"A Lapse in Judgment"

The nursing home failed to ensure resident 1 was treated with respect and dignity, when CNA 1 responded to resident 1's complaints by dumping out resident 1's drink, twice.

Resident 1's cognitive patterns were intact (based on MDS documentation).

During an interview, resident 1 said that CNA 1 dumped out his/her drink. The resident said that when CNA 1 delivered his roommate's (resident 2) dinner tray, resident 1 said he/she told CNA 1 that resident 2 could not have milk. Resident 1 said that CNA 1 told him/her resident 2 could have the milk and that CNA 1 told him/her to mind her/his own business. Resident 1 said when CNA 1 did not remove the milk from resident 2's tray, he/she (resident 1) went and took the milk from the tray and threw it in the trash. Resident 1 said CNA 1 took a glass of water from his/her (resident 1's) over the bed table and dumped it in the sink before leaving the bedroom.

Resident 1 said that after dinner, he/she told CNA 1 several times that resident 2 could not have milk and said that CNA 1 was incompetent and called her it. Resident 1 said that at some point that same evening, CNA 1 came into his/her bedroom and dumped out his/her cup of water again.

During an interview, CNA 1 said that she dumped out resident 1's drink. CNA 1 said that it was a lapse in judgment and said she should not have done that. CNA 1 said that resident 1 dumped out resident 2's milk from his/her dinner tray.

CNA 1 said she did not think that resident 1 was being fair to resident 2 because resident 2's meal instructions indicated that he/she could have the milk on his/her dinner tray.

During an interview, Nurse 1 said that during dinner resident 1 came to the nurses' station and asked for a drink. Nurse 1 said that CNA 1 dumped out his/her water. Nurse 1 said that after dinner, resident 1 reported that CNA 1 threw out his/her water a second time and that resident 1 wanted to report CNA 1. Nurse 1 said that when she realized that resident 1 was complaining that CNA 1 intentionally threw his/her water, she reported resident 1's allegation to the supervisor and CNA 1 was sent home.

The nursing home provided the Surveyor with a plan of correction which addressed the concern with a series of measures including, among others:

a. Termination of CNA 1's employment.
b. The Director of Nurses initiated an all staff retraining related to abuse prohibition, resident rights, and retaliation (the majority of staff were trained).

Name of Nursing Home	Chapin Center / Provider ID: 225291
Address	200 Kendall Street, Springfield, Massachusetts
Date investigation completed	February 3, 2020
Type of deficiency issued	F557 – Respect and Dignity
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/225291/health/complaint?date=2020-02-03