"I Am Going to Rip That Thing Off"

The nursing home failed to prevent mental, verbal, and physical abuse from a Registered Nurse (V4) to eight residents (R1, R2, R4, R5, R6, R7, R8, R9). These failures resulted in the eight residents experiencing increased anxiety, crying, and fearfulness, R4 and R5 sustaining physical abuse, and R7 sustaining bullying/disparaging comments regarding her disease. The nursing home also failed to a. immediately remove the alleged perpetrator RN (V4) after allegations of verbal, physical, and mental abuse were made; b. thoroughly investigate these allegations, and c. report these allegations to the state agency for the eight residents. These failures resulted in RN (V4) remaining in the nursing home and working directly with the eight residents, which resulted in these residents suffering continual abuse, fear, retaliation, and bullying from RN (V4). The Administrator and Director of Nursing (DON) failed to immediately act upon and follow-up on numerous physical, verbal, and mental abuse allegations.

Due to the extensive scope of the alleged abuse by RN (V4), only examples are included in this summary. The RN (V4) was described by residents as "very disrespectful," "mean," "very hateful," and "bullying."

Resident 4 had moderately impaired cognition (based on MDS assessment). Service attendant (V5) stated, "Around 6:30 PM, resident 4 was masturbating in the little room connected to the nursing area. RN (V4) went up to resident 4, grabbed his penis, and screamed, "If you don't stop that, I am going to rip that thing off." Resident 4 screamed because the RN (V4) grabbed it so hard.

Resident 5 who is cognitively intact reported that RN (V4) was openly mocking resident 7 at mealtime. Resident 7 has dementia and a repetitive verbal tick where she frequently says, "the-the-the." Resident 5 witnessed RN (V4) mock and repeat this tick to the resident and to other staff. Resident 5 feels that other residents and staff are fearful of RN (V4) and concerned about retribution if they were to report her.

During an interview, resident 5, who at times stood up to RN's (V4) abusive behavior toward other residents, stated, "The CNAs would tell me to watch my back. I was worried every night I lived there that RN (V4) would do something bad to me. I asked that RN (V4) not take care of me, but she still continued to take care of me. I was worried that she would try to kill me by overmedicating me."

Resident 6 was cognitively intact. The resident stated that one day RN (V4) "jerked me out of my chair, stomped on my feet, and punched me in the stomach. I told RN (V4) my feet were bleeding and RN (V4) said,' Good.'" The RN (V4) "then swung me around and threw me on my bed...I feared for my life."

Resident 8 stated, "I am not going to tell you anything about who has been mean to me. If I do not tell, then I do not get in trouble. If I told you what she has done to me, she would just make my life worse."

Name of Nursing Home	Sunset Home / Provider ID: 145800
Address	418 Washington Street, Quincy, Illinois
Date investigation completed	April 28 2022
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F610 – Investigate/Prevent/Correct Alleged Violation F835 – Administration
Severity level	Immediate Jeopardy
Overall Quality Star Rating: 3; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/145800/health/complaint?date=2022-04-28