"Like a Sack of Potatoes"

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

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

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

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

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

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

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

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

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