Call Light Out of Reach

The nursing home failed to ensure that: a. resident 1 was free from verbal abuse or punishment by staff. CNA 1 admitted to and was witnessed yelling at resident 1. In addition, resident 1 reported that staff, including CNA 1, removed his/her call light from within reach because they said he/she used the call light too often; b. staff consistently implemented interventions identified in his/her Care Plan to provide resident 1 with the call light, which included to make sure the call light was kept within his/her reach.

Resident 1 (cognitively intact based on MDS) required staff assistance with all activities of daily living.

During an interview, resident 1 stated that when CNA 1 came to assist him/her sometime after the start of the night shift, CNA 1 yelled at him loud enough that staff heard CNA 1 at the nurses' station. The resident said that CNA 1 accused him/her in a nasty tone of voice of treating her like his/her personal aide and said that CNA 1 said she hated coming to help him/her. The resident said he/she did not report how poorly CNA 1 treated him/her because he/she was fearful of not having his/her care needs met.

Nurse 1 said that prior to the incident, resident 1 was yelling for help so she/he asked CNA 1 to go and check on resident 1. CNA 1 said she was not going to go to resident 1's bedroom again but did finally get up and go. Nurse 1 said that CNA 1 stood at resident 1's doorway and told resident 1 (in an irritated and angry tone), "What do you need now? I am not changing you again!"

Nurse 1 stated that she checked on resident 1 after CNA 1 left the bedroom. Resident 1 reported CNA 1 was mean to him/her, and that CNA 1 hated him/her. Nurse 1 said resident 1 reported similar allegations on multiple prior occasions. Nurse 1 said she had also expressed concerns about CNA 1 being burned out, that CNA 1 worked approximately 80 hours per week between different jobs, had expressed hatred of the nursing home, that CNA 1 did not have any respect for staff or residents, and that she was a bully. CNA 1 didn't respond to attempts by the Director of Nursing to interview her by phone, but she did respond by texts stating that there was nothing to investigate, that she yelled at resident 1 for taking off his/her diaper and for making a mess of the bed.

Resident 1 said that during the incident, CNA 1 removed his/her call light from within reach because CNA 1 said he/she used the call light too much. The resident said CNA 1 has done it on prior occasions, and when CNA 1 did that, he/she would have to yell for help. Resident 1 said he/she did not report staff taking away his/her call light because he/she was fearful of not having his/her care needs met as a result. Nurse 1 said that during the incident, she/her heard CNA 1 say words to the effect of, "I am not giving you the bed remote. You can get up and get it yourself." After CNA 1 left the bedroom, Nurse 1 observed the remote control of resident 1's bed on the floor and his/her call light not within reach. Nurse 1 stated that resident 1 was not functionally able to get out of bed and/or able to pick something up from the floor without staff assistance.

Name of Nursing Home	St Francis Rehabilitation & Nursing Center / Provider ID: 225438
Address	101 Plantation Street, Worcester, Massachusetts
Date investigation completed	April 7, 2021
Type of deficiency issued	*F600 – Freedom from Abuse, Neglect, and Exploitation **F656 – Comprehensive Care Plans
Severity level	*Actual Harm; **Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 5; Staffing Rating: 4	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/225438/health/complaint?date=2021-04-07