"It Will Come Back to You"

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

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

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

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

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

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

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

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