Staff Fear of Retaliation

A Barrier for Reporting Abuse and Neglect in Nursing Homes

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DEMENTIA BEHAVIOR CONSULTING

Hosted by:

Long Term Care Community Coalition

November 18, 2025

In one word…

Silenced

Acknowledgments

- Supported in part by: Theresa Piccolo

Warning

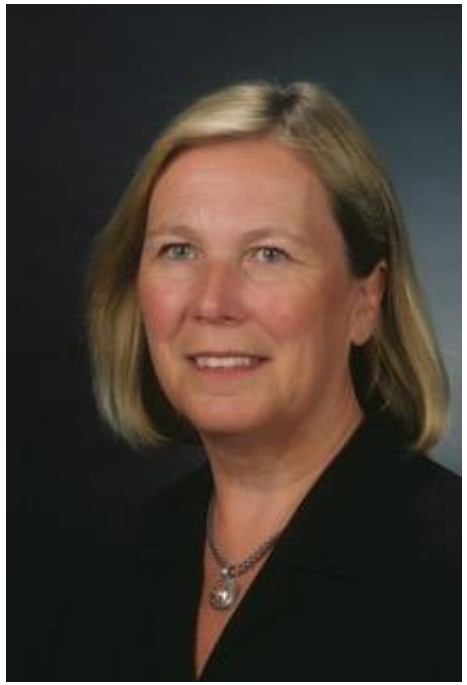
Some of the content is disturbing

Quote

elder voice ADVOCATES

"**We constantly hear about retaliation fears** and actual harms **to residents, families, and staff**.

This is a rapidly escalating problem that results in inconceivable suffering, and it must be stopped"



Kristine Sundberg
June 21, 2025

https://nursinghome411.org/retaliation/

Original Research Article

SGS SOUTHERN GERONTOLOGICAL SOCIETY

Residents' Fear of Retaliation in America's Nursing Homes: An Exploratory Study

Eilon Caspi[1]

Journal of Applied Gerontology
2024, Vol. 43(5) 497–514

DOI: 10.1177/07334648231214413
journals.sagepub.com/home/jag
Sage

https://pubmed.ncbi.nlm.nih.gov/37991342/

December 1, 2024

Quality Improvement Project

A Bridge Over Scary Water: Ombudsman Program Strategies and Barriers in Addressing Residents' Fear of Retaliation in Long-Term Care Homes

Prepared by: Eilon Caspi PhD

Image created by Kate Goebel

Funded by: Connecticut Long-Term Care Ombudsman Program

https://tinyurl.com/5n6w2a2s

New Educational Film

https://www.youtube.com/watch?v=gSizb8ooy9w&t=7s

Eight Twelve Productions

Connecticut and Colorado LTC Ombudsman Programs

Employees' Fear of Retaliation From:

Co-workers, supervisors, and managers

After they witness or otherwise become aware of rights violations, poor care, and mistreatment

McKnights Long-Term Care News

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NEWS

Many nursing home staff fearful of retaliation by superiors: study

JAMES M. BERKLAN
@JIMBERKLAN

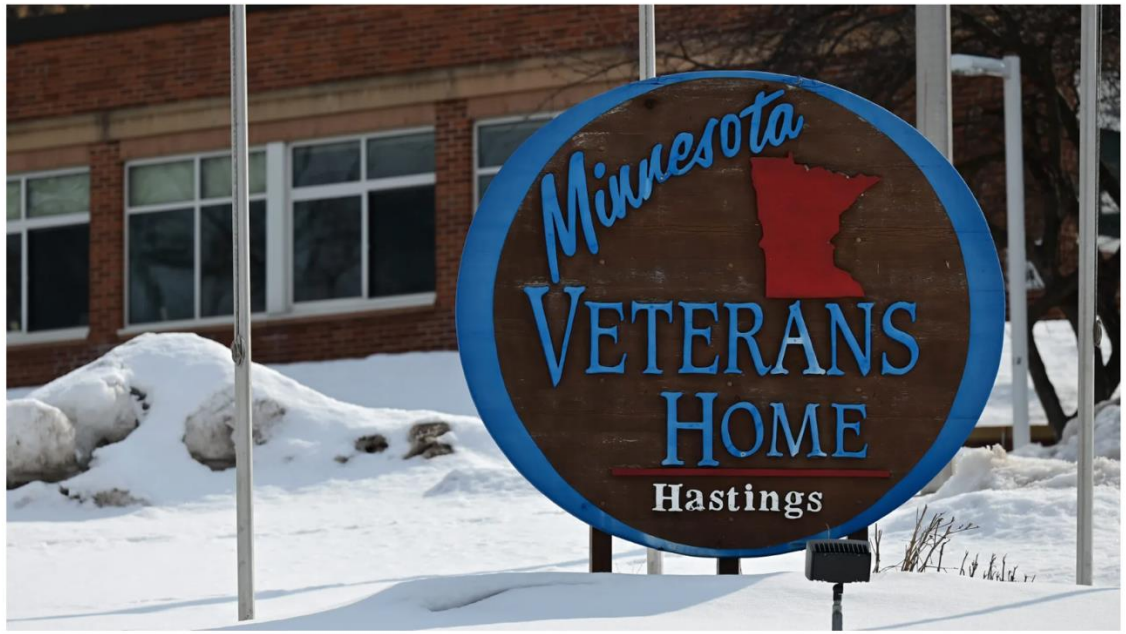
JULY 20, 2023

SHARE

https://tinyurl.com/y5va2296

Caregivers allege ‘harassment and retaliation’ at Hastings veterans home

A dozen workers say its a toxic workplace for caregivers and unsafe for veterans



The Minnesota Veterans Home in Hastings on Friday, Mar. 3, 2023. (John Autey / Pioneer Press)

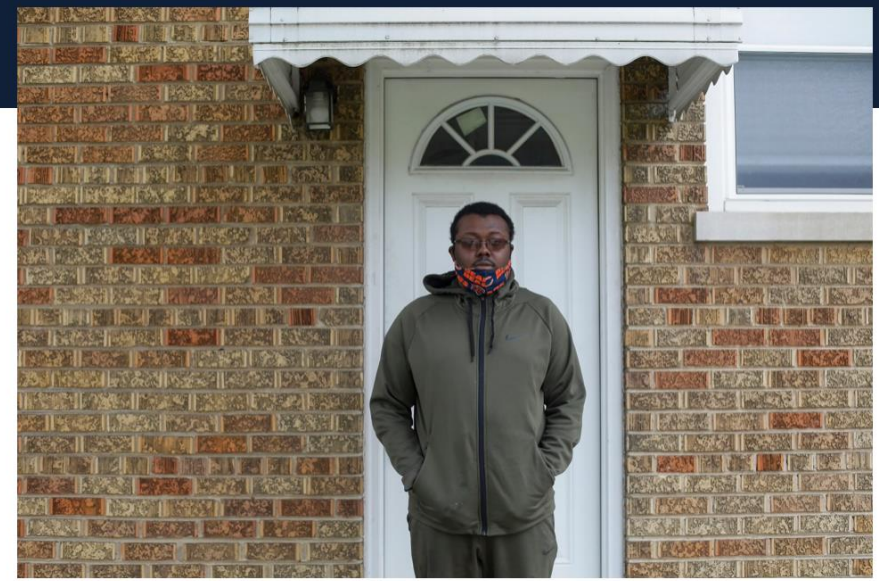
By CHRISTOPHER MAGAN | cmagan@pioneerpress.com | Pioneer Press
PUBLISHED: March 5, 2023 at 5:47 a.m. | UPDATED: March 5, 2023 at 2:18 p.m.

Pioneer Press. March 5, 2023

https://tinyurl.com/45dtj9e5

The forgotten front line: Nursing home workers say they face retaliation for reporting COVID-19 risks

“Direct care workers are already living paycheck to paycheck,” a researcher said. "Now they are being asked to put their lives on the line for $13 an hour.”



James Carter, shown outside his home in Chicago, spoke out about conditions in the nursing home where he works. Joshua Lott / for NBC News

NBC News. May 19, 2020

https://tinyurl.com/9856v9rj

Jury awards $5.2 million to former nurse at Dwight nursing home

EDITH BRADY-LUNNY and PAUL SWIECH Herald & Review News Service Dec 12, 2017 0

The nurse was **fired** after she **refused to**:

1. Follow DON's orders to double dose anti-anxiety meds for residents described as "agitated."

2. Delete records of suspicious injuries.

Source: Herald & Review. December 12, 2017: https://tinyurl.com/sywbhjsc

Fear

Definition

“An unpleasant often strong emotion caused by anticipation or awareness of danger”

– Merriam-Webster Dictionary

Fear of Retaliation

Definition

"A concern or feeling of vulnerability that one's actions may cause retaliation by another."

Source: Voices Speak Out Against Retaliation Instructor's Guide

Retaliation Definition

"An actual or perceived negative reaction of a person as a result of another person's action or behavior."

Source: Voices Speak Out Against Retaliation Instructor's Guide

Examples of Actions Constituting Retaliation Against Staff

"When a facility discharges, demotes, suspends, threatens, harasses, or denies a promotion or other employment-related benefit to an employee, or in any other manner discriminates against an employee in the terms and conditions of employment **because of lawful acts** done by the employee."

Source: CMS State Operations Manual, 10.21.22

An example of retaliation would be…

"If a staff member, on behalf of or as an agent of the facility, harasses **an employee who** had **reported a reasonable suspicion of a crime**."

Source: CMS State Operations Manual, 10.21.22

Gap in Knowledge

- Mostly anecdotal evidence
- Limited attention in research

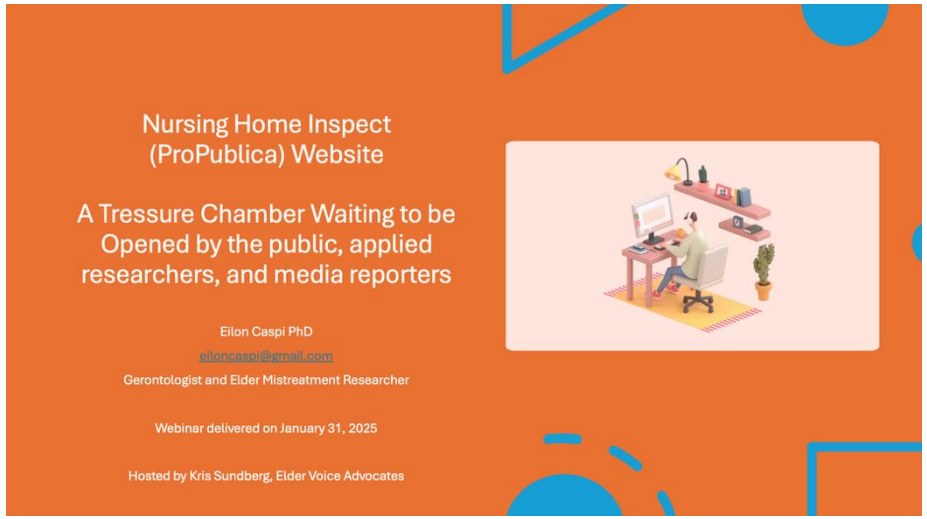
Barrier

Lack of Centralized Dataset

Investigation Reports Retrieved From

Nursing Home Inspect (ProPublica) Website

https://projects.propublica.org/nursing-homes/



https://www.youtube.com/watch?v=j-Wub3SrvpE

Goals

Identify…

- Circumstances surrounding staff fear of retaliation
- Types of resident mistreatment
- Consequences on staff
- Practical implications

Overarching goal

Empower, protect, and raise staff voice

Data

71 state investigation reports

Nursing homes in 30 states

Time period

December 21, 2017 – April 4, 2025

Selected Examples

Twenty additional examples are in Extra Slides

Not Respecting Residents' Wishes and Preferences

Baseball Game on TV

(Connecticut, June 4, 2020)

A person with **moderate cognitive impairment**

Required extensive assistance with ADLs

Care Plan

“It is important that he/she engage in daily routines meaningful to his/her preferences including watching sports on TV”

(Cont.)

