ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 2, Issue 5

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What is a "No Harm" Deficiency?

Nursing homes that voluntarily participate in the Medicare and Medicaid programs must adhere to minimum standards of care established by the federal Nursing Home Reform Law and its implementing regulations. These standards ensure that every nursing home resident is provided services that help attain and maintain his or her "highest practicable physical, mental, and psychosocial well-being." Under the Reform Law, nursing homes that fail to meet the federal requirements are subject to various penalties, based on the scope and severity of the violation(s).

Centers for Medicare & Medicaid Services (CMS) data indicate that the majority of health violations (more than 95%) are cited as causing "no harm" to residents. The failure to recognize resident pain, suffering, and humiliation when it occurs too often means nursing homes are not being held accountable for violations through financial penalties. In the absence of a financial penalty, nursing homes may have little incentive to correct the underlying causes of resident abuse, neglect, and other forms of harm.

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How to Use this Newsletter

In this issue, we focus on so-called "top performing" nursing homes, those with five-star ratings on Nursing Home Compare (NHC). CMS is proposing to reduce the survey frequency of facilities such as these to less than annual surveys. Unfortunately, as these deficiencies indicate, high ratings do not necessarily mean high quality or safety. In fact, studies have indicated that ratings for nursing homes are much better at identifying poor quality than high quality. The reason for this (in short) is that abuse and neglect often go undetected by state surveyors. That is why we believe that the examples of violations provided in these newsletters is so important. They are taken directly from Statement of Deficiencies (SoDs) on NHC that have been classified as causing neither harm nor immediate jeopardy to resident health, safety, or well-being. Our organizations encourage residents, families,

ombudsmen, law enforcement, and others to use these cases to help identify potential instances of resident harm in their own communities. While CMS may fail to properly penalize nursing homes for health violations, **it is important that the public is aware of safety concerns in nursing homes in their communities and that every suspected case of resident harm is reported, investigated, and addressed.**

Clifton Springs Hospital and Clinic Extended Care (New York)

Five-star nursing home fails to ensure that a resident is free from unnecessary drugging.

The surveyor determined that the nursing home failed to ensure that a resident's drug regimen "remained free from unnecessary medications."[1] Although the resident was inappropriately receiving daily antipsychotics, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the SoD:

- A resident's physician orders from March 5, 2019, included an antipsychotic three times a day for combative behavior. However, assessments from January 2019 and October 2018 indicated that she was cognitively intact and revealed no documented behaviors. Further, a medical progress note from January indicated that her mood was stable, and that she was alert.
- In an interview on March 13, 2019, the nurse practitioner stated, "she could not disagree with a GDR [gradual dose reduction]." She further stated that she did not see current documentation for antipsychotics and was not sure why a GDR was not done previously. The pharmacy consultant stated that she would recommend a GDR and acknowledged being unaware that the resident had no documented behaviors.
- Though there were multiple reported failed gradual dose reduction attempts in 2016, her medical progress notes indicated that GDR should be considered in the future if symptoms improved. Records indicated the resident had history of disruptive behavior related to "long-standing anxiety worries on health issues" and "becomes anxious and agitated" when she perceives that her needs are not being met. However, there was no care plan for the use of antipsychotic medication.

→ ***Abuse** is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical and/or mental harm.*

→ ***Neglect** is the failure to provide goods and services necessary to avoid physical and/or mental harm.*

→ **Note:** Antipsychotic medications can have serious, life-threatening side effects. The facility must ensure that residents using psychotropic drugs receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. For more information, please see LTCCC's Dementia Care & Antipsychotic Drug Basics fact sheet.

Fall River Jewish Home Inc. (Massachusetts)

Five-star nursing home fails to provide timely hospice services.

The surveyor determined that the nursing home failed to provide timely palliative interventions to alleviate a hospice resident's respiratory symptoms because of a communication breakdown.[2] While the resident was observed experiencing "worsened labored breathing and increased respiratory congestion," the violation was cited as no-harm. The citation was based, in part, on the following facts from the SoD:

- A resident authorized for hospice services after a recent hospitalization was observed breathing irregularly and unable to speak, according to the surveyor. Though the surveyor observed the resident's condition worsening the next day, the room did not have a suction machine or oxygen to alleviate end-of-life symptoms.
- More than 24 hours after the surveyor's initial observation, the resident was finally suctioned for a large amount of white frothy secretions and approximately 400-500 milliliters with brown liquid secretions.
- The surveyor found a communication breakdown between the facility and hospice services. The facility did not have a designated clinical staff member to coordinate care and communication with hospice, according to the director of nursing. The director said she mistakenly thought that was the social worker's role. In an interview, the hospice nurse said she was frustrated with the lack of communication between hospice and the facility.

→ **Note:** If a facility has a written agreement with a Medicare-certified hospice provider, the policies must identify the ongoing collaboration and communication processes established by the nursing home and hospice. For more information, please see CMS's "Guidance to Surveyors for Long Term Care Facilities."

