"They Would Turn on You Like a Pack of Wolves"

The nursing home failed to maintain a resident's right to privacy during a confidential conversation.

Resident 35 was cognitively intact (based on MDS assessment). During an interview, resident 35 indicated he previously had concerns related to his bath/shower days and really had to fight to get his baths on time, but since he complained, they [unnamed staff members] started treating him poorly and at times "it felt like 4 or 5 of them would turn on you like a pack of wolves, it was hard to say anything without them listening in on him, and making it worse."

Two days later, resident 35 told staff members and the Executive Director (ED) that the aides who just given care to his roommate were "the dirtiest talking women he had ever known." He could not believe the things they said to one another as they cared for his roommate. The ED asked him if he would like to have a private conversation and express his grievance. The resident agreed and they went to his bedroom.

Six minutes later, CNA 27 was observed outside resident 35's closed door. She leaned forward and pressed her ear to the door, stood quietly, and listened. After a few seconds, she left the door but shortly afterwards she returned to resident 35's closed door and pressed her ear to it once more. After she listened for several more seconds, she gave a thumbs up gesture to a CNA standing behind the nurses' station. The ED stated, "Staff should not be listening through closed doors, because all residents had the right to be treated with respect and dignity, which included the right to a private, confidential conversation."

The nursing home also failed to ensure the residents' rights to file grievances without fear of retaliation from staff. This deficient practice had the potential to affect six residents who anonymously complained.

An anonymous resident indicated agency staff were "too rough" and "mean." The resident began to cry and indicated they felt like they had to let things go because it was just part of being in a nursing home. The resident felt it did not do any good to tell anyone, because the facility kept adding more agency staff, and if the residents did tell someone, they would just be treated worse. The resident indicated they knew other residents felt the same way. If residents said anything about it, it just comes back on them.

Another anonymous resident stated LPN 31 brought them medication, but the resident noticed something was off and asked about it. LPN 31 got very upset and told the resident to either take the medication or refuse it. After that, LPN 31 was mean to the resident. One day LPN 31 came up behind the resident, leaned over to give them a hug, but then whispered in their ear, she could beat the s*** out of me, and no one would know how she did it. The resident said, "I was terrified." The resident was afraid to say anything, but finally had to when she noticed multiple medication discrepancies. The resident said she was happy that LPN 31 was not allowed to care for her but was afraid for any residents LPN 31 might work with.

Name of Nursing Home	Majestic Care of Avon /Provider ID: 155338
Address	445 S. County Road 525 E., Avon, Indiana
Date investigation completed	July 25, 2019
Type of deficiency issued	F583 – Personal Privacy / Confidentiality of Records F585 – Grievances
Severity level	Minimal Harm or Potential for Minimal Harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/155338/health/standard?date=2019-07-25