Shower Scalding

The nursing home failed to protect resident 15 to be free from mistreatment. It also failed to report an allegation of mistreatment in a timely manner.

Resident 15 had severe cognitive impairment and dementia and required extensive one-staff assistance with personal hygiene.

A Reportable Event identified abuse allegations involving nurse aide 7. During the nursing home investigation, nurse aide 4 reported that yesterday at approximately 10:00 PM, nurse aide 7 threw resident 15 onto the bed from the wheelchair and removed the resident's clothing aggressively. Resident 15 became physical and hit nurse aide 7. Nurse aide 7 then struck resident 15 back in retaliation.

The second allegation came when the nursing home was conducting interviews related to the allegation of mistreatment. Nurse aide 6 alleged that nurse aide 7 verbalized to nurse aide 6 that she intentionally scalded resident 15 in the shower in retaliation after nurse aide 7 saw resident 15 throw coffee on another resident. Nurse aide 6 also alleged that nurse aide 7 told the resident that he/she is rude and "that's why your family doesn't visit."

During an interview, nurse aide 7 denied all the allegations that were presented against her. Nurse aide 7 stated that the Director of Nursing Services had no evidence to prove the allegations against herself.

During an interview, nurse aide 4 stated nurse aide 7's attitude would reflect on the care she gave to the residents. Nurse aide 4 reported that resident 15 was brought back to his/her bedroom by nurse aide 7 and nurse aide 4. Once in the bedroom, nurse aide 7 tossed resident 15 from the wheelchair to bed. The nurse aide identified it was done in such a way that it caused resident 15 to bounce up and down on the bed from the force. Nurse aide 7 then threw a shirt at resident 15 because she saw the resident put on a shirt before and stated he/she can do it again. Resident 15 refused to place the shirt on, at which point nurse aide 7 removed the resident's clothes roughly and aggressively. Resident 15 began to call nurse aide 7 names and become resistive to care. When nurse aide left the bedroom to retrieve additional supplies, she heard a slap sound. Nurse aide 4 immediately went into resident 15's bedroom but was not able to visualize anything. Nurse aide 4 alleges the body position of nurse aide 7 and resident 15 suggested something may have occurred, but nurse aide 4 was unable to positively identify if a slap happened.

RN 2 stated the nursing home was unable to substantiate the allegations against nurse aide 7 due to too many mitigating circumstances to confirm what happened or to substantiate abuse. Nurse aide 7 was terminated from her position.

Name of Nursing Home	Cheshire House Health Care Fac / Provider ID: 075373
Address	3396 E. Main Street, Waterbury, Connecticut
Date investigation completed	May 27, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation F607 – Develop/Implement Abuse/Neglect, etc. Policies
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/075373/health/standard?date=2021-05-27