STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X3) DATE SURVEY COMPLETED
	AL11953349	R 11/08/2018
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

0000 - Initial Comments

An unannounced revisit survey was conducted through at Lamplight Inn, an assisted living facility (license #5096) in Fort Myers, Florida.

This was a follow-up to the complaint survey completed on .

This revisit was conducted in conjunction with a new complaint survey.

The following is description of the deficiencies found at the time of this revisit.

0025 - Resident Care - Supervision - 429.26(7) FS; 58A-5.0182(1) FAC

Based on record review and Department of Children and Families (DCF) staff and facility staff interviews, the facility failed to ensure each resident received appropriate supervision to meet the resident's needs for 1 (Resident #1) of 3 residents with incomplete incident reports for . Failure to provide adequate supervision lead to the injuries of Resident #1 who was sent to the emergency room for treatment because of improper supervision by staff. Lack of proper investigation of residents' , allow other residents to be injured in the same way.
This deficiency remained uncorrected.

The findings included:

1. Review of a DCF report revealed a complaint that a resident's was not consistent with what actually occurred at the facility. The investigator verified the finding of "physical injury".

In an interview on at 1:50 p.m., DCF Investigator said Staff G was being verbally and physically aggressive with Resident #1 and forced him to the shower and as a result, the Resident #1 lost his balance and . She said according to witnesses the resident was pulled out of bed by his arms and , shoved into the bathroom where Staff G forcibly removed his clothing and proceeded to shove the resident into the shower. She said witness interviews indicated that Staff G was hitting the victim's to cause him to let go of the , bar in the shower and that the resident attempted to fight and grabbed a shower chair and , hitting his on the faucet in the shower. The investigator said that Staff G was fired from the facility and she has previous allegations with adults for physical injury and has a pattern of yelling at resident and being "rough." The DCF Investigator said that the Administrator was aware the investigation was for alleged physical and of Resident #1. The administrator did not suspend Staff G until she went and tried to talk to a

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resident witness after she had been told not to. The administrator at another facility had called this administrator and told her that Staff G was also under investigation at their facility for alleged .....

Record review revealed Resident #1 was admitted to the facility with diagnoses including ....., , and had precautions. The Health Assessment noted the resident needed supervision for bathing and was independent in ...., eating, self-care (grooming), toileting and transfers. Resident #1 was Spanish speaking and needed an interpreter to communicate with staff. The resident ..... and his son was Power of Attorney due to .....

An incident report noted Resident #1 in the shower on ..... at 9:30 a.m., and 3 staff members were present at the time. No investigation was done. These staff members were Medication Technician (Med Tech) Staff G, Resident Assistant ( ) Staff F, and Spanish-speaking Housekeeper Staff H. After the , the Administrator and above staff provided first aid. Licensed Practical Nurse (LPN) Staff E filled out the incident form. Review of service notes in Resident #1's chart noted (.....) at 9:45 a.m. the resident in the shower, hit his on the of a faucet handle and had a with a small about of ..... -1 was called and the resident was transported to hospital.

On at 9:33 a.m., the Administrator said that an investigation was not done because Resident #1 was taken to the hospital and did not come . She said she did not talk to any of the staff about it because she actually went to the shower that morning and helped by holding a towel to the ... of the resident's while the staff called -1. The Administrator said the staff told her that the resident backwards while they were trying to turn him in the shower which she took at ... value.

Record review revealed that Resident #1 returned to the facility from the hospital 7 hours later. The resident was discharged from the facility the next day upon family request.

On at 9:45 a.m., Housekeeper Staff H said on the day of Resident #1's she went to the room with Med Tech Staff G to help translate. Staff G went into the room, walked towards the resident's bed, and said with a big loud voice, "you're going to take a shower." She then pulled off his covers, grabbed him by his ..... and arms, and sat him upright. She then grabbed him, stood him up, and pulled down his underwear. She was not talking to him at that point. She said the resident started to fight and Staff G started to push him towards the bathroom. Staff H said she was talking to the resident in Spanish to be calm and let Staff G give him a shower. Staff H said when Staff G got the resident into the bathroom, she forcibly started taking off his shirt and pulling it over his .... The resident was very upset and trying to stop Staff G. She then pushed him into the shower and he was hanging on to the safety bar. She was yelling at him to let go and she took hold of his ... and turned on the water. Staff H said she did not know if the water was hot or but Staff G just sprayed the resident. Staff H said

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the resident tried to pick up the shower chair and he slipped and hitting his on the faucet. Staff H acknowledged that Staff G was being very rough with the resident and she felt it was wrong. Staff H said no one ever investigated or talked with her about the incident. When all the people came into the room after the , Staff G was the one who said what happened.