After 11:00 pm, the person watched a baseball game on TV

Against the NH's policy, RN 1 told Nurse Aide 3 that all TVs had to be turned off at 11:30 PM, then went into the person's bedroom, turned off the TV, and placed the remote out of the resident's reach

Nurse Aide 3 did not report the incident because she was afraid that RN 1 would retaliate against her

Nurse Aide 2 confirmed: RN 1 shut off the TV against the resident's wish

She did not report her concerns because she was afraid of retaliation

RN 2 knew the incident should have been reported but she didn't because she was afraid of retaliation

Getting “in trouble” for Request to Respect Person’s Wishes

(*Oregon, February 11, 2021)

A CNA reported that Staff 2 frequently picks on a resident

One day, Staff 2 entered her/his bedroom

The resident became “really upset” saying Staff 2 picked on her/him

S/he asked staff 2 to leave her/his bedroom but she/he would not leave

Staff 3 asked staff 2 to respect the resident’s wish and leave the bedroom...

(Cont.)

In response, Staff 2 immediately retaliated against Staff 3 and **told her they would have a meeting the following day with the Administrator due to her insubordination**

Staff 2 frequently used threats of discipline against staff who advocated for residents

The resident said that Staff 2 “repeatedly targeted and punished her/him,” adding:

Staff 2 intended to fire Staff 3 because she stepped in during the incident

Staff 4: **Staff 3 was “in trouble” because she advocated for the resident when Staff 2 was abusive**

Neglect

CNA's Ongoing Neglect

(California, August 10, 2022)

Multiple CNAs and nurses shared concerns regarding CNA 1's ongoing neglect of residents' care:

- Resident 1 "had **watery stool all the way up to her shoulders** while sitting in her wheelchair for several hours." / "**Wet feces all the way up the bra line**, covering her head and back."

- CNA 2 said Resident 5 was **crying from being left in urine**, adding:

"When you walk in and see [her] crying because she was not taken to the bathroom,

it breaks your heart and makes you angry."

(Cont.)

CNA 2 added:

The neglect went on for about 3 to 4 months

She said that she is a mandated reporter and **she should have reported** the neglect **but did not out of fear of retaliation** from co-workers

Woman with Dementia Left Building Unattended

(Florida, February 1, 2025)

A woman with **dementia** and Parkinson's disease

Between 5am and 6am, she left the nursing home unattended

She crossed a 45 mph, moderately high trafficked 4-lane road in the dark

She was **found** approx. 30 min later by Night Supervisor (LPN A) sitting on the ground without shoes in front of a gas station approx. 0.3 miles from the NH

"She had a fall as evidenced by her muddy and wet clothing"

(Cont.)

LPN A and LPN N stated staff should not document the incident

The DON stated she did not "elope" because she was just in the parking lot and that LPN A told her "she immediately went behind her and brought her back inside." / "Determined to be a near miss."

~~~

"**Anonymous LPN N and CNA O** both **wished not to give their name as they feared retaliation and retribution** from the NH **for speaking about the elopement**."

Both witnessed the woman at the gas station as they were driving to work in the morning.

CNA O stated: "This was not the first incident swept under the rug by administration"
~~~

(Cont.)

When interviewed, Regional President of Clinical Services told State Surveyor:

"You can't blame us because we only know what we are told."

The Regional Presidents started a new investigation and found the difference in reporting between ADM/DON and staff was "egregious." / Both ADM and DON were suspended...

Surveyor issued **F610 and F689** both at "**Immediate Jeopardy**" and F641, F842 and F895 at "Minimal Harm or Potential for Actual Harm"

Not Reporting on Deceased Person

(Michigan, September 10, 2020)

A man who is **cognitively intact**

CNA C and LPN D didn't check on him throughout the night

At 7:15 am, a CNA **found** him "**clearly deceased**" and immediately reported it to LPN D

LPN D went into his bedroom and verified his condition ("Unresponsive").

Neither initiated CPR on the deceased man despite Full Code status

LPN D told the CNA C not to report it: "We didn't see anything."

They finished their shift and left the NH without notifying anyone he was "expired"

(Cont.)

Outside in the parking lot, CNA C told LPN D:

“I told you he looks dead to me and that I don’t want this to come back on us.”

CNA C didn’t tell anyone else. She explained:

She feared retaliation from the nurse “because she has gotten people fired in the past.”

~~~

LPN 2: “I don’t know how, not even as a nurse, but as a human being, how anyone could do that (not initiate CPR) to another person.”

“The LPN and CNA gave report that the resident was fine, punched out and left.”

“You wouldn’t even do that to a dog.”
~~~

Poor Staffing Levels

Ants Crawling on Woman

(Texas, September 11, 2021)

The woman had **severe cognitive impairment** and was described as "**Non-verbal**"

The nursing home failed to ensure she was checked on as needed throughout the night shift

Found with **10-15 ants crawling on her** while in bed

with ant bites throughout her body causing pain, red welts, and hives

Grimacing with her jaw clenched and her legs were shaking as if she was in pain

Several CNAs stated the **ongoing staff shortages** prevent them from caring for the residents

RN E stated the lack of care residents are receiving due to being short staff was "heartbreaking."

(Cont.)

When speaking with Surveyor, **5 staff members wanted to remain anonymous due to fear of retaliation by management** and the Staffing Coordinator

Surveyor issued:

F684 (“Provide appropriate treatment and care”) at “**Immediate Jeopardy”**

F725 (“Provide enough nursing staff”) at “Minimal Harm or Potential for Actual Harm”

“Their biggest concern was not enough staff”

(Washington State, December 12, 2018)

Dementia Unit / **Most** residents had **advanced dementia**

Surveyor: The NH failed to ensure there were enough Nursing Assistants (NAs) working on each shift to provide the care and services for residents

There were **28-30 residents** on the unit and on a good day there were 2 NAs assigned

They often worked repeated double shifts to the point of exhaustion.

They felt awful and were frequently brought to tears in frustration

(Cont.)

Five Nurse Aides wanted to remain anonymous for fear of retaliation by the administration and from some nurses.

They stated **retaliation would come in the forms of being**:

- Given the cold shoulder
- Yelled at in front of their peers
- Labeled as a “troublemaker” to the point you either got fired or quit

Verbal / Mental Abuse

Mental Abuse

(New Mexico, December 18, 2019)

A man with **dementia** and "**a really bad PTSD**" lived on a locked unit

He was "**very sensitive to sound** and **always requests that we speak very quietly to him**."

He asked Recreation Worker (RW) 1 to talk more quietly.

In response, RW 1 raised his voice to an almost shouting level:

"I can talk like this or I CAN TALK LIKE THIS!"

Staff: "I was shocked into tears."

"It was outrageous that RW 1 would act with such disregard to a very vulnerable resident."

(Cont.)

The same man asked another Recreation Worker:

"Take him [RW 1] out of my room"

In response, RW 1 started clapping very loudly and talking loudly

The man looked visibly upset

All three Recreation Workers expressed fear of retaliation from RW 1

Yelling Obscenities at Resident

(Idaho, November 9, 2018)

A person living with **severe cognitive impairment**

CNA 2 witnessed CNA 1 verbally abuse her/him

CNA 1 yelled in the person's face:

"[OBSCENITY] you! [OBSCENITY] you! [OBSCENITY] you!"

The reason? She/he had a bowel movement at shift change

CNA 2 did not report the incident until the next day because s/he was afraid of CNA 1 and didn't want to report him for fear of retaliation

“A serious life-threatening remark”

(Texas, April 16, 2024)

A woman with **Alzheimer’s disease / Severe cognitive impairment / Admitted on Hospice / Using a Wheelchair**

Hospice RN said the DON told her in the woman’s presence:

“If you don’t do something with this fucking patient, I am going to stab her in the neck.”

The DON made a hand motion as if she was holding a knife and put her hand up to her own neck.

Hospice RN:

The DON was very frustrated with the woman and she “could be a difficult patient, but it was her disease.”

She said the woman “had a mind of an 18-month-old child”

Hospice RN said “**she did not want any retaliation from the DON**”

(Cont.)

The Hospice RN said she left the NH "in tears" because she trusts these people to take care of the residents.

"**If something were to happen to the [woman], she would never forgive herself for not reporting the incident**."

She was told "there was nothing the facility could do because **it was a he said, she said**."

NH investigation: "Unable to verify accusations. Facility nurse denied making statement and no witnesses present."

The Surveyor issued **F600 and F610** both at "**Minimal Harm or Potential for Actual Harm**"

Telling a Woman to Bang Her Head in Wall

(Texas, March 29, 2025)

A woman with **Bipolar Disorder** and **Schizoaffetive Disorder** Bipolar Type / **Severe cognitive impairment**

While cleaning in the hallway, **Housekeeper witnessed** the woman being upset and banging her head on the wall

The DON, RN 1 and RN 2 made fun of the woman

RN 1 told her "to bang her head on the corner of the wall and
maybe it would knock her brain out and she would kill herself"

The Housekeeper did not feel comfortable telling the Administrator because of
how he had handled other situations in the past and **she feared retaliation**.
She said she did not know who she could trust, and she was **scared nobody would believe her**.

(Cont.)

Housekeeper:

"I did not know who I could trust to talk to.

But **I knew I had to do something**.

These residents deserve to be treated with utmost respect.

I believe in telling the truth."

The next morning, she reported it to her boss Housekeeping Supervisor.

From there, it was reported to Assistant DON and Administrator

Surveyors issued **F600, F607, F609, F610**

All at "**Immediate Jeopardy**"

Physical Abuse

Twirling Woman with Alzheimer's on Wheelchair

(Texas, July 23 2023)

A woman with **Alzheimer's disease** / **Severe cognitive impairment**

While naked on her wheelchair, she tried to stand up

An aide popped a wheelie up with the woman's legs up in the air

and was **twirling her while laughing** with another aide

The woman was screaming and hollering for her: "Stop it!"

The woman reportedly fell and was bleeding. One CNA said she broke her ankle

Over the weekend she was sick, vomited blood, and died

(Cont.)

Housekeeper C witnessed and **audio recorded it**

"but the DON made her delete it out of her phone"

Housekeeper C told the DON the woman "was being abused because she was being abused"

The DON told her she was **too emotionally involved** for that job

The Administration **told her to think "really hard" about what she wanted to do at the NH.**

Then they had her clock out

Housekeeper C came out crying and saying **she was about to lose her job**

(Cont.)