Alzheimer's Resource Center of Connecticut (Connecticut)

Five-star nursing home fails to conduct assessment following an allegation of mistreatment.

The surveyor determined that the nursing home "failed to conduct an assessment subsequent to an allegation of mistreatment."[3] The surveyor found that the clinical record failed to identify that the resident was assessed and/or a body audit was conducted after a resident-to-resident altercation involving sexually inappropriate behavior. Though the alleged victim was not assessed for injury, the surveyor still cited the violation as neither causing harm nor putting the resident in immediate jeopardy. The citation was based, in part, on the following facts from the SoD:

- A resident was observed touching another resident's genital area and attempting to kiss that resident. The altercation was reported to the facility on Jan. 10, approximately one week after it occurred. However, the facility failed to conduct body audits and assess for injury subsequent to allegations of mistreatment, according to the surveyor. In a Jan. 30 interview, the director of nursing stated that body audits and assessments were not conducted because too much time passed between the time of notification and the incident.
- The facility received numerous citations related to reporting of abuse and sexually inappropriate behavior. A separate altercation in which a resident reportedly touched another resident over her shirt was not reported to the state agency within the mandated timeframe of five working days. The director of nursing attributed the delay to the "complex nature" of the incident.

→ ***Abuse*** *and/or* ***neglect*** *can include instances of inappropriate physical contact, inappropriate antipsychotic drugging, entrapment in a bed rail, falls, pressure ulcers, wandering, infections, malnutrition, isolation, crimes against residents, and other forms of resident harm.*

→ **Note:** Facilities must ensure that each resident is free from any type of abuse, including non-consensual sexual contact of any type with a resident. Further, facilities must report all alleged violations of abuse, neglect, exploitation, or mistreatment. For more information, please see LTCCC's *Requirements For Nursing Homes To Protect Residents From Abuse, Neglect & Exploitation* fact sheet.

Oak Brook Care (Illinois)

Five-star nursing home fails to provide adequate supervision.

The surveyor determined that the nursing home failed to provide proper repositioning and mechanical lift transfers for a resident with fragile skin.[4] Although the resident suffered multiple skin tears, the surveyor cited the violation as no-harm. The citation was based, in part, on the following facts from the SoD:

- The resident suffered numerous skin tears because of improper mechanical lift transfers, according to staff. While the skin tears were reported multiple times previously, the pattern was not identified until mid-March.
- Incident reports from January through March noted that the resident was suffering skin tears possibly obtained during bed mobility, repositioning, or transfers. A March 4 report noted the resident had three wound dressings (left elbow area, right lower leg, and left upper arm) but the resident was unable to say how they occurred.
- Staff interviews revealed that several of the incidents involved mechanical lift transfers with a certified nursing assistant. In response, the certified nursing assistant was reeducated on the basics of using mechanical lifts.

→ **Note:** In 2018, the U.S. Department of Labor issued a notice of proposed rulemaking to allow trained 16 and 17-year olds to perform resident lifts without the supervision of a qualified adult caregiver. Allowing teenagers to independently operate lifts would place residents at an even greater risk of harm during an already dangerous process, and both the Center and LTCCC strongly opposes this roll back. For more information, please see our comments to the Department.

Can I Report Resident Harm?

YES! Federal laws and regulations require nursing homes and certain individuals (such as owners, staff, and contractors) to report suspected cases of resident abuse, neglect, and/or crime within a specified amount of time. Nevertheless, residents and families should not wait to report harm when it occurs. Anyone can report suspected cases of resident harm to the state survey agency, local law enforcement, and other appropriate agencies. **For more information about the federal reporting requirements and to access free resources, please visit LTCCC's Abuse, Neglect, and Crime Reporting Center.**

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To learn more about nursing home and assisted living care, visit us online at MedicareAdvocacy.org & NursingHome411.org.

Note: This document is the work of the LTCCC. It does not necessarily reflect the views of the Department of Health, nor has the Department verified the accuracy of its content.

[1] Statement of Deficiencies for Clifton Springs Hospital and Clinic Extended Care (March 13, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335361&SURVEYDATE=03/13/2019&INSPTYPE=STD&profTab=1.

[2] Statement of Deficiencies for Fall River Jewish Home Inc. (Jan. 31, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=225317&SURVEYDATE=01/31/2019&INSPTYPE=STD.

[3] Statement of Deficiencies for Alzheimer's Resource Center of Connecticut (Jan. 31, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=075378&SURVEYDATE=01/31/2019&INSPTYPE=STD. The sex of each resident is not identified in the inspection report. To make the summary more user-friendly, the residents were assigned sexes.

[4] Statement of Deficiencies for Oak Brook Care (March 14, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145458&SURVEYDATE=03/14/2019&INSPTYPE=STD.