On at 10:00 a.m., Staff F said that on the day of Resident #1's , she went into Resident #1's room and told him that she was going to help give him a shower. She said that the resident indicated that he was agreeable to it, but when Staff G came into the room, the resident became very agitated and said he was not going to take a shower. Staff F said the resident knew some English but not much. Staff G said in a loud voice, "Oh yes, he is taking a shower," then uncovered him and pulled him by his to the side of the bed. Staff F said Staff G pulled down his underwear and forcibly tried to take off his shirt. She said Resident #1 was visibly upset. Staff G proceeded to push resident across the room towards the bathroom hanging on to his shirt and arm. Staff F said she told Staff G to stop and that the resident did not want a shower and to leave him be, but Staff G continued. Once Staff G had pushed the resident into the shower, she was trying to make him let go of the safety bar. She hit the of his with the shower and hose. Staff G continued to try to get his shirt off and then turned on the water without testing it to see if it was hot or . Staff F said the resident turned and tried to grab the shower chair but lost his balance and , hitting his on the faucet. Staff F said that the housekeeper called for help and many people came into the room. She said when people asked what happened, Staff G did all the talking. Staff F said that no one ever asked her what happened in private and no investigation was done until the DCF came. Staff F stated, "it is clear that the resident would not have and got hurt if she was not forcing him and being so rough with him."

On at 11:00 a.m., LPN Staff E said that she was called to Resident #1's room the day that he in the shower and his on the faucet. She said filled out the incident report according to what was told to her. LPN Staff E said she had many issues with Staff G, and she had to attend to many residents after staff G had taken care of them. The LPN said when Staff G worked in memory unit, there were many residents getting and needed the dressed. The LPN said it seemed to be a pattern, so she asked if Staff G could be moved out of the memory unit. After she was moved, there was not half as many . She said she often got reports from residents that Staff G was "rough" and she reported it to her supervisor, but nothing had been done. The LPN said that after the DCF was there looking into Resident #1's , Staff G went and tried to talk to one of the resident witnesses who reported overhearing all the yelling in the resident's room before the .

On at 11:30 a.m., the Administrator said that on the DCF investigator told her Staff G went and intimidating the resident who overheard yelling when Resident #1 , she put Staff G on suspension. Another facility director then told her on the phone that Staff G was also suspected in an

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case at her facility. The Administrator said she called Staff G up that day and fired her for not following "the policy on and Neglect."

Record reviews of 2 other residents (#89 and #90) who had in the facility showed the same pattern of incomplete incident reports and no evidence of follow-up investigation. Both residents were sent to the hospital after the and returned to the facility after evaluation of their injuries. Both residents were unable to be interviewed due to issues.

On at 12:10 p.m., LPN Staff E said that she fills out the incident report if she is called to provide some first aid, but she is not the one that investigates anything about the or issues that require an incident report.

2. Record review of staff documentation of monitoring residents several times a shift was incomplete and was not filled out the same way by different employees. Dates and/or times were not consistently present. Some staff recorded there initials and some staff put a time. No clear indication on how to fill out the form was found on the form and one of the forms was a different format than the rest. Documentation of the education to staff on the monitoring procedure to provide supervision and a safe environment was not available. Sign-in sheets were produced but there was no indication of what they were instructed to do.

On at 3:56 p.m. Med Tech Staff I said that when she comes in on night shift she is to take the midnight census (a list of all residents in the building) and go around and check on each one of her residents on her hall. She is to go in each room and see that they are there and if everything is OK. She said she was told to check a couple of times a night. Before she goes off duty in the morning, she is to wait until the day shift staff check to make sure all residents are accounted for. She was unsure if there was a place to record her activity, she was told to document on the midnight census.

