated he/she went to the DON on November 3, 2020, because he/she wanted to leave the nursing home. According to Resident 1, the DON told him/her to go back to his/her room. Resident 1 stated the DON hit him/her in the back as she (DON) walked with Resident 1 to the resident's room. Resident 1 stated the DON was screaming at him/her saying: "I was acting like a two-year-old." When asked how this made him/her feel, Resident 1 stated: "Bad."

During an interview on November 10, 2020, LPN (El #5) stated during the shift Resident 1 was anxious, wanted to leave, was not happy and was exit seeking. LPN (El #5) said she observed the DON to raise her voice at Resident 1, Resident 1 then got upset and overturned a bedside table and chair. LPN (El #5) said the DON then got in front of Resident 1 and told the resident that he/she needed to calm down, that no one would take him/her. LPN (El #5) said that when the DON said this, Resident 1 hit the window with his/her right hand, the DON then took Resident 1 by his/her shirt and forced the resident down on the bed. According to El # 5, the Administrator (El # 2) walked in and heard the DON talking loudly to the resident and did nothing.

During an interview on November 10, 2020, RN (El # 8) stated she witnessed the DON scream at Resident 1, who was at the nurse's desk, to get back to his/her room. According to RN (El # 8), the DON told Resident 1 to go back into his/her room because he/she was on isolation. Resident 1 went into his/her room, and the DON followed the resident. RN (El #8) observed the DON to push Resident 1 onto the bed and yell at the resident. RN (El # 8) stated the DON then asked her to go and get the [MEDICATION(S)] injection. RN (El # 8) stated she brought the [MEDICATION(S)] injection back to the DON. RN (El # 8) stated she administered the [MEDICATION(S)] injection to Resident 1, who was kicking, while the DON held Resident 1's hands and arms. According to RN (El # 8), the Administrator came and saw what was going on. RN (El # 8) stated what she witnessed was considered abuse.

During an interview, El # 10 stated that at some point during the incident the DON was screaming very loud at the resident saying: "You've got to stop acting like this, nobody will take you."

During an interview, CNA (El #3) stated that during the incident the DON was screaming so much that she saw spit landing on the resident's face. CNA (El #3) stated the resident was crying, begging the DON to stop yelling and saying: "Why are you doing this to me." According to CNA (El #3), CNA (El #22) told her that she didn't need to be in the resident's room. CNA (El #3) stated the DON pointed her finger towards the resident's chest and screamed saying: "Cut your crap out, you are spreading germs throughout the facility. I don't have time for this." CNA (El #3) stated the DON touched the resident's chest with her finger and it caused the resident to go back on the bed. CNA (El #3) stated the DON was screaming so loud that she was losing her voice. According to CNA (El #3), the Administrator came and pulled the DON out of the resident's room. The DON left the facility. A staff member then called the ambulance to come and pick the resident up. When the ambulance arrived at the facility, CNA (El #3) stated a nurse (El # 7) informed the ambulance crew that Resident 1 was suicidal. According to CNA (El #3), after the incident the resident informed her that he/she wanted to die, and he/she didn't want to be at the facility if he/she was treated like that.

During an interview on November 10, 2020, Emergency Medical Services (EMS) stated that Resident 1 informed the EMS staff that he/she didn't want to go back to the facility and that he/she wanted to kill him/herself if he/she had to continue to stay at the facility.

During an interview on November 9, 2020, CNA (El #4) stated that after the incident the Administrator told the DON to leave. CNA (El #4) stated she considered the incident to be verbal abuse of Resident 1.

During an interview on November 10, 2020, the contracted mental health therapist stated that what the DON did to Resident 1 was verbal abuse. She added that after the incident, the DON came out of Resident 1's room, threw her mask down, and said that she quit.

During an interview on November 10, 2020, the DON denied being verbally, physically, and mentally abusive to Resident 1 on November 3, 2020. The DON said she may have raised her voice, but she was not abusive to the resident.

During a telephone interview on November 10, 2020, the EMS Director stated he had received a call from the Administrator, and during the call the Administrator threatened to call all the facilities whom EMS provides transport for and tell them to stop using the local EMS because they reported the facility to the State. According to the EMS Director, he informed the Administrator that he did not report the facility to the State; he stated he only reported to the receiving facility what the nursing home staff had reported to the EMS Staff.

During an interview on November 12, 2020, **CNA (El 24) stated all the staff are scared, terrified, and intimidated by the Administrator. She stated she knows she would lose her job if they talk with the State Surveyors**.

Contained within the nursing home investigation, was the Five Day Report which read: Resident 1 November 3, 2020 Incident. **Issue with Respect to Retaliation for Reporting**: While we were not specifically asked to make a determination regarding concerns about staff possibly fearing retaliation for reporting abuse, neglect, mistreatment, and misappropriation, **we have**, in order to understand how best to help the facility attain and maintain substantial compliance with reporting, **determined** the following:

Staff who had failed to report an incident prior to November 3, 2020 incidents with Resident 1 stated that they were afraid of the DON. Another licensed nurse acknowledged that **the DON was harsh with the nurses and didn't hesitate to yell at them**. Due to the termination of the DON, staff members reported that they felt more comfortable with a new Director of Nursing.

Contained within the nursing home's investigation file was the Five Day Report, which included, among others: "Based on the investigation conducted in this matter, we substantiate the following: Verbal, mental, and physical abuse by DON against Resident 1 on the morning of November 3, 2020. Verbal, mental, and physical abuse by Don against Resident 1 on the afternoon of November 3, 2020."

The DON was discharged from employment with the nursing home after submitting her immediate resignation on Friday November 13, 2020.

Name of Nursing Home	Health Care Inc
Provider ID	015407
Address [RUCA Code: 2] [% County Population Rural: 67.11]	38286 US Highway 231, Ashville, Alabama, 35953
Day Investigation Completed	November 19, 2020
Type of Deficiency Issued	*F600 **F607 ***F835
Scope Severity Level	*Immediate Jeopardy ** Immediate Jeopardy *** Immediate Jeopardy

Explaining Why They Didn't Report Administrative Staff Abuse of a Resident, Two CNAs Said They Feared Losing Their Job. One Said "*she could not be without work as she had family to support*" / Staff said "*they feared for their jobs and felt powerless to protect residents from abuse*"

The nursing home failed to treat 9 residents (81, 29, 84, 62, 64, 72, 59, 26, 30) in a respectful and dignified manner. Specifically, interviews revealed and confirmed staff engaged in the following practices: Searched and repeatedly entered resident rooms without permission; accused a resident of illegal drug use; changed resident smoking status without evidence of cause; and spoke to residents in a disrespectful and threatening manner.

Due to scope considerations and relevance to the topic of staff fear of retaliation, this summary will focus on Resident 81.

The nursing home failed to ensure residents received written notice, including the reason for change, before the resident's room or roommate was changed for Residents 81, 32, 80, 59, and 48.

Three residents (81, 88, and 64) reviewed for alleged abusive behavior towards them by staff. The incidents involving Resident 81 and Resident 88, witnessed by staff and residents, were not reported by staff to corporate leadership or to state agencies. **The nursing home's failure to prevent and address abuse contributed to an environment in the nursing home in which** residents felt humiliated, dehumanized, intimidated, and fearful of retaliation and **staff said they feared for their jobs and felt powerless to protect residents from abuse**.

The nursing home failed to implement its written policies and procedures to prohibit and prevent abuse and/or mistreatment of [MEDICAL RECORD OR PHYSICIAN ORDER] # 75, and # 31. Specifically, the nursing home failed to implement polices and procedures on the investigation of all alleged violations of abuse and/or mistreatment, the reporting of all alleged violations of abuse and/or mistreatment, and the protection of residents from harm due to abuse and/or mistreatment. **The nursing home's failure to prevent and address abuse contributed to an environment in the nursing home in which** residents felt humiliated, dehumanized, intimidated, and fearful of retaliation and **staff said they feared for their jobs and felt powerless to protect residents from abuse**.

The nursing home failed to ensure alleged violations related to abuse and/or mistreatment were timely reported to the State Survey Agency for Residents 81, 88, and 64 reviewed for abuse. The failure to timely report alleged violations to the State Survey Agency created an environment for repeat incidents of abuse and/or mistreatment by administrative staff which left residents fearful and intimidated.

The nursing home failed to have evidence all alleged violations of abuse and/or mistreatment were thoroughly investigated and failed to ensure protection from further potential abuse and/or mistreatment after allegations of abuse and/or mistreatment were known for Residents 81, 88, and 64.

The nursing home was not administered in a manner that enabled it to use its resources efficiently and effectively to attain and maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Cognitive Function. Resident 81 had **Cognitively Intact** (BIMS score of 15 out of 15).

Activities of Daily Living. She required extensive assistance with transfers. Her Care Plan indicated that she had limited physical mobility related to [CONDITION(s)], neurological deficits, and history of stroke.

During an interview on April 9, 2018, Resident 81 reported she had been harassed and humiliated by administrative staff. She said that one day, during the last week of March 2018, the Administrator entered her bedroom, uninvited with the Director of Nursing (DON) and the Activity Director. Her door was closed because she was partially undressed; her pants were pulled down halfway for a dressing change by therapy staff. She said the Administrator spoke to her in a manner and tone which was not dignified, but rather harassing and demeaning. She said neither the DON nor the Activity Director interjected to make the Administrator stop speaking to her in that way or to suggest it was inappropriate to her during the dressing change.

Resident 81 said she repeatedly asked the Administrator and others to leave her bedroom on this occasion (as well as another with the Administrator, Social Services Director, and the DON). She said the administrative staff would refuse to leave, and in one instance described above, continued to talk to her in loud and harsh tone and in a demeaning manner about money she owed the nursing home. She said when administrative staff would refuse to leave her bedroom, it made her angry and she felt humiliated to the point of tears, degraded, as well as powerless in her own home.

Resident 81 said she had notified the Ombudsman last Wednesday (April 4, 2018) and asked her to submit a complaint with the State. She also said she told Activity Assistant what had happened.

During an interview on April 9, 2018, Activity Assistant said she had concerns with how Resident 81 was treated as an individual. She said the resident was kept from going on an outing in relation to her outstanding facility bill. She said the resident had requested to go on an outing. She said she had a good rapport with the resident and that the resident had confided in her that she had not been treated with respect. She said the resident cried when she talked about her treatment by Administration. The Activity Assistant said she felt really bad for the resident.

During an interview on April 10, 2018, Physical Therapy Assistant (PTA) 2 stated he witnessed the incident described by Resident 81. He said the Administrator's behavior was very unprofessional and inappropriate. The PTA 2 said he had worked with the resident a lot and every time the Administrator was near, her demeanor would change and he saw an increase in anxiety.

During an interview on April 19, 2018, Physical Therapy Assistant (PTA) 1 said she and another therapist were transferring the resident with a sit-to-stand mechanical lift. She said the Administrator and a high ranking nurse, came into the room while she was providing personal hygiene to the resident. The Administrator said they needed to talk about the resident's outstanding bill. The resident asked the Administrator to leave and to come back later. The Administrator responded to the resident in a firm, matter of fact tone: "I will leave when you give me a check for $2,200 dollars." The PTA 1 said the resident

felt humiliated as she was receiving care at that time. The PTA told the resident to contact the Ombudsman. The PTA said she did not report the Administrator's mistreatment of [De-identified info].

CNA 17 and CNA 18 were interviewed together on April 11, 2018. They said they **felt intimidated by the Administrator, Social Services Director, and the Director of Nursing. They feared retaliation in the form of being fired if they reported how these administrative staff abuse and mistreat Resident 81**. They said they did not know how to report them, since they were in charge and were causing it, and did not know to whom to report them, **so they did not report what they saw and overheard to anyone. Both indicated they feared losing their jobs; CNA 17 said she could not be without work as she had family to support**. CNA 7, who was present, agreed with CNA 18 and CNA 17 and said she felt hopeless to tell anyone as nothing would happen.

The CNAs said it appeared to them that the Administrator was trying to get rid of Resident 81.

During an interview on April 12, 2018, **CNA 19**, who worked with Resident 81, **said** she thought the Administrator was very verbally abusive toward Resident 81. However, while she had told RN 4 about how Resident 81 was treated, **she feared retribution to report abuse to the Administrator**.

During an interview on April 19, 2018, **LPN 3 said when the Administrator arrived in February 2018, the Administrator informed staff that she (the Administrator) was the reason staff had their jobs. LPN 3 understood the Administrator's statement as a reminder the Administrator could fire staff who did not agree with the Administrato**r. CNA 16 and RN 4 who also participated in the interview stated that they had similar reports from other staff about the Administrator making such statements.

The Director of Clinical Services (DCS) and Consulting Nursing Home Administrator reported in an interview conducted on April 16, 2018 that the **staff had expressed fear of losing their jobs if they reported the Administration for abuse concerns**. The DCS said **it was upsetting to her that staff felt fearful of losing their jobs**.

Name of Nursing Home	Falcon Heights Health and Rehabilitation Center
Provider ID	065168
Address [RUCA Code: 1] [% County Population Rural: 10.25]	1795 Monterey Road, Colorado Springs, Colorado, 80910
Day Investigation Completed	April 19, 2018
Type of Deficiency Issued	*F550 **F559 ***F600 ****F607 *****F609 ******F610 *******F835
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm ***Actual Harm ****Actual Harm *****Actual Harm ******Actual Harm *******Actual Harm

Two CNAs Witnessed LPN Abuse a Resident (Verbal Abuse and Causing the Resident to Sit Naked in a Geri-Chair in the Hallway) / They Didn't Report It Immediately Due to Fear of the LPN's Retaliation

The nursing home failed to promote and maintain the dignity of Resident 1 transferred naked from the waist down into a Geri-chair in the nursing home's corridor for approximately five hours. A reasonable and prudent person would be distraught, embarrassed that he/she was in the corridor naked from the waist down, covered only by a blanket.

The nursing home failed to ensure a resident's right to be free from abuse for an incident on January 16, 2022. The nursing home substantiated that Resident 1 was the victim of abuse by the perpetrator LPN 1, and failed to ensure that all 31 residents, including Resident 1, were not at risk for potential abuse by LPN 1. This failure created an immediate jeopardy situation as the nursing home continued to allow LPN 1to work directly with residents, therefore, potentially violating all 31 residents' right to be free from abuse by a substantiated perpetrator.

The nursing home failed to implement their abuse policy in relation to reporting and investigating an allegation of abuse and protecting residents during and after the investigation. These failures affect all 31 residents who were residing at the nursing home at the time of the survey.

The Administration failed to immediately start an abuse investigation per the nursing home's Abuse Policy and Procedures, and failed to ensure that all 31 residents, including Resident 1, were not at risk for potential abuse by LPN 1.

Cognitive Function. Not Reported. Activities of Daily Living. Not Reported.

During an interview on April 12, 2022, CNA 1 stated that on January 16, 2022, approximately between 1:00 PM and 3:00 PM, Resident 1 was placed in a Geri-chair without any pajama bottoms on or underwear. **CNA 1 stated she was afraid of LPN 1 to tell LPN 1 that the resident had no bottoms on**.

CNA 1 stated the following: On January 16, 2022, between 1:00 PM and 3:00 PM, she witnessed LPN 1 rush into Resident 1's room yelling and swearing at the resident. The LPN called the resident a "[OBSCENITY]ing, [OBSCENITY]" and told the resident: "I hope you broke your other hip." She was directed by LPN 1 to put Resident 1 in a Geri-chair. Once in the Geri-chair, the LPN moved Resident 1 into the hallway. The LPN told the resident to stay there until everyone else was in bed and if he/she tried to get up, she (the LPN) would tie the resident's legs to the chair.

CNA 1 stated she was afraid of retaliation from LPN 1; therefore, she did not report her observations (she did not immediately report the abuse because she felt uncomfortable telling other Charge Nurse and was afraid of retaliation from LPN 1). On January 17, 2022 in the morning, she and CNA M reported their observations; and LPN 1 continued to work on January 17, 2022 after they reported the observations of January 16, 2022 to the Administrator.

On April 12, 2022, **CNA M** was interviewed and stated the following: On January 16, 2022, at approximately 2:00 PM, she witnessed LPN 1 loudly yelling and swearing at Resident 1. LPN 1 called the resident "[OBSCENITY]ing, [OBSCENITY]" a few times. She assisted CNA 1 in transferring the resident into a Geri-chair as directed by LPN 1. At the time of transfer, Resident 1 was crying, asking why they were doing this, and stated that he/she would be good and would not do it again. **She was afraid of LPN 1 and worried about retaliation, therefore, she did not report the incident immediately**.

CNA M also said when LPN 1 told CNA 1 and her (CNA M) to transfer Resident 1 into the Geri-chair, she [CNA M] told LPN 1 that Resident 1 did not have any bottoms on. In response, LPN1 told CNA M not to bother and get the resident into the chair.

During an interview on April 12, 2022, a Licensed Social Worker stated that LPN 1 was not removed from the nursing home during the nursing home's abuse investigation and continued to be employed after it was substantiated that she verbally abused Resident 1.

During an interview on April 12, 2022, LPN 1 confirmed that she has worked every week since the January 16, 2022 incident and that she was moved to another unit.

During an interview on April 13 2022, the Administrator confirmed that LPN 1 continued to work at the nursing home but on a different unit from where Resident 1 resides.

Name of Nursing Home	Courtland Rehab & Living center
Provider ID	205123
Address [RUCA Code: 10] [% County Population Rural: 100]	42 Bucksport Road, Ellsworth, Maine, 04605
Day Investigation Completed	April 20, 2022
Type of Deficiency Issued	*F550 **F600 ***F607 ****F835
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Immediate Jeopardy ***Minimal Harm or Potential for Actual Harm ****Immediate Jeopardy

Two CNAs Didn't Report Alleged Sexual Abuse of a Woman by LPN (Their Supervisor), Fearing He'll Retaliate / The Alleged Sexual Abuse: Oral Sex in Return for Receiving Other Residents' Medications

The nursing home failed to ensure that three CNAs (BB, CC, LL) reported to Administrative staff the suspicious behaviors of LPN AA towards Resident 183.

The nursing home failed to ensure that three CNAs notified Administrative staff immediately about suspicious behaviors or allegations of abuse of Resident 183 by LPN AA so that a thorough investigation could be initiated timely and further abuse of the resident prevented.

Cognitive Function. Resident 183 was **cognitive intact** (BIMS score 15 out of 15). The resident's Care Plan indicated that she was "very independent in decision making."

Activities of Daily Living. The resident required limited assistance from one staff person for most activities of daily living; was non-ambulatory.

Interview with CNAs BB, CC, and OO on November 22, 2017, revealed CNA CC had heard that LPN AA was giving Resident 183 other residents' medications and Resident 183 was giving him oral sex in return. CNA CC stated that LPN AA would park the medication cart in front of the resident's door, effectively blocking the entry to the room, and the LPN does not do that at any other resident's door. The room doors do not have locks but, if you tried to open the resident's door when LPN AA was in there, he would hold the door closed. CNA BB agreed at that time that the door would be blocked and if you knocked, LPN AA would say he was doing the resident's pressure sore treatments, but Hospice did all her treatments. CNA BB stated at that time that the resident had told her that LPN AA was giving her drugs and that she sometimes gave him her drugs. CNAs BB and CC stated that LPN AA would be in the resident's room up to half an hour for no reason. When the resident was out of her room, LPN AA would tell her "It's time for your treatment" and Resident 183 would go to her room with him.

Continued interview revealed that this activity had been going on for one month. CNA OO stated at that time that he knew nothing about the resident's allegations of abuse until the afternoon of November 15, 2017, when the resident was sent to the hospital. Continued interview with CNA OO revealed that the resident had made her accusations against LPN AA public that morning in the hallway and had returned to her room. CNA OO went into her room to check on her and offer assistance, and the resident told him that LPN AA had groped her, inserted his finger in her vagina, and tried to get her to perform oral ex on him. The resident told him that LPN AA would bring her [MEDICATION(S)] (an antianxiety medication), needles, and other medications. When CNAs BB, CC, and OO were asked if they had seen any other suspicious behaviors or abuse of other residents by LPN AA, they stated that Resident 183 was the only resident with whom LPN AA acted differently. **CNAs BB and CC** confirmed that they **did not report the suspicious behavior of LPN AA toward Resident 183 due to fear of retaliation from LPN AA who was their supervisor**. They further stated **they did not report to the next person in authority because they did not think they would be believed**. CNAs BB, CC, and OO stated that they had been in-serviced on how to identify different types of abuse including sexual abuse and to immediately report to administrative staff if they suspected abuse.

During a follow-up interview with **CNA BB** on December 18, 2017, she stated she became suspicious of LPN AA when he would close Resident 183's door while giving her medications and stay in her room for 30-35 minutes. Continued interview revealed that he did not stay that long in the rooms of other residents. CNA BB stated she was working the 3:00 PM to 11:00 PM shift one time in September 2018 and Resident 183 had requested to have her bed turned down so she could sleep. When another CNA had gone to her room, the door was closed and LPN AA would not let her into the room. Further interview with CNA BB revealed that she became more suspicious of LPN AA and that she and other CNAs started discussing his behavior. **She stated that she did not feel comfortable reporting her suspicions to administrative staff without proof because she felt it would go through one ear and out the other**. Further interview with CNA BB revealed that sometime in October 2017, Resident 183 told her that LPN AA wanted favors for cigarettes. She stated she didn't ask Resident 183 what favors but "I knew."

Interview with Resident Z (cognitively intact; BIMS score of 15 out of 15) on December 18, 2017 revealed that he and Resident 183 were friends. Resident Z stated that Resident 183 had first told him around June/July 2017 that LPN AA had made inappropriate comments about her breasts. He stated that Resident 183 did not tell any staff because she did not trust anyone who was at the nursing home at the time. Resident Z stated that on the day that Resident 183 went to the hospital (November 15, 2017), she told him that LPN AA had exposed himself and pushed her head down to perform oral sex on him. Resident Z stated that Resident 183 told him that LPN AA would give her drugs if she did things. Resident Z stated that Resident 183 was fed up with LPN AA at that point. Resident Z stated that he thought about telling staff, but he didn't know who to trust. Continued interview with Resident Z revealed that he was aware to whom to report abuse and he was aware of how to contact the Ombudsman.

Interview with Resident X (Cognitively intact; BIMS score of 15 out of 15) on December 18, 2017 revealed that Resident 183 was a friend. Continued interview revealed that one day about 2-3 weeks ago they were outside smoking and Resident 183 told him that LPN AA had pulled down his pants and asked her to perform oral sex. He stated that Resident 183 began to cry at that time. Further interview revealed that he did not report what Resident 183 had told him and had told her to let it go unless it happened to her again. Further interview revealed that he was aware to whom to report abuse.

Review of the Nursing Home's Incident Report Form dated November 16, 2017, sent to the State Agency revealed, among others, that the nursing home's investigation revealed: "Although the allegation of sexual abuse could not be substantiated, **LPN AA was terminated** on November 30, 2017, **due to** discourteous conduct and **intimidation of his co-workers**."

Name of Nursing Home	Westwood Healthcare and Rehabilitation
Provider ID	115601
Address [RUCA Code: 5] [% County Population Rural: 45.14]	101 Stockyard Road, Statesboro, Georgia, 30458
Day Investigation Completed	December 21, 2017
Type of Deficiency Issued	F608
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A Witnessing Aide Lived in Very Close Proximity to the LPN and "*truly felt in danger of retaliation*" Because She was the Only Staff Member Working with the LPN When the Abusive Acts Occurred / Therefore, It Would Be Obvious to the LPN That She Had Reported the Abuse (e.g. The LPN filled a gastrostomy syringe with water and squirted the water at the residents while they were sleeping)

The nursing home failed to have an effective system to maintain an environment free from physical and verbal abuse for Residents 1, 2, 3, and 4.

Due to scope considerations, this summary does not focus on Resident 4.

The nursing home failed to have an effective system to protect residents from abuse, by not implementing its abuse prevention policies to promptly investigate and report staff-to-resident physical and verbal abuse for Residents 1-4. **The nursing home failure to ensure PCA 6 immediately reported the witnessed LPN 8 abuse of Residents 1-4, per their policies, and without fear of retaliation**, delayed the initiation of the investigation of alleged staff-to-resident abuse until May 3, 2021.

It also failed to be administered in a manner that enabled effective use of its resources to attain and maintain the highest practicable physical, mental, and psychosocial well-being for Residents 1-4.

The nursing home failed to have an effective system to ensure staff immediately reported known acts of physical and verbal abuse committed by a night shift nurse LPN 8 that affected Residents 1-4.

Cognitive Function. Resident 1 was **cognitively intact** (BIMS score of 14 out of 15).

Cognitive Function. Resident 2 was **cognitively intact** (BIMS score of 13 out of 15).

Cognitive Function. Resident 3 was **cognitively intact** (BIMS score of 15 out of 15).

Cognitive Function. Resident 4 was **cognitively intact** (BIMS score of 15 out of 15).

Activities of Daily Living. Not Reported for any of Residents 1-4.

Review of the nursing home's Investigation Report dated May 7, 2021, revealed: On May 3, 2021, PCA 6 reported that former employee LPN 8 (Night Shift Nurse) displayed behaviors prior to termination of her employment, which could be classified as abuse. The abusive acts affected Residents 1, 2, and 3. According to the investigation, the Director of Nursing (DON) fired LPN 8 on May 1, 2021, because of her inappropriate treatment [MEDICAL RECORD OR PHYSICIAN ORDER]. Per the report, LPN 2 was the first staff member who reported the abuse allegations to administration, as told to her by PCA 6. LPN 2 contacted the Assistant DON (ADON) in the early morning of May 3, 2021, and reported the allegations PCA 6 made against LPN 8. Per the report, the DON conducted interviews on May 3, 2021 with Residents 1, 2, and 3. Resident 1 and 2 confirmed LPN 8 squirted them with water.

During an interview with the DON on May 3, 2021, Resident 2 confirmed that LPN 8 squirted him/her with water (the resident confirmed it after LPN 8's photo was shown to them). The resident told the DON that he/she did not report the incident because he/she did not want to get the nurse fired.

On May 3, 2021, Personal Care Attendant (PCA) 6 reported she witnessed LPN 8 commit physically and verbally abusive acts toward Resident 1, 2, and 3. According to PCA 6, LPN 8 committed the abuse over the past two months, but she could not provide exact dates she witnessed the resident abuse. **The PCA** stated she **was afraid to report LPN 8's actions while the nurse was still working at the nursing home because she feared the nurse would retaliate against her**. **She reported the abuse only after the nursing home terminated LPN 8's employment** on May 1, 2021.

Review of **PCA 6's written statement**, dated May 6, 2021, who at the time **wanted to remain anonymous**, revealed PCA 6 wrote: "LPN 8 abusive acts occurred on the night shift when no other staff member was around except her." She wrote "the nurse grabbed some cheese and threw it at Resident 1 aiming at his/her face," and she overheard LPN 8 say: "Dumb M. F-er," under her breath when she thought Resident 1 could not hear her. She also wrote that in the presence of Resident 1, LPN 8 said: "This is the reason cousins don't [Obscenity]." PCA 6's statement revealed LPN 8 filled a long syringe with water, hit it real hard, and squirted water on Residents 2 and 3. The statement revealed LPN 8 called it a "Mini Baptismal" and told PCA 6 she did similar things to residents in another facility when she did not like them. The written statement revealed other staff did not like the way LPN 8 talked to the residents. The DON added to PCA 6's written statement: **The PCA lived in very close proximity to LPN 8 and truly felt in danger of retaliation because PCA 6 was the only staff member working with LPN 8 when the abusive acts occurred; therefore, it would be obvious to LPN 8 that PCA 6 had reported the abuse**.

During an interview on May 11, 2021, **PCA 6 stated she was afraid to report the allegations. She said many other nurse aides had quit their jobs because of LPN 8**. She said **she feared LPN 8 would retaliate if she reported the abuse while the nurse still worked at the nursing home**. **She said the possibility of retaliation is always on her mind**. PCA 6 stated she reported the abuse on May 3 2021 after the DON fired LPN 8. **PCA 6 stated LPN 8 would know she was the person who reported her abusive actions, and she lived across the street from LPN 8**. She said they would sometimes take breaks together.

Interview with LPN 2 on May 11, 2021 revealed, among others, that PCA 6 told her that LPN 8 went into the bathrooms of Residents 1, 2, and 3 and filled a gastrostomy (g-tube) syringe with water, opened the bathroom door just enough, and squirted the water at the residents while they were sleeping. LPN 2 said LPN 8 did not like Resident 1 because he/she made racial slurs. PCA 6 told her that LPN 8 made fun of Resident 1. LPN 2 said PCA 6 told her that, in reference to Resident 1, in his/her presence, LPN 8 said: "Two of his/her cousins had sex and made him/her," and that was why (Resident 1) was stupid. LPN 2 said she reported the allegations to the ADON on the morning of May 3, 2021, as soon as PCA 6 reported them to her.

Interview with the ADON on May 17, 2021 revealed LPN 2 called her on May 3, 2021, very early, as she had not yet gotten out of bed, and reported the allegations of abuse against LPN 8. The ADON said she immediately called the DON and was able to reach him before 9:00 AM, which would have been before the morning staff meeting began at the nursing home.

Interview with the DON on May 17 2021 revealed: **Even though PCA 6 requested to be an Anonymous Witness when she interviewed** on May 6, 2021, **her statements were no longer considered anonymous.**

During an interview on May 15 2021, **SRNA 15 stated**: One night Resident 3 put on his/her call light and when LPN 8 went to the resident's room, she put a video on her phone with sounds of flatulence (gas sounds) and told the resident she could not help him/her right now because she had diarrhea. SRNA 15 stated Resident 3 did not think the prank was funny because he/she needed help. SRNA 15 stated **she did not report this to anyone**, and she was unsure if anyone else reported the incident. SRNA 15A stated LPN 8 was very drama-filled and picked on people. She said many nurse aides quit because of LPN 8. **SRNA 15 stated** she did not know if other staff were afraid of LPN 8., but **because of her periodic [NAME], she personally never said anything to challenge the nurse.**

During an interview on May 16, 2021, **PCA 16 revealed** she worked the night shift with LPN 8. She said when Resident 1 would yell for ice, LPN 8 would tell her not to get ice for the resident because the resident could help himself/herself. PCA 16 said working with LPN 8 made her uncomfortable. She said she thought **the LPN bullied her as well as other nurse aides**. She stated LPN 8 tried to send her home by saying the shift was overstaffed. She stated when she worked with LPN 8 on the weekend of April 23, 2021 to April 25, 2021, the LPN told other staff that she (PCA 16) had an offensive odor, and LPN 8 tried to send her home. PCA 16 said she heard the night shift nurses on A Hallway (LPN 1 and LPN 3) confronted LPN 8 over that. **PCA 16 stated LPN 8's actions upset her because she needed to work**. The PCA stated she thought **LPN 8 only wanted certain staff to work with her because she knew which ones would not report her if she did things to residents.**

During an interview on May 16, 2021, LPN 8 stated the DON told her she was not a good fit for the nursing home when he fired her on May 1, 2021, but he did not tell her there was an allegation of resident abuse against her. LPN 8 denied squirting water at Residents 1, 2, and 3, and denied she had thrown cheese at Resident 1. LPN 8 denied making abusive comments about Resident 1. She stated Resident 1 often made racist statements, and when the resident found out she had bi-racial family members, he/she made racist comments to her almost daily. She said Resident 1's racial slurs bothered her, not only because it was personal for her, but that his/her statements could offend some of the residents, too. LPN 8 stated she did not think Resident 3 had any concerns about her. LPN 8 stated some staff did not like her because she had bi-racial family members, and she thought a couple of racist nurses had something to do with her dismissal. LPN 8 said staff and residents probably learned about her bi-racial family by looking at her social media account.

During an interview on May 18, 2021, the Administrator stated, among others, he became aware LPN 8's license was under investigation by the State Board on Nursing in February 2021. He said he questioned LPN 8 about her license, and she told him that while working at another facility, she had been falsely accused of possible drug diversion. He said he did not do additional investigation of the nurse's past work history. He said he had a long talk with LPN 8 and told her, since her license was under investigation, she should perform her duties professionally and always keep the residents safe. He said that more should have been done to monitor her work. The Administrator stated the facility was ultimately responsible for any staff person employed at the facility. He stated LPN 8 was on clock when the abusive acts occurred, so the facility would be responsible for her actions.

