Be Quiet About What Happened…

The nursing home failed to a. develop and implement written policies and procedures that prohibit and prevent neglect of resident 1, resident 2, and resident 3; b. report allegations of abuse/neglect and continued to allow perpetrators access to fearful residents. The failures placed residents who experienced abuse/neglect at risk of further abuse/neglect, physical and emotional harm, and decreased quality of life.

Resident 1 had moderately impaired cognition (BIMS score 10 out of 15) and required extensive assistance with bed mobility, dressing, personal hygiene, and total dependence with 1 staff for toilet use.

During an interview, resident 1 stated CNA F (agency staff) put a towel with resident 1's feces on it in her face. The resident said that CNA F got mad at her because she did not want her to use paper towels to clean her but wanted her to use a towel. She said that CNA F was mad at her and touched her nose with the towel with feces on it. She stated that after that CNA F threw the towel on the floor because a big hunk of feces came out. The resident reported the incident to the Infection Control Specialist.

Resident 1 said when CNA F touched her nose with feces, she was upset, and it made her feel neglected. She said, "You should not treat anybody that way." Resident 1 stated she believed CNA F did it on purpose and it was retaliation. She tried not to think about it anymore because it made her upset.

The resident said that CNA C asked her if she feared retaliation and the resident told her sometimes resident 1 thinks the nursing home might put her out (discharge her from the nursing home).

When speaking with the Infection Control Specialist, CNA F denied resident 1's allegations.

Resident 3 had severe cognitive impairment (BIMS score of 3 out of 15) and required extensive assistance of one staff for bed mobility, dressing, eating, toilet use, and personal hygiene.

During an interview, Housekeeper 1 said that while cleaning resident 2 and 3's bedroom, resident 2 told her that he heard CNA B slap resident 3. Housekeeper 1 spoke with resident 3 who told her to be quiet about what happened. The resident said he did not want to say anything. While his speech was impaired, he was able to speak a few words and illustrate to the surveyor where on his head he was hit by CNA B. The resident added that he was afraid, and that CNA B was bigger than him.

Resident 2 stated that since his allegations regarding resident 3 being slapped, he was fearful of retaliation. He was afraid that staff will spit in his food and stated that once he receives his last vaccination, he desires to leave the nursing home. He added that resident 3 is so afraid of being reported to the nursing home that he picks through his food to make sure nothing is in it. CNA B denied hitting resident 3.

Name of Nursing Home	Afton Oaks Nursing Center / Provider ID: 455682
Address	7514 Kingsley Street, Houston, Texas
Date investigation completed	January 19, 2021
Type of deficiency issued	F607 – Develop/Implement Abuse/Neglect, etc. Policies
Severity level	Minimal Harm or Potential for Actual Harm
Overall Quality Star Rating: 1; Staffing Rating: 3	

Investigation report: https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/455682/health/complaint?date=2021-01-19