On at 4:10 p.m. Med Tech Staff J said that when she comes in at 10:00 p.m. she is to take a copy of the midnight census and go to each of the residents' rooms on her hall and check on them to make sure they are in their room and that they are OK. She is to record on a sheet that is included in the medication administration record that she checks on her residents at least 3 times in the shift. She said that she is to write in the area for her shift and write the time that she has checked the room. She puts one time, like 10:00 p.m., meaning they are checked between p.m. She said she could not look at them all at the same time.

On at 4:15 p.m. the Administrator acknowledged that the monitoring forms were not being filled out correctly or consistently. She said that she was not the one who had done the training on the form

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or reason for monitoring residents. She said that the previous director of nursing had done it. The Administrator also said that she has not followed up to see if staff have been doing the monitoring right and could not say for sure from the forms if the monitoring was being done.

Class II

0030 - Resident Care - Rights & Facility Procedures - 58A-5.0182(6) FAC; 429.28( ) FS

Based on record review and Department of Children and Families (DCF) staff, resident, family, and facility staff interviews, the facility failed to ensure the right to live in a safe environment free from and neglect for 1 (Resident #1) of 3 reviewed for . . . Resident #1 sustained injuries due to . . . . . by staff. Lack of proper investigation and documentation of details of residents' and failure to continue to monitor and document incidents could allow other residents to be injured in the same way.
The facility failed to honor resident rights to exercise civil liberties by admitting and keeping 2 (Resident #38 and #40) of 3 residents reviewed in a locked unit against their will. Both residents were their own legal representative.
This deficiency remained uncorrected.

The findings included:

1. Review of a DCF report revealed a complaint that a resident's was not consistent with what actually occurred at the facility. The investigator verified the finding of "physical injury".

In an interview on . . . at 1:50 p.m., DCF Investigator said Staff G was being verbally and physically aggressive with Resident #1 and forced him to the shower and as a result, the Resident #1 lost his balance and . . . She said according to witnesses the resident was pulled out of bed by his arms and . , shoved into the bathroom where Staff G forcibly removed his clothing and proceeded to shove the resident into the shower. She said witness interviews indicated that Staff G was hitting the victim's to cause him to let go of the , bar in the shower and that the resident attempted to fight . . . and grabbed a shower chair and . . . . , hitting his . . . on the faucet in the shower. The investigator said that Staff G was fired from the facility and she has previous allegations with adults for physical injury and has a pattern of yelling at resident and being "rough." The DCF Investigator said that the Administrator was aware the investigation was for alleged physical and . . . . . of Resident #1. The administrator did not suspend Staff G until she went and tried to talk to a resident witness after she had been told not to. The administrator at another facility had called this administrator and told her that Staff G was also under investigation at their facility for alleged . . . . . .

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Record review revealed Resident #1 was admitted to the facility with diagnoses including , , and had precautions. The Health Assessment noted the resident needed supervision for bathing and was independent in , eating, self-care (grooming), toileting and transfers. Resident #1 was Spanish speaking and needed an interpreter to communicate with staff. The resident and his son was Power of Attorney due to .

An incident report noted Resident #1 in the shower on at 9:30 a.m., and 3 staff members were present at the time. No investigation was done. These staff members were Medication Technician (Med Tech) Staff G, Resident Assistant ( ) Staff F, and Spanish-speaking Housekeeper Staff H. After the , the Administrator and above staff provided first aid. Licensed Practical Nurse (LPN) Staff E filled out the incident form. Review of service notes in Resident #1's chart noted ( ) at 9:45 a.m. the resident in the shower, hit his on the of a faucet handle and had a with a small about of -1 was called and the resident was transported to hospital.

On at 9:33 a.m., the Administrator said that an investigation was not done because Resident #1 was taken to the hospital and did not come . She said she did not talk to any of the staff about it because she actually went to the shower that morning and helped by holding a towel to the of the resident's while the staff called -1. The Administrator said the staff told her that the resident backwards while they were trying to turn him in the shower which she took at value.