During an interview on May 18, 2021, **the ADON stated she was not aware certain nurse aides were afraid of LPN 8**. The ADON said **she could somewhat understand the younger aides, such as the PCAs, being too insecure and perhaps fearful to report the licensed nurse**, but administrative staff thought they had trained them on the importance of reporting any form of abuse immediately.

During an interview on May 11, 2021, **PCA 6 said** it seemed **several of the young nurse aides were afraid of LPN 8**, and since she was gone, things were much better on the night shift.

Name of Nursing Home	Harborview Dover, LLC
Provider ID	185295
Address [RUCA Code: 4] [% County Population Rural: 32.30]	112 Dover Drive, Georgetown, Kentucky, 40324
Day Investigation Completed	June 3, 2021
Type of Deficiency Issued	* F600 **F607 ***F609 ****F835
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy ****Immediate Jeopardy

Fearing Retaliation, an LPN Did Not Report Employee's Verbal Abuse of Residents for a Few Weeks

The nursing home failed to ensure Residents 1-3, reviewed for verbal abuse, remained free from abuse, when a nursing assistant (Staff A) made demeaning and belittling comments, and yelled at residents. This failed practice placed the residents at risk of psychosocial harm and diminished quality of life.

The nursing home failed to ensure allegations of verbal abuse were reported immediately to the Administrator of the nursing home and to the State Survey Agency, as required. Failure to report incidents of verbal abuse placed all residents at risk of additional abuse.

Information about Cognitive Function and Activities of Daily Living was not detailed in the investigation report regarding Residents 1, 2, and 3.

During an interview on May 26, 2022, Resident 1 stated Staff A had a bad attitude, and did not talk kindly to them. Per the resident, Staff A would tell them: "When I tell you what to do, do it" like they were a child. Resident 1 stated Staff A would also yell at them which would make Resident 1 nervous and upset. Resident 1 stated Staff A no longer worked with them.

During an interview on June 8, 2022, Resident 2 stated Staff A yelled all the time, not only to them, but other residents too. Resident 2 stated they felt it was to the point of being verbally abusive and was concerned about the residents who weren't able to speak up.

During an interview on June 8, 2022, Resident 3 stated Staff A came into their room several times and yelled at them. Resident 3 stated one time it was just the two of them in the room, which was very intimidating and made Resident 3 feel fearful.

Review of May 15, 2022 nursing home's investigation: The Director of Nursing (DON) received a call from LPN (Staff B) stating they had witnessed ongoing verbal abuse from Staff A toward several residents. The allegations included yelling at forgetful residents for using their call light repeatedly, talking down to residents as if they were children, and causing other residents to be fearful so they would not call for help during the shift. **LPN (Staff B) stated it took so long to come forward because they felt they would be retaliated against**.

During an interview on June 8, 2022, LPN (Staff B) stated they witnessed Staff A talking in a demeaning manner, especially to Resident 1. **LPN (Staff B) stated they spoke to Staff A about how they were speaking to residents, and Staff A got very aggressive with them**. LPN (Staff B) stated there were definitely moments of verbal abuse towards the residents. **LPN (Staff B) stated they didn't come forward immediately because of retaliation** and confirmed they should have immediately reported the incidents. **LPN (Staff B) said they didn't report the incidents for a few weeks because they were fearful they would be retaliated against**.

On June 8, 2022, the DON stated **LPN (Staff B) reported concerns of verbal abuse when staff A was not on shift**. The DON interviewed all residents that were interviewable on the unit. The incidents had happened over a course of 3-4 weeks before LPN (Staff B) made the report. Verbal abuse was substantiated for some of the residents.

When asked if verbal abuse was substantiated for Resident 3, the DON stated "No" because Resident 3 was alert and oriented and didn't feel what they experienced was verbal abuse.

The DON stated Staff A's employment was terminated, and all staff were in-services on abuse which included definitions of verbal and mental abuse, and managed reporting including timely reporting.

Name of Nursing Home	Sullivan Park Care Center
Provider ID	505383
Address [RUCA Code: 1] [% County Population Rural: 14.63]	14820 East Fourth, Spokane, Washington State, 99216
Day Investigation Completed	June 8, 2022
Type of Deficiency Issued	* F600 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm

Due to Fear of Retaliation, Delay in Nurse's Report of Another Nurse's Physical Abuse of a Woman with Severe Cognitive Impairment on Secure Dementia Care Unit

The nursing home failed to prevent an incident of abuse. On September 26, 2021, Licensed Nurse (LN) G forcefully escorted an agitated and confused resident (Resident 1) to a room on a secure dementia unit. This deficient practice placed Resident 1 and 16 other residents on the secure dementia unit at risk for injury and/or impaired psychosocial well-being.

The nursing home failed to ensure staff immediately reported to the administration an incident of abuse. On September 26, 2021, Licensed Nurse (LN) H and Certified Medication Aide (CMA) M observed LN G forcefully escort an agitated and confused resident (Resident 1) to a room on the secure dementia unit.

Cognitive Function. Resident 1 had **severely impaired cognition** (BIMS score of 8 out of 15).

Activities of Daily Living. The resident was able to independently complete most of Activities of Daily Living. She walked without the use of any assistive devices.

Care Plan (revised November 15, 2021) documented: Resident 1 had a potential to be verbally aggressive (cussing and yelling) related to Resident 1's diagnosis [MEDICAL RECORD or PHYSICIAN ORDER].

Review of the Nursing Home Investigation dated September 28, 2021 documented Licensed Nurse (LN) H reported to Administrative Staff A an incident which occurred on September 26, 2021 between 6:00 AM and 7:00 AM. LN H reported she witnessed LN G forcefully escort Resident 1 to Resident 1's room holding Resident 1 by the shoulder and Resident 1 sustained a red mark to the left side of her neck. LN H reported Resident 1 was yelling and cussing. LN G grabbed Resident 1 by the back of the neck and arm and walked Resident 1 down the hall to her room.

The Nursing Home Investigation further documented Administrative Staff A interviewed Resident 1 at 6:40 PM on September 28, 2021 (two days after the incident). When asked if something happened to her neck, Resident 1 stated: "The little girl with white hair did this and squeezed real tight." Resident 1 identified the left side of her neck directly above her shoulder as the affected area. Administrative Staff A assessed the area and there was no apparent bruising or redness to the neck or shoulder. Resident 1 denied any previous problems or continued pain. Administrative Staff D interviewed Certified Medication Aide (CMA) M who stated she witnessed LN G push Resident 1 to her room by her shoulder.

The Nursing Home Investigation further recorded LN G denied forcefully walking Resident 1 to her room or pushing Resident 1 in the room and slamming the door. LN G reported she did not walk with Resident 1 to Resident 1's room and stated if she placed her hand on Resident 1's back when she spoke with her, it was because she always puts a hand on the back of the residents when she talked with them.

During an interview on September 30, 2021, Administrative (Staff A) stated **Licensed Nurse** (**LN) H did not report the incident the day it occurred, because LN H expressed fear of retaliation for reporting a nurse who was a nursing home employee**. **Administrative Staff A educated LN H on her obligation to report and retaliation would not occur as this also was against the law**. Administrative Staff A further stated the moment Administrative Staff A was informed of LN G's alleged actions, LN G was immediately removed of duties (suspended) pending further investigation.

During an interview on September 30, 2021, CMA M confirmed the report made by LN H. CMA M did not immediately report the incident "because, to be honest, I was so busy that day I forgot about it."

Name of Nursing Home	Heritage Gardens Health and Rehabilitation Center
Provider ID	175333
Address [RUCA Code: 10] [% County Population Rural: 99.13]	700 Cherokee, Oskaloosa, Kansas, 66066
Day Investigation Completed	September 30, 2021
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm

Due to Fear of Retaliation, a CNA Orientee Witnessed But Did Not Report Staff Abuse of a Woman

The nursing home failed to ensure Resident 34 and Resident 36 were not abused by Staff 211.

The nursing home failed to implement their policy regarding an allegation of abuse regarding Resident 36.

It failed to report an allegation of abuse regarding Resident 36 within 2 hours to the State Agency.

It also failed to thoroughly investigate an allegation of abuse regarding Resident 36.

Cognitive Function. Resident 36 had **severe cognitive impairment** (BIMS score of 6 out of 15).

Activities of Daily Living. The resident required extensive assistance from two staff for bed mobility and transferring. The resident used a wheelchair.

Cognitive Function. Resident 34. **Cognitively intact** (BIMS score of 15 out of 15).

Activities of Daily Living. She required extensive assistance with bed mobility, transferring, dressing and personal hygiene. The assessment also included she had a frequent pain level of 7 out of 10.

Review of the Nursing Home's Investigation regarding an abuse allegation revealed a witness statement from a CNA (Staff 212) regarding an incident that had occurred on April 7, 2018 at 9:00 PM in the room of **Resident 36**. CNA (Staff 212) stated that upon entering the room of Resident 36, she observed CNA (Staff 211) shaking a finger in Resident 36's face and telling her to shut up and knock it off. The witness statement also included that CNA (Staff 212) reported that she stopped in her tracks and went back to the desk and that shortly afterwards, Staff 211 was observed wheeling the resident in her wheelchair into the lobby. The statement included Staff 211 was speaking in a kind manner to the resident, but the resident looked frightened. The witness statement did not include any additional details that Staff 212 had intervened or had reported the incident to the nurse or to any other staff member.

During an interview on April 8, 2018, **CNA (Staff 212)** stated she **did not intervene or attempt to stop Staff 211 from telling Resident 36 to shut up or to knock it off**. CNA (Staff 212) stated she did not intervene or report the abuse because she was confused and did not know what to do. She stated that she was not sure if she should report what she had witnessed to a supervisor because Staff 211 had not actually touched the resident and was not sure if she had witnessed abuse.

Continued review of the nursing home's investigation revealed a statement dated April 9, 2018 that Resident 36 was interviewed by a staff member and stated that she did not remember the incident from April 7, 2018 at 9:00 PM and that she did not feel fearful.

An interview was conducted on August 7, 2018 with **CNA (Staff 212)** who had witnessed the interaction between **Resident 34** and Staff 211. The CNA stated that on April 8, 2018, she was receiving orientation training from Staff 211. She stated that she was in the hallway when she heard Staff 211 tell Resident 34: "If you would move your ass and do it yourself, then we wouldn't have this problem, remember?" CNA (Staff 212) stated that when she entered the room, she observed Staff 211 throw the resident's blanket across the room and observed Staff 211 attempting to reposition the resident in the bed. She stated that the resident was crying out in pain and repeatedly told Staff 211 that she was having pain.

Staff 212 stated that Staff 211 ignored the resident and continued to argue with the resident and reposition her despite her complaints of pain, which caused the resident's behavior and anxiety to escalate. Staff 212 stated that she attempted to help Staff 211 and that after the interaction, they left to assist other residents. During the interview, **Staff 212 stated** that they did not notify the nurse that the resident was having pain. She stated that she had not received abuse prevention training prior to the incident, and that **she did not report the abuse because she was afraid that other staff would retaliate against her**. Staff 212 stated she did not report the abuse until the next day when she was questioned by staff.

During a telephone interview on August 8, 2018, Resident 34 stated that CNA (Staff 211) came into her room and became very irritated with her and stated: "If you would move your ass" and "If you would only move your ass" and "This is the last time that I have to see you!"

Review of the Nursing Home's Investigative record dated April 9, 2018 revealed that on April 8, 2018, at 10:30 PM, Resident 34 had been hurt and called a "fat ass" by her CNA (Staff 211). A skin check had been provided to the resident and there was no new injury. Staff 211 was suspended on April 9, 2018 and terminated from employment on April 12, 2018. The report also included the resident stated to the Administrator that the night before (April 8, 2018) at 10:30 PM, she had become tangled in her sheets and had used the call light to call for help and that Staff 211 responded to the call light. The resident stated the CNA was rough with her and at one point told her to "Move your ass" and "I hope I never see your face again." The resident also stated to the Administrator that after the incident that her back pain increased. The resident further stated that she felt the encounter with the CNA was abuse.

Name of Nursing Home	Sante of Surprise
Provider ID	035282
Address [RUCA Code: 1] [% County Population Rural: 2.3]	14775 West Yorkshire Drive, Surprise, Arizona, 85374
Day Investigation Completed	August 10, 2018
Type of Deficiency Issued	*F600 **F607 ***F609 ****F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm **** Minimal Harm or Potential for Actual Harm

A Weeklong Delay in CNA's Reporting Witnessing LVN Exposing Himself to a Woman in Her Bedroom / The CNA Was Afraid to Immediately Report the Incident Fearing Retaliation If the LVN Lost His Job

The nursing home failed to ensure all allegations or suspicions of sexual abuse were immediately reported to the nursing home's Administrator and no later than 2 hours to the California Department of Public Health (CDPH) and local law enforcement. LVN 1 allegedly exposed himself to Resident 1. **CNA, 1 who witnessed it, did not report the incident to the Administrator until seven days later**. As a result, the nursing home reported the incident to CDPH, local law enforcement, and the Ombudsman seven days after CNA 1 had initially observed the sexual misconduct by LVN 1. This failure placed Resident 1 and other residents at risk for further abuse.

Cognitive Function. Resident 1 was **cognitively intact** (based on MDS assessment).

Activities of Daily Living. Not Reported.

Review of Report of Suspected Dependent Adult / Elder Abuse Form (dated October 8, 2020) showed the nursing home reported an allegation of suspected abuse, documented as a potential exposure, identifying LVN 1 as the suspected abuser. CNA 1 reported witnessing LVN 1 exposing himself to Resident 1 on October 1, 2020. The SOC 341 form showed the nursing home notified the CDPH Licensing and Certification Program, the local law enforcement agency, and the Ombudsman on October 8, 2020.

On October 16, 2020, at 15:05 hours, an interview was conducted with Resident 1. Resident 1 stated LVN 1 came to her room to measure her blood pressure. Resident 1 stated her arm accidentally brushed against LVN 1's crotch. Resident 1 stated she apologized and lifted her arm back up. Resident 1 stated LVN 1 then reached his hand into his pants and pulled out his penis. Resident 1 stated she told LVN 1 to leave her room, which he did.

On October 16, 2020 at 16:00 hours, a telephone interview was conducted with CNA 1. **CNA 1** stated on October 1, 2020, she observed LVN 1 exposing his penis to Resident 1. CNA 1 stated she went to Resident 1's room to assist her with getting ready for bed. CNA 1 stated she observed Resident 1 sitting in her wheelchair with the resident's back to her (CNA 1) and LVN 1 was standing in front of Resident 1. CNA 1 stated she observed LVN 1's penis head exposed at the top of his pants. **CNA 1 stated she was afraid to immediately report the incident because she feared retaliation if LVN 1 lost his job**.

Name of Nursing Home	South Coast Post Acute
Provider ID	055653
Address [RUCA Code: 1] [% County Population Rural: 0.25]	1030 W Warmer Ave, Santa Ana, California, 92707
Day Investigation Completed	November 19, 2020
Type of Deficiency Issued	F609
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Witnessed Physical Abuse of a Woman with Cognitive Impairment But Didn't Report It Immediately, Saying "*she liked her job and did not want her co-worker to retaliate or confront her*" / The Same CNA Also Witnessed but Was Afraid to Report the Same Perpetrator's Neglect of Another Resident with Alzheimer's Disease Who "*sat in poop and urine for eight hours*"

The nursing home failed to ensure that all alleged abuse violations are reported immediately and not later than 2 hours after the allegation is made for Residents 30 and 12.

Cognitive Function. **Resident 30** was **cognitively impaired** (the resident had long/short term memory impairment and severely impaired decision-making ability).

Activities of Daily Living. She required extensive assistance in dressing, eating, and personal hygiene.

Resident 12 had a diagnosis of **Alzheimer's Disease**.

Cognitive Function. **Resident 12** had **severe cognitive loss** (BIMS score of 3 out of 15).

Activities of Daily Living. The resident required extensive assistance with transfer, ambulation, toileting, personal hygiene and documented the resident as frequently incontinent of bowel and bladder.

Review of Five Day Investigation Summary revealed an incident involving **Resident 30** and Staff L occurred on February 25, 2021. Nursing Assistant (Staff M) witnessed what she believed to be an alleged violation involving abusive treatment of [MEDICAL RECORD OR PHYSICAN ORDER]. **Staff M failed to report the alleged abuse within two hours of the incident.**

During an interview on March 9, 2021, the Administrator reported LPN (Staff D) had called her the evening of March 2, 2021 at approximately 10:00 PM to inform her Staff M had reported an incident regarding Resident 30 and Staff L that had occurred on February 25, 2021 that could be abuse. The Administrator directed Staff M to write a statement of the events. She reported **Staff M voiced** on March 2, 2021 at approximately 10:00 PM via phone interview **she worried Staff L would retaliate or confront her and it would make it difficult for them to work together**.

On March 11, 2021, **CNA** (**Staff M) reported** on February 25, 2021 earlier in the day the Administrator had talked about getting the resident's teeth brushed. Supper had just gotten over with when Staff L called her to assist with **Resident 30**'s transfer. She reported when she entered Resident 30's room, Staff L took a swab toothette and put mouthwash into the resident's mouth two times. She observed Staff L yelling at Resident 30: "Spit it out! Spit it out!" Resident 30 held the mouthwash in her mouth. When the resident did not spit out the mouthwash, Staff L pinched the resident's nose closed to try to get her to swallow the mouthwash; Staff L pinched the resident's nose for a few seconds. The resident groaned but did not seem to be in any distress. The resident did not spit out the mouthwash. Staff L and Staff M transferred the resident to bed. Staff M reported she had been walking to the door to leave the room when she turned around and saw Staff L stick her finger of her right hand in the resident's mouth to get her to swallow. Staff M reported she heard the resident swallow and Staff L say: "The resident swallowed the mouthwash."

Staff M reported she had been afraid to report the situation in, as she had reported another situation in and the nursing home had not done anything about it. She liked her job and did not want her co-worker to retaliate or confront her. She verbalized she should have reported the incident in sooner.

On March 9, 2021, **CNA (Staff M**) reported she **had been afraid to report an abuse allegation regarding another resident after she had reported on a situation regarding Resident 12 on February 25, 2021 at the end of her shift and nothing had been done**. She stated Resident 12 had sat in poop and urine for eight hours on February 25, 2021 on the 2:00 PM to 10:00 PM shift because CNA (Staff L) did not get along with the resident. Staff L did not ask any of the other aides to help her with Resident 12, so he had not been offered toileting all shift. Staff M reported she and Staff O (CNA) went to Resident 12's room and noticed a urine and bowel odor when entering the room. They stood Resident 12 from the recliner and noted the recliner was soaked with urine. They transferred the resident to bed and Staff M described the resident as soaked with urine and bowel from his back down to his knees. Staff M reported they had to scrub him so hard his skin bled and he complained of pain during per-care.

During a phone interview on March 10, 2021, Staff O, who was present with CNA (Staff M) during the incident, basically confirmed CNA's (Staff M) report. Staff O said that after she and CNA (Staff M) witnessed Resident 12 soaked in urine and bowel movement and after they assisted the resident with cleaning it, she went to the nurse's station and asked Staff L if she had toileted Resident 12 during the shift. Staff L responded: "The resident doesn't like me." Staff L admitted she did not take the resident to the toilet the entire shift and did not ask any other aides to assist the resident until around 9:45 PM that night. Staff O stated she reported the incident to LPN (Staff P). LPN (Staff P) informed Staff O she would have to write up the incident. Staff O reported she spoke to the Administrator the next day. The Administrator had been informed of the incident and planned to follow up with Staff P. Staff O voiced Resident 12 does refuse care. He will not initiate his/her care needs so staff have to be proactive and prompt cares, otherwise he/she will sit in his urine and feces. Staff O reported it is well known that Resident 12 did not like Staff L. Staff L is banned from several residents' rooms, as they do not want her caring for them. There is no direction as to who is to cover the rooms that Staff L is banned from.

On March 11, 2021, the Assistant Director of Nursing (ADON) reported Resident 12 has not liked Staff L to provide care for him for a long time. The ADON stated they have set up a system where Staff L is to try to provide cares to the resident, but if he does not allow them to, then Staff L is supposed to go to get another CNA to provide the care. Referring to the aforementioned incident, the ADON stated that LPN (Staff P) reported early morning there had been an incident of miscommunication resulting in Resident 12 not being changed until 9:45 PM on the second shift (2:00 PM to 10:00 PM) or toileted. The ADON stated she spoke with Staff L about the incident and instructed Staff L if Resident 12 will not allow her to do cares, she needed to get another aide on the other hallway and take over their care while they go down to care for the resident. She reported Staff L said she had called on the walkie-talkie for help and no one responded. The ADON said she told Staff L she needed to report to the Charge Nurse in those situations. The ADON reported the nurse did not file a written report, but in hindsight should have written the situation up. She did inform the Director of Nursing and Administrator when they came into work the next

day. After reviewing the nursing home's Abuse Policy definition of neglect, the ADON stated in her heart of hearts she knows the situation had been neglect and it should have been investigated and reported to the state.

A Report communication provided to the Surveyor on March 11, 2021 by the nursing home documented a communication report February 25, 2021 at 10:37 PM by LPN (Staff P) which stated:

"CNAs you need to be doing checks on your residents! If you know a resident gets irritated with you, then you need to speak up and ask your co-workers for help. Resident 12 was not changed since 2:00 PM! This is ridiculous, take care of the residents! I should not nor ANY nurse have to hang over your shoulder to make sure you are doing your job."

During an interview on March 11, 2021, Staff L reported if a resident had dementia, they have to check them every couple of hours and call for assistance when needed. She reported Resident 12 would not let her provide care to him. She uses the walkie-talkie and calls other aides to provide his cares. She stated she does not go in his room to provide cares for him. If she tries to go in there, he will raise his fist at her and start yelling obscenities. She reported she had called on the walkie-talkie before supper for assistance to get him changed at approximately 3:30 PM to 4:00 PM and no one responded to the call and no one came down to the hallway. She reported when no one responded, she did not take any further action, but all the other aides have walkies and would have heard the message. Staff L reported the day after the incident with Resident 12, the ADON talked to her stating they were going to write her up, but the ADON just talked to her about the situation.

Name of Nursing Home	Osage Rehab and Health Care Center
Provider ID	165173
Address [RUCA Code: 10] [% County Population Rural: 100]	830 South Fifth Street, Osage, Iowa, 50461
Day Investigation Completed	March 11, 2021
Type of Deficiency Issued	F609
Scope Severity Level	Minimal Harm or Potential for Actual Harm

During Care, Aide 1 Witnessed Aide 2 Cause a Resident to Hit His Head on the Wall (Causing Skin Tear to Forehead and Broken Glasses) But Due to Fear of Retaliation, Reported it Only the Next Day / Aide 1 Said It Was a Mistake Not to Report It the First Time Aide 2 Was Rough With Him, But She Was Afraid of Retaliation Because It Was a Small Nursing Home and the Aide's Mom Works There Too

The nursing home failed to: 1. Prevent staff-to-resident abuse. This affected Resident 1. The nursing home also failed to timely report an allegation of staff to resident abuse. This affected Resident 1.

Cognitive Function. Resident 1 had **moderate cognitive deficits** (based on MDS evaluation).

Activities of Daily Living. The resident required extensive assistance with Activities of Daily Living, and was frequently incontinent of bowel and bladder.

Review of the SRI number 2 Narrative Summary of Incident revealed on April 20, 2022, the STNA 25 reported to the Assistant Director of Nursing (ADON) that while providing care with STNA 30 on Resident 1, that STNA 30 became verbally abusive and frustrated with Resident 1. While the two STNAs had Resident 1 standing up in front of the toilet, Resident 1 was noted to have leaned backwards and STNA 30 attempted to force him forwards causing him to hit his head on the wall. A short time later, Resident 1 was toileted in the shower room again, however only STNA 30 was in the room assisting him. STNA 25 reported that she could hear STNA 30 raising her voice and yelling at Resident 1. STNA 30 then opened the door to the shower room and requested STNA 25 get the nurse due to Resident 1 hitting his head on the wall again and sustained a skin tear to forehead and broke his glasses. STNA 30 reported to nurse that she stood Resident 1 up to clean him and pull his pants up and he started to try to sit. STNA 30 asked Resident 1 to stand up straight ad she continued trying to pull his pants up, but Resident 1 started leaning his legs and torso in the opposite directions. STNA 30 stated she put her arms around Resident 1's waist to pull him straight up and Resident 1 moved forward suddenly, and he hit his head on the wall again causing him to break his glasses and sustain skin tear. **Resident 1 stated during interview that "One gal was mad at someone and told me not to talk clamping my mouth shut," then demonstrated by placing his hand over his mouth**. He said: "Sometimes they slam me back against the wall. [STNA 30] turned one way and I turned another and didn't go fast enough or something and she said: "I don't have time for that.""

STNA 30 was placed on immediate suspension pending completion of investigation. "After thorough investigation, this facility has determined that the evidence supports the abuse allegations had occurred and are substantiated."

Review of STNA 30's telephone statement revealed Resident 1 asked to go to the bathroom, so she took him into the shower room to use the toilet because there is more room for us to move around. When she stood up Resident 1 to clean him and pull his pants up, he started to sit. STNA 30 asked Resident 1 to stand up straight which he started to do. As she was about to pull up his pants, he started to move on her. Resident 1's legs went forward, but his torso and head went back on her. STNA 30 put her arms around his waist to move his hips back towards her slowly. When she did that, Resident 1's top half moved forward really quick and he hit his head on the wall. She instantly called for the nurse and she checked

him out. STNA 30 was talking loudly because Resident 1 did not have his hearing aids in, and she was not frustrated or agitated.

Interview on May 6, 2022 with the Corporate DON 25 and the Clinical Manager 40 reported that **STNA 25 should have reported her concerns when they happened instead of waiting until the next day, however,** they stated **STNA 25 stated she was afraid of retaliation.**

A telephone interview on May 6, 2022 with STNA 25 reported the first incident when she was assisting STNA 30 transferring Resident 1 off the toilet was shortly after breakfast and stated STNA 30 was speaking roughly to Resident 1 saying: "God [expletive Resident 1], what the [expletive] are you doing?" and was really rough with him to keep him standing. **STNA 25 stated it was a mistake not to report it the first time STNA 30 was rough with Resident 1 but she was afraid of retaliation because it was a small nursing home and STNA 30's mom works there too**. STNA 25 reported the second incident she could hear STNA 30 yelling at Resident 1 from the dining room and after the nurse treated Resident 1, STNA 25 said to the nurse that it should not have happened that STNA 30 was too rough with Resident 1.

During an interview on May 6, 2022, Resident 1 reported the day he hurt his head, STNA 30 seemed angry and upset with him. Resident 1 stated she had never treated him bad before that and that no one had ever treated him that bad. He reported that he felt safe now that STNA 30 no longer works here.

Name of Nursing Home	Morris Nursing Home
Provider ID	366233
Address [RUCA Code: 2] [% County Population Rural: 26.27]	322 South Charity Street, Bethel, Ohio, 45106
Day Investigation Completed	May 10, 2022
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm

LPN 1 Didn't Report on LPN 2 Who Didn't Provide Tracheal Suctioning to a Man with a History of Respiratory Failure Because "*there was some nepotism going on*" and She Didn't Want Retaliation

The nursing home did not ensure [CONDITION(S)] [CONDITION(S)] care was provided for Resident 4.

Cognitive Function. BIMS-based cognitive function was not detailed in the investigation report. That said, LPN (Staff K) and the DON (separately) stated (see below) that the resident was "**alert and oriented**."

Activities of Daily Living (ADL). Not Reported. However, the resident's Care Plan (last reviewed on February 17, 2021) revealed an ADL self-care deficit related to [CONDITION(s)] and [CONDITION(s)] with a goal to receive appropriate level of support from staff on a daily basis. Resident 4 has a [CONDITION(S)] due to **history of respiratory failure** with a goal to have clear and equal sounds bilaterally through the review date. Interventions to include [CONDITION(S)] care as ordered.

During a tour of the nursing home on March 3, 2021 at 10:30 AM, Resident 4 was observed laying in bed watching TV. Resident 4 reported that the previous night he had waited an hour to receive [CONDITION(S)] suction care. Resident 4 said that he called for help for an hour and the evening nurse did not respond. Resident 4's [CONDITION(S)] site noted with reddish matter on ties and stoma area.

On March 3, 2021 at 3:23 PM, Resident 4 was observed in his bedroom, on the phone. The resident motioned the Surveyor to enter. The resident stated to the person on the phone whom he identified as his Responsible Party: "Tell her about the times you have called to ask staff to suction my stoma." Resident 4's Responsible Party stated: "It has been very difficult especially nights and weekends. He calls me because he feels like he is suffocating." Resident 4 stated that he has increased anxiety and fears that he might choke to death on his sputum.

On March 4, 2021, an interview was conducted with evening nurse LPN (Staff K). LPN (Staff K) stated that Resident 4 has returned to the nursing home. Resident 4 is reporting being cold, but he is alert and oriented. LPN (Staff K) confirmed that Resident 4 makes his needs known and he struggles with anxiety related to suctioning. LPN (Staff K) stated that Resident 4 fears he will choke and die. When asked if there were times Resident 4 did not get suctioned, LPN (Staff K) confirmed that there are times when some staff ignore him. When asked if she could give an example, LPN (Staff K) stated on Tuesday night, March 2, 2021 and it is not the only night, LPN (Staff I) did not provide care to Resident 4. LPN (Staff K) reported that LPN (Staff I) does not suction him. LPN (Staff K) further stated that on that night, "she [LPN (Staff I)] was nowhere to be found" and that LPN (Staff K) could not do shift hand over with her. When asked if LPN (Staff I) had reported to work, LPN (Staff K) stated that LPN (Staff I) was in the building, probably somewhere visiting with other staff or smoking. LPN (Staff K) stated that LPN (Staff I) disappears. **When asked if she had reported these concerns, LPN (Staff K) said "there was some nepotism going on" and she did not want retaliation**. She was asked if she was concerned about Resident 4's wellness or if he was being neglected, LPN (Staff K) said: "I want to say so, yes. That's why I am letting you know."

During an interview on March 4, 2021, the Director of Nursing (DON) was asked why Resident 4 was sent to the ER. The DON stated that the night shift nurse (LPN Staff I) reported that he was pale and lethargic. The DON explained that LPN Staff I reported that Resident 4 kept asking to be suctioned but LPN Staff I let him know that nothing much was coming out. The DON stated that LPN Staff I reported that she spent all night trying to convince Resident 4 to go to the ER. The DON further stated she called EMS at 6:00 AM. The DON stated that Resident 4 who is alert and oriented could not tell what time or year it was, and this was not like him. When asked what the orders are related to suctioning, the DON stated that he should be suctioned every shift as needed. The DON stated that Resident 4 makes his needs known.

In an interview with the nurse working the night Resident 4 was sent to the ER, LPN (Staff I) stated that she had been trained in [CONDITION(S)] care. LPN (Staff I) confirmed that Resident 4 had been acting odd and has been having a thick sputum. LPN (Staff I) stated that at approximately 12:30 AM, she had called the doctor but did not hear from the doctor. LPN (Staff I) was asked if there were other nurses in the building and if she had notified them of Resident 4's lethargic behavior. LPN (Staff I) stated: "No, I asked him (Resident 4) if he wanted to go to the hospital, he said "No."" When asked if she had contacted the DON, LPN (Staff I) said that at 3:00 AM, the DON was contacted and had advised LPN (Staff I) to keep monitoring Resident 4. LPN (Staff I) stated that at 5:30 AMA, Resident 4 kept getting worse and at that time the Assistant Director of Nursing (ADON) was in the building and had called EMS.

In a follow-up call on March 4, 2021 at 12:02 PM, Resident 4's Responsible Party reported that Resident 4 had called for suctioning a couple of times the night her went to the hospital. The Responsible Party stated that Resident 4's complaint is that they may take a while. It takes an hour or two hours to receive assistance. When asked if she discussed her concerns with the nursing home, the Responsible Party stated that she had spoken to a nurse. The Responsible Party further confirmed that Resident 4 was not getting the [CONDITION(S)] treatment he needs and that it causes him anxiety.

During a follow-up interview on March 5, 2021, the DON confirmed that in her investigation she learned that LPN (Staff I) could not be found during shift and that she would provide education. The DON reported that she had spoken with Resident 4 and he had reported that it takes the nurses longer to respond to his calls especially at night and on weekends, but that they do get to him eventually. The DON further stated that documentation must be completed by the end of shift per policy and she will provide education and complete auditing every day.