Staffing Coordinator:

”There was a lady who **wanted to talk to the state surveyors about the incident, but she was scared and feared retaliation** from administration. **She** saw some things but **did not want to lose her job**”

Housekeeping Supervisor told surveyor she **was ready to tell the truth** about what she knew about the incident. She said **she was previously scared to talk to her/him for fear of retaliation from administration.**

The Surveyor issued:

F600 and F610 at “**Immediate Jeopardy**” and F609 at “Minimal Harm or Potential for Actual Harm”

“Mini Baptismal”

(Kentucky, June 3, 2021)

An Aide reported **witnessing** weekend LPN commit physical and verbally abusive acts toward residents 1, 2, and 3

It was witnessed over the past two months.

Asking to remain anonymous, the aide gave this written statement:

The LPN’s abusive acts occurred on the night shift when **no other staff was around except her**.

The LPN…

Grabbed cheese and threw it at the resident’s face.

Was heard saying (under her breath): “Dum M. F-er.”

Filled a long syringe with water and squirted water on 2 other sleeping residents.

The LPN called it “**A Mini Baptismal**”

She shared she did similar things to residents at another care home when she didn’t like them.

(Cont.)

The aide lived across the street from the LPN and felt in danger of retaliation because she was the only staff member working with the LPN when the abusive acts occurred.

She reported the abuse only a day or so after the LPN's employment was terminated…

Choke Hold

(Texas, April 27, 2024)

A man with **Alzheimer's disease** / BIMS score 0 ("Unable to complete")

CNA A (a new hire / "started last week") told Surveyor:

When the man refused to be changed, CNA B grabbed him by the back of his neck and held him down in **a choke hold** saying out loud:

"You better get in there, now!"

CNA A stated she did not intervene, and she did not say anything to CNA B about it

(Cont.)

CNA A **did not report** what she witnessed to RN G or the Abuse Coordinator.

She did not intervene because she was scared of CNA B

as she was "a big girl and could beat me up."

"**I've seen her** speak loudly, aggressively and **get up into staff face**, and they have not done anything to her. They let her work here." / "No one is doing anything about it"

(Cont.)

CNA A stated "**CNA B had friends and family that worked in the facility, so she did not know who she could trust…"**

She stated "she felt **if she reported the abuse to administrative staff, the facility would retaliate against her, and she would be terminated"**

Kicked in the Shin

(* South Dakota, January 8, 2025)

A woman with **dementia / Severe cognitive impairment / Using a wheelchair**

She “tended to reach out to people walking by to hold their hand”

While sitting in the hallway, she reached out towards CNA J as she walked past and told her: “Hey come here quick.”

Anonymous Staff N observed **CNA J kick her twice in the shin**. The woman looked sad and shocked.

Anonymous Staff N also overheard CNA J tell her:

“You’re an ugly gremlin. I can tell you’ve had a hard life. I can tell you probably smoked all your life.”

Anonymous Staff N and M “**feared retaliation from CNA J**” and **did not report the incidents** at that time

Slamming Cloth Over Person's Mouth

(*South Dakota, January 8, 2025)

A person with **dementia** / **Severe cognitive impairment** / "**Non verbal**"

CNA J and another staff member (the complainant) were transferring the person using a full-body mechanical lift

CNA J slammed a cloth over the person's mouth and held it there with her fingertips "for about a minute"

The complainant felt as if CNA J did that as a means to quiet the resident

(Cont.)

An anonymous Staff M stated they were **initially afraid to come forward with the allegations against CNA J due to CNA J's retaliatory nature.**

They explained why they did not report those incidents immediately: **Because previously when incidents were reported**, CNA J's actions would improve for a short while, but then would return to the abusive behaviors.

Anonymous Staff members M and N "**finally reported their concerns to the Executive Director**."

Anonymous complainant's email to SSA: "There is a CNA that works here named [CNA J] and she is abusing residents. I have witnessed her kicking, yelling, and calling [them] names, which is mental abuse. **I have reported this to the administration** to no avail."

“Waterboarding”

(Michigan, August 6, 2021)

A woman with **severe cognitive impairment**

She was reported to hit, scratch, and bite staff during showers

Witnessing CNAs:

A CNA held the shower head directly in front of her face and told her to shut up.

“Intentionally and repeatedly sprayed [her] in the face” as a result of her “behavior” in the shower

“It appeared to me as waterboarding”

The CNA “sprayed it so long it was hard for her to breath”

Surveyor: The NH failed to ensure that reporters are free from retaliation or reprisal

Injurious Nose Twist – Not Reported for 10 Days

(*Mississippi, April 4, 2025)

A woman with **dementia** and Parkinson's disease / **Moderate cognitive impairment**

CNA 3 stated that on March 7, 2025, an LPN asked her to assist CNA 1 with providing care to her as she is "combative."

As care began, the woman swung at both CNAs. At some point, she grabbed CNA 1's hair.

"In response, **CNA 1 grabbed the resident's nose and twisted it upwards, which caused the resident's nose to bleed**."

CNA 1 then stated: "**This is how you deal with crazy (expletive) like you**."

CNA 3 recalled telling CNA 1: "You can't treat and talk to her like that."

CNA 3 **did not report the incident** to the nurse, DON, or ADM until March 17, 2025 **because she feared retaliation from other staff**.

Not Reporting Witnessed Abuse for 2 Months

(California, December 10, 2021)

A woman with **severe cognitive impairment** / Described as "**bedbound**"

CNA 1 stated that two months ago while attempting to turn and reposition her,

CNA 2 became frustrated when the woman could not participate in the turning.

CNA 2 **yelled at** the resident to turn **and** then **slapped her legs hard** when she didn't move

(it made an audible sound and left a red mark)

CNA 1 said what she witnessed was verbal and physical abuse.

(Cont.)

CNA 1 **didn't report the incident <u>at the time</u> because she was afraid of retaliation**

She came forward <u>now</u> because she did not want what happened to the resident to happen to other residents.

Remaining silent about what she witnessed bothered her.

Threat of Violence Against Resident

(*Mississippi, April 4, 2025)

A person with **severe cognitive impairment**

During an interview, CNA 2 stated overhearing **CNA 1** say to the resident:

"If you (expletive) in the bed like you did yesterday, I am going to beat your (expletive)"

CNA 2 stated she immediately told CNA 1 that she could not speak to a resident in that manner. **CNA 1** replied: **"I bet it works"**

CNA 2 **did not report the incident** at the time **because she was afraid of retaliation** from staff, stating that **people had recently been losing their jobs**..."

Administrator **found 2 anonymous letters on his desk** alleging CNA 1 had physically abused resident and verbally abused another

Surveyor issued **F600, F607, and F609** – all at "**Immediate Jeopardy**" level

Sexual Abuse

Waiting a Week to Report a Nurse Exposing Himself

(California, November 19, 2020)

A woman who was **cognitively intact** stated:

When a male LVN came to her bedroom to measure her blood pressure, her arm accidently brushed against his crotch. She apologized and lifted her arm back up.

The LVN then reached his hand into his pants and **pulled out his penis**

The woman told the LVN to leave, which he did…

A CNA who witnessed it did not report it to the Administrator for 7 days…….stating:

She was afraid to immediately report the incident because she feared retaliation if the LVN lost his job.

Sexual Abuse Allegation

(Georgia, December 21, 2017)

A woman "**alert and oriented**" and "very independent in decision making"

A CNA heard:

A male LPN gave the woman other residents' medications and **she was giving him oral sex in return**

Another CNA stated the woman told him **the LPN had groped her, inserted his finger in her vagina, and tried to get her to perform oral sex on him**.

The CNAs did not report the LPN's suspicious behavior due to fear of retaliation from the LPN.

The LPN was their supervisor.

Drug Theft

Delayed Reporting Allegation of Narcotic Drug Theft by RN

(Iowa, May 7, 2021)

An RN would come into work hang over, potentially under the influence and unsafe with residents

Staff members had concerns regarding the RN:

"He sleeps a lot, smelled like alcohol, and acting erratically, off the wall."

An LPN observed the RN hold a meds cup in one hand and water cup in the other and appeared to drink or take something in the meds cup.

(Cont.)

The LPN said:

Staff reported their concerns, but **management** had not addressed them and **often retaliated against those who would report**

The LPN was hesitant to say anything as management does not do anything and **tends to retaliate against reporters**

Retaliation for Reporting LPN's Theft of Opioid Pain Meds

(Washington State, December 16, 2020)

An LPN stole narcotics:

- Prescribed to Resident 1 on Hospice (3 x daily & every hour as needed)
- From other residents

The LPN was working under the influence

Despite multiple allegations by several staff between July 2020 and October 2020 regarding possible misappropriation of resident's [MEDICATION(S)] by the LPN, there was no investigation, reporting, prevention, or protection of Resident 1 until October 30, 2020.

Staff I knew LPN emptied an entire meds bottle belonging to Resident 1 and replaced it with water

(Cont.)

Staff B:

"**I am a whistleblower and I am being retaliated against**.
I have had problems with the [LPN] because she is stealing narcotics."

~~~

A staff member reported that the LPN's employment was previously terminated from another care home due to opioid use.
~~~

Original Manuscript

SGS SOUTHERN GERONTOLOGICAL SOCIETY

Journal of Applied Gerontology
2023, Vol. 0(0) 1–12

DOI: 10.1177/07334648231153731
journals.sagepub.com/home/jag
SAGE

Theft of Controlled Substances in Long-Term Care Homes: An Exploratory Study

Eilon Caspi[1], Wei-Lin Xue[2], and Pi-Ju Liu[2]

https://pubmed.ncbi.nlm.nih.gov/36691366/

Fear of Administrators

“Terrified” of Administrator’s Retaliation

(Texas, March 9, 2020)

The owner and management company failed to pay various vendors for services.

“These failures **placed residents at risk of serious harm or death** from going without food, water, heating / air conditioning, and essential medical equipment. It also **placed them at risk of injury or death** due to fire or infection. It placed them at risk of not having their needs met due to insufficient staff.”

The pharmacy bill went unpaid until the pharmacy threatened to discontinue delivery.

Didn’t pay Oxygen delivery company until **they ran out of oxygen tanks**.

One resident reported hard time breathing because of it.

(Cont.)

An anonymous complainant:

“**Everyone in the NH was terrified of the Administrator’s retaliation if they spoke to anyone about the issues in the building.”**

The Administrator placed cameras to monitor staff.

“This made most everyone afraid to speak freely about any problems.”

Ongoing Abuse by Administrator and DON

(Colorado, April 19, 2018)

Resident 1 said:

The ADM, Social Services Director (SSD), Assistant DON, and DON "**talk down to her like she is zero.**"

She **feels humiliated** when they speak to her **like she is a child** /

"Administrative staff charge in like an army and '**rake you over the coals**.'

It scares and **frightens her**. Afraid to say anything about how she was treated.

Resident 2 described the ADM as "bullish," "abusive," "threatening," and "humiliating."

Resident 3 described him/her as "a dictator."

(Cont.)

Staff feared for their jobs and felt powerless to protect residents

Two CNAs felt intimidated by the Administrator, DON, and SSD, and feared retaliation in the form of being fired if they reported how these administrative staff abuse and mistreat the resident (“very verbally abusive”)

One of these CNAs said she could not be without work as she had family to support. She felt “hopeless.”