Record review revealed that Resident #1 returned to the facility from the hospital 7 hours later. The resident was discharged from the facility the next day upon family request.

On at 9:45 a.m., Housekeeper Staff H said on the day of Resident #1's she went to the room with Med Tech Staff G to help translate. Staff G went into the room, walked towards the resident's bed, and said with a big loud voice, "you're going to take a shower." She then pulled off his covers, grabbed him by his and arms, and sat him upright. She then grabbed him, stood him up, and pulled down his underwear. She was not talking to him at that point. She said the resident started to fight and Staff G started to push him towards the bathroom. Staff H said she was talking to the resident in Spanish to be calm and let Staff G give him a shower. Staff H said when Staff G got the resident into the bathroom, she forcibly started taking off his shirt and pulling it over his . The resident was very upset and trying to stop Staff G. She then pushed him into the shower and he was hanging on to the safety bar. She was yelling at him to let go and she took hold of his and turned on the water. Staff H said she did not know if the water was hot or but Staff G just sprayed the resident. Staff H said the resident tried to pick up the shower chair and he slipped and hitting his on the faucet. Staff H acknowledged that Staff G was being very rough with the resident and she felt it was wrong. Staff H

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said no one ever investigated or talked with her about the incident. When all the people came into the room after the , Staff G was the one who said what happened.

On at 10:00 a.m., Staff F said that on the day of Resident #1's , she went into Resident #1's room and told him that she was going to help give him a shower. She said that the resident indicated that he was agreeable to it, but when Staff G came into the room, the resident became very agitated and said he was not going to take a shower. Staff F said the resident knew some English but not much. Staff G said in a loud voice, "Oh yes, he is taking a shower," then uncovered him and pulled him by his to the side of the bed. Staff F said Staff G pulled down his underwear and forcibly tried to take off his shirt. She said Resident #1 was visibly upset. Staff G proceeded to push resident across the room towards the bathroom hanging on to his shirt and arm. Staff F said she told Staff G to stop and that the resident did not want a shower and to leave him be, but Staff G continued. Once Staff G had pushed the resident into the shower, she was trying to make him let go of the safety bar. She hit the of his with the shower and hose. Staff G continued to try to get his shirt off and then turned on the water without testing it to see if it was hot or . Staff F said the resident turned and tried to grab the shower chair but lost his balance and , hitting his on the faucet. Staff F said that the housekeeper called for help and many people came into the room. She said when people asked what happened, Staff G did all the talking. Staff F said that no one ever asked her what happened in private and no investigation was done until the DCF came. Staff F stated, "it is clear that the resident would not have and got hurt if she was not forcing him and being so rough with him."

On at 11:00 a.m., LPN Staff E said that she was called to Resident #1's room the day that he in the shower and his on the faucet. She said filled out the incident report according to what was told to her. LPN Staff E said she had many issues with Staff G, and she had to attend to many residents after staff G had taken care of them. The LPN said when Staff G worked in memory unit, there were many residents getting and needed the dressed. The LPN said it seemed to be a pattern, so she asked if Staff G could be moved out of the memory unit. After she was moved, there was not half as many . She said she often got reports from residents that Staff G was "rough" and she reported it to her supervisor, but nothing had been done. The LPN said that after the DCF was there looking into Resident #1's , Staff G went and tried to talk to one of the resident witnesses who reported overhearing all the yelling in the resident's room before the .

On at 11:30 a.m., the Administrator said that on the DCF investigator told her Staff G went and intimidating the resident who overheard yelling when Resident #1 , she put Staff G on suspension. Another facility director then told her on the phone that Staff G was also suspected in an case at her facility. The Administrator said she called Staff G up that day and fired her for not following "the policy on and Neglect."

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Record reviews of 2 other residents (#89 and #90) who had in the facility showed the same pattern of incomplete incident reports and no evidence of follow-up investigation. Both residents were sent to the hospital after the and returned to the facility after evaluation of their injuries. Both residents were unable to be interviewed due to issues.

On at 12:10 p.m., LPN Staff E said that she fills out the incident report if she is called to provide some first aid, but she is not the one that investigates anything about the or issues that require an incident report.