A review of the nursing home's polices and procedures titled "Tracheal Suctioning" with a revision date August 24, 2017 revealed an expectation to review and follow a physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER].

Name of Nursing Home	Living Center of Safety Harbor
Provider ID	105549
Address [RUCA Code: 1] [% County Population Rural: 0.19]	1410 Dr Martin Luther King Jr St N, Safety Harbor, Florida, 34695
Day Investigation Completed	March 5, 2021
Type of Deficiency Issued	F695
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Orientee Recorded a CNA Throwing Cups of Water on a Man During Care. She Recorded It Because She Feared Retaliation and Wanted a Proof. She said: "*I am only being a whistleblower*"

The nursing home failed to ensure their abuse policy was followed for Resident 2. This failure resulted in Resident 2 having water thrown on him by a staff member while providing care.

Cognitive Function. Not Reported. Activities of Daily Living: Not Reported.

Resident 2's Health Status / Progress Note Text dated March 23, 2022 at 5:30 reads: New CNA inform writer that the CNA who is taking care of the resident in room [ROOM NUMBER] threw 3 cups of water in his face. Writer went to assess the resident. Resident observed laying on the bed in a sitting position, using profanity at the CNA. Writer asked the CNA did she throw water on the resident. She stated: "No." The resident stated that she threw 3 cups of water on him and continued to call the CNA out her name. Among other information, the Progress Note stated: "Daughter made aware."

During an interview on May 3, 2022, Resident 2 stated the lady threw water in his face and he did not like what she did. Resident 2 stated he had not seen the lady since she threw the water on him. Resident 2 stated his okay and was not scared to stay at the nursing home.

CNA (V4) stated she got hired a month ago and received abuse training. CNA (V4) stated she was on orientation and being oriented by another aide (V5) on the 10:00 PM to 6:00 AM shift. CNA (V4) stated when they got to their last resident (Resident 2) at about 5:30 AM, Resident 2 had to be changed. CNA (V4) stated V5 was trying to make Resident 2 stand up but he refused. CNA (V4) stated V5 went into the bathroom and came out with two plastic cups of water. CNA (V4) stated V5 told Resident he better get up or she would throw the water on him. CNA (V4) stated she thought V5 was playing when she made those remarks. CNA (V4) stated as V5 was talking to Resident 2, she suddenly flipped one of those cups of water onto Resident 2 and he started to curse at V5. CNA (V4) stated she pulled out her cell phone and told V5 she was wrong for doing that to Resident 2. CNA (V4) stated she started to record V5 at the same time told V5 to leave Resident 2 alone. When V5 threw the second cup of water towards Resident 2's face, the water landed on Resident 2's face and neck. CNA (V4) stated she called and got Resident 2's nurse who confronted V5 and told her she had to clock out and leave the nursing home.

CNA (V4) stated she was scared of V5 and recorded her because she wanted proof that V5 threw the water at Resident 2. V4 stated she had abuse training but did not know she could not record residents.

The Director of Nursing (DON) stated that during the course of the abuse investigation, **CNA (V4) told them she was scared of V5 and recorded V5 throwing the water because she feared V5's retaliation towards her**. The DON stated they told CNA (V4) she did the right thing immediately reporting the abuse, but she did not comply with their policy because she recorded Resident 2. The DON stated V5's employment was terminated for throwing water at Resident 2 and no longer works at the nursing home. The DON stated **CNA (V4) told her she was only being a whistleblower,** but CNA (V4) had to be reprimanded for not following the nursing home's policy of recording residents.

CNA (V5) stated she worked the third shift (10:00 PM to 6:00 AM). CNA (V5) stated the nurse told her to clean Resident 2. CNA (V5) stated she was working with an orientee (CNA V4). CNA (V5) stated they went into the room and Resident 2 asked for his wheelchair to get up but then did not want to get up. CNA (V5) stated she told Resident 2 since he was not going to get up, she was going to clean him in the bed. CNA (V5) stated she grabbed one plastic cup of water to use to wet the towel. CNA (V5) stated she asked CNA (V4) for the towel and Resident 2 suddenly knocked the cup of water out of her hand. CNA (V5) stated CNA (V4) then accused her of throwing the water at Resident 2. CNA (V5) stated the nurse on duty told her to write incident statement and punch out. CNA (V5) stated she wrote a statement and punched out. CNA (V5) stated she had been working at the nursing home for nine months.

CNA (V7) stated she works the 6:00 AM to 2:00 PM shift but always comes to work early before 6:00 AM. CNA (V7) stated she got to work early like she normally does and saw CNA (V4) on the second floor. CNA (V7) stated CNA (V4) approached her and told her that CNA (V5) is "a crazy B****" and threw water on Resident 2. CNA (V7) stated CNA (V4) told her that she had proof on her cell phone. CNA (V7) stated CNA (V4) pulled her cell phone out and showed her a video of CNA (V5) throwing water on Resident 2's face using a cup of water. CNA (V7) stated she told her supervisor and the Director of Nursing. CNA (V7) stated when she got to the nursing home, CNA (V5) had been walking out of the nursing home already and was not on the second floor at that time.

Nursing Home's Abuse Report dated May 23, 2022 denotes Final Investigation and Conclusion:

"Upon further review, it was identified the employee had poured the water on the resident."

CNA (V5) Employee Notice dated March 29, 2022 denotes: "After completing investigation, administration decided to terminate employee."

Name of Nursing Home	Symphony 87 Street
Provider ID	145983
Address [RUCA Code: 1] [% County Population Rural: 0.05]	2940 West 87th Street, Chicago, Illinois, 60652
Day Investigation Completed	May 6, 2022
Type of Deficiency Issued	F600
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Fearing Retaliation, Nurse Aides and an RN Didn't Report on an RN Who Turned Off a Person's TV (Baseball Game) Against Their Wish, Saying (Against Policy) TVs Must Be Turned Off After 11:30 PM

The nursing home failed to ensure that Resident 1's rights were maintained. The nursing home also failed to ensure incidents of potential mistreatment were reported timely for Resident 1.

Cognitive Function. Resident 1 had **moderate cognitive impairment** (based on MDS assessment).

Activities of Daily Living. The resident required extensive assistance with Activities of Daily Living.

Care Plan (dated October 11, 2019) identified that while in the nursing home, it was important that he/she had the opportunity to engage in daily routines that were meaningful and relative to his/her preferences with interventions that included the importance of watching sports on television.

Review of a Grievance Form dated October 24, 2019 identified that Resident 1's family filed a grievance because the resident informed him/her that the nurse wanted the television and lights off. The grievance further stated that the nurse thought there was a policy that lights were off by 11:00 PM. The nurse was educated that there was no such policy and the lights and television can stay on per the resident's choice. The grievance form further identified that the grievance / concern was confirmed.

Resident 1 had been discharged from the nursing home and was unavailable for an interview.

During an interview on June 1, 2020, Nurse Aide 1 identified that the nurse requested that she turn Resident 1's television off. When she entered the room, the resident was watching a baseball game and wanted to continue watching the game, so she lowered the volume and closed the door. She further identified that it was the nurse (RN 1) who had turned the resident's television off.

Attempts to contact RN 1 were unsuccessful.

During an interview on June 1, 2020, the Administrator identified she had addressed the grievance and interviewed the resident who stated that he/she was upset because he/she was watching a baseball game, and RN 1 came in and told him/her that the television and lights had to be off. The Administrator stated that RN 1 was educated that the resident had a right to watch television and keep the lights on, and that there was no policy on what time the television had to be turned off.

Interview with RN 2 on June 1, 2020 identified at the beginning of May 2020 on the 11:00 PM to 7:00 PM shift there was an incident with a resident (could not recall the resident's name) who had the television at a loud volume. RN 2 asked the resident to turn the volume down, and the resident did so. RN 1 was on the unit and explained to RN 2 that the resident knows the rules and he/she is not supposed to have the television on. RN 1 went into the room and told the resident that he/she had to turn the television off, but the resident did not want to turn the television off. RN 1 was then heard telling the resident in a rude and aggressive tone that he/she knew the rules and needed to turn the television off. The resident was trying to explain to the nurse that he/she wanted the television to stay on, but RN 1 turned the television off. **RN 2 identified that although she knew that the incident should be reported, she was afraid of retaliation and did not report the incident**.

Interview with Nurse Aide (NA) 2 on June 1, 2020 identified a few weeks ago on the 11:00 PM to 7:00 AM shift, RN 1 told NA 2 that Resident 1's television needed to be turned off. NA 2 went into Resident 1's room and the resident wanted the television to stay on, so NA 2 left the television on. NA 2 stated that RN 1 then went into Resident 1's room and shut off the television. **NA 2 stated that RN 1 is very stern when speaking to the residents, and she had not reported her concerns because she was afraid of retaliation and she had quit shortly after the incident**.

Interview with Nurse Aide (NA) 3 on June 1, 2020 identified that although she could not recall the resident's name, sometime in mid-May 2020, he/she was working on the 3:00 PM to 11:00 PM shift and a resident asked him/her to shut the television off because s/he didn't want the nurse (RN 1) come in and yell at her/him for having the television on. NA 3 identified that he/she did not report what the resident said because she did not want to get the resident in trouble. NA 3 stated another incident occurred last week on the 11:00 PM to 7:00 AM shift with a different resident where RN 1 told NA 3 that all televisions had to be turned off at 11:30 PM. NA 3 went into the resident's room and the resident did not want the television turned off, so he/she turned it down. RN 1 then told NA 3 that the television needed to be off, then proceeded to go into the residents room and take the television remote, turn the television off, and placed the remote on top of the television (out of reach of the resident). **NA 3 stated she did not report the incident because she was afraid that RN 1 would retaliate against her/him**.

During an interview on June 1, 2020, RN 1 stated she never turned a television off if the resident wanted it to remain on. She further stated that if the television was too loud for the roommate, the nursing home provided ear plugs. She further stated that she has never spoken to a resident in a disrespectful manner, but her loud voice could be misinterpreted as intimidating.

During an interview on June 1, 2020, the Director of Nursing (DON) stated that although there had been a grievance filed for RN 1 for turning a resident's television off in October of 2019 which was addressed, she had not heard of any recent incidents, and no one had ever reported to her that RN 1 had yelled or was rude to the residents. She further stated the allegations should have been reported at the time of the incident and she would have started an investigation. The DON stated that she would be initiating an investigation to look into the allegations.

Name of Nursing Home	Fox Hill Center
Provider ID	075183
Address ["Not located in RUCA Tract"] [% County Population Rural: No % Available for CT planning regions]	1253 Hartford Turnpike, Vernon, Connecticut, 06066 [Google search: "Considered semi-rural community" ⇨ Equivalent to RUCA Codes: 4-6]
Day Investigation Completed	June 4, 2020
Type of Deficiency Issued	*F550 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm

"Many other staff feel the same way but are afraid to say anything for fear of retaliation"
– A Nurse, while reporting to a state Surveyor on poor staffing levels / The Same Nurse Said:
"The ones who suffer are the residents, they get pressure ulcers, they end up infected"

The nursing home failed to ensure adequate staffing of nurses and CNAs to provide ordered care and services to residents or to designate a charge nurse on each tour of duty. This affects all residents in the nursing home and resulted in adverse outcome for Resident 2 who did not receive ordered interventions to prevent worsening of a right heel pressure ulcer.

Cognitive Function. Not Reported.

Activities of Daily Living. The resident did not walk, was dependent on staff for transfers, dressing and toileting, and had a pressure ulcer to the right heel.

Record review revealed Resident 2 had no wound or skin assessments between the dates of August 10, 2020 and August 24, 2020, and that the skin assessment of August 24, 2020 indicated her skin was intact. A wound consultant's visit note for August 24, 2020 documented the continued presence of an unstageable pressure ulcer the left heel. Despite indicating the skin was intact, the same nurse that conducted this skin assessment also documented completion of two different wound treatments to Resident 2's right heel, once with [MEDICATION(S)] and once with the new treatment of [MEDICAL RECORD OR PHYSICAN ORDER].

The wound consultant Nurse Practitioner's visit note for August 31, 2020 documents Resident 2's right heel had excessive black / yellow necrotic tissue and moderate serious drainage, measured 7 x 6 x estimated 0.4 cm depth, and interventions that included offloading heels, turning and repositioning schedule, and heel protection.

During a telephone interview on September 17, 2020, Nurse (Staff A) was asked about missing documentation for Resident 2's heel boots, off-loading heels, turning and repositioning every 2 hours in bed, and checking heels when she cared for Resident 2 on the day shift of August 20, 2020. Nurse (Staff A) remembered Resident 2 and stated firmly that she did not have any wounds, that she checked her heels because sometimes she complains her leg bothers her and told her there was nothing, and that she definitely did not do would care for her because she didn't have any wounds. Nurse (Staff A) also stated Resident 2 did not have any heel boots. Nurse (Staff A) stated the CNAs are supposed to turn the resident every 2 hours but are not always able to because it depends if they are short staffed, that sometimes the CNAs are short.

During a telephone interview on September 17, 2020, Nurse (Staff C) stated nurses may have up to 30 residents each which is too many and most nurses must cut corners. Nurse (Staff C) stated she does not have time to measure wounds and has never seen wound measurements by other nurses. Nurse (Staff C) stated there are not enough CNAs to do everything they are supposed to do and to ensure residents are turned every 2 hours. Nurse (Staff C) stated no one is in charge at night and that there used to be a supervisor who worked in the evenings and sometimes stayed until 1:00 AM or 2:00 AM, but that person has been out for weeks without anyone being in charge. Nurse (Staff C) stated if a resident needs to go to

he hospital, it is a time-consuming process for the nurse with no one to help them since everyone has their own assignments, and if they send the person out, they will be behind on all of their work. Nurse (Staff C) also reported that when staff call off, they are not replaced and often not even taken off the schedule, such that the nurse only learns by who shows up. She stated that after call-offs, there may be one CNA for 50+ residents or one nurse for a unit with capacity for 60 residents. Nurse (Staff C) stated when this happens, staff can't do all that is supposed to be done, residents can't be turned as they should, and they can barely get them cleaned for the next shift.

During a telephone interview on September 18, 2020, Nurse (Staff D) stated there is not enough staffing to care for residents properly; that two nights before there were 2 CNAs who had 26 residents each; that management seems to think CNAs can take care of 25 to 26 residents each but they are total care and incontinent, need to be turned and repositioned, and what happens is they are lying in their feces and urine; that the CNAs do all they can do but there is only so much they can do in 7 ½ hours. Nurse (Staff D) stated it is not physically possible for the CNAs to get to all their residents every two hours, as they are supposed to. Nurse (Staff D) stated: "The ones who suffer are the residents, they get pressure ulcers, they end up infected." Nurse (Staff D) stated families complain and management tells staff not to tell them the caseload or that they are short staffed, but that is what is causing most of these issues. Nurse (Staff D) stated they must consistently work through breaks, that management tells them to take their breaks, but it is not possible with the caseload. Nurse (Staff D) says tat when there is a deficiency, management tells them what they need to do but never addresses the underlying issue of staffing ratios, which is the reason they can't do everything properly. **Nurse (Staff D) stated**: "**Many other staff feel the same way but are afraid to say anything for fear of retaliation**." Nurse (Staff D) stated there is no one in charge of evening shifts during the week on any units since the evening supervisor is out sick or in charge on the night shifts on any units. Nurse (Staff D) stated there is no time to review CNA documentation for completeness. Nurse (Staff D) stated there can be multiple admissions despite only two nurses on a unit with full caseloads and no assistance to do the admissions.

Name of Nursing Home	Hillcrest Health Care and Rehabilitation Center
Provider ID	105495
Address [RUCA Code: 1] [% County Population Rural: 0.01]	4200 Washington St, Hollywood, Florida, 33021
Day Investigation Completed	September 14, 2020
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Didn't Tell Administration About a CNA Who Allegedly Screamed at a Resident with Cognitive Impairment Because "*s/he felt bullied by his/her peers and was fearful of retaliation for reporting*"

The nursing home did not 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 o not later than 24 hours if the events that cause the allegation do not involve abuse or result in serious bodily injury, to the Administrator of the nursing home 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 for Resident 17. Specifically, for Resident 17, the nursing home did not ensure that an alleged incident involving a staff member screaming at Resident 17 was reported to the Administrator.

Cognitive Function. Resident 17 had **moderate cognitive impairment** (based on MDS assessment).

During an interview on September 15, 2020 at 11:40 AM, CNA 1 stated he/she was told by multiple residents on the Unit B/C that Resident 17 and CNA 7 were screaming at each other in the resident's bedroom on Friday evening / night. **CNA 1 stated he/she did not tell the administration about this incident as he/she felt bullied by his/her peers and was fearful of retaliation for reporting.**

During an interview on September 15, 2020 at 3:16 PM, Resident 17 stated he/she put his call light on Friday night. He/she stated when CNA 7 entered his/her room, CNA 7 yelled at the resident and told him/her he/she would not assist the resident to the bathroom. Resident 7 stated this incident was not reported to staff. Resident 17 stated he/she did not feel threatened or fearful of this staff member any longer.

During an interview on September 16, 2020, the Administrator stated he was not informed of any incidents occurring with Resident 17 and CNA 7. The Administrator stated the expectation was any incident with staff allegedly yelling at a resident should be reported to the supervisor and the Administrator immediately. The Administrator stated the nursing home provided education upon hire and at a minimum annually.

During an interview on September 16, 2020, the Director of Nursing (DON) stated she was unaware of an incident occurring Friday night at the nursing home. The DON stated all staff were educated on abuse and reporting at time of hire and a minimum of yearly.

Name of Nursing Home	Delmar Center for Rehabilitation and Nursing
Provider ID	335735
Address [RUCA Code: 1] [% County Population Rural: 9.57]	125 Rockefeller Road, Delmar, New York, 12054
Day Investigation Completed	September 16, 2020
Type of Deficiency Issued	F609
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Fearing Retaliation, a Staff Member Delayed Reporting On a Staff Member Who Was Witnessed Kissing (at Times on the Lips) Three Residents with Severe Cognitive Impairment

The nursing home failed to protect Residents 30, 35, and 49 from a staff member who kissed residents on the face, mouth, and forehead, but the residents lacked the cognitive ability to consent for the kissing by a staff member.

Cognitive Function. Resident 30 had **severe cognitive impairment** (BIMS score of 0 out of 15).

Cognitive Function. Resident 35 was **severely cognitively impaired** (BIMS score of 4 out of 15).

Cognitive Function. Resident 49 was **severely cognitively impaired** (BIMS score of 7 out of 15).

Activities of Daily Living. Not Reported for Residents 30, 35, and 49

The nursing home failed to ensure an environment in which staff feel safe to report alleged violations of abuse without fear of reprisal for Residents 30, 35, and 49.

During an interview on May 30, 2018, **Staff F** stated she had witnessed Staff C kiss Residents 30, 35, and 49 on the forehead, the cheek and at times on the lips. **She stated she had wanted to report the incidents immediately but was afraid of retaliation from staff members B, C, and H**. She stated she had been trained to report any concerns with abuse to the nurse manager or to Staff B. She stated she did eventually share her concerns with Staff E and believed that the staff member had reported the incident. She stated after she reported the incidents to Staff E, she noticed Staff C was still kissing the residents. She stated **after she realized nothing had changed, she thought she should tell Staff B but was afraid of retaliation.** She said she had called and reported the kissing to the Ombudsman but was told "that was not my area" and after that, she stated she did not feel anyone would listen to her concerns.

Staff F also stated that Staff C would kiss residents almost everyday. Staff F stated two of the residents were married and she believed their wives would not be comfortable with another individual kissing their husbands. She said she did not feel the actions of Staff C were appropriate or professional, especially for residents who could not cognitively give consent.

During an interview on May 30, 2018, **Staff E** stated she had witnessed Staff C kiss Residents 30, 35, and 49 on the mouth, the cheek, and the forehead. She also stated she had received a report of the same concern from another staff member. She stated she reported the incident to Staff B immediately after she witnessed it. **She stated she was fearful of reporting, because she was afraid of retaliation from Staff members B, C, and H**. She stated she had reported these incidents to Staff B several weeks back, and nothing was done.

Staff F stated the kissing occurred on several different occasions, almost every day. She stated she did not feel this was appropriate for the staff member to kiss the residents since thy had cognitive deficit and could not communicate their consent.

During an interview on May 30, 2018, **Staff B** stated staff were trained routinely on how to report, when to report, and what to report. He stated he thought the staff were comfortable to report any incidents of alleged abuse, even if allegation was of staff to resident abuse. He stated **he was not aware any staff were fearful of retribution if they reported allegation of abuse regarding another staff member**.

Staff B stated he had witnessed Staff C kiss Resident 30 on the lips several weeks ago when the resident's family was there, and they seemed comfortable with the interaction. He stated he had not reported the incident or educated Staff C after that witnessed interaction.

During an interview on May 30, 2018, Staff C stated kissing a resident who lacked the cognitive ability to provide consent would be considered abuse. She stated: "I may be the worst at it," and she said she would kiss certain residents on their cheeks or lips, because "They like it, and they get upset if I don't give them a kiss." She stated she had kissed Residents 30, 35, and 49, but felt they wanted the interaction. She said they would not be able to give her consent to kiss them because of their cognitive deficit. She stated she would not tolerate other staff to kiss the residents if the resident was not comfortable or was cognitively intact to give consent for the interaction. She stated she knew Resident 30's family was comfortable with her kissing the resident but was not sure how the resident himself might feel about the interaction because he was not able to express his own feelings. She stated she was not sure how other residents or their families might feel about her kissing them either.

During an interview on May 30, 2018, Resident 30's family stated they did not mind if Staff C kissed the resident. They stated they were not sure how the resident might feel about it, but felt he enjoyed the interaction.

During an interview on May 30, 2018, Resident 35's wife stated she would not like it if the staff kissed her husband. She stated she was not aware if staff kissed her husband but said she would not tolerate it. She stated she would put her foot down immediately if she witnessed it.

During an interview on May 30, 2018, Resident 49 stated she did not recall if a staff member had kissed her, but stated: "They would not dare, because I would pop them one."

Name of Nursing Home	Cooney Healthcare and Rehabilitation
Provider ID	275080
Address [RUCA Code: 1] [% County Population Rural: 26.20]	2555 E Broadway, Helena, Montana, 59601
Day Investigation Completed	May 31, 2018
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm

A CNA Witnessed a Woman with Severe Cognitive Impairment Being Physically Restrained to Her Wheelchair – for About a Year – But Didn't Report It Due to Fear of Retaliation

The nursing home failed to ensure Resident 1 was free from physical restraints (any device attached or adjacent to the body that cannot be easily removed and restricts freedom of movement). CNA 2 and CNA 3 tied Resident 1 with a cloth gown and/or a bed sheet to the waist and around the wheelchair to prevent Resident 1's freedom of movement when agitated and prevent a fall for about one year (date unknown) since CNA 1 first reported (July 29, 2020) the improper use of restraint to the Administrator. The deficient practice resulted in Resident 1's rights being violated, abused, and held against her will.

The nursing home failed to implement its policy and procedure to report all allegations of abuse (use of physical restraints without a physician's orders [MEDICAL RECORD OR PHYSICIAN ORDER]). CNAs 2 and 3 tied Resident 1, using a cloth gown and/or a bed sheet to her waist and around her wheelchair with a knot to prevent Resident 1's freedom of movement when agitated and prevent a fall.

CNAs 1, 3, 4, 5, and 6 did not report witnessing Resident 1 being physically restrained to a wheelchair.

Cognitive Function. Resident 1 was "**severely impaired in cognitive skills** (thought process) for daily decision-making" (based on MDS assessment). Activities of Daily Living. Not Reported.

Care Plan. A review of Resident 1's Care Plan titled Behavior dated February 1, 2020 (re-evaluated on May 1, 2020), indicated Resident 1 had episodes of going out to the patio unassisted. The Care Plan indicated Resident 1 had episodes of being aggressive when staff would try to assist, high risk for fall and injury, and elopement (to escape or run away). The Care Plan interventions included assessing what may cause Resident 1's behavior and what may trigger behavior and attempt to reduce / eliminate those triggers if possible. The interventions indicated to respect Resident 1's rights to refuse treatment and care.

A review of a nursing home document titled Interview Record: Allegation of improper use of Resident Restraints dated July 29, 2020, indicated **CNA 1 reported she had allegedly witnessed** Resident 2 being restrained to a wheelchair. The document indicated CNA 1 stating that this has been going on since CNA 1 started at the nursing home over a year ago. The document indicated everyone knows about it, especially LVN 1 and CNA 2. The document indicated CNA 1 had seen Resident 1 would be restrained when combative or agitated at the Nursing Station, hallway, and resident's room. The document indicated **CNA 1 did not report Resident 1 being restrained because CNA 1 was afraid of retaliation**.

A review of a nursing home document titled Interview Record: Allegation of improper use of Resident Restraints dated July 29, 2020, indicated CNA 2 was questioned by the Administrator on whether she had ever restrained Resident 1 while in the wheelchair. The documented indicated CNA 2 responded yes she had, however, CNA 2 added that the resident had occasional behavior issues that increased her risk of fall and CNA 2 want to keep Resident 1 safe.

A review of a nursing home document titled Interview Record: Allegation of improper use of Resident Restraints dated July 29, 2020, indicated CNA 3's allegations to CNA 2 of restraining Resident 1 for a long time, perhaps more than a year. The document indicated CNA 3 stating she believed that the restraints was done for Resident 1's safety since the resident had occasional behavioral outburst that increased her

risk of falling. In a document dated August 10, 2020, CNA 3 admitted that CNA 3 had also restrained Resident 1 previously, but only to keep Resident 1 safe.

During an interview on February 3, 2021, the Administrator stated he initially could not substantiate the investigation, but when a previous employee spoke up, he was able to substantiate the allegation. He stated multiple night shift employees were terminated or resigned (CNAs 1, 2, 3, 5, and LVNs 1 and 2) due to the incident (including staff that had knowledge of Resident 1 being restrained and did not report).

During an interview and review of two photographs provided by the Administrator, on February 3, 2021, one photograph showed Resident 1 from a front view, sitting on a wheelchair with a while and blue cloth patient gown tied to the waist around the wheelchair. The second photograph showed Resident 1's back of the wheelchair with the same white and blue patient gown tied in a knot at waist level. **The Administrator said he received the photographs from CNA 1 via text message on July 29, 2020.**

During a telephone interview on February 9, 2021, LVN 1 stated she was not employed at the nursing home anymore. LVN 1 stated she did not want to be involved with the incident anymore.

During a review of Resident 1's records with the Director of Nursing (DON), on February 22, 2021, the DON stated there were no documented physician's orders [MEDICAL RECORD OR PHYSICAN ORDER].

During a phone interview on February 22, 2020, the DON stated the use of physical restraint was not a nursing home practice. The DON stated that restraining Resident 1 physically was a form of abuse. The DON stated nurses should always assess the residents for behavior and should try to figure out the cause of the behavior if it was associated with pain. The DON stated the nurses should try to figure out if the resident needed one-on-one monitoring and should not restrain the resident.

The DON stated Resident 1 used to have a one-on-one caregiver (Caregiver 1) during the day provided and hired by Resident 1's family. The DON stated Caregiver 1 would come during the day and stay with Resident 1. The DON stated it had been a while that Caregiver 1 was in the nursing home to stay with Resident 1 (since November 2019; approximately three months ago). The DON could not provide documented evidence from Resident 1's medical records of nursing interventions provided by the licensed nurses and CNAs to manage Resident 1's behavior during the night shift.

During a telephone interview on March 23, 2021, the Administrator stated that Caregiver 1 was a companion for Resident 1 during daytime unlike what the Care Plan indicated. The Administrator stated Resident 1 would have occasional behavioral outbursts and that was when CNAs would stay with her during the day. The Administrator stated the CNAs would sit with Resident 1 for a few hours. The Administrator stated Resident 1 did not require constant one-on-one care.

Name of Nursing Home	College Vista Post-Acute
Provider ID	555030
Address [RUCA Code: 1] [% County Population Rural: 0.89]	4681 Eagle Rock Blvd., Los Angeles, California, 90041
Day Investigation Completed	April 29, 2021
Type of Deficiency Issued	*F604 **F609
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm

A Woman with Cognitive Impairment Told a Hospice Nurse "*They hit me*" and Being Told "*Shut up and turn over*" by Employee But the Nurse Did Not Report It to Any Staff Due to Fear of Retaliation

The nursing home failed to implement written policies and procedures that prohibited and prevented abuse and neglect of Resident 31 and Resident 65.

The Administrator failed to follow their policy and immediately report to the State Survey Agency when Resident 65 sustained a fractured ankle of unknown origin.

The Hospice Nurse failed to immediately report to the Administrator and/or Director of Nursing after Resident 31 reported she was verbally and physically abused.

Cognitive Function. Interview with Resident 31 on December 4, 2018 revealed the resident was **confused** and **could not answer questions**. Review of Resident 31's Care Plan dated August 4, 2017 revealed the resident was **at risk for cognitive loss and dementia**.

Activities of Daily Living. Not Reported.

Due to scope considerations and relevance to the topic of staff fear of retaliation, this summary only focuses on violations related to Resident 31.

Interview with **Hospice Nurse** on December 5, 2018 revealed she went to see Resident 31 between six and seven at night on October 4, 2018, Thursday, and the resident asked her to shut the door. She stated Resident 31 told her: "They hit me" and [being told by staff] "Shut up and turn over." The Hospice Nurse revealed **she reported this allegation to her supervisor the next day** (October 5, 2018, Friday) after Resident 31 made the allegation. **She stated she did not report the allegation to any staff at the nursing home because she was afraid of retaliation**. The Hospice Nurse stated she was never educated by the nursing home about when and to whom she had to report allegations of abuse.

During an interview on December 6, 2018, the Assistant Administrator revealed she received a call from the Hospice Administrator on October 5, 2018 about Resident 31 making an allegation of abuse on October 4, 2018. The Assistant Administrator stated **Resident 31 could not remember an incident that happened 24 hours prior because of her confusion**. The Assistant Administrator stated she told the Hospice Administrator a serious allegation should have been reported to her right away. The Assistant Administrator revealed she did not train contract employees about the abuse and neglect policy. She stated she would have wanted to Hospice Nurse to report the allegation immediately so the nursing home could have taken action.

Name of Nursing Home	Village Creek Nursing Home
Provider ID	675977
Address [RUCA Code: 1] [5 County Population Rural: 1.23]	3825 Village Creek Rd, Fort Worth, Texas, 76119
Day Investigation Completed	December 6, 2018
Type of Deficiency Issued	F607
Scope Severity Level	Minimal Harm or Potential for Actual Harm

An LVN Witnessed a Sexually Inappropriate Incident Between Two Male Residents (One Cognitively Intact and the Other Severely Cognitively Impaired) But Didn't Chart It at the Direction of and Due to Fear of the DON's Retaliation / The LVN stated the DON had "*crossed her before and had multiple shifts taken away from her. She needed the shifts and therefore followed her direction even though she knew it was not right*." / After the DON directed the LVN Not to Inform the Residents' Families About the Incident, a Physician said: "*And that is how you keep state out of your building*"

The nursing home failed to protect residents' right to be free from sexual abuse for Residents 7, 8, 9, and 12). The nursing home failed to: Protect Resident 12 (unable to consent) from Resident 8 being sexually inappropriate with him on June 11, 2021. Resident 8 was observed by staff to display inappropriate sexual behavior with Resident 12 when guiding Resident 12's hand on Resident 8's penis in an up/down motion.

Protect Resident 9 on July 14, 2021 from exposure to Resident 8 standing over him, masturbating while Resident 9 was lying in his bed (Resident 9 unable to consent).

Protect Resident 7 and Resident 8 from being sexually inappropriate (Resident 7 unable to consent) with one another on an unknown date the mid part of July 2021, unknown date around the end of July 2021, and on July 28 2021. Specifically, Resident 7 and Resident 8 were witnessed being fully exposed from the waist down and engaged in inappropriate sexual activity that ranged from Resident 7 having his hand on Resident 8's erect penis moving in and upward and downward motion, Resident 7's hand being observed in the anal region of Resident 8's body moving in an upward and downward motion and Resident 7 having his erect penis between Resident 8's buttocks.

The failures placed residents at risk of unwanted sexual advances, abuse, and mistreatment.

