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

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

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

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

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

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

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

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

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

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

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

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