"I Am Not Saying More"

The nursing home failed to: a. protect resident 1 from verbal abuse. Verbal abuse occurred when a staff person screamed at resident 1 and called her a liar and the nursing home failed to take immediate action to protect resident 1 from further abuse; b. ensure allegations of abuse/neglect were reported to the Administrator and State Agency within two hours as required for resident 1; c. ensure a thorough investigation was completed and adequate protection provided to ensure resident 1's freedom from abuse.

Resident 1 was cognitively intact (based on MDS assessment) and dependent on staff for bed mobility, transfers, locomotion on the care unit, dressing, toileting, and hygiene.

During an interview with Social Worker A, resident 1 stated she loves all the girls except one who she did not get along with. She added that a staff member had screamed in her face and called her a liar. Resident 1 went on to say that she did not want her to do anything about it for fear of retaliation, adding that if she said too much, the staff person might yell at her more. Following this allegation, Social Worker A spoke to Social Worker B and RN B about the allegation, but no further action was taken.

Social Worker A's interview with nurse aide (NA) B indicated that on Christmas Eve resident 1 was crying because NA A was rude and mean. Resident 1 got off the bed pan and still had to go. NA A said, "I am not dealing with her." NA B answered resident 1's call light and resident 1 said she had an accident because NA A wouldn't bring her the bed pan. NA B has reported it to RN A, but nothing was done.

That same evening, RN A emailed the Director of Nursing (DON) and Social Workers A and B indicating NA C told RN A that resident 1 does not want NA A in her bedroom. Resident 1 did not tell NA C and RN A why. It was not until four days later that the DON instructed NA A not to go into resident 1's bedroom during the investigation. NA A stated that at that point, she had already been there 2-3 times.

During an interview, when asked how she was treated by staff, resident 1 stated, "I talked to someone about it and that just caused trouble and I am not going to cause trouble." When asked if a staff person yelled at her, resident 1 stated, "I will not answer that. I've prayed that she finds happiness and completeness." The resident added, "My condemning her is my fault. I am not saying more." About an hour later, resident 1 confirmed that she was referring to NA A. During an interview, NA A denied the allegations.

A week after the abuse allegation, RN A stated, "I didn't think there was physical harm, so I didn't report it." RN A didn't think any abuse occurred. The Administrator stated that he first learned of the abuse allegation four days after it was made. He added, "I completely missed it." Social Worker B stated the Administrator should have been notified about it as soon as possible. She added, "It was my bad."

Name of Nursing Home	St Johns on Fountain Lake / Provider ID: 245635
Address	1771 Eagle View Circle. Albert Lea, Minnesota
Date investigation completed	January 7, 2021
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F609 – Reporting of Alleged Violations *F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	*Immediate Jeopardy **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 4; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/245635/health/complaint?date=2021-01-07