The nursing home failed to ensure all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property were reported to the appropriate authorities within the prescribed timeframes 15 residents (1-15) and that all these alleged violations were thoroughly investigated, prevented further abuse and neglect, and put corrective actions in place for these15 residents.

Cognitive Function. **Resident 8** (male) was **cognitively intact** (BIMS score of 14 out of 15).

Cognitive Function. **Resident 7** (male) had "**cognitive skills for daily decision making" that were "moderately impaired"** (the resident was unable to perform the BIMS evaluation).

Cognitive Function. **Resident 9** (male). Not Reported.

Cognitive Function. **Resident 12** (male) was "**not interviewable**" ("**Severely cognitively impaired"**).

Due to scope considerations and relevance to the topic of staff fear of retaliation, this summary focuses primarily on violations related to Resident 8 and Resident 12.

During an interview on August 15, 2021, LVN B said that she had worked at the nursing home off and on since 2008, she said that she often is assigned to Unit 1, which is a male secure unit. LVN B said that she had been a witness to several inappropriate behaviors on Unit 1, specifically she recalled an incident that

happened on June 11, 2021, she said she recalled the day specifically because it was a day [Physician A] was in the building rounding on residents. She said that she and Physician A entered Resident 8's room and found Resident 8 with Resident 12's hand wrapped around Resident 8's erect penis.

LVB said that Resident 8 had his hand wrapped around Resident 12's hand guiding Resident 12's hand up and down in a motion that appeared to be masturbating. LVN B said that Resident 12 was just sitting there he did not seem distressed, appeared to be going along with it. LVN B said that **Resident 12 was severely cognitively impaired** and was not able to make his own decisions. LVN B said that she intervened and instructed Resident 8 that the actions were inappropriate, and she said Resident 8 began pulling his pants back up. LVN B said she immediately informed the DON and due to Physician A being right there with me, she did not have to call him, he already was witness to it. LVN B said that when she notified the Former Director of Nursing (DON), she seemed kind of giddy as if it was funny to her, and she specifically instructed LVN B not to chart it because nobody was in distress. LVN B said she did not notify any family members at the direction of the Former DON and after the communication to the Former DON, Physician A responded to her: "And that is how you keep state out of your building." LVN B said it appeared he was in agreement with the Former DON and agreed not to document anything in the chart. The Former DON had stressed to LVN B that as long as both residents were not in any distress and they were okay. There was nothing to chart. **LVN B said she disagreed with the Former DON but due to previous circumstances, she followed her direction and did not chart it for fear of retaliation**. She said that **the Former DON had a persnickety attitude and she had crossed her before and had multiple shifts taken away from her**. **LVN B said that she needed the shifts and therefore followed her direction even though she knew it was not right**. LVN B said that she personally did not notify the Administrator regarding the incident. LVN B said that Resident 8 is often redirected due to masturbating in inappropriate places, she said often times he will be at the doorway in his room, peaking his head out and masturbating. She said that he is redirected to his side of the room and offered a privacy curtain.

During an interview on August 18, 2021, the Former DON said she had been suspended pending an investigation that she was not sure what for and that she voluntarily resigned from the nursing home. The Former DON denied having any knowledge of LVN B reporting any alleged allegations involving Resident 8 being inappropriate with Resident 12. When asked if she had ever instructed her staff to not document or tell staff that she would document an incident, the Former DON replied: "I have helped them with charting if they needed help."

During an interview on August 17, 2021, Resident 8 said that he had come from another long-term care facility, was not certain why he had to move from that facility and did not care that he was on a male secure unit. The resident was alert and oriented and was able to recall his name, the date, where he was at, nursing facility, town, state; was able to recall who the President was currently. Resident 8 said that he had had sexual interactions with male residents on the secure male unit, specifically Resident 8 named [Resident 7]. Resident 8 said the sexual interactions took place in his room more than once and Resident 7 had given me a hand job. Resident 8 said the sexual interactions with Resident 7 made him feel bad and he did not want to be touched by Resident 7. He said he was scared when Resident 7 touched his penis. Resident 8 said that Resident 7 had touched him on his butt with his penis and that he had not told any

staff members because he was scared. Resident 8 said he did not want to be touched there. Resident 8 denied being inappropriate sexually with any other residents on the male unit, specifically Resident 12. He stated: Resident 7 no longer resided on the unit and that made him feel good.

During an interview on August 16, 2021, Resident 8's Family Member A indicated that she did not have medical power of attorney for Resident 8 and she did not make medical decisions for him / Resident 8 makes all of his own medical decisions. Family Member A did indicate that she had been contacted by the Administrator and informed her that Resident 8 had been having inappropriate sexual behaviors that ranged from masturbation in other resident's rooms to an inappropriate sexual act with a man that had Alzheimer's disease. Family Member A said that the nursing home told her that if the behaviors continued, Resident 8 would have to be discharged and that they were going to have him evaluated and maybe start some new medication but did not explain what the medication was or what it was for.

During a telephone interview on August 14, 2021, **the Vice President of Operations (VPO) said** that she and the Regional Nurse Manager (RNM) had just acquired the oversight of the nursing home approximately two weeks ago and had **received an anonymous call to the Corporation Hotline** number that they have internally for staff to report concerns to. The VPO said that the Corporate Office reacted to the allegations made immediately and she and the RNM were at the nursing home the next day. The VPO said that through investigation and interviews with staff and residents, it was identified that there were approximately 11 allegations that required a self-report, which were 4 allegations of resident to resident inappropriate sexual behaviors, 4 allegations of resident to resident altercations that resulted in injury, 2 elopements that were not documented accurately or reported, and an unwitnessed fall that resulted in injury. In addition, there were numerous clinical records that had been marked "Invalid" by the Former DON without permission from the original author of the entry. The VPO said that through interviews conducted with staff, they had been reporting the allegations to the Former DON and the Administrator and nothing was being done regarding the allegations. Staff were being directed to not chart regarding some of the allegations or were told that the Former DON would do the charting. The VPO said that the Administrator, DON, and both the ADONs were all suspended, however it was felt that the ADONs had no involvement and therefore has been brought back to work and is currently serving as the Interim DON. The VPO said the Administrator and the DON voluntarily resigned the following day and since have not returned phone calls in attempts made to interview either of them.

The VPO said the RNM, ADON, and other Department Heads had worked diligently to ensure the safety of all the residents and had put several interventions in place immediately (details in investigation report). The corporation also hired an Interim Administrator and she was currently in route to the nursing home.

Name of Nursing Home	Coronado Nursing Center
Provider ID	675746
Address [RUCA Code: 1] [% County Population Rural: 17.51]	1751 N 15th St, Abilene, Texas, 79603
Day Investigation Completed	August 24, 2021
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm

A Confidential Employee Told Surveyor They Are Scared to Say Anything to Director of Care Services About the Poor Staffing Levels "*because she will retaliate and fire you if you voice a concern*"

The nursing home failed to ensure it provided services by sufficient numbers of each type of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans for four residents (Residents 83, 54, 105, and 74) for ADL care. The nursing home failed to assure there were sufficient CNAs available to provide care for resident acuity in the nursing home for the secured locked unit and Hall 600.

Resident 83 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. Resident 83 had **severe cognitive impairment** (BIMS score of 5 out of 15).

Activity of Daily Living. She was totally dependent on staff for bathing with one-person support provided.

Cognitive Function. Resident 54. **Not Reported**.

Activity of Daily Living. She required extensive assistance from staff on personal hygiene, such as bathing and dressing.

Cognitive Function. Resident 74. **Not Reported**.

Activity of Daily Living. He required total assistance from staff for personal hygiene, such as shaving.

Cognitive Function. Resident 105. **Not Reported**. Activity of Daily Living: Not Reported.

A confidential interview with Staff J during Survey revealed the lack of sufficient staffing had been at its worst for a long time and started with the previous Administrator (DCS) who still works in the nursing home. He/she said there used to be two CNAs on each hall, but when DCS became the Administrator, she made changes including decreasing CNAs to one per hall. Staff J said he/she was responsible for 20 residents presently but whereas he/she used to be on a specific hall, now management moved CNAs around from one shift to the next on different halls. He/she said as a result, residents cannot get to know their CNAs and CNAs cannot get to know their resident as well. Through the course of a typical shift, Staff J stated they shower residents, complete ADLs, check and provide incontinent care every two hours, but sometimes he/she had to rush in order to get everything done on time. If a resident requires assistance with eating, Staff J has to come in early and start feeding them, because there is not enough time to get all the tasks done on the shift with one CNA. Staff J said new CNAs struggle to complete their required assignments when they are the only CNA on the hall for a large number of residents, even if the CNA is good at their job. He/she said it was too much for most CNAs to handle, not for a lack of trying, there was just not enough staff. Staff J said CNAs often have to answer a call light but cannot complete what the resident's request was and then had to go back later because there were not enough CNAs to help on the floor. Staff J said some staff had gone to DSC and told her more CNAs were needed, but nothing got done.

Staff J also stated they need more lifts in the building because several were broken down and cannot be used. He/she said the full body Hoyer lifts were on the 1st floor and cannot be used for the residents on the 2nd floor. He/she said presently, there was one Hoyer lift for the whole building, and it was used by the

Restorative Aide. Staff J said CNAs try to use the broken lifts because residents want to get up. Staff J said in the secured units, there was only one CNA and one nurse. He/she said that CNAs do not like that because residents are exit seeking, or having sun-downing behaviors throughout the day, and then ADLs and care needs to be done as well. Staff J said he/she sees turnover, day and night, some staff would come in, see they were the only person on the hall and then walk out; They feel it is too much for one person to do. This work is heavy enough, **mainly they are scared to say anything to the Director of Care Services (DCS) "because she will retaliate and fire you on a time if you voice a concern**."

A confidential interview with Staff K during the Survey revealed he/she had anywhere from 15 to 21 residents on his/her hall to care for. He/she said they felt they did not have enough time to complete all required tasks and there was no other CNA on the floor to help with ADLs. He/she said there were broken lifts in the nursing home that could not be used so a lot of time, residents cannot get transferred up and into their wheelchairs or showered as a result or only one Hoyer lift available in the building. Staff K said with 20-21 residents to care for, he/she was not able to do all the scheduled showers and they took the longest to do out of all CNA tasks. Staff K said if he/she was feeding a resident in their room and a call light went off on the hall, he/she would have to go answer the call light and tell the resident they would have to wait because there was no one to help as far as another CNA. Staff J [Note: Surveyor may have meant Staff K] said the charge nurse for his/her hall worked three halls by themselves, so even though the nurse was there, they were busy doing nursing duties. Staff K said presently, there was one nurse over three halls. He/she also said there was one CNA on each hall only.

Interview with the SDC on November 21, 2019 revealed there were two CNA vacancies on the pm 7:00 AM to 3:00 PM shift and four vacancies on the 3:00 PM to 11:00 PM shift and she had just filled the overnight vacancy. She said the 3:00 PM to 11:00 PM shift was the shift she was having difficulty filling, and the CNA staffing was low, but she was trying to get PRNs to pick up those shifts. She said she felt 25 residents would be too many for a CNA to handle alone.

Name of Nursing Home	Skyline Nursing Center
Provider ID	455653
Address [RUCA Code: 1] [% County Population Rural: 0.58]	3326 Burgoyne, Dallas, Texas, 75233
Day Investigation Completed	November 21, 2019
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Two Nurse Aides Expressed Concern of Retaliation by Management for Talking with Surveyors About a Man with Cognitive Impairment Who Left the Building Unaccompanied for Three Hours / He Was Located by Law Enforcement About Half a Mile Away in a Ditch

The nursing home failed to ensure Resident 20 and Resident 62 were free from neglect. The nursing home failed to ensure that Resident 20's Wanerguard and/or system was in working order, which led to resident eloping from the building and being missing for approximately 3 to 4 hours and resulted in abrasions to his left leg. The nursing home failed to ensure Resident 62's Wanderguard and alarm system was in working condition, which led to her eloping from the building (she was found outside sitting in the grass).

The nursing home failed to report the incident or sent the report within 5 working days for Residents 20 and 62 reviewed for abuse and neglect. It also failed to have evidence that all alleged violations were thoroughly investigated, prevent and protect from further potential neglect, and report the results of all investigations in accordance with federal regulations for Residents 20 and 62 reviewed for neglect.

The nursing home failed to ensure each resident received adequate supervision and assistive devices to prevent accidents for Residents 20 and 62 reviewed for Wanderguard. The nursing home failed to provide supervision for Resident 20 who had a history of exit seeking behaviors, to prevent him from eloping from the nursing home on July 1, 2021. The nursing home was unaware the resident had exited the nursing home, at an unknown time, and as a result, the resident was missing for approximately 3 hours and located by assistance from First Responders via use of a drone.

The nursing home failed to provide supervision for Resident 62, who had a history of exit seeking behaviors, to prevent him from eloping from the nursing home on December 15, 2020. The nursing home was unaware the resident had exited the nursing home for an unknown period of time. Resident 62 was located at 11:40 PM by an employee's spouse while Resident 62 was sitting in grass in front of building.

Due to scope considerations, this summary focuses primarily on violations related to Resident 20.

Cognitive Function. **Resident 20**. The resident did not have a recorded BIMS score. That said, staff assessment for mental status: **Short term memory problem, long term memory problem, no memory / recall ability, severely impaired – never / rarely made decisions**.

Cognitive Function. **Resident 62**. **Not Reported** (The resident did not have a BIMS score).

Record review of Resident 20 progress notes dated July 2, 2021 at 12:52 AM, Assistant Director of Nursing (ADON) documented: "Yesterday evening around 18:00 resident went out gate of front porch obtained a fall. Scratches and abrasion noted to bilat lower extremities and favored right leg."

During an interview on July 8, 2021, the Assistant Director of Nursing (ADON-RN) stated that on the evening in question they started looking for Resident 20 around dinner time, she was not sure of time but that his tray was in his room. ADON-RN stated that they had looked back at a video and saw the resident go outside whenever another resident opened the door. The ADON-RN stated that she called Law Enforcement but was not sure of time. The ADON-RN stated that Law Enforcement found the resident, but not sure of time and place. The ADON-RN stated she completed an Event Report.

Review of the Event Report showed that it indicated that the resident had fallen but did not state where he had fallen or mention the elopement. The ADON-RN stated that the incident should have been a self-report and that the Administrator would be the one who should have made the self-report. At that point, the ADON-RN stated she needed to get the DON and did not want to answer any more questions.

During an interview on July 8, 2021, the DON stated that Resident 20 sat on the porch exited the gate. The DON stated she doesn't know how long Resident 20 was missing that she wasn't at the nursing home. ADON-RN had called and informed her resident missing. The DON stated that Law Enforcement is the one who found him but did not know where they found him. The DON stated that the incident should have been a self-report, and the Administrator would be the one to make the self-report. The DON stated that anything related to the elopement and fall should be documented in progress notes, that documentation would not be anywhere else.

During an interview on July 8, 2021, the Administrator stated he knew about Resident 20 leaving the building but did not know how long the resident had been gone. The Administrator stated that Law Enforcement had located the resident with a drone. The Administrator stated that anything related to the incident should be documented in matrix system on computer. The Administrator stated that he didn't self-report because there were no real injuries at the time he didn't think it should be reported. The Administrator then said: "Oh my god, did I do something wrong." He said the resident could have the Wanderguard on and another resident could've opened the door. The Administrator said that he thought the staff called quickly, doesn't know the time or location Resident 20 was located. The Administrator did not state any type of interventions placed after the elopement including checking of doors.

Review of a video without sound on July 8, 2021: Resident 20 was observed on July 1, 2021 at 5:49 PM walking out of the building. Resident 20 sat in chair on the porch and was observed at 5:53 PM walking out of the open patio gate. A video from inside lobby showed that Resident 20 was standing to the side of the lobby area watching another resident in wheelchair trying to get out of the building. Resident 20 was observed walking to front door and opening the door for himself and the resident in wheelchair. It did not appear to sound an alarm when door opened because no staff were observed doming to door.

During an interview on July 9, 2021, Sergeant with Police Department stated there was a KAT Call ID #507 received at 7:27 PM on July 1, 2021. The call was made to Police Department and the Fire Department responded. A request was put in by the Fire Department for a drone for assistance. Resident 20 was found at 9:00 PM in a ravine / embankment near a juvenile center approximately [space blank in investigation report] mile away from the nursing home. Resident 20 was transported to the hospital.

During an interview on July 9, 2021, the RN M stated that Resident 20 was being transferred to another facility later today, for his safety. RN M stated that the Administrator had been suspended. RN M stated that after further investigation, the resident was gone for 3 hours and staff were out looking. RN M stated that Administrator had informed her that Resident 20 was found in the Cul-de-sac. RN M led surveyors to the location where Administrator stated that Resident 20 was found. RN M stated that she was waiting on police report to see the exact location resident was located. RN M stated the resident did not have any other elopements. RN M stated the resident was a safety risk because he had removed his Wanderguard.

RN M doesn't know how Resident 20 is getting Wanderguard off and that his Wanderguard was never located. RN M stated that he wouldn't have gotten out if the gate had not been left open.

During an interview on July 8, 2021, **TNA 1 and TNA 2 both expressed concern of retaliation by management for talking with Surveyors**. TNA 1 and TNA 2 stated the nursing home was short staffed and that they work long hours to cover other shifts. TNA 1 and TNA 2 both stated that Resident 20 was gone for over 3 hours and then it was about an hour before Law Enforcement was called. TNA 2 stated that Resident 20 was located about half a mile away, in a ditch. Both TNAs stated that he had taken off the Wanderguard but did not know if the Wanderguard was located. Neither TNAs were sure how he was able to get the Wanderguard off. TNA 1 and TNA 2 both did not state that alarm was heard prior to discovering resident missing.

Name of Nursing Home	The Oaks at Radford Hills Healthcare Center
Provider ID	675330
Address [RUCA Code: 1] [% County Population Rural: 17.51]	725 Medical Dr., Abilene, Texas, 79601
Day Investigation Completed	July 13, 2021
Type of Deficiency Issued	*F600 **F609 ***F610 ****F689
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm ****Immediate Jeopardy

Due to Fear of Retaliation, Aide 2 Did Not Initially Report Witnessing Aide 1 Physically Abuse a Person with Severe Cognitive Impairment (Pushing Her/His Head on the Nightstand) / Aide 2 Stated "*she had verbally told the Director of Nursing that she witnessed the incident, but because she was interviewed in front of [Aide 1], she did not write it on her* statement" / Aide 2 said Aide 1 "*had been verbally abusive to her in the past and she was afraid of retaliation*"

The nursing home failed to protect the residents' right to be free from abuse and/or neglect (for Residents 4, 1, 21, and 23 who alleged rough care was provided by staff and alleged incontinence care was not provided timely).

The nursing home failed to ensure allegations of abuse were reported immediately to the State Agency as required (within 2 hours if resulted in serious bodily injury or not later than 24 hours if no bodily injury); this, for residents 1, 4, 11, 5, and 2).

The nursing home failed to provide evidence that allegations of abuse and/or neglect were thoroughly investigated and failed to ensure an accused staff member was immediately suspended pending investigation to ensure all residents were protected from potential abuse in accordance with the nursing home policy; this for twelve residents (13, 14, 15, 12, 11, 1, 7, 10, 4, 9, 2, and 5).

Resident 4 had a diagnosis of **dementia** (based on statement made by the nursing home's social worker).

Cognitive Function. Resident 4 had **severe cognitive impairment** (based on MDS assessment).

Activities of Daily Living. S/he was dependent on staff for ADLs and maximum assist of 2 for bed mobility.

Due to scope considerations and relevance to the topic of staff fear of retaliation, the summary focuses primarily on violations related to Resident 4.

Review of a nursing note dated June 18, 2024 identified that at 12:30 AM, Resident 4 alleged he/she had been harmed by a Nursing Assistant (NA) during care on the evening of June 17, 2024. Resident 4 identified that NA 1 stated he/she was like moving a thousand pounds and that NA 1 was not hurting her back to move Resident 4. Resident 4 further stated that NA 1 is rough with care, used a stern / unfriendly tone when answering the call bell, and had pushed him/her hard several times and hit Resident 4's head into the nightstand. The resident reported slight pain to the left eyebrow, and the nurse observed a 2-centimeter by 2-centimeter area of faint swelling and redness to the left brow. Resident 4 indicated that NA 2 witnessed the incident.

Interview with Social Worker 1 on August 6, 2024 identified **although Resident 4 had a diagnosis of dementia, he/she had consistent recall of the incident and was an accurate reporter**. On August 1, 2024, Social Worker 1 stated that there have been many issues and complaints from both families and staff regarding NA 1.

During an interview with Administrator 2 (former Administrator who was serving in the role when the incident took place) stated there have been numerous complaints regarding NA 1 from residents and families. Details about violations related to other residents are included in the investigation report.

Nursing Home incident report dated June 18, 2024 identified Resident 4 alleged staff were rough during a Hoyer lift transfer that occurred on June 17, 2024 and hit his/her left eyebrow on the nightstand.
The report included two statements from **NA 2** dated June 18, 2024 that **she witnessed the interaction between NA 1 and Resident 4 and identified no abuse was witnessed**.

Nursing Home Incident report dated June 18, 2024 identified Resident 4 alleged staff were rough during Hoyer lift transfer that occurred on Jue 17, 2024 and hit his/her left eyebrow on the nightstand. No injury was noted, and staff were provided with education.

Interview with NA 2 on August 5, 2024 identified that on June 17, 2024 on the 3:00 PM to 11:00 PM shift she witnessed NA 1 speak to Resident 4 disrespectfully and forcefully pushed Resident 1 [Note: Surveyor may have meant Resident 4], hitting the left side of Resident 4's head on the nightstand. NA 2 stated the area was reddish purple after the incident. **NA 2 stated that her written statements dated June 18, 2024 were not accurate of the events she witnessed**. NA 2 stated when the Director of Nursing Services (DNS) interviewed her about the incident, she had NA 1 present. **Because she is afraid of NA 1, she did not report the abuse**. **NA 2 stated she had verbally told the DNS that she witnessed the incident, but because she was interviewed in front of NA 1, she did not write it on her statement**. NA 2 further stated **NA 1 had been verbally abusive to her in the past and she was afraid of retaliation**.

Interview with RN 9 on August 6, 2024 identified on June 18, 2024, NA 5 reported Resident 4's allegation that NA 1 was rough with care and made verbal comments. RN 9 stated she called and texted the DNS, notified the local police, and completed an incident report.

Interview with DNS on August 8, 2024 identified although Resident 4's story was consistent, and NA 2 stated she witnessed NA 1 provide rough care to the resident, the nursing home did not substantiate the allegation of abuse. The DNS was unable to explain why the allegation of abuse was not substantiated.

Interview with RN 2 on August 7, 2024 identified that NA 1 was irate about being taken off the schedule on July 23, 2024 pending investigation. She indicated that NA 1 was repeatedly calling the nursing home and staff members personal phones on August 2, 2024, threatening to drive to the nursing home if she wasn't given information on the investigation. RN 2 stated the nursing home called the police and then NA 1 subsequently called the nursing home back and stated she was resigning on August 7, 2024.

Interviews with NA 1 was unable to be obtained during the survey.

Name of Nursing Home	Apple Rehab Colchester
Provider ID	075231
Address [Not located in RUCA Tract] [No Rural % info available for CT planning regions]	36 Broadway Street, Colchester, Connecticut, 06415 [Google: Considered "Rural to Suburban mix" / Equivalent to RUCA Codes: 4-6]
Day Investigation Completed	August 8, 2025
Type of Deficiency Issued	*F600 **F609 **F610
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

An LPN Witnessed Another LPN Kick the Shin of a Man with Dementia and Severe Cognitive Impairment but Did Not Report It for About Two Weeks Due to Fear of Retaliation

The nursing home failed to ensure staff reported allegation of physical abuse of Resident B.

Resident B had a diagnosis of **Dementia**. Cognitive Function. **Severely cognitively impaired** (based on MDS assessment). Activities of Daily Living. Not Reported.

During an interview on January 3, 2024, the Administrator indicated on December 30, 2023, an allegation was made that LPN 1 witnessed LPN 2 and Qualified Medication Aide (QMA) 1 abruptly put Resident B in bed. Once Resident B was in bed, he sat up and LPN 2 kicked Resident B. **It was alleged this took place a coupe of weeks ago, but unfortunately it was not reported until December 30, 2023**.

During an interview on January 3, 2024 at 9:50 AM, LPN 1 indicated approximately 2 to 3 weeks ago, on evening shift after 7:00 PM, Resident B was on the floor, on his knees, at the foot of his bed. He had a small can in his hand that LPN 1 thought was a shaving cream. LPN 1 asked LPN 2 and QMA 1 to help get Resident B off the floor and into his bed. LPN 1, LPN 2, and QMA 1 entered Resident B's room to get him up and LPN 2 indicated that Resident B's legs needed to be straightened first. After Resident B's legs were strengthened, QMA 1 put an arm under Resident B's left armpit and LPN 2 put an arm under Resident B's right armpit and each of them grabbed the back of Resident B's pants. Then LPN 2 and QMA 1 flung Resident B's upper body into his bed with Resident B's legs still hanging off the bed. LPN 1 described the flung as rough. When LPN 2 and QMA 1 flung Resident B into bed, Resident B hit his head on the right siderail. Once Resident B hit his head, Resident B sat up and threw the can he had been holding. The can grazed QMA 1, so QMA 1 immediately left the room. Then Resident B and LPN 2 had a back and forth. LPN 1 described the back and forth as talking at each other instead of to each other. LPN 2 was speaking English at Resident B and Resident B was speaking Spanish at LPN 2. LPN 2 was telling Resident B to be quiet. LPN 2 seemed frustrated. Then, LPN 2 extended her left leg out and kicked Resident B in the lower shin as they were still going back and forth. LPN 1 indicated the kick didn't seem forceful, but it seemed purposeful. At that time, there was no reason for LPN 2 to extend her leg and make any contact with Resident B's leg. LPN 1 put Resident B's legs in bed, made sure Resident B was comfortable, and LPN 1 and LPN 2 left the room and went to the nurse's station. **LPN 1 should have reported that she witnessed LPN 2 kick Resident B immediately but was afraid of retaliation**.

A review of the nursing home's current policy, titled Abuse and Incident Reporting to Indiana Department of Health, dated May 12, 2023, indicated physical abuse included kicking. The nursing home will ensure that all alleged violations of abuse are reported immediately to the Administrator and the other officials according to State and Federal regulations.

Name of Nursing Home	Chalet Rehabilitation and Healthcare Center
Provider ID	155336
Address [RUCA Code: 1] [% County Population Rural: 0.88]	4851 Tincher Rd, Indianapolis, Indiana, 46221
Day Investigation Completed	January 4, 2024
Type of Deficiency Issued	F609
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Witnessed an RN Spitting at a Woman with Dementia but Did Not Report It for 2 Days Because She "*was afraid of retaliation from RN due to issues in the past, not related to residents*"

The nursing home failed to protect the rights of Resident 6 related to physical abuse from a staff member.

The nursing home failed to report an alleged violation involving abuse immediately or no later than 2 hours for Resident 6.

Resident 6 had a diagnosis of **dementia**.

Cognitive Function. "The mental status examination showed the resident had **poor insight, judgement, short and long term memory**, and the fund of knowledge was insufficient and unreliable."

Activities of Daily Living (ADL). Resident 6 was dependent on staff for ADLs. In addition, a note in the resident's Care Plan stated: "Has self-care deficits and needs assistance completing ADLs due to (d/t) recent Cerebral Vascular Accident (CVA), impaired visual function, stability, poor balance, and mobility.

On September 23, 2024, Resident 6 reported mistreatment considering how she was treated and informed writer "You're probably the worst one." The resident would not explain the statement related to mistreatment stating: "It's over and done with hopefully." The resident reported being **blind**.

During an interview on September 23, 2024 at 1:18 PM with the Administrator, Director of Nursing (DON), and the Regional Health Services Director (RHCD), the Administrator reported that at approximately 10:00 PM on September 14, 2024, there was an incident of Resident 6 being combative with care while staff were trying to change her shirt. Staff A had asked RN (Staff B) to assist as the resident had refused care and was combative. The Administrator reported despite multiple follow-ups (with the resident), Staff A and RN (Staff B) were assisting to change the resident's shirt and the resident spat at RN (Staff B). The Administrator reported RN (Staff B) spat back at the resident and held the resident's hands down during the care. RN (Staff B) was immediately suspended during the investigation. RN (Staff B) reported holding the resident's hands down as the resident was in the mechanical lift. Staff A reported RN (Staff B) spit back and the resident and RN (Staff B) spit again at each other. The Administrator stated **unfortunately Staff A did not report the incident right away**. The Administrator reported RN (Staff B) had become aggressive with the Administrator, DON, RHCD during the interview and refused to answer questions. [The next day RN (Staff B) said: "I may have spit back during my aggressive speaking; when the RHCD attempted to address how to handle a resident with cognitive impairment, RN (Staff B) raised voice, asking: "What do you want me to do? Am I just supposed to leave her like that?"] The RHCD reported the allegation (of abuse) was verified as RN (Staff B) confirmed holding down the hands of the resident and spitting back at the resident.

During an interview on November 12 at 12:04 PM, 2024 with the Administrator, DON, and RHCD, the management team reported **Staff A had not reported the incident for two days**. The DON stated the staff member should have reported to the weekend supervisor who was in the nursing home until 11:00 PM and the supervisor would have notified the DON. The DON stated if another staff member was aware of the situation, they should have reported it also. The DON stated she was unaware of any other staff member being aware of the incident. The Administrator stated Staff A had texted him on September 16,

2024 at approximately 1:00 PM, prior to the email. The Administrator and DON stated they did not interview any other staff regarding the incident. The RHCD **stated Staff A "was afraid of retaliation from RN (Staff B) due to issues in the past, not related to residents and Staff A did not report informing anyone else of the incident**."

Review of the Timeline provided by the Administrator revealed, among other things, that on September 16, 2024 at 1:42 PM (**39 hours and 12 minutes after the incident) Staff A called the Administrator to report the incident between Resident 6 and Staff B**.

During a telephone interview on September 24, 2024, LPN (Staff D) confirmed working on the 11:00 PM to 7:00 AM shift, having the most seniority on shift so guessed that made her the Charge Nurse. Staff D reported walking up on the CNA who had witnessed the incident on September 14, 2024, speaking with someone else (unidentified) about the nurse spitting on the resident. LPN (Staff D) reported advising the CNA if something had happened, it would have to be reported. Staff D reported not saying anything to anyone else (regarding the incident) because she was not the supervisor on duty when it happened.

Review of the statement dated September 16, 2024 from Staff B showed RN (Staff B) had reported assisting Staff A with putting Resident 6 into bed at approximately 10:00 PM – 11:00 PM on September 14, 2024. The resident was resistive to care, hitting, clawing, and spitting at staff. RN (Staff B) reported holding the resident's hands so the CNA could put gown on. RN (Staff B) confirmed Resident 6 spat at her and she may have spit back during aggressive speaking and made spitting noise. The nurse reported Resident 6 was an angry bitter person.

Name of Nursing Home	Westminster Suncoast
Provider ID	105926
Address [RUCA Code: 1] [% County Population Rural: 0.19]	1095 Pinellas Point Dr S, Saint Petersburg, Florida, 33705
Day Investigation Completed	November 12, 2024
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm

A CNA Witnessed LPN Verbally Abuse a Woman with Cognitive Impairment, but She Didn't Report it for Two Weeks, explaining: "*A lot of CNAs on the floor will say they are afraid to report abuse because when you do, they are the ones that end up getting fired instead of the abuser*"

The nursing home failed to protect 3 residents (Resident 2, 3, and 9) when LPN 1 yelled at and threatened Resident 2, and CNA 4 refused to provide needed care to Resident 3 and Resident 9. This resulted in Resident 2 and Resident 3 sustaining psychosocial harm.

The nursing home failed to timely report allegations of abuse to the State Survey Agency for 3 residents (Resident 2, 3, and 9) when LPN 1 yelled at and threatened Resident 2, and CNA 4 refused to provide needed care to Resident 3 and Resident 9.

Cognitive Function. Resident 2 had **moderate cognitive impairment** (BIMS score of 9 out of 15).

Activities of Daily Living. Her Care Plan stated: Assist with dressing, grooming, hygiene care, and toileting.

Due to scope considerations and relevance to topic of staff fear of retaliation, this summary focuses primarily on violations related to Resident 2.

