"Done With the Abuse"

The nursing home failed to ensure staff treated six residents in a dignified and respectful manner. This failure placed the residents at risk of experiencing a high level of frustration, embarrassment, and the need to constantly advocate for their care.

Due to scope consideration, the following summary focuses on Resident 221 who was cognitively intact.

During an interview, resident 221 stated they were discharging home the next day. The resident shared that there was no home health service availability but that was okay because they can leave this abuse.

Resident 221 stated Staff B – an LPN – was very verbal with her. She expressed concerns that the LPN waited until late at night to do their dressing change. She added that Staff B "was tired as hell and shouldn't have been here. They were on their second shift, and it was very busy, but I am also a patient too. I just needed a little help, that's all." She added, "Staff B was not organized for dressing changes and would leave their stomach exposed three times while going out to retrieve forgotten supplies."

Resident 221 stated, "After this Staff B won't be caring for me. I think this should be investigated. There are people here that need not be neglected."

Resident 221 shared that she reported this complaint to another nurse and added that they told Staff B they were going to report them for mistreatment.

The resident said Staff B was very rude now after they complained about them. Resident 221's roommate interjected saying, "Yes, very rude." Resident 221 added that Staff B came in today and slammed their pills down and rudely said "Take them." The resident said there was no reason Staff B should act like that. Maybe it was because they got in trouble when I reported them. The resident said they did not want to make a bigger fuss, just done with the abuse and can go home now to avoid it.

In a joint interview with resident 221 and her roommate resident 178. Resident 221 had told the Administrator that Staff B was completely rude to them and said, "Take your pills" while they were in the middle of sewing. They told Staff B, "Wait, I just have four more stitches, or I will lose my needle." The resident added, "I didn't want to lose the needle in my bed." Staff B said, "Take your pills, I need to watch you." Resident 221 added, "There is no reason to act that way."

Resident 221 was worried Staff B was retaliating against them since they reported them to management.

Administrator: "This may have been avoided had Staff B been reassigned from resident 221's care.

Name of Nursing Home	Everett Center / Provider ID: 505491
Address	1919 112th Street Southwest, Everett, Washington
Date investigation completed	September 21, 2021
Type of deficiency issued	F550 – Resident Rights / Exercise of Rights
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 1; Staffing Rating: 1	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/505491/health/standard?date=2021-09-21