CNAs' Fear of Losing Their Jobs

In 2024, direct care workers' hourly wage in nursing homes

$18.83

Source: U.S. Bureau of Labor Statistics, as cited in PHI report

Annual salary $39,166

"**Wages** for direct care workers are **untenably low** and have barely budged over the last 10 years. As a result, direct care workers are **often forced into poverty**, **cannot make ends meet** or support their families, and end up leaving this field for other industries, such as fast food and retail." – PHI

“Conditioning”

(Colorado, April 19, 2018)

An LPN said when **the Administrator** arrived at the nursing home, she **informed the staff she was the reason they had their jobs**.

The LPN understood the statement as **a reminder that the Administrator could fire staff who did not agree with her/him**

DON's Fear of Administrator's Retaliation

(Wisconsin, April 27, 2022)

A man who is **cognitively intact** lived with Hemiplegia
(paralysis of 1 side of his body)

The Administrator threatened to drop him off at a homeless shelter
"Due to non-payment and his level of care needs"

It caused him to feal humiliated, intimidated, threatened, and scared / fears the ADM
Social Worker and DON said they observed the ADM verbally and mentally abuse him

The man told the DON, ADON, and others about it

The DON stated she **feared retaliation and even losing her job if she spoke out against the ADM**

She said being an advocate for the resident was high priority, but there was no way around the ADM

Fear of Speaking with State Surveyors

“There would be consequences for talking to the state”

(Colorado, March 7, 2024)

A frequent visitor told a Surveyor she had several complaints about the NH:

Many residents complain about not getting their medications.

Many residents complained about roommates with mental health issues. Their requests to be moved to a new bedroom were not honored.

One resident was found with a blanket being held around her head by another resident. She could not defend herself due to her immobility.

(Cont.)

The visitor was concerned for residents' safety and "**the staff were being intimidated and afraid to speak up**."

She said: "**The Administrator led the facility by fear and retribution**."
She added: "The **staff had been told** during the current survey **there would be consequences for talking to the state**."

Restorative **Nurse Aide** (RNA) said he was **afraid to be seen talking to the state**.
He added: **"Staff had been threatened and feared retaliation if they spoke up** and **he needed his job**."

RNA: "**Many staff were afraid of retaliation** by the facility **and were not going to say anything**."

RNA: "**The Administrator** was overpowering conversations and **shutting down concerns** reported by the staff."

An LPN was **concerned about the Administrator finding out she was discussing things with the state surveyors**."

Retaliation Against Staff

The Nurse “rides you”

(Texas, February 1, 2022)

Multiple staff members stated:

LVN forces residents to get out of bed against their will

(some were begging not to be bothered)

Resident 1 and 2 (**both with moderate cognitive impairment**) voiced concerns to DON about LVN’s bullying.

CNA 1 stated this was reported to the administration
but nothing was done and **the staff fears retaliation, so they don’t mention it anymore**

The DON, who was aware of it, stated:

“It does not get reported to her often due to staff concern about retaliation.”

(Cont.)

CNA 2 described **the ways LVN retaliates** against staff members:

- Making your work more difficult. / “Rides you”
- Pressuring staff to get things done in a hurry when they have the entire shift to do their tasks
- Making sarcastic and rude comments to staff

Targeted After Report on Abusive Nurse

(*Oregon, February 11, 2021)

A person with **dementia** / Using a wheelchair

An LPN **tipped his/her wheelchair backwards** and aggressively told him/her to stay in his/her bedroom

Allegedly, the LPN also told a staffer to withhold juice the person requested without a medical reason.

Five months later, **the LPN shoved the person in his/her wheelchair into his/her bedroom forcefully**

Confidential staff stated:

LPN treated the person "like a dog" when they pointed down the hallway and told him/her to go to his/her bedroom

(Cont.)

Staff were afraid to report it due to fear of retaliation

CNA 1 reported the LPN's mistreatment to the Administrator

As a result, she became the target of hostile staff

CNA 2 reported concerns of verbal abuse towards the person

She said that when she advocated for residents,

she was disciplined for minor infractions or punished with schedule changes

Forced to Re-write Abuse Statements

Charts “conceal as much as they reveal”

– Timothy Diamond, author of *Making Grey Gold*, 1992

Slammed Down Into Wheelchair

(California, May 16, 2024)

A woman living with **Alzheimer's disease /** Described as "fall risk"

LVN 1 witnessed:

Around 6pm, she was sitting in her wheelchair in the hallway

She stood up. CNA 1 helped her sit back down in her wheelchair

The woman stood up again and **CNA 1 yanked her down into her wheelchair**

CNA 1 began yelling at the woman and then poked her in the cheek.

(Cont.)

The woman then swatted CNA 1's hand away from her face

CNA 1 **smacked** the woman's **hand**

The woman stood up again

CNA 1 grabbed the woman by her pants and **slammed her back down in her wheelchair**

The woman **yelped out in pain** / Surveyor: "**Causing her to cry out**"

LVN 2 said the woman was "**hyperventilating** and **visibly shaking**"

LVN 1 stated she told CNA 1 to stop because her actions were abusive.

(Cont.)

LVN 1 then called Nurse Consultant and Administrator (ADM) to report the abuse she had witnessed.

LVN 1 submitted a written statement to ADM about the abuse incident.

LVN 1 stated **the ADM told her to take out the part where CNA 1 poked the woman in the cheek and smacked her in the hand because it made CNA 1 look bad**.

LVN 1 stated **she then re-wrote her statement because she was afraid of being retaliated against by ADM**.

The Surveyor issued F600 at “Minimal Harm or Potential for Actual Harm” and **F610** at “**Immediate Jeopardy**”

H E C FORUM
2002; 14(3):224-234.

TOUGH SPOT

CONCEALING ACCIDENTAL NURSING HOME DEATHS

STEVEN H. MILES, M.D.

https://pubmed.ncbi.nlm.nih.gov/12405042/

LPN's License at Risk

(Miles, 2002)

An LPN found a woman trapped between the mattress and bedrails. She died.

The DON told the LPN not to record the entrapment in the rails.

After speaking with the Administrator…

The DON warned the LPN that her license was at risk if she did not chart as directed.

After the LPN refused to tell the family that she died in her sleep, she overheard the Charge Nurse tell her daughter she died peacefully. She later told her that her mother had simply stopped breathing.

The Charge Nurse told the aides not to discuss this accident with other staff.

(Cont.)

The police received **anonymous tip** that she suffocated or strangled.

As the family assembled for the funeral, the Medical Examiner demanded the body for an autopsy.

It confirmed death by asphyxiation (Suffocation).

The family sued the nursing home.

Retracting Abuse Statements

Pillow Pressed Over Head for 10 Seconds

(Michigan, February 1, 2021)

Resident with **moderate impaired cognition**

Did not want to be changed but was changed anyway

Became “combative” and called the CNA with racial names...

The CNA pressed a pillow over his/her head for 10 sec while making racial slurs to him/her

Witness CNA Trainee 1 was “pretty shaken up” by what she saw & **reported it to administration**

(Cont.)

While in a locker room…

The CNA perpetrator told the 3 CNA Trainees (witnesses) that they need to say that while rolling the resident, his/her head got pushed up against the pillow...

After being questioned about the incident by the DON, **CNA Trainee 1 felt intimidated.**

In fear of retaliation from the CNA perpetrator, she retracted her statement

She quit her job after her shift ended...

Summary

Employees' fear of retaliation often resulted in lack of or delays in reporting and investigation of rights violations, poor care, and mistreatment.

Victims left without assessment of harm and protection as perpetrators continued to have access to them

Neglect, abuse, and thefts continued…

Staff fear of retaliation contributes to:

Underestimation of abuse and neglect

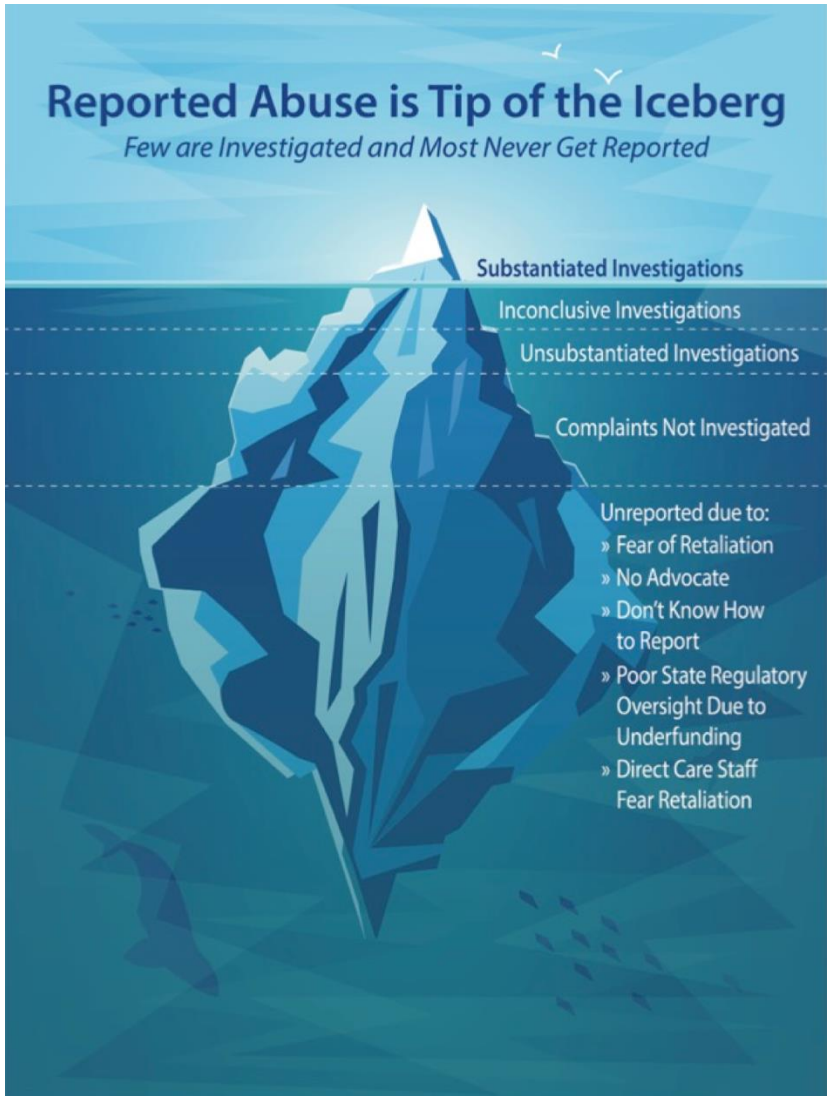


Image credit: Elder Voice Advocates

Summary of Mistreatment Types

- Ignoring requests (that abusive aide leave bedroom, watch TV, cup of juice)
- Forced to do things against their will (to get out of bed)
- Dangerous staffing levels (ants crawling on a woman)
- Neglect of care (lying in feces and urine for hours, infected pressure ulcers)
- Leaving the building unattended and falling
- Verbal and mental abuse (made fun of, yelled at, cursed, harassment and taunting)
- Encouragement to self-harm (to bang head in wall)

Summary of Mistreatment Types (Cont.)