Review of the nursing home's investigation showed an incident occurred on May 24, 2023 on the evening shift 3:00 PM to 11:00 PM, between Resident 2 and LPN 1. Review of the Director of Nursing (DON)'s witness statement dated May 25, 2023, showed: The nursing supervisor (RN 1) notified me that [Resident 2] told her that the nurse on the 3:00 PM to 11:00 PM had told her that if she didn't stop yelling, that she would have her moved to a different floor. I spoke with the nurse who stated that the resident was sitting up in the hallway and wanted to be put to bed before dinner. The nurse stated she told her she would have the CNA lay her down before dinner, but she would have to wait a few minutes because they were all in other rooms right then. The nurse stated that the resident was yelling in the hallway to any visitors that walked by "They won't take care of me, they won't put me to bed." The nurse told her again they would lay her down in just a few minutes. The nurse [LPN 1] stated that she never made the statement about her [Resident 2] moving to a different floor and that they had the resident in bed by 4:30 PM and the resident was in bed before dinner which was her request. There were no other concerns reported and the resident is to be put to bed at her requested time.

During an interview on June 20, 2023, CNA 2 stated the incident had probably occurred 2 weeks prior to her witness statement which was dated June 7, 2023. CNA 2 stated: "I was in Orientation at this time and working along with CNA 3. I heard LPN 1 say that she didn't threaten to move her [Resident 2] to another floor but if she [LPN 1] had that power, she would have already moved her a long time ago. Resident 2 is very set in her ways but if you do your job and what she asks of you, then your[sic] fine. You don't have to yell at her [Resident 2], just communicate with her." **CNA 2 stated she was aware the incident was abuse occurrence but had been afraid to report the incident and stated: "A lot of CNAs on the floor will say they are afraid to report abuse because when you do, they are the ones that end up getting fired instead of the abuser." They said they watch people go and report and they get fired instead of the person they reported on,** and that is exactly why [CNA 3] handled that situation the best way she knew how to get the situation diffused was to get the resident away from [LPN 1].

Review of LPN 2's witness statement dated June 7, 2023, showed [Resident 2] seemed upset upon entering her room. The resident stated that she was upset because the nurse the night before told her that if she did not stop yelling, that she [LPN 1] would get her kicked off of the floor. I informed her [Resident 2] that she had nothing to worry about and she would not be kicked off of the floor.

Review of CNA 3 witness statement dated June 7, 2023, showed, among other things, that on May 24, 2023, "I came out of putting [Resident 10] to bed to hearing screaming and [LPN 1] saying she [Resident 2] needed to shut her mouth and saying she needed to act right that no one would want to take care of her acting like that. I immediately took [Resident 2] to her room and shut the door and me and [CNA 2] talked to [Resident 2] to calm her down as she had tears in her eyes and she told me that [LPN 1] told her that if she didn't act right, she was going to move her to another floor. I finally got her [Resident 2] calm and told her that in the morning she needed to report it and if she needed me to tell them what I saw, that I would and if [LPN 1] said anything else to her or in wrong tone, to call me on light [call light]."

Review of RN 1's witness statement dated June 7, 2023 showed, among other things, that on May 25, 2023 "I was called to the 3rd floor by [LPN 2] she stated that Resident 2 was upset about an incident that occurred on May 24, 2023 on the evening shift and wanted to speak to a supervisor. I went into [Resident 2's room] and asked if she was having an issue that she needed to see a supervisor. [Resident 2] started crying and saying that the nurse [LPN 1] and herself was yelling at each other because she asked if she could lay down before 4:30 [PM] because she gets up early. She [Resident 2] said that she talks loud because she is hard of hearing. She proceeded to say that [LPN 1] told her that if she didn't be quiet, that she was going to have her moved to another floor. I reassured her that we would lay her down @ her preferred time for her not to worry, that we would take care of the situation. I then went to the nursing office and reported the incident to the DON."

Review of Resident 2's Psychiatric Evaluation dated June 7, 2023, showed, among other things, Resident 2 is anxious since the incident has happened, as she is afraid of making somebody angry. The resident added that she liked to get up very early and has most of her life. Because of this, she liked to get in bed early, and go to sleep right after dinner. She said she feels bad for getting somebody in trouble. Informed her that she did the right thing and that staff were concerned about her. She feels she is ultimately very well taking[sic] care of and feels safe in that environment at this time. She stated: "That is the only thing I have ever had a problem with." She is thankful for everyone's help in dealing with the situation. No other complaints. The evaluation stated: "The staff member is no longer taking care of this patient."

Relating to LPN 1's actions, Resident 2 told Surveyor: "It hurt my feelings. I went to my room and cried."

Review of Disciplinary Warning Notice dated September 16, 2022 [approximately 8 months prior to the incident), showed: "Despite numerous conversations regarding [LPN 1's] negative attitude, there continues to be no improvement. [LPN 1] has been rude, hateful, and extremely negative to co-workers and department heads, even going so far as to say she had thought about putting a sign out front that reads: "Welcome to Hell." This will no longer be tolerated. Any future conduct of this nature will lead to additional disciplinary action, up to and including termination.

Review of a Disciplinary Warning Notice dated June 6, 2023, showed effective immediately pending complaint investigation. Review of a handwritten letter dated June 7, 2023, showed: "I resign my position as LPN with [name of nursing home] effective immediately," and signed by LPN 1.

Name of Nursing Home	Legacy Park Health and Rehabilitation
Provider ID	445105
Address [RUCA Code: 1] [% County Population Rural: 9.19]	7424 Middlebrook Pike, Knoxville, Tennessee, 37909
Day Investigation Completed	June 26, 2023
Type of Deficiency Issued	*F600 **F609
Scope Severity Level	*Actual Harm **Actual Harm

CNA 2 Witnessed CNA 1 Smacking the Hand of a Person with Severe Cognitive Impairment. CNA 2 Also Witnessed CNA 3 Sexually Abuse Another Resident. Due to Fear of Retaliation, CNA 2 Delayed Reporting the Former Incident and Did Not Report the Latter

The nursing home did not ensure that all alleged violations involving abuse were reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse to the State Survey Agency in accordance with State law through established procedures for Resident 1 and Resident 3. Specifically, allegations of physical and sexual abuse that involved 2 residents was not reported by staff to the nursing home's Administration.

Resident 1 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. Resident 1 had **severe cognitive impairment** (based on MDS assessment).

Cognitive Function. Resident 3 was **cognitively intact** (based on MDS assessment).

Activities of Daily Living. Not Reported for both residents.

An email dated May 29, 2024 at 8:46 PM, written by CNA 2 to RN Manager 1 documented they reported they were working with CNA 1 the evening of May 28, 2024 when Resident 1 grabbed CNA 1 by their wrist. CNA 1 pulled away but then smacked Resident 1 on the top of their hand loudly and was kind of nasty to Resident 1.

The nursing home investigation report dated June 3, 2024, documented the alleged incident occurred on May 29, 2024 at 7:00 PM (date and time differ from the nursing home's submission of the alleged incident that documented it occurred on May 28, 2024 at 9:00 PM). It documented CNA 2 reported CNA 1 allegedly struck Resident 1 on the hand when the resident allegedly grabbed CNA 1's wrist. CNA 1 stated Resident 1 dug their hand into their wrist, and they had to pry the resident's hand off their wrist. CNA 1 denied smacking the resident's hand.

During an interview on June 6, 2024, CNA 2 stated they and CNA 1 were putting Resident 1 to bed about 8:00 PM (May 28, 2024). Resident 1 grabbed CNA 1's arm when they were rolling the resident to change them. CNA 2 stated CNA 1 pulled back hard to free their arm from the resident's grip and then slapped the resident on the top pf their hand making a loud sound. They stated they waited to talk with their Union representative (CNA 4) when they came into work at 9:30 PM because they were more comfortable speaking with them about the incident and were not sure how to handle the situation. They stated the Union representative told them they had 24 hours to report abuse. They stated they sent an email to RN Unit Manager 1 at 8:00 AM on May 29, 2024. **CNA 2 stated they wished they had reported the alleged abuse sooner but was overwhelmed and did not know how to handle the situation**.

During an interview on June 14, 2024, CNA 4 stated CNA 2 reported to them (on May 5, 2024) that Nurse Aide 1 had slapped another resident. **CNA 2 told them they were afraid of retaliation**. **CNA 4 stated they told CNA 2 no matter what, CNA 2 still needed to report it**. CNA 4 stated they did not tell anyone about it after CNA 2 reported it to them. They stated they should have also reported the alleged abuse rather than taking CNA 2's word that they were going to report it.

During an interview on June 7, 2024, the Director of Nursing (DON) stated they first learned of the alleged incident until May 29, 2024 at 10:30 AM and reported it to the Department of Health shortly after they were told. They stated when they learned about the incident, it was reported to them CNA 2 witnessed CNA 1 smack Resident 1 on their hand when trying to remove their wrist from the resident's grip. The DON stated CNA 4 (regarding the May 28m 2024 incident) told them CNA 2 did not know how to proceed and CNA 4 told them to report it. The DON stated it was unknown if CNA 4 told CNA 2 to report right then, or within a specific timeframe. They stated **CNA 2 should have told someone immediately about the alleged incident.** They stated they could have told the chare nurse, and if they felt comfortable, they could have called the Patient Care Coordinator (a nursing supervisor) and management. The DON stated the phone numbers were posted at the nurse's station, and the numbers were provided to staff upon hire. They stated **CNA 2 was worried about retaliation from their coworkers if they reported the alleged incident**.

During an interview on June 7, 204, **the Administrator stated** abuse was to be reported immediately upon happening, and within 2 hours to Department of Health. They stated **they would be meeting with CNA 2 and their Union Representative for verbal counseling regarding timely abuse reporting, and people to report to if they felt uncomfortable with notifying their direct supervisor.**

During an interview on June 6, 2024, CNA 2 stated they witnessed CNA 3 squishing Resident 3's breasts together, making a kissy sound, and asking Resident 3 if they liked that. They stated they reported it to RN Unit Manager the same day (this statement differs from CNA 2's written statement and the following interview with the DON).

During an interview on June 7, 2024, the DON stated they interviewed CNA 2 who told them about the breast squishing incident with Resident 3. The DON stated **CNA 2 stated they did not report it because they were afraid of what others would think and was afraid of retaliation.**

An untimed statement dated June 22, 2024, written by CNA 2: CNA 2 witnessed CNA 3 allegedly squish their breasts together and asked Resident 3 if they liked them while moving closer to the resident. CNA 2 documented they had witnessed that while working with CNA 3 that week. They also documented the last time they had worked with CNA 3, they were taking care of a male resident (name not provided), and CNA 3 stated 3 different times that CNA 2 just wanted to see the resident's penis. **CNA 2** documented they **were afraid to report it because they were afraid CNA 3 would retaliate against them**.

Name of Nursing Home	Champlain Valley Physicians Hosp Med Ctr S N F
Provider ID	335442
Address [RUCA Code: 4] [% County Population Rural: 63.73]	75 Beekman Street, Plattsburgh, New York, 12901
Day Investigation Completed	July 10, 2024
Type of Deficiency Issued	F609
Scope Severity Level	Minimum Harm or Potential of Actual Harm

Intimidation /

Threats of Retaliation

CNA N Reported Feeling "*extremely intimidated*" by CNA M After Witnessing Injurious Transfer of a Woman with Severely Impaired Cognition Against Her Care Plan / CNA N Said CNA M Advised Her: "*You are not to tell anyone that this incident happened*"

The nursing home failed to ensure dependent Resident 1 remained free from neglect, when CNA M attempted an unsafe transfer of the resident from the bath chair to her wheelchair, without use of the care planned mechanical lift on December 20, 2022. The resident's legs buckled during the transfer and CNA M called for assistance; however, when CNA N entered the room, the two staff continued to transfer the resident to her wheelchair without use of the care planned mechanical lift. CNA N and CNA M did not report the unsafe transfer and Administrative Nurse D began an investigation on December 26, 2022, after she was notified that the resident had complained of pain, and had faint yellow bruising to her lateral side (outside) of her left leg, just below her knee, since December 23, 2022. Six days after the incident, on December 26 2022, X-rays completed and the resident was diagnosed with an oblique nondisplaced hairline fracture to her left fibular head (upper end of one of the two bones of the lower leg at the knee area). The staff failure of an unsafe transfer of the resident with the care planned mechanical lift and failure to report the fall, placed the resident in immediate jeopardy, and placed all 11 residents who used mechanical lifts at risk of unsafe transfers.

Resident 1 lived with a diagnosis of **vascular dementia**.

Cognitive Function. The resident had "**severely impaired cognition**" (BIMS score 2 out of 15).

Activities of Daily Living. As of October 6, 2022, she required extensive assistance of two staff for bed mobility, transfer, and toileting, and required total assist with bathing. She used a wheelchair for mobility.

The October 17 2022 Fall Care Area Assessment (CAA) documented the resident required a mechanical full body lift (Hoyer Lift) for transfers as she could not bear weight.

CNA N stated that s/he answered the call light to the shower room, after CNA M gave the resident a shower. CNA M placed her arms around the resident's waist and lifted her to a standing position. When CNA N entered the shower room, the resident's knees began to buckle and the resident was in a squatted position, but her knees did not touch the floor while CNA N was in the room. CNA N assisted CNA M with transferring the resident to her wheelchair. **CNA N reported she was extremely intimidated by CNA M**, however CNA N told CNA M the resident was to transfer with a mechanical lift per her Care Plan. CNA M advised: "**When I work with her, nothing is reported to the nurse's**, she does not have time to wait for someone else. **You are not to tell anyone that this incident happened**."

The nursing home investigation indicated the resident was "lowered to the ground onto her knees" during the transfer and the two CNAs picked the resident up from the floor and placed her into her wheelchair.

CNA M stated that after they transferred the resident to the wheelchair, she advised CNA N that the resident no longer required a mechanical lift and CNA N argued about it, "but I told her that I knew the resident better than her." CNA M stated: "**I told her not to report the incident to the charge nurse or anyone else in the facility**." CNA M stated she transferred the resident on several occasions without using the gait belt and the mechanical lift, because she had worked at the facility for two and a half years.

CNA M reported she did not know where to find the resident's care plans or tasks, to see what cares the residents required. She reported she only received the information from the previous shift or charge nurses. CNA M reported she continued to transfer other residents as well, on several occasions, without the gait belt or use of mechanical lift. CNA M reported she did know the policies of the facility; however, she could transfer the resident by herself without difficulty. She stated she would continue transferring residents without another staff member, because she did not want to wait for another staff member to help her.

On December 26 2022, Administrative Nurse D started the nursing home's investigation. During the investigation, **CNA N reported she should not have listened to CNA M, who advised her not to report to the charge nurse that the resident was lowered to the floor.** Administrative Nurse D reported she then visited with **CNA M** who **verified** that the resident was lowered to the floor, and **she told CNA N not to report the fall**. CNA N was suspended for 3 hours. Then on February 7, 2023, Administrative Staff A terminated CNA N's employment and escorted her out of the building.

CNA M was suspended for one week. CNA M received Abuse, Neglect, and Reporting of Incidents prior to her shift and placed on a 90-day probation.

Name of Nursing Home	Flint Hills Care and Rehabilitation Center
Provider ID	175280
Address [RUCA Code: 4] [% County Population Rural: 25.16]	1620 Wheeler Street, Emporia, Kansas, 66801
Day Investigation Completed	February 16, 2023
Type of Deficiency Issued	F600
Scope Severity Level	Immediate Jeopardy

"*If they wanted a paycheck, they better not say anything bad*" to State Surveyors

The nursing home failed to ensure: a. Sufficient and competent staff available to provide care to all residents as evidenced by residents with pressure ulcers and not being repositioned, lack of adequate staffing supervision of a resident observed near a hazard and a resident who tipped his motorized wheelchair when outdoor and hit his head, and failure to administer treatments and medications timely; b. Call lights within reach of residents and failed to ensure staff responded and answered residents' call lights within 15 minutes to meet resident's needs in a timely manner for two nursing units observed.

Cognitive Function. Not Reported. Activities of Daily Living. Not Reported.

During anonymous interviews, two staff members reported hesitancy to speak to the surveyor unless away from the Administrative offices for fear of being seen and retaliation. Four staff reported the Administrator and Director of Nursing (DON) told staff whenever State (Surveyors) asked the staff questions, they needed to respond everything was fine. If they wanted a paycheck, they better not say anything bad. Staff reported the CNAs' schedule changed and hours were cut back after the new company took over. The nursing home was short staffed and used a lot of agency [staff] to fill hours, even though the nursing home's employed CNAs wanted and could work the hours. Staff were told options for schedule (8 hours) and they could take it or leave it. However, a CNA related to the Director of Nursing got a special schedule created for her, and whenever this CNA worked, there was only one CNA on the hall assigned after 9 PM when that CNA's shift ended, and if residents not put in bed by 9 PM, they were left up until anther staff person came in after 10 PM. Staff reported being yelled at or treated rudely by the Administrator. Staff members reported names listed on daily assignment lists but staff not aware they were scheduled to work. The daily assignment sheets looked like they had adequate staff but, in reality, staff not scheduled to work. One staff reported lack of dietary staffing and only had a cook and dietary aide who worked in the kitchen; suppose to have four staff in the kitchen during their shift. One staff member reported only 1 CNA scheduled on the [NAME] Hall on [Name] level but supposed to have two staff. One CNA can't do everything needed for the residents on [NAME] Hall; It's a heavy load. A lot of residents required two staff for assistance and transfers. Unable to provide showers and baths, answer call lights, and care for all of those residents without adequate number of staff working.

During a confidential interview, **RN (Staff J) stated** that residents' medications and treatments administered late or not administered because the nursing home was short staffed, adding that several residents had developed pressure ulcers because residents not getting repositioned like they should.

Resident 28 was observed at 7:21 PM in her wheelchair by nurse's station yelling: "Help me, help me please." At 7:37 PM, she hollered: "Hurry, hurry, restroom." At 7:38 PM, when RN (Staff J) asked her what she was doing, she said: "Bathroom." The RN told her the bathroom at the nurse's station was not a resident bathroom. Resident 28 responded: "How do I get to a bathroom?" The RN didn't respond. At 7:49 PM, Resident 28 was down the hall calling: "Help me, help me please." At 7:51 PM, CNA (Staff K) walked by her and told her she planned to assist her to bed soon.

Name of Nursing Home	Harmony West Des Moines
Provider ID	165601
Address [RUCA Code: 1] [% County Population Rural: 4.47]	5010 Grand Ridge Drive, West Des Moines, Iowa, 50265
Day Investigation Completed	June 8, 2023
Type of Deficiency Issued	F725
Scope Severity Level	Immediate Jeopardy

A Behavioral Health Manager Intimidating Witnessing Staff Not to Report His/her Physical Abuse of a Person with Schizophrenia (Hitting Him/Her with a Closed Fist, Causing Him/Her to Cry and Be Fearful)

The nursing home failed to ensure Resident 4's right to be free from physical and verbal abuse, when two residents had a physical altercation (Resident 1 and Resident 4). In addition, the Behavior Health Manager (BHM) punched Resident 4 in his/her right shoulder, resulting in the resident crying out in pain.

The nursing home failed to follow their policy to conduct a complete and thorough investigation of an allegation of physical and verbal abuse, when BHM punched Resident 4 in his/her right shoulder, resulting in him/her crying out in pain, followed by the BHM's verbal threat of additional physical harm.

Resident 4 had a diagnosis of **Schizophrenia**.

Cognitive Function. The resident was reported to have "**cognitive impairment**."

Activities of Daily Living. Not reported.

During an interview, Resident 4 said the BHM hit him/her with her/his fist in his/her shoulder. The BHM works security. The resident said after the BHM hit him/her, he/she started crying, because it hurt his/her feelings. The BHM told him/her he/she was sorry, but the resident is afraid of him/her.

During an interview, Resident 3 said he/she witnessed Resident 4 hit Resident 1. Resident 3 said he/she saw BHM hit Resident 4 on his/her arm and that it happened 3 to 4 weeks ago, the BHM hit him/her with a closed fist. Resident 3 said the BHM said to Resident 4 after he/she hit him/her: "How does that feel when someone hits you?" After it happened, Resident 4 didn't say anything, but it made him/her stop hitting.

During an interview, CNA C said he/she was the only CNA on the secured D Hall. He/she said Resident 4 was hitting the other residents and he/she hit Certified Medication Technician (CMT) B. Resident 4 was sitting in a chair across from BHM and the BHM punched Resident 4 in the arm after Resident 4 hit CMT B. The BHM told Resident 4: "The next time it will be harder."

CNA C wrote a statement, but the Director of Nursing (DON) did not ask him/her for a statement. The DON came on the D Hall and he/she informed the DON that BHM hit the resident. The DON said that's not what he/she was there for and told him/her: "You'll have to talk to the Administrator about that," which he/she thought was odd. The DON only asked him/her what happened on the hall regarding the resident on resident altercation. The BHM was trying to get him/her to lie. The BHM told him/her to write a statement which needed to say Resident 4 was aggressive to him/her, which he/she was not aggressive to him/her. CNA C heard Nurse A told the Administrator what happened. But neither the DON nor the Administrator have asked him/her about this incident. CNA C said: "It's so fishy." He/she was waiting for someone to ask him/her about BHM hitting the resident. He/she knew the state would try to reach out to him/her. **CNA C was not about to lose his/her license and lie**. He/she told BHM he/she will give his/her statement to the DON or Administrator. When CNA C went to the Administrator's office, the Administrator never mentioned he/she needed his/her statement: "It's like they don't care." CNA C said he/she was right there and saw everything, and he/she heard they are going to try to make it look like the Charge Nurse is not telling the truth. CMT B refused to give the BHM a statement and told him/her he/she will

only give a statement to the DON or Administrator. Resident 4 had to be scared because he/she did not hit the BHM back. Resident 4 has a mentality of a 7 or 8 year old. Later, when CNA C saw the BHM, the BHM wouldn't even look at him/her in his/her eyes. The BHM knows he/she did something wrong. The BHM has been back at work. CNA C had never seen anyone abuse a resident and was shocked. CNA C said it happened right in front of him/her and his/her mouth just dropped. CNA C said he/she walked out of the D Hall, right behind Nurse A. Nurse A went into the medication room and the BHM got on his/her phone and called the Administrator, then handed Nurse A his/her phone. CNA C didn't think the BHM saw Nurse A was on the Hall. CNA C didn't know how he/she didn't see him/her, but then the BHM said to him/her: "**This bitch snitched on me**, now (he/she) needed to get statements and (he/she) would be getting off early that day. CNA C said: "**The BHM came back on his/her hall twice, trying to pressure CNA C into writing a statement and lie about what happened**."

During an interview, Nurse A said when he/she saw the BHM hit Resident 4, he/she left the secured D unit and went to the medication room to call the Administrator. The Administrator told the BHM to clock out and leave. He/she said he/she assessed Resident 4 for injury and there was no redness or swelling on his/her arm. About 15-20 minutes later, he/she saw the BHM again and told him/her: "Weren't you supposed to be leaving?" **The BHM** said he/she was collecting statements, and **asked Nurse A why did he/she report him/her? Now he/she is going to get fired**. About an hour later, the BHM was still in the building. The DON arrived to send a report to state, because of the two-hour window for reporting. The BHM was still there, and they were standing by the DON's office talking. Nurse A left a witness statement underneath the Administrator's door. Nurse A said BHM worked this weekend, and he/she saw him/her numerous times since the incident. When Resident 4 returned from the hospital, he/she said he/she didn't want to be here because he/she didn't want the BHM hitting him/her.

During an interview, BHM said his/her position is a supervisory position over all the CNAs. He/she ensures they have no problems with the residents and everything goes smoothly. He/she is called if staff need help to diffuse situations. He/she worked in the mental health field for over 10 years and is trained in Crisis Prevention Intervention (CPI, management of disruptive and assaultive behavior) and he/she knows how to restrain people without hurting anyone. The BHM said Resident 4 was hitting people and he/she blocked the resident with his/her hand. The BHM stated that he/she never hit Resident 4 and that he/she does not hit people.

A witness statement from BHM's included, among others, that when the nurse on duty tried to administer as needed (PRN) medication to Resident 4 (after he/she was aggressive towards other residents and staff), Resident 4 became aggressive and struck the nurse, causing the BHM to administer CPI to the resident in order to get the situation under control.

During an interview, the Administrator stated she/he was not aware of reports stating that BHM hit Resident 4 and that she/he was only aware of the resident-to-resident altercation. The Administrator denied knowledge of a witness statement from Nurse A which was placed under her/his door. The nursing home's investigation also included a note stating that the Administrator was unaware of the allegation that BHM struck Resident 4.

Name of Nursing Home	Estates of Spanish Lake, The
Provider ID	265776
Address [RUCA Code: 1] [% County Population Rural: 1.35]	610 Prigge Road, Saint Louis, Missouri, 63138
Day Investigation Completed	February 9, 2023
Type of Deficiency Issued	*F600 **F610
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm

A Registered Nurse Slapped the Face of a Woman with Dementia and Then Intimidated Two Witnessing CNAs (Telling Them Not to Snitch on Her)

The nursing home failed to protect Resident 1's right to be free from physical abuse by Registered Nurse (RN) B while providing evening cares to the resident.

Review of the nursing home's investigation revealed that the provider had determined that physical abuse had occurred when RN B slapped Resident 1 while providing evening cares on January 14, 2025.

Resident 1 had a diagnosis of **dementia**.

Cognitive Function. The resident had **moderate cognitive impairment** (BIMS score of 8 out of 15).

Activities of Daily Living. Not reported.

During an interview, CNA C stated Resident 1 did not want to go to bed and RN B had been forcing her. CNA C said RN B told her a skin assessment needed to be completed. CNA C felt uncomfortable with what RN B was doing and tried to leave, but RN B told her she had to stay. CNA C stated RN B had been forceful with her handling of the resident, the resident hit her and RN B then slapped Resident 1 in the face. After RN B slapped Resident 1, CNA C and CNA D told RN B she needed to leave and that they would finish getting Resident 1 ready for bed. CNA C stated **RN B pulled her aside later and told her what happened had been her fault, CNA C should not snitch on her** and RN B would call the Administrator.

During an interview, CNA D stated she came in at 9:00 AM for her shift to relieve CNA C, and she could tell RN B was agitated when she arrived. CNA D stated RN B told both the CNAs that Resident 1 wanted to lie down, but CNA D stated that Resident 1 did not want to lie down. When Resident 1 refused to lie down, RN B seemed upset and pushed her backward in her wheelchair, transferred her onto her bed, and started taking Resident 1's clothes off of her. CNA D confirmed that CNA C tried to leave but RN B would not let her. Resident 1 was getting upset and was hitting and slapping RN B. After RN B slapped Resident 1, she said CNA C and herself told RN B to leave and they would get Resident 1 ready for bed. CNA D stated that **RN B pulled her aside and told her not to snitch on her**.

On January 15, 2025 (a day after the incident), Resident 1's skin assessment revealed: Bruising to right side of forehead from previous fall, right side of face and cheek-redness, right skin tear has reopened – are cleansed and redressed.

RN B's employment was terminated on January 15, 2025 (a day after the physically abusive incident). The incident was reported to the state's Board of Nursing and to local law enforcement.

Name of Nursing Home	Rolling Hills Healthcare
Provider ID	435035
Address [RUCA Code: 7] [% County Population Rural: 50.32]	2200 13th Ave, Belle Fourche, South Dakota, 57717
Day Investigation Completed	January 28, 2025
Type of Deficiency Issued	F600
Scope Severity Level	Actual Harm

An LVN Delayed Reporting Employee's Physical Abuse of a Person with Schizophrenia and Severe Cognitive Impairment After the Employee Threatened to Kidnap the LVN, Take Her to a Secluded Place, Rape Her, Dismember Her, Put Chloroform on Her Face, Put Her in the Trunk, and Throw Her into the River / He Was Also Reported to Pull a Knife on the LVN in the Breakroom a Few Days Later

The nursing home failed to ensure Resident 1 and Resident 2 had the right to be free from abuse. The nursing home failed to ensure a safe environment free from abuse for Resident 1. On July 22, 2023, at 11:15 PM, Employee I A was observed by LVN B cleaning Resident 1's bleeding ear lobe and denied knowing what happened. Resident 1 was transferred to the hospital with multiple injuries.

The nursing home failed to ensure all alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source, are reported immediately, but no later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, for Resident 1 and Resident 2.

LVN B failed to report physical abuse of Resident 1 after witnessing Employee I A's rough actions with the resident during incontinent care.

The Administrator failed to report serious and multiple injuries on Resident 1 to Police or State Agency. The Assistant Director of Nursing notified the Administrator on July 23, 2023 at 1:39 AM. The Administrator did not report the incident until 11:28 PM, which was more than 9 hours later.

The nursing home failed to, in response to allegations of abuse, thoroughly investigate the alleged abuse of Resident 1. The nursing home failed to thoroughly investigate an incident of physical abuse of Resident 1 when LVN B observed rough action by Employee I A while providing incontinent care to Resident 1.

Employee I A was also physically abusive to Resident 2 (as shown in 3 videos recorded on three different days). Due to scope considerations, this summary focuses primarily on violation related to Resident 1.

Resident 1 had diagnoses of **vascular dementia** and **Schizophrenia**.

Cognitive function. Resident 1 has **severe cognitive impairment** (BIMS score of 1 out of 15).

Activities of Daily Living. Resident 1 required extensive assistance with most ADLs and transfer. He was frequently incontinent of bowel and bladder.

During an interview with LVN A on July 25, 2023 at 10:54 AM, LVN A said on July 23, 2023, at about 11:00 PM, Resident 1 was found with fresh bruises, lacerations, and abrasion after changing shift with LVN B. LVN A said LVN B informed her she saw Employee I A cleaning the bleeding earlobe of Resident 1. LVN B asked Employee I A what happened and I A responded: "I don't know." LVN B said she notified the physician and received orders to send the resident to the hospital to rule out internal injuries. LVN A explained **LVN B on July 18 2023, informed her that she was afraid because Employee I A threatened to kidnap, rape, put her in the trunk, and throw her in the river.** She was shocked and immediately went to Human Resources (HR) E. LVN A and HR E walked to the Administrator's office and informed him of the threat from Employee I A. LVN A said she did not hear from the Administrator or aware of any

investigation. The Administrator didn't talk to others about the issues and Employee I A was still reporting to work as if nothing happened. There was no investigation, suspension, or disciplinary actions.

LVN A stated she was very concerned when LVN B informed her Employee I A pulled a knife on her in the breakroom a few days after the rape threat. She noted LVN B was visibly terrified and said she did understand why the Administrator had not acted on her complaint regarding Employee I A.

During an interview with LVN B on July 25, 2023, she said she was working on Hall 100 where Resident 1 and Resident 2 were residing. On July 18, 2023, she was working with Employee I A who threatened her. She explained **Employee I A told her he was going to kidnap her, put chloroform on her face, take her to a secluded place, rape her, dismember her, put her in a car trunk and throw her in the river. LVN B stated she was scared to death** because of the tone and his look when he was talking. She immediately informed LVN A who was changing shift with her. LVN B said LVN A was just as scared and notified the Administrator immediately. She explained that the Administrator did not take any action. He did not talk to her or LVN A after the report. The Administrator did not investigate, suspend, terminate Employee I A's employment. Employee I A was still on schedule working with her. A few days after his threat, LVN B said Employee I A pulled a knife on her in the break room. She screamed but nobody heard her. She was convinced he was going to hurt or kill her and her two kids. **She was terrified and looking over her shoulders with sleepless nights looking to see if Employee I A would come to attack knowing he knew where she lives**.

The LVN B went on to say that on July 23, 2023 at about 11:00 AM, she walked into Resident 1's room and saw Employee I A cleaning the resident's bleeding earlobe. She asked him what happened. Employe I A responded: "I don't know." **LVN B states** Resident 1 looked like he was in WWF fight. She said Resident 1's wounds were new and fresh because she took care of him less than 24 hours earlier. **She was horrified and terrified of Employee I A and did not immediately report the incident**. She told LVN A what she saw. LVN B notified the Assistant Director of Nursing (ADON) C who instructed her to transfer the resident to the hospital. LVN B explained that the Administrator was notified. The Administrator informed them not to send Resident 1 to the hospital but to call Hospice Nurse to do an assessment. LVN B said she took the advice of ADON C and transferred Resident 1 to the hospital for evaluation and treatment because Resident 1's wound was serious. She noted Employee I A was asked to write a statement and sent home. **LVN B** stated Employee I A continued to say he didn't know what happened. She believed Employee I A did something to the resident because he was the only aide assigned to that hall. Meanwhile, **she went to the police to report the threat on her life by Employee I A** since the Administrator was not doing anything. The police wanted to come to the nursing home that night to watch the videos, but the Administrator told them "Wait till the morning" because it was too late at night for him.

