"Reflexive" Hitting

The nursing home did not ensure that resident 1 was free from physical abuse. Specifically, resident 1 slapped LPN 1 and the LPN retaliated by striking the resident. The incident was captured on surveillance video recording.

Resident 1 had moderately impaired cognition and physical and behavioral symptoms directed towards others such as hitting, kicking, pushing, screaming, and threatening others.

The nursing home investigation documented "there was no indication that there was any intent to harm resident 1. Although, it is reasonable to conclude that LPN 1's actions provoked resident 1 to the extent that resident 1 became physically aggressive and hit LPN 1. Final review of the video footage was done, allowing the camera to run past an incident between resident 1 and another resident. LPN 1 was observed on the surveillance camera aggressively approaching resident 1. LPN 1 was in face-to-face proximity with the resident in an intimidating manner waving his arms instructing the resident to leave the area. Resident 1 was seen slapping LPN 1 with an open right hand to his/her left cheek. Resident 1 started to run away, and LPN 1 ran after the resident. LPN 1 reacted and was seen grabbing the resident's left hand and pushing the resident against the wall. LPN 1 was acting in an aggressive manner by raising her right hand to strike the resident. Both CNA 1 and CNA 2 witnessed the incident and separated LPN 1 from resident 1.

During an interview, the Chief Nursing Officer (CNO) stated that he/she reviewed the resident-to-resident incident on the surveillance camera and allowed the video recording to run past the resident-to-resident incident and that was when he/she observed the incident between LPN 1 and resident 1. The CNO stated that resident 1 suddenly hit LPN 1 and LPN 1 hit resident 1 back. The CNO stated that he/she immediately started an investigation.

On the day of the incident, resident 1 was transferred to the hospital via New York Police Department for aggressive behavior and the resident was admitted to inpatient psych and will be re-evaluated.

During an interview held nearly four months later, LPN 1 stated that he/she was at the far end of the hallway when he/she heard a resident-to-resident altercation that involved resident 1. LPN 1 stated that after the residents were separated, LPN 1 spoke to resident 1 to try and redirect resident 1 back to his/her bedroom. LPN 1 stated resident 1 slapped him/her on the left side of the face and that his/her (LPN 1) reflex came in back at the resident. CNA 1 pushed LPN 1 into another resident's bedroom stating, "Remember your job, remember your job." LPN 1 discontinued the phone interview by hanging up the phone. Two additional attempts to contact LPN 1 via phone call were unsuccessful.

Name of Nursing Home	Highland Care Center / Provider ID: 335505
Address	91-31 175th Street, Jamaica, New York
Date investigation completed	November 19, 2021
Type of deficiency issued	F600 – Freedom from Abuse, Neglect, and Exploitation
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/335505/health/complaint?date=2021-11-19