- **Physical abuse** (pushed, slapped, punched, nose twist, hair pull, kicked, choke hold, pillow pressed over head, slamming cloth over mouth and holding it for a minute, and “waterboarding”) / **Several incidents were physically injurious**
- Abusive physical restraints
- Threats of violence
- Sexual abuse (inappropriate kissing, alleged oral sex, res-to-res sexual incidents)
- Allegation of misappropriation of personal funds
- Theft of opioid pain meds
- Records’ falsification / Instructions to fabricate evidence

Summary
Consequences on Employees

- Feeling intimidated
- Distress and fear (scared, terrified) of retaliation / Many asked to remain anonymous
- Experienced **excruciating dilemma** as to whether to report mistreatment
- Fear of losing their jobs / Threats of being fired / Being fired / Quitting their jobs
- Labeled as a “troublemaker” to the point you either got fired or quit
- Being disciplined for advocating for residents
- Making your work more difficult (the nurse “rides you”)
- Targeted by hostile staff (cold shoulder; sarcastic/rude comments; yelled at near peers)
- Punished with schedule changes (multiple shifts taken away from a nurse)
- Forced to re-write witness statements (downplaying severity and harm)
- Retracting abuse reports

Summary
Consequences on Employees

- Feeling powerless to protect vulnerable residents (Experiencing anxiety and fear for residents' safety)
- Feeling hopeless
- Learned helplessness (discontinuing to voice care concerns)

Quote

“We want to be listened to and taken seriously about our concerns.”

“We want to be worked with on solutions to make it a better place for staff to work in, so these residents have a better place to live in.”

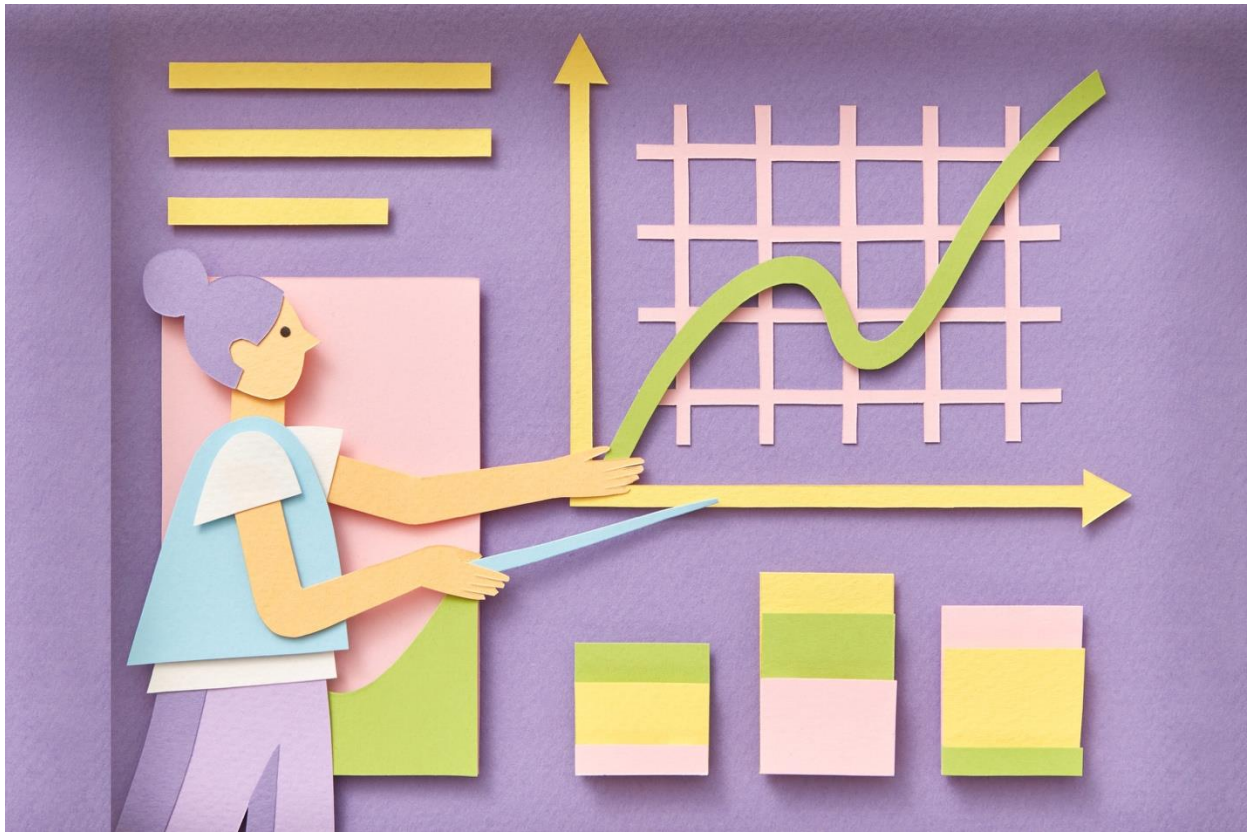
– Aide in a NH with poor staffing levels

Quote

“We have to find our angel…
that person that will always be there for us,
our ‘ride or die’ type of person.”

– Ombudsman representative

The Empirical Case



Study in Hospitals

Anonymous survey

527 staff members

(Including nurses, nurse aides, physicians, others)

Findings

Higher levels of staff fear of retaliation was related to lower overall patient safety

Source: Layne et al. (2019). Negative behaviors among healthcare professionals: Relationship with patient safety. Healthcare: 7(1), 23. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6473815/

Study I

Nursing Homes

4,000 Administrators and DONs of nursing homes

Consensus managers

=

“Leaders who solicit, and act upon, the most input from their staff”

Findings

This leadership style had a strong association with better quality of care

Source: Castle & Decker (2011):
https://pubmed.ncbi.nlm.nih.gov/21719632/

Study II

Nursing Homes

Survey among 2,900 Administrators

Findings

Being an Administrator who is a **“consensus manager”**

was associated with the **lowest turnover levels**

(44% for nurse aides, 7% for RNs, & 3% for LPNs)

Vs.

Being a “Shareholder manager” was associated with the highest turnover levels

(168% for nurse aides, 32% for RNs, and 56% for LPNs).

Source: Donaghue et al. (2009): https://pubmed.ncbi.nlm.nih.gov/19363012/

A study “The Courage to Speak Out” on Fear of Retaliation among RNs in Hospitals

Concluded

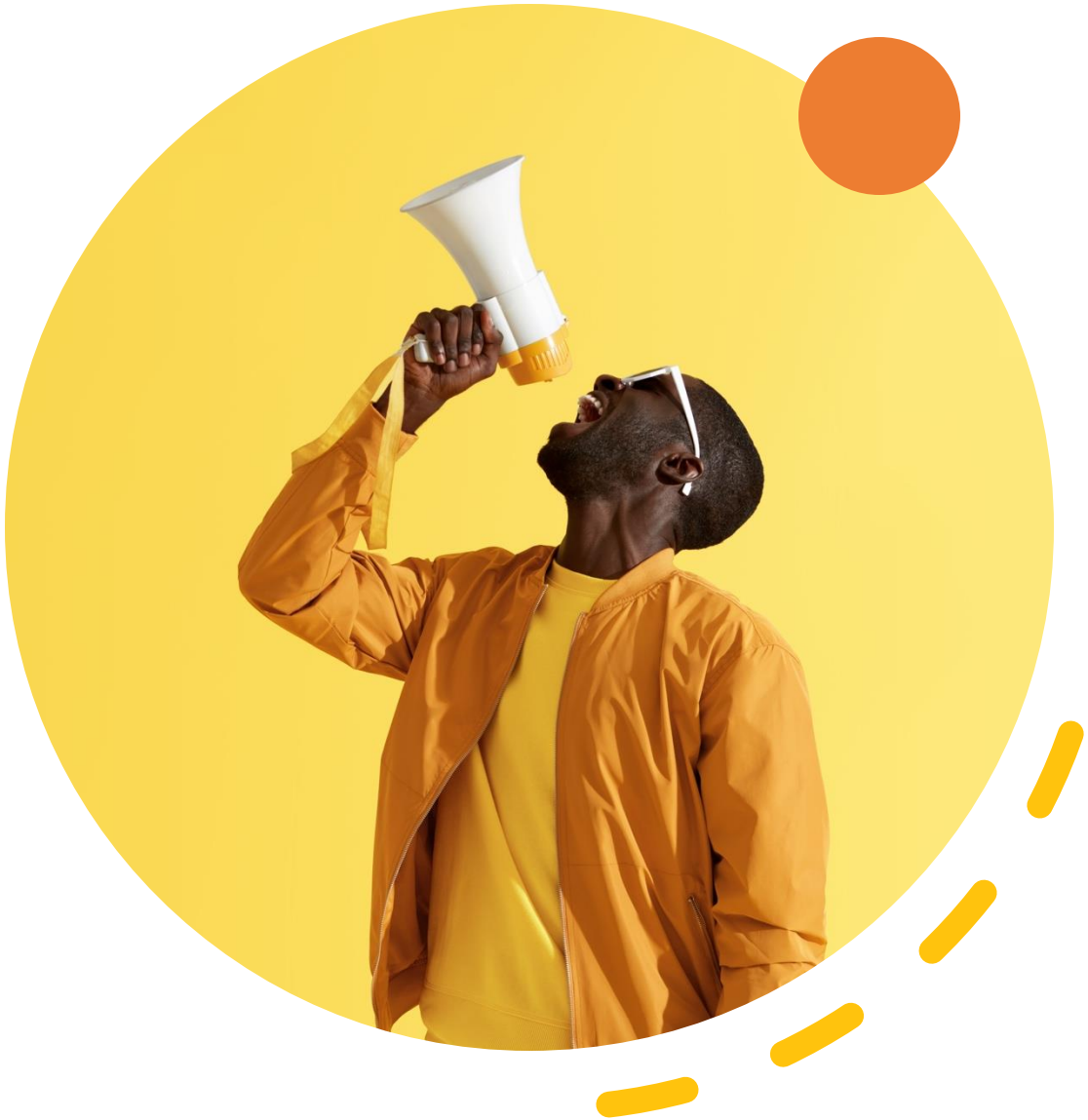
“**Nursing leadership’s ability to facilitate a culture of safety** by proactively addressing unsafe practices **fosters** a level of **comfort for** patient **advocacy** and willingness to report issues.”

“**Organizations need to create supportive workplace environment** whereby, through collective input and leadership, reporting protocols are in place that **empower RNs to report unsafe conditions**.”

Source: https://onlinelibrary.wiley.com/doi/10.1111/jonm.12789

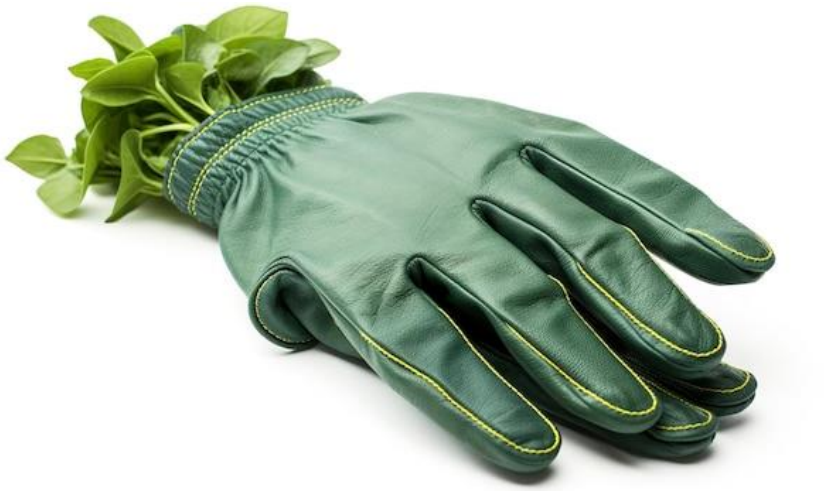
Practical Implications

- Break the silence
- Raise awareness to this phenomenon
- Empower employees to speak up
- All employees must be free from fear of retaliation when voicing concerns about right violations, poor care, and mistreatment
- The quality of care can only be as good as the extent of listening to and acting upon staff concerns



Educational Resources Needed

- Fact Sheet
- Infographic
- Educational Film
- Documentary Film



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Consumer Voice? National Center on Elder Abuse?