In another interview with LVN B on July 27, 2023, she stated that on July 22, 2023, LVN B entered Resident 1's room. LVN B saw Employee I A cleaning Resident 1's bleeding earlobe. LVN B stated when asked multiple tomes to Employee I A what happened, Employee I A would only reply "I don't know." LVN B asked Resident 1 what happened, Resident 1 made a motion with hands, like he got into a fight. LVN B asked Resident 1 who he got in a fight with, he pointed to Employee I A.

Review of Hospital Admission for Resident 1 dated July 23, 2023 indicated: “Patient is noted to have multiple superficial bruises over the left ER left forearm, left shoulder and left lower extremity and imaging study showed multiple rib fractures as well as lumbar spine fracture.

Observation of Resident 1 on July 24, 2023 in the hospital revealed Resident 1’s injuries included a bruised penis, left shoulder lacerations, left ear lobe lacerations, a hematoma to left leg and left abdomen, and multiple rib fractures.

During an interview on July 26, 2023, the Administrator confirmed, among others, that s/he did not talk to Employee I A about the rape issue or the incidents of physical abuse Resident 1 and Resident 2.

On July 23, 2023, the employee in question was suspended immediately pending investigation and terminated on July 23, 2023, after discovering evidence of him committing abuse of a resident.

Name of Nursing Home	Avir at San Angelo
Provider ID	676100
Address [RUCA Code: 1] [% County Population Rural: 16.68]	5455 Knickerbocker Rd, San Angelo, Texas, 76904
Day Investigation Completed	July 28, 2023
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy

A CNA Slapped the Face of a Woman with Alzheimer's Disease. Then He Intimidated a CNA Witness Who Feared Retaliation and Delayed Reporting It / The Perpetrator Followed the Witnessing CNA Around Throughout the Rest of Their Shift and Asked: "*Are you going to tell on me?*" She Said She Didn't Get a Chance to Say Anything to the Nurse with the Perpetrator Always Behind Her

The nursing home failed to protect Resident 2 from unnecessary punishment and abuse. On January 26, 2024, CNA (Staff G) reported that while she and CNA (Staff F) helped Resident 2 to the toilet, Resident 2 kicked, slapped, and spit at them. Staff G said that Staff F slapped Resident 2 on the face, stepped on her foot, and manhandled her into the wheelchair.

The nursing home failed to immediately report allegations of abuse to the proper authorities for Resident 2 and Resident 15. On January 26, 2024, CNA (Staff G) reported on the overnight shift of January 25, 2024 January 26, 2024, Resident 1 hit, kicked, and spit at the staff. CNA (Staff F) took over for Staff G, and proceeded to slap Resident 2 on the face, step on her foot, and manhandled her into the wheelchair sometimes around 12:30 AM to 1:15 AM on January 26, 2024**. Staff G failed to report the alleged abuse to the Administration until later in the morning of January 26, 2024**.

While investigating the situation between Staff F and Resident 2, RN (Staff P) reported approximately 3 months before, she had a similar situation with Staff F. Staff F told Staff P as Resident 15 became combative, he tapped her a little hard when he tried to get her dressed for bed. Staff P denied reporting the incident to the Administration or to the state authorities. The failure to report or intervene to ensure residents' safety resulted in an Immediate Jeopardy to the health, safety, and security of the residents.

The nursing home failed to immediately separate an alleged abuser (Staff F) from Resident 2 and 15. **Staff G failed to report an incident of alleged abuse until a few hours after Staff F and her shift.** This allowed Staff F to work with other residents until the end of their shift at 6:00 AM. Staff P reported a similar situation with Staff F approximately 3 months earlier. Staff P failed to notify the Administration or separate Staff F from the residents. This allowed him to allegedly abuse Resident 2. With the failure to report, this resulted in a failure to investigate and prevent additional incidents from occurring.

Resident 2 had a diagnosis of **Alzheimer's disease**.

Cognitive Function: The resident had **severe cognitive deficits** (BIMS score of 4 out of 15).

Activities of Daily Living. She required total staff assistance for toilet use, showering and dressing. She required partial assistance with toilet transfers. She was frequently incontinent of urine and bowel.

Resident 15 had a diagnosis of **Alzheimer's disease**.

Cognitive Function. Resident 15 had **severely impaired cognition** (BIMS score of 1 out of 15).

Activities of Daily Living. Resident 15 required total assistance from staff for lower body dressing, toilet hygiene, and putting on footwear.

Due to scope considerations, the summary focuses primarily on Resident 2.

Staff G said the incident with Staff F and Resident 2 happened so fast. Resident 2 was being difficult, hitting, and spitting which was not unusual for her. Staff G took her to the bathhouse to toilet her and she asked Staff F to assist. As Resident 2 sat on the toilet, she went to spit on Staff F. He got to eye level with her and said: "We don't spit." The resident told him to go to hell. Staff F went back to eye level with the resident again, said: "Fuck it" and slapped her on the cheek. When Resident 2 tried to kick him in the genitals, Staff F stepped on one of her feet to keep her from kicking him. Staff G got between the two of them and Resident 2 said: "I'd rather deal with you, because I don't want to be black and blue." Staff G got Resident 2 up from the toilet, pulled her pants up, Staff F then grabbed the back of Resident 2's pants, whipped her around, and swung her into the wheelchair. The chair tipped back and if it hadn't had the anti-tip bar on the back, she could have fell backwards in her chair. Staff G said she got Resident 2 to the dining room and tended to her the rest of the night. About an hour after the incident, Resident 2 went to sleep in her room. Staff G said that hours went by before she saw the nurse. **Staff F followed Staff G around throughout the rest of their shift and asked: "Are you going to tell on me?" Staff G said she didn't get a chance to say anything to the nurse with Staff F always behind her**. Staff G said the slap was not hard enough to leave a bruise, but it did leave a red mark on Resident 2's cheek that disappeared by morning. **Staff G** said she witnessed Staff F lose his temper at residents, as he would yell at them. **She being afraid of Staff F that she could be retaliated against for reporting the incident.**

The nursing home investigation included, among others, these notes: When asked, Staff F stated: "Yes, I tapped her (Resident 2) on the face and said to her "Can you please stop?"" Staff F described the tap as very soft with no power behind it. Staff F stated: "I am sorry – I wasn't trying to hurt her." Staff G expressed she wasn't sure if she should call it a tap or a smack or what.

Review of Police Report included an interview between Staff and Police Officer. Staff F reported Resident 2 had dementia and often caused problems for the workers. The night of the incident, Resident 2 yelled and screamed, he knew that she would get better when people were around her and could bring her back to reality. He told the officer that he saw Staff G having trouble with Resident 2. As Resident 2 hit and screamed at Staff G so he decided to go in and help Staff G. While Resident 2 sat on the toilet, he got down to her eye level and tapped on her cheek to bring her back to reality. Resident 2 got more upset and threatened to kick him in the genital area. At that time, Staff F took his foot and placed it on top of Resident 2's foot to prevent her from kicking him.

The Administrator said Staff G should have reported the alleged abuse immediately. She said she addressed the concern as soon as she learned about it on the morning of January 26, 2024. She educated all the staff that day that they must report alleged abuse immediately so the alleged abuser could be separated from the residents.

Name of Nursing Home	Blackhawk Life Care Center
Provider ID	165499
Address [RUCA Code: 10] [% County Population Rural: 100]	73 West 5th Street, Lake View, Iowa, 51450
Day Investigation Completed	April 2, 2024
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Immediate Jeopardy ***Immediate Jeopardy

An LPN's Hit the Face of a Person with Paraplegia. A CNA Who Witnessed it Changed Her Statement During the Nursing Home's Internal Investigation Because She Was Afraid of Retaliation by the Nursing Home for Telling the Truth. When in the presence of the Surveyor the Director of Nursing Asked the CNA: "*Which one is your statement? You keep changing your statement*," the CNA said: "*You see, this is the intimidation I am talking about, and I might lose my job for telling the truth*"

The nursing home failed to ensure Resident 1 was free from physical abuse. This failure to prevent abuse caused Resident 1 to have a cut to Resident 1's face near the nose.

Resident 1 had a diagnosis of **paraplegia** and had a history of **Traumatic Brain Injury**.

Cognitive Function: **No cognitive deficits** (BIMS score of 15 out of 15).

Activities of Daily Living. The resident needed limited assistance, one person physical assist with bed mobility, transfer, locomotion on and off unit, dressing, toilet use, personal hygiene, and supervision, setup help only with eating. The resident uses a manual wheelchair.

On December 10, 2022, Resident 1 said that on November 26, 2022, Resident 1 went to the nursing station to get Resident 1's medication from LPN (V10) for Resident 1's spasms. Resident 1 said that LPN (V10) was not happy and told Resident 1 that Resident 1 would get Resident 1's medications later. Resident 1 said that as Resident 1 was attempting to get into the elevator, LPN (V10) came and started pulling Resident 1 from the elevator. Resident 1 said LPN (V10) then balled LPN's (V10) fist and hit Resident 1 in the face. Resident 1 said Resident 1 started bleeding on the nose where Resident 1 had a cut. Resident 1 said a CNA saw what happened and came and separated Resident 1 from LPN (V10) and took Resident 1 downstairs to the Social Services office. Resident 1 said Resident 1 called the police and the police came and saw that Resident 1 had a cut on Resident 1's face near the nose.

On December 10, 2022, Assistant Administrator (V12) said Resident 1 was trying to get on the freight elevator which is for staff, outside venders and ambulance use only. V12 said staff heard somebody moving food carts by the elevator. LPN (V10) went to the elevator to see what was going on. V12 said LPN (V10) held Resident 1 to prevent Resident 1 from going into the elevator. V12 said instead of LPN (V10) holding Resident 1's hands, LPN (V10) should have walked away and called another staff member to come assist with Resident 1 since Resident 1 was already upset with LPN (V10). V12 said: "We had that conversation and we talked to LPN (V10) what LPN (V10) could have done differently." V12 said: LPN (V10) should not have held Resident 1's hands to try to prevent Resident 1 from hitting LPN (V10).

On December 10, 2022, CNA (V13) said that she (V13) heard a commotion by the freight elevator and went to see what was going on. CNA (V13) said she (V13) found Resident 1 and LPN (V10) in a lock hold. CNA (V13) pulled them (V10 and Resident 1) apart. CNA (V13) said LPN (V10) had a bad attitude that morning since LPN (V10) got to work. CNA (V13) said Resident 1 rolled up to the nursing station and asked LPN (V10) for medicine. CNA (V13) said LPN (V10) was yelling at Resident 1 saying: "I just got here." CNA (V13) said Resident 1 then rolled Resident 1's wheelchair towards the elevator. LPN (V10) followed Resident 1 and tried to pull Resident 1 from the elevator doors, when Resident 1 resisted, LPN (V10) physically grabbed Resident 1. Resident 1 started using Resident 1's leg to kick LPN (V10) so that LPN

(V10) would let Resident 1 free. CNA (V13) said CNA (V13) pulled Resident 1 from LPN (V10) and CNA (V13) took Resident 1 to Resident 1's room, before escorting Resident 1 downstairs.

CNA (V13) added she (V13) **changed her (V13) statement during the nursing home internal investigation because she (V 13) was afraid of retaliation by the nursing home for telling the truth**. The Director of Nursing (DON) who was present during this surveyor's interview asked CNA (V13): "Which one is your statement? You keep changing your statement." CNA (V13) said: "**You see, this is the intimidation I am talking about, and I might lose my job for telling the truth."**

The surveyor asked the DON to let this Surveyor complete the interview with CNA (V13) without interrupting the interview. CAN (V13) said after she (V13) took Resident 1 downstairs, she (V13) told the Director of Staffing (V14) that she (V13) had seen LPN (V10) hit Resident 1 on the face. CNA (V13) said Resident 1 had a scratch on Resident 1's nose, and the scratch was bleeding.

Name of Nursing Home	Bria of Forst Edge
Provider ID	145864
Address [RUCA Code: 1] [% County Population Rural: 0.05]	8001 South Western Avenue, Chicago, Illinois, 60620
Day Investigation Completed	December 11, 2022
Type of Deficiency Issued	*F600
Scope Severity Level	Actual Harm

Administration's Intimidation of a Housekeeper Who Witnessed and Audio Recorded Abuse of a Woman with Alzheimer's Disease (While Laughing, Two Night Aides Were "*twisting her around naked in her wheelchair with her feet up in the air*"). The Director of Nursing Made Her Delete It Out of Her Phone When She Came to Report it and the Administration Told Her She Was "*too emotionally involved*" for that job. The administration also told her to "*think really hard about what she wanted to do at the nursing home"* and then they had her clock out

The nursing home failed to ensure Resident 70 was free from abuse. The nursing home failed to ensure Resident 70, who was cognitively impaired and had a history of aggressive behaviors and resided in the memory care unit, was free from abuse when she was observed yelling and screaming for TNA A and TNA B to stop when they were twisting her around naked in her wheelchair with her feet up in the air.

The nursing home failed to ensure all alleged violations involving abuse, neglect, including injuries of unknown source were reported immediately, but no later than 2 hours if the alleged violation resulted in serious bodily injury, to the Administrator of the nursing home and to the State Survey Agency for Resident 70. The nursing home failed to thoroughly investigate and report an allegation of abuse for Resident 70. It also failed to report Resident 70's injury of unknown source from an unwitnessed fall.

The nursing home failed to have evidence that all alleged violations of abuse or mistreatment were thoroughly investigated and prevent further potential abuse or mistreatment while the investigation was in progress for Resident 70. The nursing home failed to initiate protective interventions and continued to allow TNA A to provide care for Resident 70 after the abuse incident.

Resident 70 had a diagnosis of **Alzheimer's disease** and Generalized Anxiety Disorder.

Cognitive Function. The resident was **severely cognitively impaired** (BIMS score of 00).

In a telephone interview, Housekeeping C stated she worked as a Houskeeper in the nursing home for about one month and a couple of weeks, so she was familiar with Resident 70, and she would not confuse her for Resident 2. She said that she was cleaning in the memory care unit on [DATE] and she heard a lady, Resident 70 screaming. She said earlier that day Resident 70 was perfectly fine. She said at 7:12 PM exactly, two of the night shift girls (TNA A and TNA B) had Resident 70 stripped naked with no brief, twirling her. She said Resident 70 was in her wheelchair and one of the staff was sitting in a regular chair behind the resident. She said the staff had her foot on the back of Resident 70's wheelchair like she was popping a wheelie with Resident 70's legs up in the air. She said the staff was moving Resident 70's wheelchair side to side and Resident 70 was screaming and hollering for her to stop. She said the screaming was what got her attention and she rolled her housekeeping cart to the very end of the hall where Resident 70's room was. She said another resident was walking by and told the staff to stop when she saw what the aides were doing to Resident 70. Housekeeper C said the aides were laughing during the incident. She said one of the aides was pregnant and the other was not. She said Resident 70 was bleeding, but she could not see where the blood was coming from. She said one of the aides wiped Resident 70's blood with her bed sheet. She said the pregnant aide saw her in the doorway and told her to get the bloody sheet. Housekeeper C said Resident 70's legs were still up in the air when she (Housekeeper C) walked out of the room with the bloody sheet. She said Resident 70 let out a very loud

scream when she (Housekeeper C) was walking out of the room but she did not know if that was when the staff let Resident 70's wheelchair down to the floor because she (Housekeeper C) did not turn around to look (later she said she knew something was wrong but was too afraid to turn around at that point). **She said she had a video of the incident that was only audio and no visual** (she started recording with her phone when she heard Resident 70 screaming; she turned her video recording on and placed the phone in her pocket so the video will pick up the audio of the resident yelling: "Stop it!"), **but the Director of Nursing (DON) made her delete it out of her phone when she was called in to report the incident**. Housekeeper C said she initially reported the incident to her supervisor, the Housekeeping Supervisor, and then the DON told her to come into the office (the DON's office) and tell her what happened on Sunday, [DATE]. She said she had initially texted her supervisor the night of [DATE], but her (Housekeeper Supervisor) phone was off, and she did not see the message until the next day. She said **the Administrator, DON, Assistant DON, and the Housekeeping Supervisor were all present in the room when she reported what happened**. She said the video slipped her mind at first, so she did not mention it during the first meeting. She said the DON said sometimes they had to restrain residents when the residents tried to harm them. She said that **they told her she was too emotionally involved for that job.** She said **she told the DON and the Housekeeping Supervisor** she thought Resident 70 was being abused because **she was being abused**. She said she also showed the video/audio to two other staff members CNA K and CNA Y, but she did not say when this happened. Housekeeper C said CNA K and CNA Y asked her if she was going to report the incident to Resident 70's family member when she visited. She said CNA K told her Resident 70's leg was purple and it looked like they (TNA A and TNA B) broke her leg. She said the DON called her into her office the second time and asked her who she had shown the video/audio to. She said she did not know how the DON found out about the video/audio, but **after she played it for the DON, she made her air drop it to her (the DON) phone and then made her delete it from the phone and trash (in the phone)**. She said the DON said the voice in the audio was the lady who hollered all the time, Resident 2, but Housekeeper C said it was not Resident 2, it was Resident 70. She said **the administration told her to think really hard about what she wanted to do at the nursing home and then they had her clock out.**

Housekeeper C said she quit when they told her to get out of the office and clock out. She said **she tried to go to the nursing home and get her paperwork to resume her state benefits earlier that morning [DATE] but they (administration) would not allow her into the building**. She said **she assumed it was because state was in the building and they did not want her to talk**.

In a telephone interview, **Housekeeper Supervisor** said she **was ready to tell the truth** about what she knew regarding the incident with Resident 70. She said **before she went to the conference room to speak with the State Surveyor on [DON], the DON texted her and told her to go to her (DON) office. She asked her what she was going to say to the State Surveyor**. She said she was going to tell the State Surveyor what Housekeeper C told her. She said **the DON said: "Please don't do that**." She said **the DON asked her to not tell the State Surveyor everything**. She said the DON told her to say Housekeeper C said she heard someone yelling down the hallway. **The Housekeeping Supervisor said she was previously scared to talk to the State Surveyor or fear of retaliation by administration**. She

said **the Staffing Coordinator told her the DON called her into the office before she spoke to the State Surveyor on [DATE] and told her the same thing, not to tell State the truth**.

Housekeeping Supervisor said **Housekeeper C said she was scared to lose her job**. She said that **Housekeeper C** was in a meeting with the Administrator and the DON and then **came out of it crying saying she was about to lose her job**. The Housekeeping Supervisor said **they (administration) made her send Housekeeper C home because the State was in the building.** The Housekeeping Supervisor said she never saw the video/audio because the DON made Housekeeper C send the video/audio to her (DON) phone and then made Housekeeper C delete it. She said that Housekeeper C also told her that CNA K said Resident 70's ankle was broken.

During an interview, the DON stated Housekeeper C never sent her a video or audio and she never heard one regarding the alleged incident with Resident 70. The DON said there was talk around the nursing home about a video or audio, but she never told Housekeeper C to delete it.

During an interview, the Administrator stated there was no evidence that Resident 70 was abused and employees denied it. He said the two people (Housekeeping Supervisor and Housekeeper C) who made the accusations did it in retaliation because he made them do their jobs. He said there was an ulterior motive to the allegations.

During an interview, Staffing Coordinator said that when she came to work on [DATE], one of the aides was really upset because Resident 70 had passed away. She said the anonymous aide stated: "If it had anything to do with what I am hearing about, I am not comfortable." **The Staffing Coordinator stated Housekeeper C was not the one who gave her the anonymous note to show the State Surveyors. The Staffing Coordinator was given an anonymous note to show the State Surveyors on [DATE], saying they had concerns about a resident who passed away**.

The Staffing Coordinator said staff had concerns because there was an incident with Resident 70 last week [DATE] and then she died over the weekend. She said other staff told her two aides were taking care of Resident 70, and they were swinging her around and she fell. The Staffing Coordinator said the fall was not reported and over the weekend Resident 70 was sick and vomited blood. The Staffing Coordinator said **there was a lady who wanted to talk to the State Surveyors about the incident, but she was scared and feared retaliation from administration**. The Staffing Coordinator said **the lady who wanted to talk said she saw some things but did not want to lose her job.** The Staffing Coordinator said **Housekeeper C was the original source of the information, but the person who wanted to talk to the State Surveyors was a different person**. The Staffing Coordinator said: "Recently, both TNA A and TNA B had been calling in sick, which was unusual."

Name of Nursing Home	Seabreeze Nursing and Rehabilitation
Provider ID	675222
Address [RUCA Code: 1.1] [% County Population Rural: 4.06]	6602 Memorial Drive, Texas City, Texas, 77590
Day Investigation Completed	July 23, 2023
Type of Deficiency Issued	*F600 **F609 ***F610
Scope Severity Level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm ***Immediate Jeopardy

"*The Administrator led the facility by fear and retribution*" / A Frequent Visitor said: "*Staff had been told during the current survey there would be consequences for speaking to the state*" / An Aide Said: "*Many staff were afraid of retaliation by the nursing home and were not going to say anything*"

The nursing home failed to effectively administer its resources to attain the highest practicable well-being for each resident. Specifically, the nursing home failed to: a. Implement and maintain safety measures to prevent elopements with significant injury; b. Prevent, report, and investigate allegations of resident-to-resident abuse; c. Provide sufficient leadership to address and/or avoid multiple significant concerns.

Cognitive Function. Not Reported. Activities of Daily Living. Not Reported.

During an interview on March 4, 2024, a frequent visitor (FV) said she had several complaints regarding the nursing home. She said she had heard many residents complain about not getting their medications and that the environment was bad. She said **residents and staff were afraid of retaliation from administration for reporting things such as abuse**. The FV said the nursing home had had a large influx of admissions with mental health and substance abuse, but the staff had not been offered any training in those areas.

The FV said many residents complained about roommates with mental health issues and requested to be moved to a new room, however, she said the residents' requests to move rooms were not being honored.

The FV said Resident 7 was found with a blanket being held around her head by Resident 6. The resident could not defend herself due to her immobility. She said Resident 6 was then moved to another hall where she pushed Resident 3 down. She said the resident had head trauma and had to get 12 stiches. The FV said she saw his face which was completely black and blue. The FV said the staff told her they would report the abuse as a fall by the Director of Nursing (DON). The FV said neither she nor the police were notified of the incident.

The FV said she was concerned for the safety of the residents, and the **staff were being intimidated and afraid to speak up**.

The FV was interviewed again on March 6, 2024. The FV said **the Administrator led the facility by fear and retribution**. **The staff had been told during the current survey there would be consequences for speaking to the state**. She said the Administrator dismissed what the staff and residents told her.

Resident 17 was interviewed on February 29, 2024. Resident 17 said Resident 4 threatened to harm her but there was no follow up from Administration. She said she had missed multiple doses of medication including pain medication. Resident 17 said when the Administrator was dismissive of her concerns when she reported them and Resident 17 was made to feel like she was the problem.

Resident 8 was interviewed on March 4, 2024. He said he was told that many staff members had resigned due to poor management. He said he had missed several doses of his medications including pain medications. He said he had reported this to the DON, but there was no follow up. He said a resident was beaten up by a female resident and the staff told him they were instructed by the DON not to call the police. He said there was a resident who drank alcohol and smoked in his room. He said residents and

staff were fearful of him, but nothing had been done to address the concerns. Resident 8 said the Administrator did not follow up on concerns with abuse or other resident behaviors. He said she dismissed things and talked down to people. He said the corporation that provided oversight to the building needed to know what was happening at the nursing home.

Restorative Nurse Aide (RNA) was interviewed on March 7, 2024. **The RNA said he was afraid to be seen talking to the state**. He said the **staff had been threatened and feared retaliation if they spoke up and he needed his job.** He said one of the main problems was the lack of communication by the DON and Administrator. He said the Administrator was overpowering conversations and shutting down concerns reported by the staff.

The RNA said things were falling apart. He said roommates were often put together who were not appropriate such as putting those with behaviors in with residents who were unhappy with the behaviors. He said abuse by Resident 6 had not been thoroughly investigated and the staff had been told to document the abuse as a fall by the DON. The RNA said there had been an increase in admissions of residents who had mental health conditions and behaviors, but no training had been provided to staff. He said **many staff were afraid of retaliation by the nursing home and were not going to say anything**.

LPN 4 was interviewed on March 5, 2024. **The LPN** said she **was concerned about the Administrator finding out she was discussing things with the state surveyors.** She said Resident 6 beat up Resident 3. She said the police were never called but a family member had heard about the abuse and called the police. She said the nursing home was admitting a lot more residents with mental health issues and behaviors, but the staff had not received any training on how to handle the residents' behaviors.

The Administrator and DON were interviewed on March 6, 2024. The Administrator said the elopements were discussed but not in enough detail to identify and correct all of the issues such as Resident 2 removing her wanderguard. The Administrator said she was not aware the smoking assessments had not been completely timely, and smoking assistive devices were not provided. She said they started accepting residents who smoked a few months ago but had not reviewed what the smoking program would entail. The Administrator said the multiple missing medications and unavailability of medications was not identified. The Administrator said the abuse investigations needed to be more thorough and she could not recall if she had reported them to the state or police.

Name of Nursing Home	Winding Trails Post Acute
Provider ID	065267
Address [RUCA Code: 1] [% County Population Rural: 9.4]	2800 Palo Pkwy, Boulder, Colorado, 80301
Day Investigation Completed	March 7, 2024
Type of Deficiency Issued	F835
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A Nurse Perpetrator Told a CNA About a Resident Found Unresponsive: "*We didn't see anything*" / When Asked Why She Didn't Tell Anyone About the Unresponsive Resident, the CNA Said she "*feared retaliation from her nurse because she has gotten people fired in the past*" / Another Nurse Said About the Failure to Perform CPR: "*You wouldn't even do that to a dog*"

The nursing home failed to ensure an environment free from neglect for Resident 160 resulting in Resident 160 not receiving regular rounding/observations by staff for an extended period of time, staff failing to appropriately act and report a change in condition and the potential for further unmet care needs.

The nursing home failed to initiate Cardiopulmonary Resuscitation (CPR) when a resident was found unresponsive, and to immediately begin CPR when a Code Blue (Unresponsive person) was called for Resident 160 who had a documented Full Code status resulting in Immediate Jeopardy when the resident was found unresponsive with no pulse or respirations.

Resident 160's Cognitive Function: "**Alert and oriented**." Activities of Daily Living: Not Reported.

During a phone conversation, CNA C was queried regarding the incident involving Resident 160 on [DATE]. CNA C reported they had gone into Resident 160's room at approximately 6:50 AM and that Resident 160 appeared deceased. CNA C indicated they came out of the room and informed LPN D about Resident 160. LPN D then went into the room followed by CNA C and LPN D reportedly looked at Resident 160 and told CNA C: "**We didn't see anything**." CNA C was queried if either of them (CNA C or LPN D) performed CPR on Resident 160 and they indicated they didn't. **CNA C** then indicated they **went into another room to do charting but didn't finish because they were intimidated by LPN D who was in the room with them**. CNA C then reported they clocked out and left the building with LPN D. CNA C was queried if they told anyone about Resident 160 change in condition before they left the building with LPN D and they indicated that they didn't. CNA C was queried why they didn't tell anyone about Resident 160, and they reported they did not have the Director of Nursing's (DON) phone number, and they felt they did not know the oncoming nurse well enough.

A written statement of a phone interview conducted and signed by the DON on [DATE] with CNA C regarding Resident 160's death on [DATE] revealed the following: "I am the Director of Nursing at [Name of Nursing Home] and I am writing this statement related to second phone conversation I had with CNA C on [DATE]. The Administrator in training present. CNA C wanted to talk about the situation related to the deceased <sic> patient Resident 160 and actual conversation she had with LPN D during report. CNA C stated that during conversation with nurse, that she told the nurse that she thought the patient looked dead. She and the nurse shortly thereafter went into <sic> and noted that the patient was unresponsive. They did not call for a Code Blue (process of initiating CPR) or tell the oncoming shift who were present on the unit. I asked her why she did not tell the AM nurse about the patient unresponsiveness, she stated she does not know her, and she told her nurse. **I asked her why did<sic> not to tell anyone so patient care could be initiated**; she stated <sic> **she feared retaliation from her nurse because she has gotten people fired in the past**. She stated her and the nurse had a conversation outside in the parking

lot whereas per recording CNA C states: "I told you he looked dead to me and that I don't want this to come back on us."

A Corrective Action Report for LPN D dated [DATE] revealed the following: Date of Violation [DATE]. Nature of Unacceptable Behavior: "On the midnight shift of [DATE], employee did not complete rounding as necessary on Resident 160. Employee failed to properly check patient between approximately 9:00 PM and 7:14 AM. At approximately 7:14 AM, the nurse was notified by CNA C that the patient expired. Nurse then advised the CNA C not to tell anyone, and they both proceeded to leave for the day at the end of their shift shortly thereafter without informing any that the patient has expired."

LPN G was asked about Resident 160. LPN G explained she wasn't surprised, as LPN D and CNA C were both known as the laziest employees the nursing home had and staff had complained about them both several times. LPN G added that the "staff worked hard to make it a good facility and that all the staff were upset that two people could destroy all that work by their inaction."

LPN G stated: "I don't know how, not even as a nurse, but as a human being, how anyone could do that (not initiate CPR) to another person." LPN G added that after not doing anything for Resident 160, LPN D and CNA C gave report that Resident 160 was fine, punched out and left. LPN G stated: "You wouldn't even do that to a dog."

Review of the nursing home security camera revealed LPN D did not enter Resident 160's bedroom to provide CPR, medication, monitoring, assessment, treatment and/or care to Resident 160 from 7:00 PM to 7:00 AM (12 hours).

The DON stated that it did not matter how long a person had been unresponsive, when found, CPR was to be initiated. Both CNA C and LPN D were terminated from their employment.

Name of Nursing Home	Oakland Nursing Center
Provider ID	235523
Address [RUCA Code: 1] [% County Population Rural: 5.54]	22401 Foster Winter Drive, Southfield, Michigan, 48075
Day Investigation Completed	September 10, 2020
Type of Deficiency Issued	*F600 **F678
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Immediate Jeopardy

Anonymous Complainant Stated: "*Everyone in the facility was terrified of retaliation by the Administrator if they spoke to anyone about the issues in the building*." S/he Also Stated that the Administrator "*placed magnetic cameras that connected to a phone application he had and allowed him to monitor both audio and video from his phone, so that made most everyone afraid to speak freely about any problems*" / An Anonymous Employee Said: "*The personal cameras went to his house, and they had audio, so he listened to the staff and retaliated by yelling at them and threatening their jobs*" / Another anonymous employee stated: "*Nobody wanted to talk to the State because the Administrator warned them all and threatened them if they do*"

The governing body failed to implement policies regarding the management and operation of the nursing home and the OMC (the owner and management company) failed to be actively engaged and involved in the management of the nursing home, in that: 1. The OMC failed to ensure sufficient funds in a payroll account for at least 27 employee paychecks between November 2019 and February 2020. 2. The OMC failed to pay the licensed dietitian for five months resulting in her suspension of services from October 2019 to February 28, 2020. 3. The OMC allowed the pharmacy bill to go unpaid until the pharmacy threatened to discontinue delivery. 4. The OMC did not pay the food service delivery company regularly or on time. 5. The OMC did not pay the Oxygen delivery company regularly or on time. 6. The OMC failed to pay three medical supply companies, resulting in suspension of delivery services and a credit hold from these vendors. 7. The OMC failed to pay one pest control company, resulting in a suspension of service and a credit hold. 8. The OMC failed to maintain funds monthly to keep the water utility bill current.

These failures placed residents at risk of serious harm or death from going without food, water, heating/air conditioning, and essential medical equipment. It also placed them at risk of injury or death due to fire or infection. It placed them at risk of not having their needs met due to insufficient staff.

No details were included in the investigation report regarding any residents' Cognitive Function and Activities of Daily Living.

