Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
What "No Harm" Really Means for Residents

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Introduction: What is a "No Harm" Deficiency?

Effective monitoring and oversight of nursing home care is critical to ensuring the safety and dignity of residents, as well as the integrity of the public programs which pay for a majority of nursing home care. Nevertheless, numerous studies over the years have indicated that, too often, the state agencies responsible for ensuring that nursing homes meet minimum standards of care fail to identify when residents experience substandard care, abuse, or neglect. Furthermore, CMS data indicate that, even when state surveyors *do* identify a health violation, they only identify the deficiency as having caused any harm to a resident about four percent (4%) of the time.

The failure to identify resident harm has pernicious implications at many levels. Fundamentally, it means that resident suffering and degradation–even death– go unaccounted for and are left unheard. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes that violate a resident's right to quality care and quality of life services rarely face financial penalties for "no harm" deficiencies. In our view, this leads to systemic under-enforcement.

Share your thoughts with us on Twitter using **#HarmMatters**.

For more information on the nursing home standards of care, please see LTCCC's **Issue Alerts**.

The purpose of this newsletter is to provide the public with examples of these "no harm" deficiencies, taken from Statements of Deficiencies (SoDs) on Nursing Home Compare. Surveyors classified all of them as "no harm," meaning that they determined that residents were neither harmed nor put into immediate jeopardy for their health or well-being. We encourage our readers to read these residents' stories and determine for themselves whether or not they agree with the "no harm" determination.

Safire Rehabilitation of Southtown, NY

Two-star facility fails to complete a facility assessment to determine the needs of residents and the resources necessary for resident care

Surveyors found that the nursing home did not complete a facility assessment to determine the needs of residents and the resources required to provide care and services to residents.[1] The facility assessment tool that the nursing home administrator provided the surveyors showed that there was no “documented evidence that a complete assessment of the resident population considering the types of diseases, condition, physical and cognitive disabilities, and overall acuity was done.” When the surveyors interviewed the nursing home administrator, the administrator told surveyors that she “did not have a completed facility assessment . . . [and] that she was aware of the requirement but had not completed the assessment.”

The surveyors determined that the facility did not “ensure that a facility-wide assessment was conducted to thoroughly assess the needs of its residents and to determine the required resources to provide the care and services to its residents during its day-to-day operations.” Despite the nursing home’s failure to adequately assess the needs of residents and the facility’s ability to meet those needs, surveyors cited the deficiency as “no harm.” During this inspection, surveyors also cited the nursing home for four other deficiencies, including failing to “have sufficient staff with the appropriate competencies and skill sets to provide nursing related services to assure resident safety and attain or maintain the highest practicable, physical, mental, and psychosocial well-being of each resident .” This latter standard specifically requires facilities to factor in information from the facility assessment.[2]

Caretel Inns of Brighton, MI

Five-star facility searches a resident’s room for cigarettes and a lighter without his consent, resulting in the resident leaving the facility

Surveyors first observed the resident in bed watching television.[3] A few moments later, a social worker entered the resident’s room and told him that she “needed to search his room for cigarettes.” The resident asked the social worker who had told her to search his room. As the social worker was going through his drawers, she told the resident that her supervisor had authorized the search. According to the surveyors, the resident’s voice was “loud and sounded upset.” After the social worker left the resident’s room empty-handed, the resident stated that “he could not stay at the facility any longer, they just came in and tore my room apart.”

The surveyors later interviewed the social worker who “did not have a response as to why the action was not documented in . . . [the resident’s] medical record.” The social worker, however, did tell surveyors that she did not find cigarettes or a lighter in the resident’s room. The assistant director of nursing told surveyors that the residents were not allowed to have lighters in their rooms but was not sure if there was a prohibition against having cigarettes. Subsequently, the social worker again spoke to the surveyors and showed them the “Anti-Violence Rule letter” that was in the resident admission packet. The letter prohibited anyone from possessing “firearms, weapons or any other dangerous item . . . in the event that the possession of firearms, weapon or

any other dangerous item is suspected, the General Manager will ensure that the involved premise is searched."

The letter did not mention cigarettes or lighters. The "Guests and Visitors Smoking policy" also did not discuss the storage of cigarettes and lighters "or that their [(residents)] private things would be searched without consent." The resident ultimately left the facility the same day as the incident.

Surveyors determined that the facility "failed [to] include residents accessibility of cigarettes and lighters in the facility policy for those residents who smoke . . . resulting in negative psychosocial outcomes." Despite staff searching the resident's room without his consent, and the substantiation of negative psychosocial outcomes, surveyors cited the facility's failure as causing "no harm."

Good Shepherd Care Center, MO

Four-star facility fails to develop behavioral health competencies, potentially endangering a resident who attempted suicide

The resident was "determined to have a serious mental illness . . . or related condition."[4] In addition to other orders, the resident's care plan called on staff to "assess [the resident] weekly when taking antipsychotic medication for effectiveness and any adverse findings" and to monitor for signs of depression and anxiety. However, the resident's chart did not show "behavior, anxiety, depression, or monitoring for medication effectiveness and or any adverse effects."

In one incident, documented in the resident's progress notes, the resident walked up to the nurses' station in tears and told staff that she[5] had cut her wrists. Facility staff immediately went to the resident's room and discovered a rusty pocket knife with "blood all over the blade." The resident told staff that she had "nothing to live for, no one loves me, my family member has just dumped me off here . . . ." The resident was then transferred to a hospital for evaluation and treatment.