2. Record review of staff documentation of monitoring residents several times a shift was incomplete and was not filled out the same way by different employees. Dates and/or times were not consistently present. Some staff recorded there initials and some staff put a time. No clear indication on how to fill out the form was found on the form and one of the forms was a different format than the rest. Documentation of the education to staff on the monitoring procedure to provide supervision and a safe environment was not available. Sign-in sheets were produced but there was no indication of what they were instructed to do.

On at 3:56 p.m. Med Tech Staff I said that when she comes in on night shift she is to take the midnight census (a list of all residents in the building) and go around and check on each one of her residents on her hall. She is to go in each room and see that they are there and if everything is OK. She said she was told to check a couple of times a night. Before she goes off duty in the morning, she is to wait until the day shift staff check to make sure all residents are accounted for. She was unsure if there was a place to record her activity, she was told to document on the midnight census.

On at 4:10 p.m. Med Tech Staff J said that when she comes in at 10:00 p.m. she is to take a copy of the midnight census and go to each of the residents' rooms on her hall and check on them to make sure they are in their room and that they are OK. She is to record on a sheet that is included in the medication administration record that she checks on her residents at least 3 times in the shift. She said that she is to write in the area for her shift and write the time that she has checked the room. She puts one time, like 10:00 p.m., meaning they are checked between p.m. She said she could not look at them all at the same time.

On at 4:15 p.m. the Administrator acknowledged that the monitoring forms were not being filled out correctly or consistently. She said that she was not the one who had done the training on the form or reason for monitoring residents. She said that the previous director of nursing had done it. The Administrator also said that she has not followed up to see if staff have been doing the monitoring right

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and could not say for sure from the forms if the monitoring was being done.

3. In an interview on at 11:00 a.m., Resident #38 said he was admitted to the facility from a rehabilitation unit. He said he toured the facility and was shown a model room on the assisted living side. He said he agreed to come here for a short time after rehabilitation. He said when he arrived at the facility, he was taken to the unit and locked in. He said he was his own legal representative and did not have a power of attorney.

In an interview on at 11:00 a.m., Resident #40 said the daughter of Resident #38 signed her into the facility after a stay at the same rehabilitation center Resident #38 was staying. She said the daughter did not have power of attorney for her.

Review of Resident #38's initial physician's assessment (form 1823), showed he did not have an diagnosis of , nor was he deemed an elopement risk.

Review of Resident #40's initial physician's assessment (form 1823), showed she was not considered an elopement risk.

Review of the admission contracts for Resident #38 and #40 revealed Resident #38's daughter signed the contract for services as legal representative for both Resident #38 and #40. There was no copy of the power of attorney or legal representative paperwork in the residents' files giving the daughter authority to make decisions for either of them.

On at 11:35 a.m., the Administrator admitted she could not find the power of attorney paperwork for Resident #40.

On at 1:15 p.m., Resident #38's daughter confirmed she was not the power of attorney for Resident #38 or for Resident #40.

On at 9:45 a.m., Memory Care Coordinator Staff B said Residents #38 and #40 were very well behaved and , . She said they stayed in their room except for meals.

On at 10:00 a.m., the Executive Director said she allowed Resident #38's daughter to sign the contract for both residents because the daughter told her she had power of attorney for both residents and promised to bring in the paperwork at a later date.

Class II

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0056 - Medication - Labeling and Orders - 58A-5.0185(7) FAC

Based on record review and resident and staff interview, the facility failed to ensure prescriptions were filled in a timely manner for 1 (Resident #39) of 3 residents reviewed. Resident #39 did not receive a , patch for three days. Failure to provide this medication caused the resident to experience , and discomfort.
This deficiency remained uncorrected.

The findings included:

Record review showed Resident #39 was admitted to the facility on . She had a , patch applied prior to admission on this date.
The physician's admission order was to apply a , 50 microgram patch to the Resident #39's skin every 72 hours. , patch is used to help relieve severe ongoing , (https://www.webmd.com/drugs/2/drug-6253/ , - /details).
Review of the Medication Observation Record (MOR) for Resident #39 showed the next patch was due to be applied on . The record showed this patch was not available and was not applied.