LTC Ombudsman Program? PHI? Unions? LTC Trade Associations?

Who is willing to fund it?
~~~

Practical Implications

- Ensure all employees know their rights
- Ensure care homes know their responsibilities
- Whistleblowers protections (Polices & Procedures)
- Educate providers / staff about potential consequences
- “It starts from the top” – Owners, ADMs, Abuse Coordinator, DON
- Zero tolerance policy
- Mandatory reporter accountability
- Social worker and psychologist role / HR role
- Open communication / Teamwork
- Trust and Support vs. Hostile and bullying environment
- Culture of learning → Culture of Safety (Staff and Residents)
- Mechanisms for identifying and addressing staff concerns
- Ombudsman role
- Union role (SEIU, AFSCME, National Nurses United)
- Strengthen CMS / SSA understanding, oversight, and enforcement

Employee Rights

Post in Central Locations

- As a mandated reporter
- As reporters of a crime against a resident / The Elder Justice Act (part of Patient Protection & ACA)
- To be free from retaliation and reprisal when reporting abuse
- The National Labor Relations Act

Locations:

- Staff break room
- Hallway by HR Office
- Bulletin board in front lobby

Size and type requirements:

“Should be no less than the minimum required for any other required employment-related signs.”

Ask Employees

Do you feel safe reporting care concerns?

Are you reluctant or afraid to report abuse and neglect?

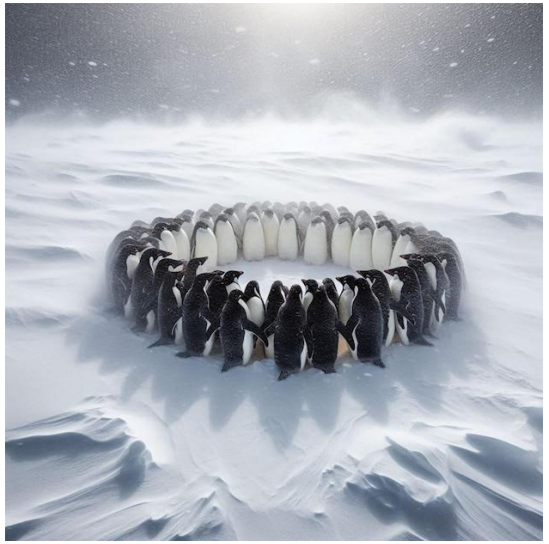
~~~

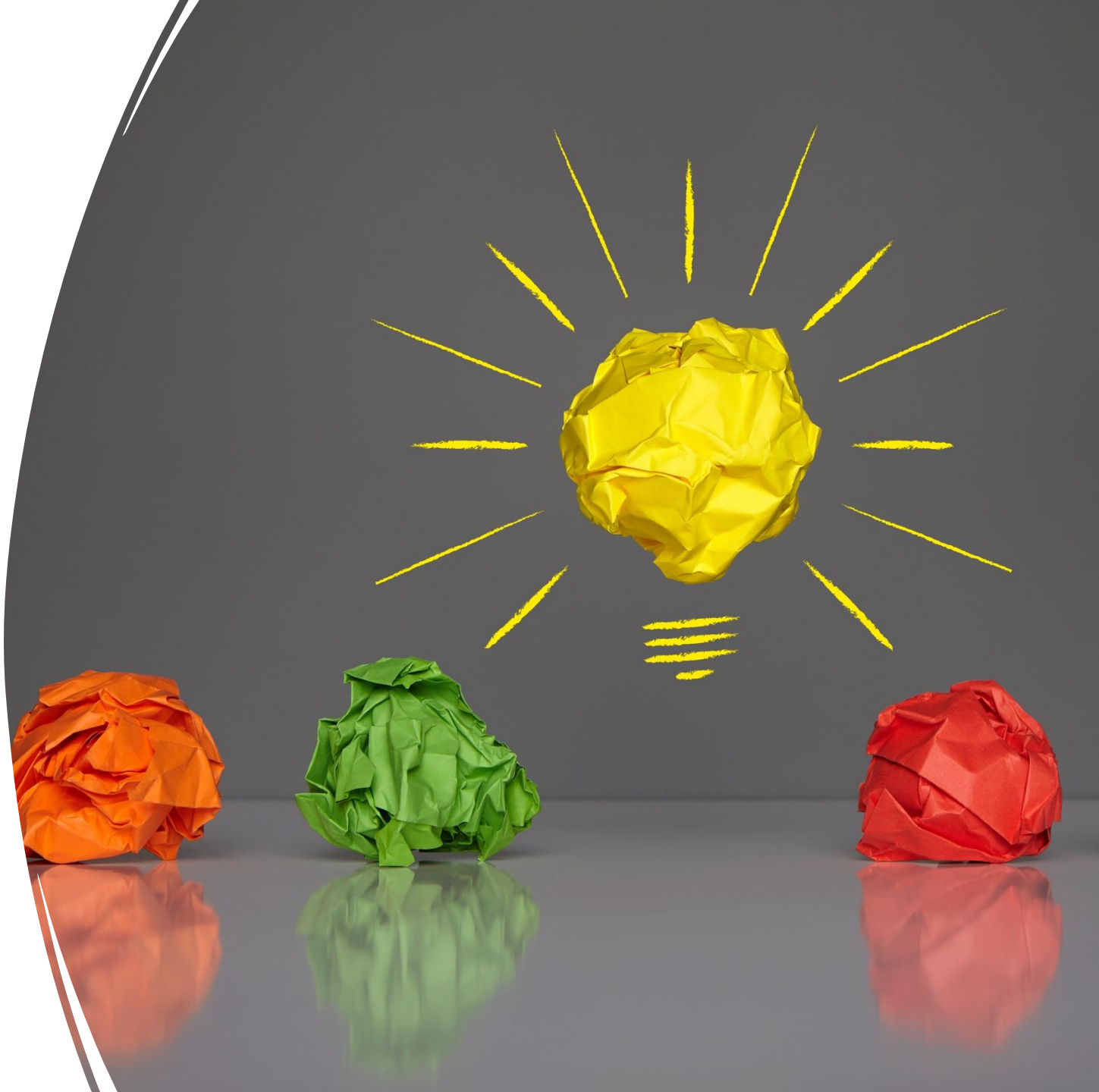
“Ask staff if they are confident in reporting compliance matters without fear of retaliation” – CMS 2022
~~~

There are Resident and Family Councils

What about private staff-run

Staff Councils?





Protections from Retaliation Against Employees

The nursing home must have **written procedures** that must include:

Assuring that reporters are free from retaliation or reprisal.

"**To encourage reporting of reasonable suspicions of a crime**, facilities should **develop and implement policies and procedures** that promote a **culture of safety** and **open communication** in the work environment.

This may be accomplished through **prohibiting retaliation against an employee** who reports a suspicion of a crime."

Source: CMS State Operations Manual, 10.21.22

F608

Requirements for Reporting Reasonable Suspicion of a Crime

"**The facility may not retaliate against an individual who lawfully reports a reasonable suspicion of a crime** under section 1150B of the Social Security Act."

"LTC facilities are also subject to **civil money penalty and exclusion sanctions for retaliating against any employee who makes a lawful report**, causes a lawful report to be made, or for taking steps in furtherance of making a lawful report pursuant to the statute."

Conspicuously **post,** in an appropriate location, **a notice** for its employees **specifying the employees' rights**, including the **right to file a complaint under this statute.** The notice must include a statement that **an employee may file a complaint with the State Agency against a LTC facility that retaliates against an employee** as specified above, as well as include information with respect to the manner of filing such a complaint.

CMS Memo 2012: https://tinyurl.com/m5umf73s

Affordable Care Act

Effective implementation of section 1150B of the Act may promote a timely response to potential crimes, thereby protecting residents of such facilities. The statute requires that:

- Covered individuals timely report any reasonable suspicion of a crime against a resident of, or who is receiving care from, a LTC facility;
- If the events that cause the reasonable suspicion result in serious bodily injury, the report must be made immediately after forming the suspicion (but not later than two hours after forming the suspicion). Otherwise, the report must be made not later than 24 hours after forming the suspicion;
- Covered individuals are subject to civil money penalty and exclusion sanctions for failure to meet the reporting obligations of the statute;
- LTC facilities are ineligible to receive Federal funds for any period that they employ an individual classified as an excluded individual under sections 1150B(c)(1)(B) or 1150B(c)(2)(B) of the Act; and
- LTC facilities are also subject to civil money penalty and exclusion sanctions for retaliating against any employee who makes a lawful report, causes a lawful report to be made, or for taking steps in furtherance of making a lawful report pursuant to the statute.

Source: CMS 2011 Memo: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility

A “Covered Individual”

Defined at section 1150B(a)(3) of the Act as each individual of the nursing home who is:

- **An owner**
- **Operator**
- **Employee**
- **Manager**
- **Agent**
- **Contractor**

F609
Reporting of Alleged Violations

In response to allegations of abuse, neglect, exploitation, or mistreatment, **the nursing home must:**

§483.12(c)(1)

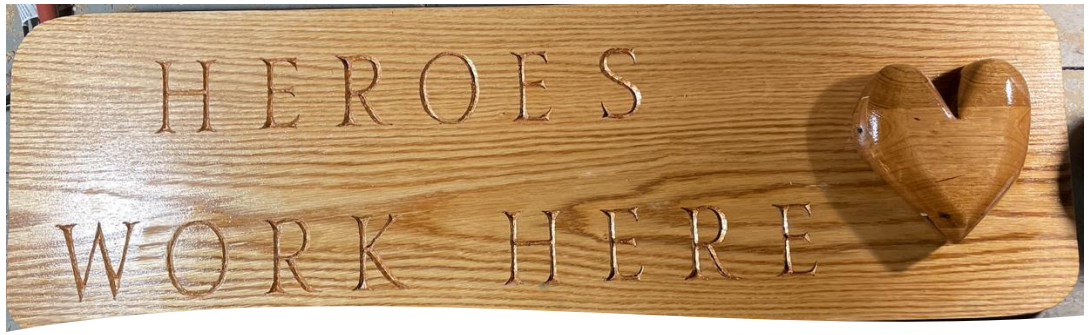
Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, **are reported immediately...** [SPECIFIC TIME FRAMES REQUIRED]

§483.12(c)(4)

Report the results of all investigations to the administrator or his or her designated representative **and** to other officials in accordance with State law, including to **the State Survey Agency,** within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Dignity

