Abuse Allegation Recanted

The nursing home failed to protect a resident from abuse and neglect; failed to adequately address a resident's concerns associated with care provided by a staff member; and failed to implement strategies to mitigate a resident's fear of ongoing neglect associated with reporting of concerns for resident 38. The deficient practice caused the resident to experience feeling fear of neglect by staff L, and possible retaliation, which occurred over extended time. The nursing home also failed to report an allegation of abuse to the State Survey Agency within 24 hours of notification for resident 38.

During an interview, resident 38 stated there was a staff she had a problem with. Resident 38 was very resistant to discussing the issue. Resident 38 stated Staff L tickled the ears and necks of female residents. She stated, "He would not stop even when asked."

The resident stated he had yelled at her, yelled across the dining room, and had refused to assist her with care requests. The resident added that she had also witnessed staff L handling her roommate roughly when he lifted her roommate under the arms with his hands and slamming her into a chair. The resident described a similar transfer having occurred in the dining room with another resident.

Resident 38 was upset and wanted something to be done. The resident stated she wanted to remain anonymous because she was afraid of how she might be treated if others knew she had complained.

Because the resident stated she had not previously reported the allegations to the nursing home, this was immediately reported to the Administrator.

A review of the nursing home's Complaint Log showed a complaint from resident 38, alleging staff L was refusing to help her when requested. The log showed the original statement was recanted.

During an interview, when asked why she recanted her complaint, resident 38 stated she was afraid that staff L would still be assigned to her hall, and he would not take care of her.

Resident 38 stated staff L continually expected her to walk to the bathroom when she was not able. The resident stated she did not think she deserved to be treated that way. She added that she was afraid of being neglected if she complained about staff L.

A review of staff L's Corrective Action Notification showed a resident reported she was not getting help when requested and was told by staff L to "Do it yourself." The form documented a history of disrespect towards residents, and an expectation for immediate, significant, and sustained improvement in this area.

Name of Nursing Home	Sidney Health Center Extended Care / Provider ID: 275121
Address	104 14th Ave NW, Sidney, Montana
Date investigation completed	December 12, 2019
Type of deficiency issued	F600 – Free from Abuse and Neglect F609 – Reporting of Alleged Violations
Severity level	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/275121/health/standard?date=2019-12-12