In an interview on at 12:13 p.m., Resident #39 said she went without her , patch for several days after she was admitted. She said she had a lot of , ranging from level 6 to 8 on a 0-10 , scale during this time. A , level of 6 to 8 is considered moderate to severe , (https://www.healthline.com/health/ -scale).

In an interview on at 12:00 p.m., Licensed Practical Nurse Staff E said the pharmacy refused to deliver the medication because her insurance had already filled this prescription at another facility and would not pay for it to be filled twice. She said the previous director of nursing called the previous facility and was told they still had two , patches left for this resident.

Record review of the PharMerica Patch Controlled Drug Decline record showed two , patches were delivered to the facility on .

Record review of the MOR for Resident #39 showed on the , patch was applied to the resident on (3 days late).

Resident #39 was left without , control from until .

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0165 - Risk Mgmt & QA; Adverse Incident Report - 429.23(&) FS; 58A-5.0241 FAC

Based on record review and Department of Children and Families (DCF) staff and facility staff interviews, the facility failed to file 1-Day or 15-Day adverse incident reports as required for 3 (Resident #1, #89, and #90) of 3 residents reviewed for adverse incidents. The residents were transferred to a unit providing more acute care for injuries, but the facility failed to report it. This deficiency remained uncorrected.

The findings included:

1. Review of a DCF report revealed a complaint that a resident's was not consistent with what actually occurred at the facility. The investigator verified the finding of "physical injury".

In an interview on at 1:50 p.m., DCF Investigator said Staff G was being verbally and physically aggressive with Resident #1 and forced him to the shower and as a result, the Resident #1 lost his balance and . She said according to witnesses the resident was pulled out of bed by his arms and , shoved into the bathroom where Staff G forcibly removed his clothing and proceeded to shove the resident into the shower. She said witness interviews indicated that Staff G was hitting the victim's to cause him to let go of the , bar in the shower and that the resident attempted to fight and grabbed a shower chair and , hitting his on the faucet in the shower. The investigator said that Staff G was fired from the facility and she has previous allegations with adults for physical injury and has a pattern of yelling at resident and being "rough." The DCF Investigator said that the Administrator was aware the investigation was for alleged physical and of Resident #1. The administrator did not suspend Staff G until she went and tried to talk to a resident witness after she had been told not to. The administrator at another facility had called this administrator and told her that Staff G was also under investigation at their facility for alleged .

Record review revealed Resident #1 was admitted to the facility with diagnoses including , , and had precautions. The Health Assessment noted the resident needed supervision for bathing and was independent in , eating, self-care (grooming), toileting and transfers. Resident #1 was Spanish speaking and needed an interpreter to communicate with staff. The resident , and his son was Power of Attorney due to .

An incident report noted Resident #1 in the shower on at 9:30 a.m., and 3 staff members were present at the time. No investigation was done. These staff members were Medication Technician (Med Tech) Staff G, Resident Assistant ( ) Staff F, and Spanish-speaking Housekeeper Staff H. After the , the Administrator and above staff provided first aid. Licensed Practical Nurse (LPN) Staff E filled

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	AL11953349	R 11/08/2018
NAME OF PROVIDER OR SUPPLIER **LAMPLIGHT INN**	STREET ADDRESS, CITY, STATE, ZIP CODE **1896 PARK MEADOW DRIVE** **FORT MYERS, FL 33907**	

SUMMARY STATEMENT OF DEFICIENCIES
(FINDINGS PRECEDED BY TAGS AND REGULATORY IDENTIFYING INFORMATION)

out the incident form. Review of service notes in Resident #1's chart noted ( ) at 9:45 a.m. the resident in the shower, hit his on the of a faucet handle and had a with a small about of -1 was called and the resident was transported to hospital.

On at 9:33 a.m., the Administrator said that an investigation was not done because Resident #1 was taken to the hospital and did not come . She said she did not talk to any of the staff about it because she actually went to the shower that morning and helped by holding a towel to the of the resident's while the staff called -1. The Administrator said the staff told her that the resident backwards while they were trying to turn him in the shower which she took at value.

