"Extremely Fearful"

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

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

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

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

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

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

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

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