During a confidential interview, an anonymous complainant stated the Administrator rarely came into the building and many of the vendors were not being paid. Complainant stated there have been problems with the pharmacy, the dietitian, the oxygen delivery company, and the mobile imaging company being paid. Complainant stated that at the end of October staff paychecks started bouncing. Complainant stated that the water was almost cut off, but they paid $7,000 at the last minute to get it back on. Complainant stated that they were completely out of oxygen tanks about a month ago, and now they were back in the same situation with the oxygen. Complainant stated they owed close to $6,000 to the oxygen company. Complainant stated when they ran out before, they had to borrow three from a nearby facility. Complainant stated they had 16 tanks at the time of the interview, and they regularly used two or three a day. Complainant stated as far as the Complainant knows, they could not get more when they ran out. Complainant stated it was possible the Administrator had paid the oxygen bill by then but was not sure. Complainant stated they lost services from more than one medical supply company due to unpaid balances, and now they were getting their medical supplies through a local paper company that had some kind of personal connection to the Administrator. Complainant stated that the pharmacy was going

to stop delivering medications, but they put the nursing home on a payment plan. Complainant stated that these issues have been ongoing for months, and the Administrator has done nothing to solve them permanently. Complainant stated she has never heard back from the OMC and they have not helped. Complainant stated: "**Everyone in the facility was terrified of retaliation by the Administrator if they spoke to anyone about the issues in the building**." Complainant stated **the Administrator placed magnetic cameras that connected to a phone application he had and allowed him to monitor both audio and video from his phone, so that made most everyone afraid to speak freely about any problems**. Complainant stated there was no corporate level consultant and the staff all tried to figure out if the Administrator had a boss. Complainant stated that when they asked him who his boss was, he didn't answer and only said that the OCM was not communicating with the nursing home.

During an interview, an anonymous employee stated that the nursing home was bought by the OMC in 2014, and they had directly managed the nursing home since 2017. Anonymous employee stated there were minor issues with vendors being paid late since they took over management in 2017, but in 2019 the vendors stopped getting paid altogether. Anonymous employee stated that supplemental vendors were being used to keep the nursing home afloat, but the sale of the nursing home that was supposed to occur in December 2019 did not occur as planned. Anonymous employee stated that since then, the owners have not been paying vendors, and the Administrator has been paying the water bill and food for the nursing home out of his own account. Anonymous employee stated that the food delivery company wouldn't send much food at a time because the nursing home was in debt to them. Anonymous employee stated that the office supplies had to be provided by staff. Anonymous employee stated that all the residents' payments had to be sent to the central office in New York, and they did not know what was happening to that money. Anonymous employee stated that the banks in the nursing home' city would not cash the employee checks. Anonymous employee stated the Administrator found one bank that would allow them to cash checks for a $5 fee with a 7-day hold. Anonymous employee stated that, often, the last person that cashed their check would have it returned because the OMC emptied the account if it started to run out of money. Anonymous employee stated that in November 2019, everybody's check was bouncing. Anonymous employee stated that since then, a few paychecks have still bounced.

During an interview, **an anonymous employee stated** the OMC did not pay the bill for the informational technology service company, so staff were unable to connect to the printer near the kitchen and print meal tickets and snack labels. Anonymous employee stated that the nursing home did not have a licensed dietitian since October 2019, because they did not pay the dietitian they had. Anonymous employee stated that **all the staff have been in fear of retaliation, because the Administrator put up personal cameras and was monitoring anything they say**. Anonymous employee stated that **the personal cameras went to his house, and they had audio, so he listened to the staff and retaliated by yelling at them and threatening their jobs**. She stated that each department head ran their own department, and the Administrator was never there. She stated that the corporate office wouldn't answer the phone since all the checks bounced and the OMC set up a bootleg account by sending the money directly to the Administrator's personal account. She stated he has paid the employees out of his account. She stated this has been going on since the summer. She stated that they have had to stand in

line for the Administrator, and they took their checks and gave them cash. She stated that the kitchen had run out of food before because they ran out of budget. She stated she had paid for food for breakfast out of her own pocket. She stated that the corporate office stopped paying the food vendor, so the Administrator started paying out of his own pocket. She stated the Social Worker has failed to fill in her MDS sections in a timely manner and has cost a lot of money to the nursing home that should have been reimbursed by Medicaid. She stated the Administrator and the Social Worker were both hardly ever in the nursing home. She stated the Social Worker was not advocating for the residents and did not attend morning meetings.

During a confidential interview, **an anonymous employee stated** that **nobody wanted to talk to the state because the Administrator warned them all and threatened them if they do**. She stated that the Administrator gave a big in-service about five weeks ago, and one of the nurses confronted him in front of everyone, asking: "Why are you never here? Why are we low on supplies? Why are you bouncing paychecks? Why is there no food?" She stated he responded by promising that checks wouldn't bounce, which they later did, and by saying he was doing the best he could. She stated he never answered her question about what he was never there.

During an interview, Resident 1 stated the nursing home is low on oxygen tanks. She stated she is ordered 2 liters of O2, but she prefers 3 liters, but they don't have enough. She stated that she is having hard time breathing because of it. She stated she used to be a Registered Nurse and that the Administrator told staff not to say too much around her because she knows too much about nursing regulations. When asked how that makes her feel, she stated she has given up trying to make a difference and doesn't care anymore.

During a telephone interview, a representative from the FMC stated that his company has done fire monitoring and fire safety inspections and repairs for the nursing home. The representative stated that the nursing home has an ongoing history of delinquency. He stated that the nursing home didn't leave the FMC much recourse other than to hold their feet to the fire, which means they threatened to discontinue services. He stated it was an old building that always had repairs and he could tell the Administrator were not coming to do the repairs unless they got the check. The Administrator would usually cut them a check in that case.

During an interview, the area Ombudsman stated the nursing home was known to have ongoing issues with meeting payroll and paying vendors for services.

Name of Nursing Home	Quality of Care of Waco
Provider ID	455478
Address [RUCA Code: 1] [% County Population Rural: 24.02]	2501 Maple Ave, Waco, Texas, 76707
Day Investigation Completed	March 9, 2020
Type of Deficiency Issued	F837
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Alleged Retaliation

A CNA Refused to Help with Resident Care After an RN Reported to the Executive Director that the CNA Abused a Person with Multiple Sclerosis

The nursing home failed to ensure Resident 1 was free from abuse. The nursing home failed to keep Resident 1 safe from being yelled at, humiliated, and being denied care by CNA B.

Resident 1 lived with **multiple sclerosis** (a chronic autoimmune disease that affects the central nervous system, which includes the brain and spinal cord).

Activities of Daily Living. The resident required partial / moderate assistance with shower / bathing, upper body dressing, lower body dressing, putting on / taking off footwear and personal hygiene. The resident usually required partial / moderate assistance with chair to bed / bed to chair transfers, toilet transfers, sit to stand and lying to sitting on edge of bed.

Cognitive Function: Not reported (review of quarterly MDS reflected no BIMS was conducted).

During an interview, Resident 1 stated usually she was able to do most transfers by herself but by the evening she got tired and needed help. The resident said that CNA B came into her bedroom and yelled at her and told her: "You can do it [transfer] yourself, you do not need help." The resident added that a few weeks ago, CNA B refused to help her go to the bathroom. The resident stated she ended up having an accident in her brief and that CNA B did not transfer her to the toilet. The resident stated that another time CNA B yelled over her while she was lying in bed to another CNA that Resident 1 did not need help and could do it herself. She said that CNA B made her feel bad about herself and bullied her. She felt that CNA B's behavior toward her was abusive. She reported her concerns to the Executive Director but felt that s/he brushed her off.

Resident 1's family stated she did not believe Resident 1 should have to put up with being bullied in her own home and wanted the issues with CNA B to be addressed.

During an interview, RN A stated that she had witnessed CNA B talking down to residents multiple times. **RN A stated that she talked with the Executive Director about her concerns, and she felt CNA B retaliated and refused to talk with RN A for the rest of the shift or help with resident care**. RN A stated that she received complaints at least every shift about CNA B. RN A stated CNA B refused to assist Resident 1, and Resident 1 could perform that care herself. RN A stated that Resident 1 often felt talked down to because she could not always transfer on her own. RN A stated that generally CNA B would tell residents with dementia: "You do not have a clue what's going on." RN A stated that CNA B also yelled down the hall for staff not to help another resident because she did not do anything by herself.

During an interview, CNA B denied having ever raised her voice to Resident 1 or denying her care. CNA B denied telling Resident 1 she could transfer herself. CNA B stated she was not abusive to Resident 1.

CAN B's employment was terminated. During an interview, Resident 1 stated she was safe, very pleased and relieved that CNA B was no longer working in the nursing home. She added that all the other staff were wonderful, and she did not have any issues or concerns, and she was very thankful that the situation has been resolved.

Name of Nursing Home	Granite Mesa Health Center
Provider ID	676220
Address [RUCA Code: 7] [% County Population Rural: 67.32]	1401 Max Copeland Dr., Marble Falls, Texas, 78654
Day Investigation Completed	January 27, 2025
Type of Deficiency Issued	F600
Scope Severity Level	Immediate Jeopardy

An Office Manager Was Suspended After Confronting the Administrator About the Need to Report an Allegation of Sexual Abuse of a Cognitively Intact Woman Living with Lung Cancer

The nursing home failed to keep Resident 1 safe from sexual abuse. Resident 1 reported a male CNA forced her to perform sexual acts on him. Despite the allegation of sexual abuse from the male CNA to Resident 1, the nursing home failed to prevent him from working with other vulnerable residents in the corporation.

The nursing home failed to prevent retribution to Resident 1 and a staff member. Resident 1 reported that a male CNA sexually abused her. After the nursing home learned of the allegations on October 24, 2023, they discharged Resident 1 to a homeless shelter on October 25 2023, with only approximately 30 minutes to pack. In addition, **former Office Manager (Staff P) reported the nursing home suspended her after she confronted the Administrator regarding the need to report the abuse.**

The nursing home's treatment of Resident 1 after the nursing home learned of the allegation of abuse caused Resident 1 to become afraid and cry during an exchange of yelling between her and the Administrator.

The nursing home failed to report allegations of abuse of Resident 1. Resident 1 reported to staff on October 23, 2023 that a staff member abused her. The nursing home did not report the incident to the appropriate authorities until the evening of October 24, 2023.

The nursing home failed to adequately investigate allegations of abuse of Resident 1. After Resident 1 reported allegations of sexual abuse, the Administrator minimized and failed to fully investigate the allegations of sexual abuse.

It also failed to meet a resident's needs related to adequately planned transfers for Resident 1. It discharged Resident 1 abruptly after allegations of abuse to a homeless shelter that did not know of her transfer. The homeless shelter did not have nurses on staff to meet her medical needs, and they did not have any staff overnight. After arriving at the homeless shelter, Resident 1 began to stumble and fall. The homeless shelter transferred Resident 1 to the hospital as she could not remain in the homeless shelter.

The nursing home failed to meet Resident 1's needs related to discharge planning. Resident 1 was discharged abruptly after allegations of abuse and was sent to a homeless shelter that was unaware that she was coming and could not meet her medical needs.

Resident 1's diagnoses: Disorder of the kidney, heart failure, depression, PTSD and lung cancer.

Cognitive Function. The resident was **cognitively intact** (BIMS score 14 out of 15).

Activities of Daily Living. The resident could independently provide her own hygiene, toilet use, and transfers. The resident was frequently incontinent or urine and always continent of bowel.

Resident 1 stated that when she reported her abuse to a couple of staff members, somehow, they twisted the story around. Due to this, she did not trust anyone at the facility anymore.

She said the Administrator came into her bedroom one day, yelling, and told her that she had to leave because the staff reported that she provided sexual favors for cigarettes. Resident 1 stated staff took her outside to have cigarettes, and she shared with a couple of them. Staff I sexually attacked her. She could not remember the date when Staff I took her to his car and made her perform oral sex on him. She felt like the nursing home kicked her out because of the lies told about her.

A hand-written note signed by Resident 1 indicated that she was "very upset" by the Administrator's accusations that she provided sexual favors for cigarettes. She wrote that she would never do anything so vile. She denied the allegations.

During an interview with a Police Officer, Resident 1 stated, among others, that Staff I sent her a sexually explicit video of himself.

Former Office Manager (Staff P) said that she no longer worked at the facility. She **felt that the Administration was looking for some reason to terminate her because she questioned them on reporting the events to the proper authorities.** Staff P said she heard about the allegations of abuse later in the day on October 24, 2023, and **sent a text to the Regional Manager at 5:30 PM, expressing that they should report the event**. She then got a call back from Corporate that Resident 1 recanted the allegations so they did not think they needed to report it. She said that when she came into work on the 25th, her office had been in shambles because they were looking through for missing orders. They suspended her because of her missing orders.

The Administrator stated that Staff I denied any sexual activity with Resident 1.

Name of Nursing Home	Correctionville Specialty Care
Provider ID	165323
Address [RUCA Code: 10.1] [% County Population Rural: 16.13]	1116 East Highway 20, Correctionville, Iowa, 51016
Day Investigation Completed	November 20, 2023
Type of Deficiency Issued	*F600 ** F607 ***F609 ****F610 *****F622 ******F660 *******F835
Scope Severity Level	*Immediate Jeopardy **Actual Harm ***Immediate Jeopardy **** Immediate Jeopardy ***** Immediate Jeopardy ****** Minimal Harm or Potential for Actual Harm ******* Minimal Harm or Potential for Actual Harm

A Housekeeper Was Fired for Suggesting a Family Member to Install a Camera in Their Loved One's Bedroom "*because she believed he was being mistreated by staff*" / The Housekeeper was reportedly also fired "*for not reporting the abuse allegations to the Administrator*"

The nursing home failed to provide a safe environment free from abuse for four residents (Resident 3, 12, 13, and 14). The nursing home failed to protect and assure the safety of these residents when verbal abuse was reported on October 19, 2022 and October 20, 2022. Resident 3 was verbally abused by staff (recorded on video footage) and Residents 12, 13, and 14 said they were verbally abused by CNA E. These failures placed residents at risk of abuse, and mental anguish caused by fear.

The nursing home failed to implement their written policies and procedures that prohibit and prevent abuse of the four aforementioned residents. It also failed to ensure all alleged violations involving abuse or mistreatment were reported within required timelines to the Administrator and the State Survey Agency for the four residents. It also failed to ensure allegations of abuse were thoroughly investigated, prevent further potential abuse and mistreatment while the investigation was in process, and report the results of all investigations to the Administrator and the State Survey Agency per requirements in law.

Cognitive Function. Resident 3 had **dementia** and was assessed to have **severe cognitive impairment**.

Care Plan. Resident 3 "had behaviors which included combativeness, physical and verbal aggression with staff. The interventions included to provide physical and verbal cues to alleviate the resident's anxiety and give positive feedback. If the resident resists care, reassure the resident, leave, and return 5-10 minutes later and try again."

A video footage recorded on October 16, 2022 at 12:09 AM with a hidden camera placed by Resident 3's Responsible Party showed a male staff person (CNA D) enter Resident 3's bedroom when the resident was in bed. CNA D picked up the bed sheet but the resident tugs on the sheet, and CNA D lets go of the sheet. The resident says: "Get off me, you mother fucker" and throws the sheet at CNA D. CNA D walked to the foot of the resident's bed and told the resident: "I am going to kick your ass." The resident responds but this response could not be understood on the video.

During an interview, CNA D admitted telling the resident he was going to kick his as because he was under pressure, but he would not have physically hurt the resident because it was not in his heart to do so. He said what he said was abuse. He said he was frustrated and tired of the resident being so mean.

A second video was recorded on October 13 2022 at 7:36 PM inside Resident 3's bedroom. It showed two staff (LVN C and CAN E) providing care to the resident while he was in bed. LVN C was encouraging him to allow care, but he was saying: "Don't do that." CNA E was observed getting some wipes and joined LVN C at the resident's bedside. The resident could be heard saying: "God dammit." At that point, LVN C's left hand went up with her hand open, while she leaned toward and told the resident to stop it, she does not hit the resident, but it appeared to be a gesture like she was going to slap the resident. A third video showed LVN C abuse the resident inside his bedroom.

During an interview, LVN C said her right hand was in a fist and pulled back because she thought the resident was going to grab or bite her. She denied ever threatening or hitting the resident. She said she should not have raised her voice to the resident.

During an interview, CNA E said that yesterday (October 19, 2022) around 10:00 PM Resident 3's Responsible Party asked her if she was aware there had been a camera in Resident 3's bedroom. She said she told her she was not aware. She said the resident's Responsible Pary told her she put the camera in the room because the resident was abused by the staff. She said she told the resident's Responsible Party she did not believe that would happen at the nursing home. She said she did not tell anyone the resident's Responsible Party reported the resident had been abused. She said LVN C overheard her talking with the resident's Responsible Party and knew about the allegation. She said she was supposed to inform the Administrator of any abuse allegations; however, she did not report it.

Resident 3's Responsible Party said on October 19 2022 she spoke to CNA E regarding the abuse concerns and why she installed the camera. She said she asked if she could show CNA E the videos of the abuse, but the CNA told her eyesight was not good and she did not think she could see the videos. She said she believed CNA E did not wish to see the videos because she would have to report the abuse to the Administrator. She said it further showed how staff wanted to turn a blind eye to reports of abuse.

In a telephone interview on October 20, 2022, **Former Housekeeper F** said she was the housekeeper on Resident 3's hall and she felt staff were not caring for the resident appropriately. She believed staff were not assisting him with meals, were abrupt and discourteous to him. She said she spoke with the Administrator and Director of Nursing (DON) about her concerns, but she believed they were not addressed. She said **she spoke to the resident's Responsible Party regarding her concerns and told her she should put a camera in the resident's room because she believed he was being mistreated by staff**. She said when the nursing home found out she told the resident's Responsible Party she suspected abuse, the DON called her on September 10, 2022 to question her if she knew who the Abuse Coordinator was, and she told her it was the Administrator. She said **the Administrator wanted to meet with her the next day (September 11, 2022) in his office, but she did not meet him for fear she would be terminated. She said her last day of employment was September 11, 2022**. She said the nursing home's inaction regarding allegations made employees not want to report anything. She said **other employees knew about things but don't report it**. She would not give the surveyor their names. She said there were employees, still working at the nursing home, who abused residents.

Resident 3's Responsible Party said **Houskeeper F was terminated for telling her about the mistreatment of Resident 3 and for not reporting the abuse allegations to the Administrator**.

In an interview on October 24, 2022, the Administrator and DON said the videos showed, based on their investigation, verbal abuse, and included intimidation and seclusion. They said they were going to terminate LVN C and CNA D for abuse. They said CNA E would be terminated for not reporting the allegation of abuse to the Administrator. The Administrator and DON said Former Housekeeper F never reported any abuse, neglect, or mistreatment of Resident 3 to them.

Name of Nursing Home	Westpark Rehabilitation and Living
Provider ID	676029
Address [RUCA Code: 1] [% County Population Rural: 1.23]	900 Westpark Way, Euless, Texas, 76040
Day Investigation Completed	November 14, 2022
Type of Deficiency Issued	*F600 **F607 ***F609 ****F610
Scope Severity Level	*Immediate Jeopardy **Immediate Jeopardy ***Immediate Jeopardy ****Immediate Jeopardy

A CNA Told a Surveyor She Was Fearful of Retaliation When Speaking About Short Staffing
She added: "*There is a culture of retaliation at the facility*"

The nursing home failed to provide sufficient nursing staff to meet the needs of the resident's acuity (the level of severity of residents' illnesses, physical, mental, and cognitive limitations and conditions) when: The nursing home failed to sufficiently staff multiple nursing stations during the week of March 30, 2024 through April 5, 2024. Residents 14, 2, 3, 4, 5, 6, and 8 did not receive showers as scheduled. The failure resulted in long wait times for call lights to be answered (average 30 minutes) and residents not receiving Activities of Daily Living (ADLs) including hydration and shower assistance. This had resulted in residents to feel neglected and affected their dignity.

The residents' Cognitive Function and Activities of Daily Living are not detailed in the investigation report.

During an interview, LVN A stated that low staffing has continued to be an issue at the nursing home. LVN A stated there were only two staff on Station 3 and 4 that morning. LVN A stated she helped Station 3 and 4 as much as possible. This led to multiple late resident medication administrations by 30 minutes. LVN A stated that her understanding of the shower team is that it is supposed to be comprised of 4-5 CNAs. She stated that two CNAs walked out two weeks ago, and two recently quit. LVN A stated it was her understanding that there was only one staff member currently on the shower team.

During an interview on April 12, 2024, Resident 3 stated he had been waiting in the hallway in his wheelchair needing to be wiped for over 30 minutes. He stated that it happens all the time where he must use his wheelchair to ambulate to the hallway to get staff assistance. Resident 3 stated that he wants to leave the nursing home.

During an interview on April 12, 2024, Resident 4 stated he does not use his call light because he does not expect anything. Resident 4 stated he has waited up to 2 hours to have staff answer his call light. Resident 4 preferred to sit in the hallway in his wheelchair to get staff assistance. Resident 4 stated hydration is not adequate at the nursing home and prefers to sit by the hydration cart when staff get around to giving residents water.

During an interview on April 12, 2024, Resident 6 stated that she became nauseated due to limited access to hydration. She stated she did not have access to receiving medications on time. Resident 6 stated when she has a headache, she must ambulate in wheelchair down to the nurse's station to request pain medication.

During an interview on April 12, 2024, Resident 2 stated she received one shower a week. Resident 2 stated that she used to receive two showers a week on Mondays and Wednesdays. She stated her showers are now on Mondays only. Resident 2 stated this has been going on for four weeks now.

During an interview on April 15, 2024, RN A stated she had been pulled onto the floor to help staff. RN A stated: "Call offs happen often." She felt this was due to a general overwhelming feeling among staff. RN A stated she raised staffing concerns with Admin. Admin frequently asked staff to do a double shift. Admin has utilized outside registry, but registry employees regularly do not show up for scheduled shifts.

During an interview on April 15, 2024, Nursing Assistant (NA A) stated the nursing home is chaotic most of the time. NA A voiced concerns to management of not feeling comfortable managing a Station on her own since she is new. NA A stated it is difficult to get staff to come in and help. NA A stated staff is calling off due to being overworked. During March 2024, NA A worked 10 days in a row due to feeling pressured to work because of the low staffing issues. NA A said residents complain regarding not receiving showers. NA A stated management does not come help on the floor is [if] there is low staffing during a shift.

During an interview on April 15, 2024, CNA C stated the nursing home felt like a roller coaster. CNA C acknowledged staffing issues and that staffing comes and goes. She felt management is working on it. CNA C believed staff is feeling pressure and overwhelmed. She stated there is resistance to change amongst the staff, and this is why staff was quitting without notice, not showing up for shifts.

A review of document titled Resident Council Meeting Minutes dated February 27, 2024, it was noted: Residents concerned about slow call light response time. They feel it is "all shifts and all Stations."

During an interview on April 15, 2024, CNA B stated she had witnessed staff take 40-60 minute breaks even when there is low staffing. CNA B spoke to management regarding short staffing issues. **CNA B is fearful of retaliation**. She stated: "**There is a culture of retaliation at the facility**." CNA B felt her license at risk due to workload and emotionally stressed after witnessing staff members be mean to residents. CNA B stated comfort care residents requested pain medications and are ignored due to staff feeling overwhelmed with workload. CNA B visited a Crisis Center after a recent shift at the nursing home due to feeling stressed. CNA B told management that she needed time to recover and felt they were not receptive when they ask her to return to work the following day. CNA B witnessed CNA D handle 50 residents on a shift because another CNA left their shift. No other staff were called to assist CNA D. In regard to the shower team, CNA B stated: "Forget that. That's nonexistent." Residents and family members tell her that they are not receiving showers. CNA B stated that her understanding is that residents are supposed to receive 2-3 showers a week.

During an interview on April 12, 2024, the Administrator stated the nursing home used outside agency for staffing. Regarding answering call lights, the Administrator stated: "Residents' perceptions are different, we all know this." The Administrator stated the expectation for answering call lights is get there as soon as they can. Regarding the shower team, the Administrator stated: "I have four people Monday to Friday that do the whole building. All they do is shower residents." The Administrator stated: "Staff calls off all the time" and added: "A CNA clocked out at 3:00 am and never returned to her shift." The Administrator stated this was a common occurrence. During an interview on April 28, 2024, the Director of Nursing stated the Administrator has tried to weed out CNAs that do not perform and call out chronically.

Name of Nursing Home	Autumn Creek Post Acute [*There is another investigation report from this nursing home]
Provider ID	056074
Address [RUCA Code: 1] [% County Population Rural: 21.02]	587 Rio Lindo Avenue, Chico, California, 95926
Day Investigation Completed	May 24, 2024
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

A CNA Said She Reported to Management (Including to the Administrator) Concerns About LPN's Mistreatment of a Person with Severe Cognitive Impairment, and "*as a result became the target of hostile staff*" / Another CNA Stated "*most of the staff were hesitant to speak up because the staff they reported would make our [de-identified] tougher*"

The nursing home failed to protect Resident 16 and Resident 21 from verbal and mental abuse. This failure resulted in psychosocial harm as evidenced by Resident 16's depressed mood and expression of fear and anxiety. The nursing home failed to ensure residents were free from involuntary seclusion for Resident 16. The nursing home failed to develop and implement written policies related to required abuse training and reporting of abuse for Resident 16 and Resident 21.

Due to scope considerations, this summary focuses primarily on Resident 16.

Cognitive Function. **Resident 16** had **severe cognitive impairment** (BIMS score of 2 out of 15).

Activities of Daily Living. Not Reported.

Cognitive Function. Not reported for **Resident 21**. Activities of Daily Living. Not reported.

A complaint intake dated May 1, 2020 indicated LPN (Staff 6) tipped Resident 16's wheelchair backwards with the resident in it and aggressively told the resident to stay in her/his room. Additionally, the complaint intake revealed LPN (Staff 6) instructed the Complainant (Witness 1) to withhold juice the resident requested without a medical reason. **The Complainant (Witness 1) indicated in the complaint they did not report the concerns to management due to fear of retaliation.**

A complaint intake dated September 29, 2020 indicated LPN (Staff 6) shoved Resident 16 in her/his wheelchair through the door into her/his room forcefully. **The complaint further indicated the behavior had gone on for some time, but staff were afraid to report due to fear of retaliation.**

On January 26, 2021, CNA (Staff 20) stated she reported to management concerns about evening shift staff yelling at Resident 16 and treating her/him roughly. She stated **other staff would not report because they worried about retaliation.**

On January 26, 2021, CNA (Staff 16) described the way LPN (Staff 6) and Staff 12 treated Resident 16 as both abuse and a dignity issue. She stated she reported her concerns to the Administrator (Staff 1). She further stated she probably should have made more of an official statement however she was used to things being swept under the rug by management. **CNA (Staff 16) stated "most of the staff were hesitant to speak up because the staff they reported would make our [NAME] tougher."**

On January 26, 2021, **CNA (Staff 15) stated** she reported concerns of verbal abuse towards Resident 16 by Staff 10 to management, but nothing usually happened when concerns were brought to management. She reported **when she advocated for residents, she was disciplined for minor infractions or punished with schedule changes.**

On January 26, 2021, CNA (Staff 11) stated that on January 22, 2021, LPN (Staff 6) pushed Resident 16 to her/his room and once she reached the entrance to her/his room, LPN (Staff 6) pushed the resident into the room and let go of the wheelchair after she pushed. She stated LPN (Staff 6) did the same thing many times previously and it stopped for a short period of time when she was talked to by management.

On January 27, 2021, CNA (Staff 18) reported LPN (Staff 6) repeatedly took Resident 16 back to her/his room and pushed her/him in a hateful way. She demonstrated a hard forward pushing motion with her arms and hands. Staff 18 stated during one incident, LPN (Staff 6) leaned down and whispered to the resident and the resident began to cry. She reported several times Resident 16 described LPN (Staff 6) to her and told her she was mean. **CNA (Staff 18) also stated she reported to management (including to the Administrator) concerns of mistreatment by LPN (Staff 6) towards Resident 16, and as a result became the target of hostile staff.**

On February 1, 2021, Confidential Staff (Staff 23) reported during the week of January 18, 2021, Resident 16 told her she/he was scared of the mean people. She stated the resident told her they're mean; they're scary and it's bad out there. Staff 23 reported the resident held onto her hand and asked her not to leave. She stated the resident appeared scared and it was difficult to leave. Staff 23 reported the evening shift staff were not as patient with Resident 16 and tended to get upset with her/him. She reported LPN (Staff 6) and Staff 12 yelled at the resident and pointed down the hallway like a dog when they told her/him to go to her/his room. Staff 23 stated they did not treat the resident like a human being.

On February 3, 2021 at 2:23 PM, a tray table was observed in the doorway of Resident 16's room, placed like a gate (CNA 11 states it made it seem the resident was locked in the room). The resident pushed the table out of the way and exited her/his room in her/his wheelchair. Once the resident arrived at the Nurse's Station, Staff 12 immediately instructed (in agitated tone) the resident to go back down the hall.

On January 26, 2021, CNA (Staff 20) stated the Director of Nursing told staff that all of the residents were to stay in their rooms due to COVID-19. She reported it seemed only Resident 16 was told to return to her/his room while other residents who came out in the hall were not stopped.

On February 2, 2021, CNA (Staff 19) reported when Staff 2 went into Resident 21's room, she remained near to witness the interaction because Staff 2 frequently kind of picks on the resident. She reported on the evening of February 1, 2021, the resident became really upset and asked Staff 2 to get out of her/his room twice, but Staff 2 would not leave. **CNA (Staff 19) reported she asked Staff 2 to respect the resident's wishes and leave the room**. **Staff 2 immediately retaliated against her and told her they would have a meeting the following day with the Administrator to discuss her insubordination**. She stated **Staff 2 frequently used threats of discipline against staff who advocated for residents**.

On February 3, 2021, RN CM (Staff 3) said Resident 21 informed her she/he felt like Staff 2 repeatedly targeted and punished him/her. Staff 3 said most staff witnessed how Staff 2 [NAME] up Resident 21. She added **Staff 2 intended to fire Staff 19 because she stepped in during the February 1, 2021 incident.**

On February 4, 2021, CNA (Staff 14) referred to the February 1, 2021 evening incident: Staff 2 told Staff 19 she would be disciplined for intervening. CNA (Staff 14) reported **Staff 19 was "in trouble only because she advocated for the resident when Staff 2 was abusive**."

Name of Nursing Home	Myrtle Point Care Center
Provider ID	385254
Address [RUCA Code: 5] [% County Population Rural: 38.14]	637 Ash Street, Myrtle Point, Oregon, 97458
Day Investigation Completed	February 11, 2021
Type of Deficiency Issued	*F600 **F603 ***F607
Scope Severity Level	*Actual Harm **Minimal Harm or Potential for Actual Harm ***Actual Harm

An Employee Who Requested to Remain Anonymous Said That When She Spoke Up About Physical and Mental Abuse of a Woman with Cognitive Impairment, "*she was bullied and retaliated against*"

The nursing home failed to implement their abuse policy to ensure allegations of staff to resident abuse were reported to the Oklahoma State Department of Health, thoroughly investigated, and residents were protected from further potential abuse for Residents 1, 5, and 6.

The nursing home failed to ensure allegations of staff to resident abuse had been reported to the Oklahoma State Department of Health for Residents 1, 5, and 6.

The Nursing home failed to ensure allegations of abuse had been thoroughly investigated and residents have been protected from further potential abuse during the investigations for Residents 1, 5, and 6.

Resident 5. Cognitive Function: **Moderately impaired cognitive skills** (based on quarterly assessment).

Resident 6. Cognitive Function. **Moderately impaired cognitive skills** (based on annual assessment).

Resident 1. Cognitive Function: **Cognitively alert** (based on a 5-day assessment).

A nursing home document titled Resident / Family / Grievance Concern Form, dated May 5, 2020, documented: Person filing complaint [Resident 5]. Nature of Concern: Left arm hurts really bad. Staff twisted her arm 4-5 weeks ago and threw her up against the wall. The staff's daughter works here and does the same thing. The grievance form documented the Director of Nursing (DON) had been assigned to investigate and the documented had been signed with the DON on May 14, 2020, the Social Services Director on May 15, 2020, and the Administrator on July 9, 2020.

The grievance form documented the DON interviewed the resident and staff members who worked the night shift and the day shift. The resident had been assessed by the DON. The document did not indicate how the resident had been protected during the investigation.