“The quality or state of being worthy of honor and respect”

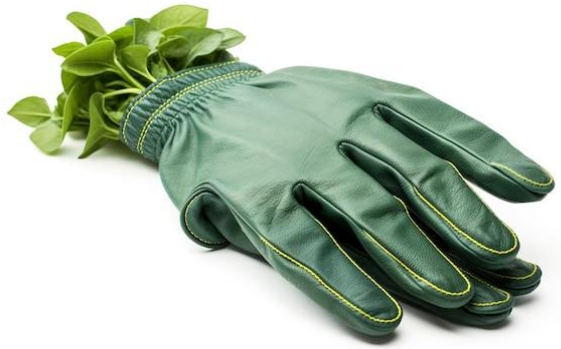


Woodcarver: Eilon Caspi

Next Steps

Need funding for reports on:

- Staff fear of retaliation



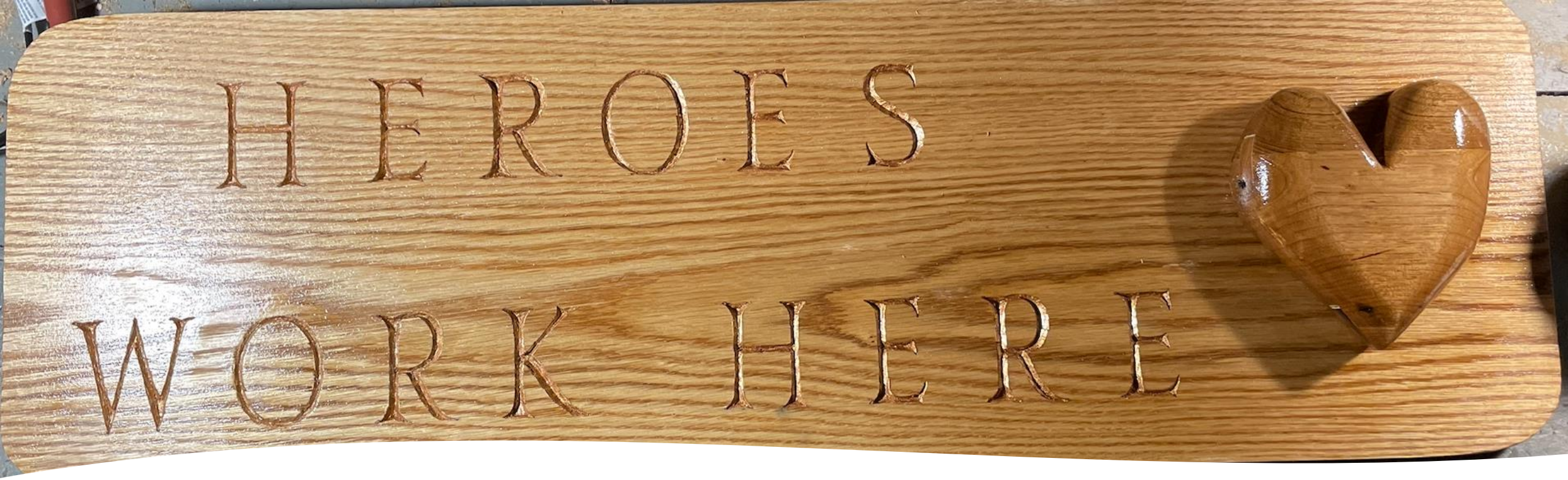
- Family fear of retaliation
- Concealment of evidence related to abuse and neglect

Thank you!

Q&A

Care employees should never fear retaliation

Extra Slides



Certified Nursing Assistants: The Foundation

MA Alzheimer's Association
Annual Meeting. 5.14.08

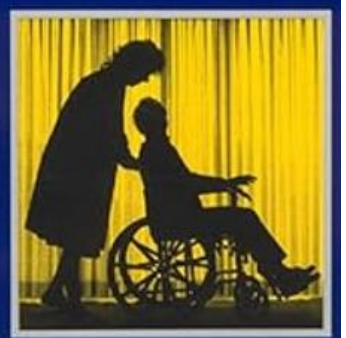
"Certified Nurses Assistants (CNAs) are **the foundation** of the Caregiving industry. I use the word foundation because just like putting up a building, **first you have a strong foundation or else the building will not stand up**. The CNAs are **the backbone** of the organization because, as caregivers, we are with the residents 24 hours a day, seven days a week, from the time they [are] awake to the time they go to sleep. We know each and every one of our residents intimately.

We love working with the residents, it gives us joy that we can assist them in the evening of their lives. We truly care for the residents and that honest care shows in the work we do.

In closing, while we do not hold a MD or PhD, **CNAs are equally as important** because we are the foundation and bridge between the residents, family, and management."

MAKING GRAY GOLD

NARRATIVES OF NURSING HOME CARE



FOREWORD BY CATHARINE R. STIMPSON

TIMOTHY DIAMOND

A study by Black (2011) “Tragedy into Policy”

Among 564 Nevada RNs found

34% were aware of conditions that may have caused patient harm but had not reported it

The most common reasons identified for failing to report issues were:

- Fear of retaliation (44%)
- A belief that nothing would prevail from the reports (38%)

Source: https://pubmed.ncbi.nlm.nih.gov/21613917/

Quote

"**The** complexity of **effort to alter records** and **the** essential **intimidation to secure silence of** the frontline clinical **staff create the evidence** and forces **by which an attempt to conceal** a lethal accident **is discovered**."

"These situations are extremely difficult for **nurses aides** and front line nurses. **They are often intimidated**, fired, and disparaged. **Resolution of these events should also address the needs of these victimized staff.**"

– Steven Miles M.D. 2002

Poor Staffing Levels

Dangerous Staffing Levels

(Florida, September 14, 2020)

The NH failed to ensure adequate staffing of nurses and CNAs to provide ordered care and services to residents

Nurse 1 stated there is not enough staffing to care for residents properly:

Two nights prior 2 CNAs had 26 residents each

”They are total care and incontinent, need to be turned and repositioned, and **they are lying in their feces and urine**”

Staff 2 stated: “The ones who suffer are the residents, **they get pressure ulcers, they end up infected**”

(Cont.)

Staff 2 added: “Families complain and management tells staff not to tell them the caseload or that they are short staffed, but that is what is causing most of the issues”

“Management never address the underlying issue of staffing ratios”

“**Many other staff feel the same way but are afraid to say anything for fear of retaliation**”

Ongoing Low Staffing Levels

(California, May 24 2024)

Slow Call light response time on “all shifts”

Low Frequency of shower assistance

Regarding Shower Team (4-5 vs. 1), CNA B said: “Forget that. That’s nonexistent.”

RN A: Staff “call offs happen often”

CNA C said the NH “felt like a roller coaster”

Nursing Assistant A: The NH ”is chaotic most of the time.”

(Cont.)

CNA B told Surveyor she spoke to management about short staffing issues.

She said she is **fearful of retaliation** and added:

“There is a culture of retaliation in the facility.”

Neglect

LPN Not Providing Tracheal Suctioning

(Florida, March 5, 2021)

A man "**alert and oriented**" with history of respiratory failure

Struggles with anxiety related to tracheal suctioning

He **fears he will choke** in his sputum (secreted mucus) **and die**

Responsible party: "It has been very difficult **especially nights and weekends**. He calls me because **he feels like he is suffocating**."

(Cont.)

LPN 1 stated that there are times when LPN 2 does doesn't suction him

One night "she was nowhere to be found"

When asked if she had reported these concerns, LPN 1 said:

"There was some nepotism going on and **she did not want retaliation."**

Verbal Abuse

“You need to shut up”

(Texas, May 19, 2023)

A woman living with **quadriplegia**

CNA A said on May 1 2023 around 7am, MA B came down the hallway talking loudly

CNA A told him to lower his voice as residents were still sleeping

The woman yelled from her bedroom:
“You need to be quiet. You are too loud. I am still trying to sleep.”

MA B: “You need to shut your door then.”

Woman: “This is my house and if I want my door open, I can have it.”

MA B walked into her bedroom and told her: “You need to shut up” and left her bedroom

(Cont.)

CNA A stated she knew she was supposed to report it to the Administrator, but she **did not report it** to anyone **because she was afraid of** the previous administration **retaliating against her** and **she would lose her job**.

She added previous administration did not seem to take concerns seriously

