Demeaning, Demoralizing, and Belittling

The nursing home failed to ensure two residents were free from abuse. Specifically, the nursing home failed to protect resident 22 and resident 34 from verbal and mental abuse from the Dietary Manager (DM) after voicing food related concerns. The nursing home also failed to have evidence that a timely, thorough, and complete investigation was conducted for abuse allegations related to these two residents.

A small group interview was conducted with members of the Resident Council. The members expressed concerns with the DM. They said they have expressed their concerns related to the quality of food using the appropriate channels but have felt retaliation from the DM. Four residents said the DM showed disrespect in the way she handled herself and addressed grievances with food. They said the DM would frequently call them "the troublemakers" because of their concerns regarding the quality of the food.

Two of the council members said the DM wrote a letter to the council members to humiliate and retaliate against them after they submitted a food-related grievance. It made them feel fear and humiliation. The Social Services Director thought the letter was "demeaning, demoralizing, and belittling." The nursing home investigation substantiated the letter as "verbal and physical abuse."

The council said the DM was later ordered to write an apology letter to them (acknowledging she was "unkind, inappropriate, and unprofessional") but it was impersonal and did not resolve their frustrations.

The following concerns were voiced by residents attending a Resident Council meeting held several months earlier. The grievance card described concerns of food that was over and undercooked, tough to chew, and overall concern with palatability. The residents felt upset, poorly treated, unimportant, and not cared for. Words such as "dumb" and "idiot" were also used in the way they felt treated.

During an interview, resident 22 shared that the DM called him a "troublemaker," "bastard," "son of a (expletive)," and made him feel small when he complained about the food. He said that he told the SSD he felt intimidated and scared of DM because she handled his food. While crying, he said that the DM might poison his food. He felt fearful for himself and others who took a stand against her. He added that the DM told him that if the nursing home got rid of him, the problem would go away. He said that he was told an investigation would be conducted but never received a follow up to his report. Resident 34 also felt that DM retaliated against him in response to their food concerns.

The residents felt they were "fighting a losing battle," concerns were thrown back in their lap, their intelligence was attacked, they were bullied, and they felt they were treated as the lowest form of life. Several residents retracted their food related concerns when they were individually approached by the DM. They felt they could not voice their concerns because the DM did not take the concerns well.

Name of Nursing Home	Colorado State Veterans Nursing Home – Rifle / Provider ID: 065386
Address	851 E. 5th Street, Rifle, Colorado
Date investigation completed	October 27, 2020
Type of deficiency issued	F600 – Free from Abuse and Neglect F610 – Investigate/Prevent/Correct Alleged Violation
Severity level	Minimal harm or potential for actual harm
Overall Quality Star Rating: 5; Staffing Rating: 5	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/065386/health/standard?date=2020-10-27