On November 2, 2020, the DON was asked what she did when there was an allegation of abuse reported. She stated she would investigate by asking questions of staff, resident, family, and staff involved.

The DON was asked what the reporting requirements were when there was an allegation of abuse. She said: "If I find it substantiated, I report to the state. If I don't find it to be substantiated, then I don't report." She stated she was not aware that all allegations of abuse had to be reported to the state.

The DON was asked to review the grievance document dated May 13, 2020. She was asked if the allegation of abuse had been reported to the Oklahoma State Department of Health. She stated: "I did not report."

The Administrator was asked what the reporting requirements were when an allegation of abuse was reported. She stated all allegations should be reported to the Oklahoma State Department of Health. The Administrator was asked to review the grievance document dated May 13, 2020. She was asked if the allegation of abuse had been reported to the Oklahoma State Department of Health. She said: "No."

A nursing home document titled Resident / Family / Grievance Concern Form, dated July 24, 2020, documented: Person Filing Complaint documented: [**Name of staff who had requested to remain anonymous**]. Nature of the concern: Weekend staff would yell at [Resident 6] when she came out of her room to go back, would walk her back, close the door so she couldn't open it. The med aide grabbed her walker, yanked it around and said: "I am tired of this [explicit word]." **When [named staff who requested to remain anonymous] said anything, she was bullied and retaliated against**.

The grievance document included the following information gathered by the complainant: A list of staff involved, how often the allegation of abuse occurred, a specific date of July 19, 2020 as one of the dates the incident occurred, the complainant notification to Charge Nurse with refusal to intervene, **request for the staff reporting the allegation to remain anonymous**, as request of resolution.

The grievance documented the Assistant DON (ADON) had been assigned to investigate. The document reported the investigation included the ADON had reviewed camera footage for the second shift on July 19, 2020, and could not confirm the allegation occurred. The document reported the ADON had spoken to the nurse and no concerns had been reported to her. The document had been signed by the ADON on July 27, 2020 and Administrator on July 30, 2020. The grievance documented the resolution: A written warning and suspension of one day from the DON and ADON to the complainant a staff **who requested to remain anonymous and reported the allegation of abuse**.

On November 2, 2020, the Administrator was asked to review the grievance document dated July 24, 2020 and was asked if the allegation of abuse had been reported to the Oklahoma Department of Health. She stated: "No, it was not." She was asked if the allegation of abuse should have been reported to the Oklahoma Department of Health. She stated: "Yes."

She was asked how the residents had been protected. She stated no staff were suspended. She stated: "We watched the camera, the ADON and myself, and we saw nothing on July 19, 2020. I even looked at Saturday (July 18, 2020) by myself and saw nothing."

The Administrator was asked to read the additional page of the handwritten account documented by the Social Service Director with the statement: "This happens every weekend he has worked." The Administrator was asked if there were any other dates on the weekend the camera was reviewed for the allegation of abuse. She stated: "No." She was asked if the allegation of abuse was thoroughly investigated. She said: "No."

Due to scope considerations, the details regarding the alleged mental abuse of Resident 1 aren't included in this summary (details can be found in Resident Grievance Form in the investigation report).

Name of Nursing Home	The Commons
Provider ID	375488
Address [RUCA Code: 1] [% County Population Rural: 20.13]	301 South Oakwood Road, Enid, Oklahoma, 73706
Day Investigation Completed	November 2, 2020
Type of Deficiency Issued	*F607 **F609 **F610
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm

***"I am a whistleblower and I am being retaliated against. I have had problems with [Nurse's name] because she is stealing narcotics"* – Staff Member**

The nursing home failed to protect Resident 1 from misappropriation of controlled medications (narcotics) by LPN (Staff A), reviewed for drug diversion (transfer of medication from the resident it was prescribed for to another person for unlawful use). This failure resulted in diversion of Resident 1's controlled medication for use other than for her pain management program, placing her at risk of unresolved pain.

The nursing home failed to implement their abuse/neglect policies and procedures related to prevention, protection, investigation, and reporting abuse/neglect and possible misappropriation of property allegations for Residents 1-5.

The nursing home failed to report to the State Survey Agency and/or law enforcement allegations of abuse, misappropriation of resident property, and a substantial injury of unknown source resulting in hospitalization, involving Resident 1-5. Failure to report the incidents placed the residents at risk for further abuse / neglect and misappropriation of property.

The nursing home failed to identify and conduct thorough investigation for Residents 2 and 3, reviewed for abuse allegations; Residents 1, 4, and 5 involving LPN (Staff A) and allegations of misappropriation of resident medications, and Resident 2 reviewed for fall investigations. The failure to collect and review information, investigate and rule out abuse and/or neglect, determine what / if any further actions were necessary to reduce the risk of recurrence, and to protect residents in a timely manner placed them at risk for further abuse/neglect, misappropriation, and falls with injury. In addition, the failure to investigate misappropriation of resident narcotic medications placed residents at risk for having their pain medication diverted.

The nursing home also failed to ensure medication administration practices were maintained in accordance with accepted standards of nursing practices for Resident 1. The failure placed the residents at risk for medication errors, and a potential for diversion of narcotic medication.

Due to scope considerations, the summary focuses only on Resident 1.

Resident 1 had received **Hospice services** since March 9, 2020.

Cognitive Function and Activities of Daily Living. Not Reported.

On October 30, 2020, at 6:48 AM, the Director of Nursing and the Administrator received a text message from Staff E stating the [MEDICATION(S)] belonging to Resident 1 and given to LPN (Staff A) was not in the medication cart (per notification from Staff D). After a few unsuccessful attempts to contact LPN (Staff A), she called Staff B at 8:06 AM and stated the [MEDICATION(S)] was locked up in the office of Staff B. At 8:10 AM, Staff B was unable to locate the [MEDICATION(S)] in the office, so she contacted LPN (Staff A), and informed her the [MEDICATION(S)] was not there. LPN (Staff A) stated she had accidentally taken it home in her bag and was enroute to the nursing home to return it. At 9:40 AM, LPN (Staff A) arrived at the nursing home and was taken to the Administrator's office, where she removed what appears to be a

closed box of [MEDICATION(S)] out from her bag. Per the investigation, LPN (Staff A) removed the cap from the [MEDICATION(S)] bottle, and it was very clear the inner seal was missing. At 1:30 PM on October 30, 2020, the bottle of [MEDICATION(S)] was taken to the pharmacy where specific gravity testing was done, which confirmed a difference between the facility bottle of [MEDICATION(S)] and a newly opened bottle in the pharmacy. At 2:08 PM, LPN (Staff A) stated she had a headache and was leaving the nursing home to go home. Drug tests done on both the pharmacy driver and LPN (Staff A) were negative. On October 30, 2020, Staff A was placed on suspended leave.

Review of LPN (Staff A) personnel file showed she was placed on administrative leave on October 30, 2020 as she had taken [MEDICATION(S)] home and brought it back to the nursing home on [DATE], it had been tampered with, and drug diversion confirmed. Staff A was then terminated from employment at the nursing home. Resident 1 did not miss any doses of the medication or experience any unresolved pain.

Despite multiple allegations by several staff members between July 2020 and October 2020, as evidenced during staff interviews, regarding possible misappropriation of Resident 1's [MEDICATION(s)] by LPN (Staff A), there was no investigation, reporting, prevention, or protection of the resident until October 30, 2020. At that time, Staff A was observed returning a bottle of [MEDICATION(s)] belonging to the resident, from her home back to the nursing home. The new bottle of [MEDICATION(s)] had a broken seal and was identified by the pharmacy company (through testing the specific gravity of the substance), that it had been tampered with. Staff A was immediately removed from work, placed on suspension, and following the nursing home's investigation, terminated from employment.

The investigation report detailed information from a few staff members regarding their suspicions about LPN (Staff A) stealing narcotics medications (e.g. missing narcotic medications and emptying an entire bottle of medications belonging to Resident 1 and replacing it with water).

A text message sent by Staff I to Staff K on July 23, 2020 showed another staffer had reported to Staff B and C that LPN (Staff A) had been terminated from another facility, due to opioid use. Documentation showed LPN (Staff A) was stealing narcotics from other residents and was working under the influence.

Review of Performance Documentation from **Staff I**, dated July 23, 2020, and signed by Staff B, showed Staff I had documented on the form: "**I am a whistleblower and I am being retaliated against. I have had problems with 2-10 [shift] nurse [LPN Staff A] because she is stealing narcotics**."

Name of Nursing Home	Avalon Care Center – Pullman
Provider ID	505246
Address [RUCA Code: 4] [% County Population Rural: 31.86]	Northwest 1310 Deane, Pullman, Washington State, 99163
Day Investigation Completed	December 16, 2020
Type of Deficiency Issued	*F602 **F607 ***F609 ****F610 *****F658
Scope Severity Level	*Minimal Harm or Potential for Actual Harm **Minimal Harm or Potential for Actual Harm ***Minimal Harm or Potential for Actual Harm **** Minimal Harm or Potential for Actual Harm ***** Minimal Harm or Potential for Actual Harm

An LPN Witnessed an RN Consume Medications but Didn't Report it Until the Next Day. She was "*hesitant to say anything as management does not do anything and tends to retaliate against reporters*" / The LPN Said: "*She and many other staff have concerns regarding RN, noting others reported him sleeping a lot, smelling like alcohol, acting weird, and making inappropriate comments*" / Another RN said the RN was scheduled the overnight shift and was "*acting off the wall and unsafe with residents*"

The nursing home failed to ensure discrepancies with narcotics were promptly reported and investigated as potential abuse and incidents of potential abuse for Residents 2 and 6.

The nursing home failed to thoroughly investigate an incident of potential abuse, failed to report a potential narcotic discrepancy to the State Agency and failed to report the nursing home's investigation results in accordance with State law (for Resident 6).

Cognitive Function. **Resident 2** had "**minimally impaired cognitive status**" (BIMS score of 12 out of 15).

Activities of Daily Living. Resident 2 required limited assistance from others with bed mobility, transfers, dressing, toilet use, and personal hygiene needs.

Cognitive Function. **Resident 6** had **severely impaired cognitive status** (BIMS score of 0 out of 15).

Activities of Daily Living. Resident 6 required extensive assistance from others with bed mobility, transfers, dressing, toilet use, and personal hygiene needs.

In an interview on April 7, 2021, Certified Medication Aide (CMA) Staff A stated that on the morning of March 9, 2021, she and RN (Staff B) were completing a shift change narcotic count and noticed the liquid [MEDICATION(S)] belonging to Resident 2 was clearly not the right color. CMA (Staff A), in the presence of RN (Staff B), poured out the liquid into a medication cup. The liquid appeared to be diluted dark soda color with black particles floating in it. RN (Staff B) stated she checked the expiration date, and the liquid [MEDICATION(S)] was still fine. **RN (Staff B) stated she noticed the discoloration during her shift change narcotic count with RN (Staff C) at 6:00 PM on March 8, 2021, but felt uncomfortable to bring it up with RN (Staff C).**

In an interview on April 7, 2021, the Director of Nursing (DON) stated that on the morning of March 9, 2021, she received a call from Staff E, reporting Resident 2's liquid [MEDICATION(S)] was not right. Staff E reported CMA (Staff A) and RN (Staff B) were conducting a shift change narcotic count and the [MEDICATION(S)] was not the proper bright pink, but instead a brown color. RN (Staff B), who had worked the overnight shifts that weekend stated she noticed the dichotomization two days earlier on March 7, 2021, but failed to report the discrepancy.

In an interview on April 7, 2021, RN (Staff B) stated on the morning of March 9, 2021, she and CMA (Staff A) were conducting the shift change narcotic count when they noticed Resident 2's liquid [MEDICATION(S)] was a clear-ish gray. RN (Staff B) stated she noticed this during the weekend but was not 100% certain there was a problem. RN (Staff B) stated she completed shift change narcotic counts with RN (Staff C) at 6:00 PM on March 7, 2021, 6:00 AM on March 8, 2021, and 6:00 PM on March 8, 2021.

RN (Staff B) stated she was uncertain and did not want the confrontation with RN (Staff C). RN (Staff B) stated **she did not alert anyone of the discrepancy**.

In an interview on April 8, 2021, **LPN (Staff G) stated** she and many other staff have concerns regarding RN (Staff C), noting others reported him sleeping a lot, smelling like alcohol, acting weird, and making inappropriate comments. **LPN (Staff G) stated staff have reported their concerns, but management had not addressed it and often retaliated against those who would report**. LPN (Staff G) stated that Staff F told her that a bottle of liquid [MEDICATION(S)] belonging to Resident 6 appeared clear, rather than the normal pink color. Staff F brought it to the attention of the previous DON (PDON) and the PDON took it and stated she would take care of it and opened a new bottle.

During the same interview, **LPN (Staff G) stated** that on November 4, 2020, **she observed RN (Staff C)** standing at the end of 400 Hall with the top drawer of his medication cart open. LPN (Staff G) stated the top drawer contained the liquid [MEDICATION(S)] and [MEDICATION(S)]. LPN (Staff G) noted there were no residents on 400 Hall that were being given liquid [MEDICATION(S)] or [MEDICATION(S)]. RN (Staff) C was observed wiping up something from the top of the cart. RN (Staff C) had medication cup in one hand and a water cup in the other and appeared to drink or take something in the medication cup. **LPN (Staff G) stated she was hesitant to say anything as management does not do anything and tends to retaliate against reporters**. LPN (Staff G) stated that the next day she decided to report the observation. LPN (Staff G) stated she was suspended for failing to report immediately.

In an interview on April 12, 2021, LPN (Staff F) stated RN (Staff C) was a Registered Nurse, but initially worked as an aide (July 2020). He would come into work hung over and tell co-workers. Staff F stated she and Staff G informed management that RN (Staff C) was potentially under the influence while working and was unsafe with residents. Nothing was done and the PDON eventually allowed him to work as a nurse (August 2020). Staff F stated sometimes in the fall (October 2020), she recalled Resident 6 having two bottles of liquid [MEDICATION(S)]. One unopened bottle was bright pink color and the opened bottle was barely pink. Resident 6 was also not resting well and Staff F suspected the [MEDICATION(S)] might have been tampered with. Staff F told the PDON, who acted put off. Staff F was uncertain what was done with the opened bottle of [MEDICATION(S)].

In an interview on April 12, LPN (Staff F) stated one evening she was working with RN (Staff C). LPN (Staff F) stated she was scheduled until midnight, however RN (Staff C), who was scheduled the overnight shift, was acting erratically, off the wall and LPN (Staff F) thought he had been taking something. RN (Staff C) wrote on the report sheet "leg and dick" instead of leg pink. LPN (Staff F) stated she did not want to leave in fear that RN (Staff C) might do something. LPN (Staff F) called the PDON and told her RN (Staff C) was acting off the wall and unsafe with residents. The PDON told her not to take her eyes off him, but the PDON did not come in. LPN (Staff F) states this happened on October 31, 2020, a Saturday night. LPN (Staff F) stated that RN (Staff C) finally left prior to the end of his shift at 3:23 AM, and she worked the remaining of the overnight shift.

In an interview on May 5, 2021, the PDON stated on November 1, 2020, LPN (Staff F) called her at about 2:00 AM, stating RN (Staff C) was acting erratically, yelling things, and making sounds. The PDON stated she had spoken with RN (Staff C) on the phone, noting he was not slurring his speech and sounded fine. RN (Staff C) told her he had not had any sleep and was tired. The PDON stated she suggested he go home and get some rest. RN (Staff C) texted her later and stated he was going home. The PDON stated she did not suspect RN (Staff C) was impaired when she spoke with him.

In an interview on May 6, 2021, the Administrator stated if someone was suspected to be under the influence at work, the nursing home should follow the policy addressed in the Employee Handbook. The Administrator stated he expected staff to report to management immediately with any concerns of staff impairment. The Administrator stated he expected someone from his management team to respond to the nursing home in person and evaluate the staff member for impairment and if there is a reasonable suspicion the staff member is impaired, he/she should be drug tested, sent home, and be subject to disciplinary action.

In an interview on April 14, 2021, RN (Staff C) stated he had worked day shifts (6:00 AM to 6:00 PM) during the weekend of March 6, 2021. RN (Staff C) stated he completed shift change narcotic counts, including Resident 2's liquid [MEDICATION(S)] and everything was fine. RN (Staff C) admitted he does not pay too much attention to the color.

In an interview on May 5, 2021, the PDON stated on November 4, 2020, Staff G allegedly witnessed RN (Staff C) consume something believed to have come from his medication cart but failed to report it until the next day. Staff G was suspended for failing to report immediately. The PDON stated RN (Staff C) was also suspended pending an investigation. The PDON stated she was involved with the investigation, that there was an incident report, and that there was no evidence of (RN) Staff C consumed any resident medications.

In an interview on May 5, 2021, the Administrator stated he was unable to find any investigation related to suspicion of RN (Staff C) allegedly consuming medications from his medication cart on November 4, 2020, or of any suspensions related to that allegation.

Name of Nursing Home	Newton Health Care Center
Provider ID	165427
Address [RUCA Code: 4] [% County Population Rural: 57.84]	200 South Eighth Avenue East, Newton, Iowa, 50208
Day Investigation Completed	May 7, 2021
Type of Deficiency Issued	* F609 **F610
Scope Severity Level	*Minimum Harm or Potential for Actual Harm ** Minimum Harm or Potential for Actual Harm

Five Aides Said: "*Retaliation would come in the forms of being given the cold shoulder, yelled at in front of their peers, and/or labeled a troublemaker to the point you either got fired or quit*"

The nursing home failed to ensure there were enough Nursing Assistants (NAs) working on each shift in the 400 Hall to provide the care and services for residents who resided in that hall, most of which had advanced dementia. This failure placed all residents residing on the 400 Hall at risk of not receiving basic care and services such as personal / incontinence care, assistance to rest in bed when tired, supervision to prevent falls and resident-to-resident altercations. This resulted in those residents who wandered and/or were assessed as a high risk being required to remain in the dining / activity room in the 400 Hall from before breakfast through dinner because the 400 Hall lacked enough care staff at all times and across all shifts.

Cognitive Function. N/A. Activities of Daily Living: N/A.

An interview was conducted with **five NAs**. All of the NAs were long-term employees and had been employed at least one year or longer in their positions. They stated they worked on the 400 Hall on all three shifts. They **agreed they would like to remain anonymous for fear of retaliation by the Administration and some of the nurses** (thus the date and time of the interviews are intentionally omitted). Note: The nursing home staff referred to the 400 Hall as **the Dementia Hall** / Unit as most residents had dementia.

All of the NAs stated retaliation would come in the forms of being given the cold shoulder, yelled at in front of their peers, and/or labeled a "troublemaker" to the point you either got fired or quit."

They stated they felt discouraged to report concerns because too many times their names were then brought up in the morning administrative meeting. Then someone in the meeting told others on the floor what was said or reported. They stated there was a lot of distrust between the NAs and the administrative staff because of this.

The biggest concern they had on the Dementia 400 Hall was not enough staff to care for the residents as they should be cared for. They stated any resident who needed to be watched for behaviors, like wandering into others' rooms, or were a high fall risk, had to sit in the [NAME] dining room from before breakfast until after dinner for their safety. They stated this was a directive from the Administrator which came to staff in approximately July of this year.

They stated there were 28 to 30 residents who resided on the Dementia 400 Hall and on a good day there were two NAs assigned there. They stated frequently, especially on the weekends and evening shifts, one of them had to work part of the time on another hall.

They stated they were supposed to change and lay down the residents between meals and as needed, but it frequently was not done. They stated the majority of the residents on the Dementia 400 Hall required two-person assists, and they had to wait until someone could come and assist them.

They all stated they were constantly trying to do their best and often worked repeated double shifts to the point of exhaustion. They stated they felt awful, were frequently brought to tears in frustration, and did

not enjoy their jobs because every day they left their shifts knowing some of the residents had sat in the [NAME] dining room from before breakfast until after dinner.

They stated they were excited when the new owners took over at the beginning of the year and thought there were going to be positive staffing changes for the Dementia 400 Hall.

They stated they liked it when more activity staff were hired to help with staffing so the residents would have more to do. They added: "In reality, it had turned into the residents just being babysat in the [NAME] room, causing them to be more restless and have more behaviors."

They stated at first they got good training about caring for residents with behaviors, but training and communication about the residents stopped in July after the Staff Development Director and the former Social Services Director quit working there.

They stated they felt the owners were good people and cared about doing things correctly, but believed the administrative staff were sugar-coating how things really were for them when the owners came to the nursing home.

They stated they all got good raises as promised by the new owners, and they were compensated well for working overtime and extra shifts. But, they stated, "that was not what we really wanted. **We want to be listened to and taken seriously about our concerns. We want to be worked with on solutions to make it a better place for staff to work in, so these residents have a better place to live in**."

Name of Nursing Home	Cashmere Post Acute
Provider ID	505151
Address [RUCA Code: 1] [% County Population Rural: 33.63]	817 Pioneer Avenue, Cashmere, Washington State, 98815
Day Investigation Completed	December 12, 2018
Type of Deficiency Issued	F725
Scope Severity Level	Minimal Harm or Potential for Actual Harm

Concerns by an Anonymous Employee's About an LPN Overmedicating Residents or Misusing Their Controlled Medications "*were swept under the rug with no repercussions other than* [the nurse] *retaliating against those she felt turned her in*"

The nursing home failed to ensure residents' controlled medications were not misappropriated. **This affected Residents 9, 29, 40, 42, and 43. ***The nursing home identified eight additional residents (Residents 1, 16, 20, 21, 25, 26, 47, 48) as part of their facility-wide investigation who had discrepancies in the use of their controlled medications where misappropriation was likely to have occurred.

The nursing home failed to implement their abuse / misappropriation of resident property policy to ensure an allegation of misappropriation of a controlled medication was investigated thoroughly and timely. In addition, see ** and *** (above).

The nursing home failed to investigate an allegation of misappropriation of a controlled medication timely and thoroughly at the time it was initially reported. In addition, see ** and *** (above).

The nursing home failed to ensure controlled medication records were in order and an account of all controlled medications were maintained in sufficient detail to enable an accurate reconciliation of the controlled medication. In addition, see ** (above).

The nursing home failed to ensure narcotic pain medications used on an as needed (prn) basis had clear parameters on when to use, were only administered as necessary, and non-pharmacological interventions were attempted prior to the use of the prn narcotic pain medications. This affected three residents (Residents 29, 42, and 43).

Cognitive Function and Activities of Daily Living were Not Reported for any of the residents.

Due to scope considerations, this summary focuses primarily on violations related to Resident 40.

A review of the nursing home's investigation of an allegation of the misuse of a resident's controlled medication revealed a written statement from the prior Director of Nursing (DON). The written statement indicated she was informed on July 22, 2020 by LPN 4 (a night shift nurse) that the count on Resident 40's liquid [MEDICATION(s)] stored in the medication refrigerator was not correct. It was reported that the bottle of liquid [MEDICATION(S)] had been opened and approximately 10 milliliter (ml) of the liquid [MEDICATION(S)] was missing. The controlled substance record for the liquid [MEDICATION(S)] did not show any doses had been signed out for the amount that was missing. The next morning the prior DON reported she verified the bottle of [MEDICATION(S)] had been opened and she confirmed only about 20 ml of the 30 ml bottle remained. She then removed the bottle of [MEDICATION(S)] and the controlled substance record from the count and placed them in her office. The prior DON felt the wrong dose of the liquid [MEDICATION(S)] was being administered to Resident 40 and he was being given more than the ordered dose. She did not want it left accessible to be administered further so she had it removed and discontinued.

Disciplinary Action form issued to the prior DON revealed she was given a final written warning on August 28, 2020 by RN 50. The final written warning was given for a violation occurring on July 22, 2020. The detailed description of the incident revealed the prior DON was informed by her staff of a bottle of liquid [MEDICATION(S)] missing approximately 10 ml of the medication with no record of administration. She then removed the bottle of [MEDICATION(S)] and the count sheet placing them in her office. She failed to investigate the missing controlled medication and failed to report it when it was made known. As part of her disciplinary action, she received re-education related to the management of controlled medications from receipt of medications to the destruction of those medications. The expectation was any controlled medication discrepancy would be reported and thoroughly investigated with reporting to the pharmacy as required.

On October 26, 2020, an interview with RN 50 revealed, among others, that she did the nursing home investigation on the alleged misappropriation of Resident 40's liquid [MEDICATION(S)] when it was brought to her attention the prior DON failed to do so. She stated some of the staff had informed her they brought concerns to the prior DON that seemed to go nowhere. As a result of the investigation, they gave the prior DON a final written warning for failing to investigate and report concerns with the missing controlled medication. The prior DON had called off for a couple of days after that for a family emergency and did not return. She stated her investigation determined LPN 62 gave Resident 40 extra doses of liquid [MEDICATION(S)] he did not have ordered at the time it was being administered so her shift would be uneventful. She added that they reported and forwarded their investigation to the State Board of Nursing.

An investigation was not initiated by the nursing home for the allegation of the missing controlled medication for Resident 40 until August 25, 2020 (over a month after it was first reported) **when statement from LPN 20 was given to RN 50**. The statement indicated the following had been reported multiple times by multiple staff members. **They were fearful to speak due to previous retaliations when doing so**. The following reports provided in LPN 20's written statement pertained to LPN 62. Another resident (Resident 29) was mentioned with concerns regarding the misuse / misappropriation of a controlled medication from LPN 20's written statement. LPN 20 reported in her statement that she had been asked by LPN 62 to sign that she witnessed a controlled narcotic pain medication being dropped for Resident 29 when she did not witness it. She then reported that a night shift nurse (LPN 4) had noted LPN 62 signed out an extra dose of [MEDICATION(S)] for Resident 29 on August 6, 2020 at 8:20 PM when LPN 62 only worked until 3:40 PM that day.

A review of another **anonymous witness statement** that was part of the nursing home investigation revealed additional concerns of LPN 62 possibly overmedicating residents or misusing their controlled medications was brought to the attention of the nursing home. The statement indicated **those concerns were swept under the rug with no repercussions other than LPN 62 retaliating against those she felt turned her in**.

A written statement from RN 44 revealed she heard LPN 62 state several times she had given someone a [NAME] dose as if they received a bigger dose than what had been prescribed. She too had been asked by LPN 62 to be witness to a dose of controlled medication she allegedly dropped and wasted. She identified Residents 9, 29, 42, and 43 as being other residents who had concerns on their controlled medications that needed to be looked into.

A review of the nursing home investigation revealed, among others, another anonymous witness statement alleged LPN 62 had made comments to other staff to not worry as they (referring to residents) had been [NAME] medicated. When asked to clarify, the nurse indicated she slipped them a little extra to help them sleep. The same anonymous witness statement indicated LPN 62 was known to give prn pain medications to residents that did not ask for them nor did they complain of pain.

The nursing home investigation included an interview with LPN 62 who was asked to explain the extra dose that had been signed out by her for Resident 29 on August 6, 2020 at 8:20 PM for a time she was not there to administer the medication. The nurse had no explanation to explain why she signed out a dose for a time she was not there.

Name of Nursing Home	Amberwood Manor
Provider ID	366253
Address [RUCA Code: 4] [% County Population Rural: 49.85]	245 South Broadway, New Philadelphia, Ohio, 44663
Day Investigation Completed	November 18, 2020
Type of Deficiency Issued	*F602 **F607 ***F609 ****F610 *****F755 ******F757
Scope Severity Level	*Minimal Harm or Potential for Actual Harm ** Minimal Harm or Potential for Actual Harm *** Minimal Harm or Potential for Actual Harm **** Minimal Harm or Potential for Actual Harm ***** Minimal Harm or Potential for Actual Harm ****** Minimal Harm or Potential for Actual Harm

Appendix 6

Need for CMS Memorandum to State Survey Agencies

The new CMS Memorandum needs to address, among others, the following issues:

- **Staff reporting obligations** pertaining to right violations and mistreatment of residents as required in federal nursing home laws and regulations. In addition, requirements for reporting reasonable suspicion of a crime against a resident as well as mandatory reporting requirements.
- **Staff rights** in the context of reporting alleged mistreatment violations without fear of retaliation, without threats of retaliation, and without actual retaliation against them.
- **Examples of situations where staff members may feel fearful** of retaliation after witnessing, suspecting, or otherwise becoming aware of resident right violations and mistreatment as well as examples of intimidation, threats of retaliation, and actual retaliation against staff members.
- **Nursing home's legal and regulatory obligations to protect staff rights** in the context of staff fear of retaliation, intimidation and threats of retaliation, and actual retaliation against them. Examples include: The development and implementation of policies and procedures addressing staff fear of retaliation and prohibiting intimidation, threats of retaliation, and actual retaliation against them; requirement to provide ongoing oversight and supervision of staff in order to assure that these policies are implemented as written; requirements to immediately and thoroughly investigate alleged applicable violations in accordance with federal laws and regulations as well as the requirement to report these alleged violations to the State Survey Agency and law enforcement per federal laws and regulations (including to report the findings as required including within mandated timelines); requirement to protect staff and residents during the nursing home's investigation; the steps the nursing home must take to prevent further potential harm from occurring (e.g., protection of staff and residents from retaliation; suspending an alleged perpetrator pending the investigation; employment termination upon substantiation of mistreatment and retaliation allegations; reports to the Nurse Aide Abuse Registry and professional licensing boards such as the Board of Nursing in the case of nurse perpetrators; and report to law enforcement per requirements); the requirement to implement meaningful corrective actions to prohibit and prevent reoccurrence and further potential harm to staff and residents; and the requirement to post in central locations employees' applicable rights.

- **Nursing home's obligation to provide training to staff** on their rights and protections related to staff fear of retaliation, threats of retaliation, and actual retaliation against them when witnessing, suspecting, or otherwise becoming aware of resident right violations and mistreatment.
- **Nursing home's obligation to ensure that all employees are informed about applicable reporting responsibilities**, including how to identify possible and applicable violations and how to report them, to whom, and when.
- **Making it clear that intimidation, threats of retaliation, and actual retaliation against staff members for lawfully reporting resident right violations and mistreatment are considered violations of staff rights** and that these actions carry consequences for perpetrators and the nursing home (the Memorandum should detail the potential consequences).
- **State Survey Agency responsibilities** pertaining to staff fear of retaliation, threats of retaliation, and actual retaliation against them. Examples include: Actions state Surveyors need to take to ensure that the nursing home is in compliance with federal laws and regulations related to staff fear of retaliation, threats of retaliation, and actual retaliation against them. In addition, guidance to state Surveyors regarding identification and investigation of staff fear of retaliation when witnessing, suspecting, or otherwise becoming aware of resident mistreatment (including identification of the state survey deficiency citations (Ftags) that need to be issued for applicable violations). Importantly, what specific strategies state Surveyors should use to navigate and address staff fear of retaliation so that employees will feel comfortable and safe speaking with them about resident right violations and mistreatment. Current guidance to Surveyors on staff fear of retaliation generally and the specific ways to address it (i.e., decrease it while keeping staff safe) does not rise to a level that could be characterized as comprehensive, structured, and systematic.
- **Examples illustrating the varied seriousness (i.e., scope and severity determinations) of applicable violations** such as those related to staff fear of retaliation when witnessing, suspecting, or otherwise becoming aware of resident right violations and mistreatment. For example, Immediate Jeopardy determination when a nurse perpetrator's ongoing and violent threats of retaliation against a CNA result in the CNA not reporting witnessing the nurse physically abuse a resident in advanced stages of dementia; leaving the victim not only to physically and psychologically suffer from the injuries without timely and adequate medical treatment and psychosocial support but also permitting the abuser to have continued direct access to the victim and other vulnerable residents for months and the CNA to be fearful for their own safety.

- **State Survey Agency's responsibility to report nurse aide perpetrators to the Nurse Aide Abuse Registry and other professionals to other State Licensing Agencies** (such as reporting a nurse perpetrator to the Board of Nursing) when violations applicable to staff fear of retaliation, threats of retaliation or actual retaliation against these employees are found (that is, violations that warrant reporting to this registry and other licensing agencies beyond required reporting for substantiated mistreatment of residents). For example, Employee A was found to make threats of retaliation against Employee B after Employee B witnessed Employee A sexually abuse a resident with dementia. When Employee B reported it to the Administrator, Employee A made threats to physically harm Employee B.
- **Other state agencies** such as police, Medicaid Fraud Control Unit, and the courts (criminal conviction can trigger registry action) **need to meet their applicable reporting requirements**. `