~~~

MA B worked for another 7 days and then verbally abused the woman again

In an interview, the resident stated that on May 12 2023: "**I called the state** because I got tired of telling the previous administration about my concerns and they never listened."

The SSA investigation resulted in **F600 and F609** issued – both at the "**Immediate Jeopardy**" level
~~~

Physical Abuse

Verbal and Physical Abuse of Two Residents

(Iowa, September 11, 2024)

A CNA (Staff U) verbally and physically abused a woman and a man – both with **severe cognitive impairment**

Staff U stood the woman up next to the sink and changed her.

She would not sit down so **Staff U forcefully pushed her down in the wheelchair**.

A CNA (Staff G) stated she had heard Staff U speaking "very verbally abusive to residents."

She felt Staff U **would have retaliated** if she told the nurses or administration.

CNA (Staff L) reported multiple times to the ADM about the way Staff U spoke to the residents.

She **worried about retaliation** at work.

The Surveyor issued **F600, F609,** and **F610** – all at "**Immediate Jeopardy**"

Slapped in the Face

(North Dakota, October 15, 2024)

A person with **Alzheimer's Disease**

CNA 1 and CNA 3 provided evening cares to the person

The person yelled at CNA 3 to "Get out" and spit at her

CNA 3 slap the resident **in the face** and **cover her/his head with a blanket**.

CNA 3 said: "This is how you calm [resident] down"

When CNA 3 pulled the blanket down, the person spit

CNA 3 slap her/him again, made faces, and stuck her/his tongue out at her/him

(Cont.)

CNA 1 reported being shocked and scared during the abuse incident

S/he feared retaliation from CNA 3

CNA 1 confirmed **not reporting it until the next day**

Surveyor: The staff failure “to immediately report a witnessed incident of staff to resident abuse to the appropriate supervisor delayed the removal of the accused abuser, the start of the facility investigation, and assessment of the resident for injury”

The Surveyor issued **F600** at “**Actual Harm**”

Pushed into Wall

(New York, January 7, 2025)

A person with **Parkinson's Disease** and **Moderate cognitive impairment**

Before dinner, they approached LPN 1 and requested their anxiety meds

Another resident (fully alert and oriented) said LPN 1 told the person:
"I told you it is not time, and I am sick of this [expletive]"

LPN 1 pushed the person into the wall with their head hitting it

CNA 3 said the resident hit the wall "**like a basketball**." /
CNA 2 started crying / CNA 3 was "initially shocked"

The resident's "eyes teared up" and they were "shaken up."
They suffered a **fractured nose** and a nosebleed

(Cont.)

While CNA 2 and CNA 3 were afraid of retaliation,

they called the DON and reported the incident.

LPN 1 stated they were “unaware of what happened”

LPN 1 stated the resident “asked for medication all day long”

The LPN was suspended and later their employment was terminated

Police were called and **arrested** LPN 1

Charged with assault and endangering the welfare of a vulnerable adult

Pulling Woman's Hair

(Colorado, September 21, 2023)

A woman "who was able to appropriately respond to questions" said:

CNA 1 came to her bedroom, "grabbed her left arm, **shook her body,** & **pulled her hair**, which hurt the back of her head."

Staff A who **wished to remain anonymous reported** that CNA 1 was observed **screaming, cursing, and yelling** at the woman and a day or two later CNA 1 was observed **pulling the woman's hair and laughing about it**.

The staff said **this was all reported to the previous facility administration** and all that happened was that CNA 1 was moved to a different unit where the CNA would no longer be working with the resident."

Staff B who wished to remain anonymous asked about their rights not to be retaliated against when reporting a crime.

The staff member was **fearful** that the facility was going to proceed with **termination**.

LVN's Physical Abuse

(California, February 11, 2020)

Resident 2 – A man who is **severely cognitively impaired**

A CNA called for help in his bedroom

An RN entered and saw resident 2 standing by Resident 4's bed

Resident 2 asked CNA to get Resident 4 out of his bedroom (R4 lived in that room)

The CNA saw a jar of water thrown on Resident 4's bed

An **LVN** grabbed resident 2's forearms and **pushed him down to his bed**.

Resident 2 started kicking so LVN **put her knee on his abdomen until he stopped**

When the LVN leg go, RN saw **the skin** on resident 2 was **torn and bleeding**

(Cont.)

The RN “seemed shocked” and was “scared and shaking”

She did not report the incident because she was scared of being retaliated against by the LVN.

The next morning, the RN spoke with a friend who told her she had to report it... so she did…

“You see, this is intimidation I am talking about”

(Illinois, December 11, 2022)

A person who is cognitively intact living with **paraplegia**
(Paralysis of the lower body)

The person rolled her/his wheelchair to the nurse’s station to ask for medication for spasm

The LPN yelled “I just got here” and said they’ll give it to her/him later

The person attempted to get into the freight elevator
(which is for staff, outside vendors, and ambulance use only)

The LPN started pulling the person from the elevator doors.

(Cont.)

When the person resisted, the LPN physically grabbed and **punched her/him in the face**, causing a bleeding cut.

A CNA who witnessed it said she **changed her statement** during the NH's investigation **because she was afraid of retaliation** by the NH **for telling the truth**.

During a surveyor interview, the DON asked the CNA: "Which one is your statement, you keep changing your statement."

CNA: "**You see, this is the intimidation I am talking about, and I might lose my job for telling the truth.**"

When the surveyor asked the DON not to interrupt the interview, **the CNA said that after the incident, s/he told the DON that s/he had seen the LPN hit the person on the face and that s/he has a bleeding scratch on the nose.**

The surveyor issued F600 at "Actual Harm"

“Oh my God, you hit me in my mouth”

(Iowa, October 3, 2023)

A woman with **dementia** and **severe cognitive impairment**

Staff A witnessed Staff B grab the woman’s hands pretty quick, which triggered her

The woman called Staff B: “The devil”

Staff B pushed her “hands into her face causing her to hit herself”

The woman yelled: “Oh my God, you hit me in my mouth”

Staff B told her she “hit herself”

Staff A got Staff B out of there

(Cont.)

Staff A stated she **wasn't sure who to report it to since Staff B's spouse was the supervisor**

Staff A later acknowledged **she didn't report this incident right away**

She said **there was fear of retaliation** with reporting, and she didn't know if they would do anything about it anyway, since they changed another report:

When another resident was "flicked" in the ear,

"they changed it from "flicked" him to "brushed" his ear when she was getting him ready."

Reflexive Retaliation

(Michigan, January 29, 2021)

A woman with **moderate cognitive impairment**

At approx. 8:45am, as she entered another resident's bedroom,
RN followed her into the bedroom, approached her from behind, and placed both of her hands on the back of her shoulders. It startled her.

The RN used her hands to guide her out of that bedroom.

RN yelled at her: "None of your things are in there. Go back to your room."

(Cont.)

Things began to “get heated” between them.

The woman yelled at the RN a [OBSCENITY / “The B-word”] / “Both their voices went up”

“Things began to escalate”

The woman began to hit the RN in the face

The RN then **struck the woman in the face twice**

The RN then grabbed her jaw with both of her hands and told her:
“You are not going to treat me that way.”

The woman “cried and was upset by the event.”

(Cont.)

The CNA who witnessed it waited until approx. 10:45am to report it to the DON.

When asked why she waited 2 hours to report it, the CNA stated **she was initially hesitant to report things to the administration for fear of retaliation.**

The CNA stated that **she had reported a staff member's actions in the past and somehow her name got out there** for reporting them **and** felt that the **staff had retaliated against her for speaking up** for the resident's safety.

Delay in Reporting Abusive Physical Restraint

(New Jersey, October 26, 2020)

Resident with **severe cognitive impairment** and history of stroke

S/he had a habit of kicking the left leg off the side of the bed but doesn't try to get out of bed

A CNA tied the resident's hospital gown at the back of his/her knees

Staff members **were aware** of the abuse **but failed to report it to Supervisor or ADM**

Next day: The CNA again tied the resident up with a gown knotted behind the knees

tied in back (causing skin tear and bruising to both shins)

(Cont.)

Four staff members observed it including an RN but **failed to report it immediately**

The RN waited until the next day to report it because she wanted to remain anonymous and **keep it confidential so there would not be any retaliation against her.**

Sexual Abuse

Inappropriate Kissing

(Montana, May 31, 2018)

Residents 1-3 were **severely cognitively impaired** / They lacked cognitive ability to consent to being kissed

The NH failed to:

- Protect the residents from **a staffer who kissed residents on the face, mouth, and forehead**.
- **Ensure an environment where staff feel safe to report alleged violations of abuse w/o fear of reprisal for Residents 1-3**.

One staffer observed the kissing of residents 1-3.

She wanted to report it immediately but was afraid of retaliation from the perpetrator and two other staff members

She eventually reported it, but the kissing continued.

She reported it to the Ombudsman but was told “that was not not my area.”

After that, she did not feel anyone would listen to her concerns.

(Cont.)

Another staff witnessed the kissing ”on several occasions, almost every day.”

She reported it immediately but was fearful of retaliation from the perpetrator and two other staff members.

Resident's Attempt to Have Oral Sex with Another

(Ohio, May 20, 2024)

A **woman** (R3) with Schizoaffective Disorder, Bipolar disorder / **Impaired cognition**

A **man** living with **dementia** (R2)

Fearing retaliation from the NH, an employee **anonymously called the police** and reported:

On April 25, 2024

R2 "placed his genitals in R3's face in attempt to have oral sex in the common area."

On April 29, 2024, R2 was "caught by staff with his hands down Resident 3's pants."

(Cont.)

Surveyor: "**A reasonable person** in the resident's position **would** potentially **have experienced** severe psychosocial harm such as dehumanization as a negative outcome resulting from having been **treated as an inanimate object** or as having no emotions or feelings, and/or humiliation as a result of a feeling of shame due to being embarrassed, disgraced, or depreciated by being subjected to sexual abuse / assault."

LPN said: After the April 29th incident, R3 "was really upset and shaking" and "looked scared" and sat with staff until she calmed down."

Surveyor: R3 "who used to attend many activities and was social now self-isolates in her room, even to eat meals and has expressed feeling "scared to come out of her bedroom and fearful of R2."

Surveyor investigated and issued **F600** at "**Immediate Jeopardy**" & F609 at "Minimal Harm or Potential for Actual Harm"

LVN Not Charting Witnessed Male-to-Male Guided Masturbating

(Texas, August 24, 2021)

Resident 8 (man) was **cognitively intact** / Resident 12 (man) was **severely cognitively impaired**

An LVN and physician entered resident 8's bedroom...

They found **Resident 8 guiding Resident 12 in masturbating Resident 8's penis**

When the LVN notified former DON, she seemed giddy as if it was funny for her

The Former DON instructed LVN not to chart it

The LVN did not notify any family members at the direction of former DON and **did not notify the ADM**

The witnessing physician said: "**And that is how you keep state out of your building**."

(Cont.)

LVN said she disagreed with the former DON but **due to previous circumstances,**

she followed her direction and did not chart it for fear of retaliation, adding:

The former DON had crossed her before and had multiple shifts taken away from her

She needed the shifts and therefore followed her direction even though she knew it was not right.

Misappropriation of Personal Funds

Allegation of Misappropriation of Personal Funds

(Michigan, December 15, 2021)

A man who is **cognitively intact** (BIMS score 14/15)

He was about to be transferred from the hospital to a nursing home

He asked if his belongings (clothes and wallet) could be obtained from his apartment prior to being transferred to the nursing home.

During the course of gathering the items from his apartment, Social Services Director saw the Administrator remove $100 bills from a drawer and “place it in her back pocket of her pants.”

The SSD stated the Administrator did not give the money in her pocket to the resident.

(Cont.)

The following day, SSD asked the ADM about the money and the ADM told her it was going to be put in a trust.

The money was not put in a trust.

When asked about the location of the money, the ADM said it was “in the conference room.”

But the money in the conference room (Around $300) was in $50 bills.

The ADM confirmed she didn’t count the money on the day of the admission.

“**When asked why SSD did not report this allegation sooner, SSD stated she was afraid of retaliation**”

Surveyor: The NH failed to follow its policy and procedures to obtain resident funds and prevent misappropriation of his personal funds.

The deficient practice resulted in the potential for misappropriation of the resident’s personal monies.

Fear of Administration

Fear of Retaliation From Administrator and Abusive DON

(Alabama, November 19, 2020)

A man who is **cognitively intact** lived with PTSD

The DON was witnessed by multiple staff to verbally and physically abuse him at 8:00 AM and 3:30 PM

The DON **screamed at him to get back into his bedroom** because he was on isolation

The DON **pushed him onto the bed**, yelled at him, and then **administered him [medication] injection**

He was crying, begging the DON to stop yelling: “Why are you doing this to me?”

DON: “Cut your crap out, you are spreading germs throughout the facility. I don’t have time for this.”

(Cont.)

After the incident, the man told a CNA:

He wanted to die and didn't want to be in the NH if he is treated like that

At the hospital, he told an RN he didn't want to go back to the NH because the DON had hit him

Another CNA stated **all the staff are scared, terrified, and intimidated by the Administrator**

The CNA added **she knows she would lose her job if they speak with the State Surveyors**

The DON's employment was terminated → Staff felt more comfortable with the new DON

Record Falsification

Pressure to Falsify Insulin Records

(Pennsylvania, September 21, 2021)

An employee who **wished to remain anonymous for fear of retribution and retaliation** by the nursing home told state Surveyor:

Was told by the Assistant DON that if staff were to give insulin late, they have to go into the e-records, **falsify documentation**, and change the time the insulin was given to reflect what the order indicates (to avoid non-compliance).

She stated she won't falsify documentation and risk her nursing license.

She added that the nursing staff just follow along with the instruction.

Fear of the Board of Directors

(Washington State, July 27, 2022)

The Board of Directors (BoD) acted with disregard to the well-being of the residents

It did not take effective action to address staffing shortage

Surveyor:

"This impacted all residents and contributed to multiple clinical failures at the harm level"

Staff members were:

"Afraid, had distrust and **job insecurity** as a result of the interactions with the BoD"

(Cont.)

Staff members **wished to remain anonymous**:

"The Board doesn't take any suggestions we have into consideration, and it is impacting the safety of the residents."

"**I am afraid to say anything, because the Board will retaliate**."

"We are kept in the dark and are afraid of the future."

"We love our residents and **the level of stress this is creating is enormous**."