When the resident returned to the facility, she told surveyors "I have not had any counseling or anyone to talk to me about it since I have been out of the hospital, and I don't think I have any appointments." The director of nursing told surveyors that the "facility has not completed training on behavioral health residents but plans to in the near future." The social service director added that the resident had not received a psychiatric follow up since she returned to the facility and that "staff are not doing behavior monitoring every day or every shift, they have not updated her care plan since the wrist incident."

Surveyors determined that the facility "failed to train staff to adequately care for one resident . . . with behavioral health care needs." Despite the facility's failure to build staff competencies on the behavioral health needs of residents, or address at least one documented case of significant mental illness or emotional distress (in violation of the resident's written care plan) surveyors cited the deficiency as causing "no harm."

Laurels Peak Care & Rehabilitation Center, MN

Two-star facility fails to monitor compliance with certain standards of care after being identified in a previous inspection

Based on interviews and record reviews, surveyors found that the quality assessment and assurance (QAA) committee met on a quarterly basis.[6] The nursing home administrator, medical director, director of nursing, and other staff members took part in these meetings. Concerns that were identified during the survey were discussed with the administrator, including the "lack of monitoring non-pressure related skin conditions as well as lack of revising the plan of care when needed."

In response to being asked how the QAA committee monitored these concerns since being identified in the previous survey, the administrator stated that "she was unaware of any ongoing audits and/or corrective action plans which had been implemented over the past year . . . and was unable to verify a corrective action plan had been implemented to achieve continued compliance." The administrator added that she was "unaware of any continued non-compliance concerns since the last survey."

The surveyors cited the facility for failing to "ensure the quality assessment and assurance (QAA) committee monitored compliance related to skin conditions and care plan revisions to ensure correction was achieved and sustained since the previous survey . . . result[ing] in lack of monitoring and treatment . . . ." Despite the facility's failure to monitor its adherence to these standards of care after being previously identified, surveyors still cited the deficiency as "no harm."

A Note on This Month's Deficiencies

On November 24, 2017, following requests from industry lobbyists for "burden reduction," CMS issued new guidance announcing that violations of eight standards of care would not result in any financial penalty for the next 18 months. According to CMS, this time "will be used to educate facilities" about the standards.

Each of the "no harm" deficiencies highlighted in this month's newsletter relates to one of the standards for which CMS announced it is delaying enforcement. To see deficiencies related to the standards below, but which were not covered in this issue, please see last month's newsletter.

The standards for which CMS is delaying enforcement are:

- Baseline Care Plan, §483.21(a)(1)-(a)(3)
- Behavioral Health Services, §483.40
- Sufficient/Competent Direct Care/Access Staff-Behavioral Health, §483.40(a)(1)-(a)(2)
- Psychotropic Medications related to PRN Limitations, §483.45(e)(3)-(e)(5)
- Facility Assessment, §483.70(e)
- Antibiotic Stewardship Program, §483.80(a)(3)
- QAPI Program and Plan related to the development of the QAPI Plan, §483.75(a)(2)
- Smoking Policies, §483.90(i)(5)

Further Reading from LTCCC & the Center:

1. LTCCC Issue Alert: Bed Rails
2. LTCCC Mid-Term Report to United Nations: U.S. Nursing Home Antipsychotic Drugging
3. Center's Fact Sheet: Skilled Nursing Facility Coverage In Light of *Jimmo v. Sebelius*
4. Center's Alert on the NPR Observation Status Story: *How Medicare's Conflicting Hospitalization Rules Cost Me Thousands Of Dollars*

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[1] Statement of Deficiencies for Safire Rehabilitation of Southtown, LLC, CMS (Dec. 28, 2017), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335663&SURVEYDATE=12/28/2017&INSPTYPE=CMPL&profTab=1&state=NY&lat=0&lng=0&name=SAFIRE%2520REHABILITATION%2520OF%2520SOUTHTOWN%252C%2520L%2520L%2520C&Distn=0.0.

[2] *See* 42 C.F.R. § 483.35 (requiring facilities to "have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment").

[3] Statement of Deficiencies for Caretel Inns of Brighton, CMS (Jan. 30, 2018), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235615&SURVEYDATE=01/30/2018&INSPTYPE=STD&profTab=1&state=MI&lat=0&lng=0&name=CARETEL%2520INNS%2520OF%2520BRIGHTON&Distn=0.0.

[4] Statement of Deficiencies for Good Shepherd Care Center, CMS (Dec. 22, 2017), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=265528&SURVEYDATE=12/22/2017&INSPTYPE=STD&profTab=1&state=MO&lat=0&lng=0&name=GOOD%2520SHEPHERD%2520CARE%2520CENTER&Distn=0.0.

[5] The Statement of Deficiencies does not indicate whether the resident was male or female. To make the case study reader-friendly, we have noted the resident as being female.

[6] Statement of Deficiencies for Laurels Peak Care & Rehabilitation Center, CMS (Jan. 12, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=245516&SURVEYDATE=01/12/2018&INSPTYPE=STD&profTab=1&state=MN&lat=0&lng=0&name=LAURELS%2520PEAK%2520CARE%2520%2526%2520REHABILITATION%2520CENTER&Distn=0.0.

Elder Justice: What "No Harm" Really Means for Residents is a monthly newsletter published by the Center for Medicare Advocacy and the Long Term Care Community Coalition. The purpose of the newsletter is to provide insights into how the classification of harm by state surveyors too often fails to consider the impact of the deficiency on residents.