"Total Terrors"

The nursing home failed to: a. ensure that grievances were thoroughly investigated according to the nursing home's policy for residents 1 and 4 and failed to ensure efforts were promptly made to effectively resolve concerns identified for all residents; b. prevent ongoing physical and mental abuse, isolation, and neglect for residents 4, 16, and 22; c. ensure that reports of alleged abuse and/or neglect were reported to the Department of Public Health within two hours as required; d. conduct thorough investigations of alleged incidents of abuse and neglect; e. protect residents from accused staff following abuse allegations.

The Grievance Log was reviewed. The residents said that they were not apprised of the investigation, action plan, and resolution to their complaints. The residents felt the staff's treatment of residents was disrespectful and intimidating. Residents said that staff yelled at them for using their call lights and threatened them against reporting complaints. The residents said the administration disregarded their complaints and that the staff (especially agency staff) made up rules as they went along and did not allow them to report complaints.

During an interview, resident 4 stated that filing grievances was pointless. The resident added that staff back each other up when asked about a situation and then become total terrors (toward the resident).
The resident stated that CNA 5 pushed his/her wheelchair into the wall of the elevator and whispered into his/her ear that she wanted to push resident 4 down the stairs and that she could do whatever she wanted to resident 4 and no one would ever know, or words to that effect. The resident stated that staff had threatened the resident and his/her roommate if they complained to the survey team and said that once the Surveyors were gone, things would go back to the way they were. The resident added, "Staff acted like we were non-people" and "they don't even acknowledge that we are human."

Resident 1 told the Surveyor that staff were miserable, mean, rude, and had made everything he/she did an issue. The resident had a list of concerns and complaints that he/she had tried to address with the nursing home but had given up because the staff make him/her feel that he/she is the problem and this increases his/her anxiety and had made him/her feel trapped, hopeless, and depressed.

The resident said he/she had complained about: 1. call bells not being answered and was afraid if something happened to him, no one would come; 2. A nurse saying that if the resident wanted to go to the hospital, the resident would have to call an ambulance himself/herself; 3. Seeing a resident dragged by their arms and feet down the hall; 4. Hearing a CNA slap resident 1's roommate. The resident expressed fear of reporting concerns because of staff intimidation. Resident 1's family reported their concerns to the nursing home and outside agencies but felt that had made it worse.

Name of Nursing Home	Garden Place Healthcare / Provider ID: 225267
Address	193-195 Pleasant Street, Attleboro, Massachusetts
Date investigation completed	October 19, 2017
Type of deficiency issued	F166 – Right to prompt efforts to resolve grievances F223 – Right to be free from abuse F225 – Report and investigate abuse, neglect or mistreatment F226 – Develop/implement policies prohibiting abuse/neglect/misappropriation/exploitation
Severity level	Actual Harm
Overall Quality Star Rating: 2; Staffing Rating: 2	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225267/health/standard?date=2017-10-19