Record review revealed that Resident #1 returned to the facility from the hospital 7 hours later. The resident was discharged from the facility the next day upon family request.

On at 9:45 a.m., Housekeeper Staff H said on the day of Resident #1's she went to the room with Med Tech Staff G to help translate. Staff G went into the room, walked towards the resident's bed, and said with a big loud voice, "you're going to take a shower." She then pulled off his covers, grabbed him by his and arms, and sat him upright. She then grabbed him, stood him up, and pulled down his underwear. She was not talking to him at that point. She said the resident started to fight and Staff G started to push him towards the bathroom. Staff H said she was talking to the resident in Spanish to be calm and let Staff G give him a shower. Staff H said when Staff G got the resident into the bathroom, she forcibly started taking off his shirt and pulling it over his . The resident was very upset and trying to stop Staff G. She then pushed him into the shower and he was hanging on to the safety bar. She was yelling at him to let go and she took hold of his and turned on the water. Staff H said she did not know if the water was hot or but Staff G just sprayed the resident. Staff H said the resident tried to pick up the shower chair and he slipped and hitting his on the faucet. Staff H acknowledged that Staff G was being very rough with the resident and she felt it was wrong. Staff H said no one ever investigated or talked with her about the incident. When all the people came into the room after the , Staff G was the one who said what happened.

On at 10:00 a.m., Staff F said that on the day of Resident #1's , she went into Resident #1's room and told him that she was going to help give him a shower. She said that the resident indicated that he was agreeable to it, but when Staff G came into the room, the resident became very agitated and said he was not going to take a shower. Staff F said the resident knew some English but not much. Staff G said in a loud voice, "Oh yes, he is taking a shower," then uncovered him and pulled him by his to the side of the bed. Staff F said Staff G pulled down his underwear and forcibly tried to take off his shirt. She said Resident #1 was visibly upset. Staff G proceeded to push resident across the room towards the bathroom hanging on to his shirt and arm. Staff F said she told Staff G to stop and

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that the resident did not want a shower and to leave him be, but Staff G continued. Once Staff G had pushed the resident into the shower, she was trying to make him let go of the safety bar. She hit the of his with the shower and hose. Staff G continued to try to get his shirt off and then turned on the water without testing it to see if it was hot or . Staff F said the resident turned and tried to grab the shower chair but lost his balance and , hitting his on the faucet. Staff F said that the housekeeper called for help and many people came into the room. She said when people asked what happened, Staff G did all the talking. Staff F said that no one ever asked her what happened in private and no investigation was done until the DCF came. Staff F stated, "it is clear that the resident would not have and got hurt if she was not forcing him and being so rough with him."

On at 11:00 a.m., LPN Staff E said that she was called to Resident #1's room the day that he in the shower and his on the faucet. She said filled out the incident report according to what was told to her. LPN Staff E said she had many issues with Staff G, and she had to attend to many residents after staff G had taken care of them. The LPN said when Staff G worked in memory unit, there were many residents getting and needed the dressed. The LPN said it seemed to be a pattern, so she asked if Staff G could be moved out of the memory unit. After she was moved, there was not half as many . She said she often got reports from residents that Staff G was "rough" and she reported it to her supervisor, but nothing had been done. The LPN said that after the DCF was there looking into Resident #1's , Staff G went and tried to talk to one of the resident witnesses who reported overhearing all the yelling in the resident's room before the .

On at 11:30 a.m., the Administrator said that on the DCF investigator told her Staff G went and intimidating the resident who overheard yelling when Resident #1 , she put Staff G on suspension. Another facility director then told her on the phone that Staff G was also suspected in an case at her facility. The Administrator said she called Staff G up that day and fired her for not following "the policy on and Neglect."

2. Record reviews of 2 other residents (#89 and #90) who had in the facility showed the same pattern of incomplete incident reports and no evidence of follow-up investigation. Both residents were sent to the hospital after the and returned to the facility after evaluation of their injuries. Both residents were unable to be interviewed due to issues.

On at 12:10 p.m., LPN Staff E said that she fills out the incident report if she is called to provide some first aid, but she is not the one that investigates anything about the or issues that require an incident report.

Class III