

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 9

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How Do “No Harm” Infection Control Violations Impact Nursing Home Quality and Safety?

According to the Centers for Disease Control and Prevention ([CDC](#)), 1 to 3 million serious infections occur every year in nursing homes and assisted living facilities. The CDC also reports that 388,000 residents die each year due to these infections. While nursing homes are required to follow federal standards of care, recent analysis by Kaiser Health News ([KHN](#)) finds that a shocking two-thirds of facilities have been cited at least once in the past three years for infection control violations. Moreover, KHN finds that “all but 1% of violations [are cited] as minor and not warranting fines.”

Unfortunately, KHN’s findings are not surprising. The overwhelming majority of *all* health violations in nursing homes are identified as causing “no harm” to residents. Nevertheless, weak enforcement of the infection control standards is exceedingly concerning due to the existing vulnerabilities of nursing home residents. For instance, the [Washington state nursing home](#) with a deadly outbreak of COVID-19 (coronavirus) was previously cited for a no-harm infection control violation. Although the facility was fined, [KHN](#) indicates that the fine “was for other, largely unrelated violations that inspectors uncovered during their visit” As this may demonstrate, weak enforcement of the standards provides nursing home operators little incentive to improve nursing home quality and safety.

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Purpose of this Newsletter

This issue of the *Elder Justice* newsletter provides examples of infection control violations that surveyors (nursing home inspectors) have identified as neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's [Nursing Home Compare](#) website. While CMS may fail to properly cite and penalize nursing homes for infection control violations, it is important for the public to be aware of safety concerns affecting members of their community. **For more information about infection prevention and control in nursing homes, including fact sheets and searchable files of infection control violations nationwide, please visit [LTCCC's Coronavirus Resources webpage](#).**



Central Park Rehabilitation and Nursing Center (New York)

Five-star facility fails to perform basic hand hygiene to prevent the spread of infection.

The surveyor determined that the nursing home failed to “maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections”¹ Although the licensed practical nurse failed to perform proper hand hygiene, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The facility’s own policies documented that staff were to follow infection control procedures, including handwashing and wearing gloves, when they administered medications to residents. The hand hygiene policy directed staff to follow CDC guidelines for handwashing.
- During observations, a licensed practical nurse (LPN) was seen preparing a resident’s medication without performing hand hygiene. The LPN later admitted that she should have performed hand hygiene “to prevent spread of infection.”
- **Note:** [KHN](#) found that 4 in 10 (40 percent) of nursing homes with an overall 5-star rating on Nursing Home Compare had been cited for infection control violations.

→ **Every facility must establish an infection prevention and control program, including developing policies for hand hygiene and transmission-based precautions.**

→ **Every facility must designate at least one individual to serve as an infection preventionist and be responsible for the facility’s infection prevention and control program.**

Medilodge of Frankenmuth (Michigan)

One-star nursing home fails to clean a quadriplegic resident’s adaptive device, creating the possibility for an upper respiratory infection.

The surveyor determined that the nursing home failed to “implement a plan to clean, sanitize, assess functionality and document” one resident’s specialty adaptive equipment, resulting in the resident “utilizing daily his mouth-controlled (by suction and blowing) television remote without proper cleaning/sanitation and the possibility for upper respiratory infection.”² Although the surveyor determined that this failure could result in an upper respiratory infection, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The surveyor observed a resident in bed watching television. The resident told the surveyor that he was quadriplegic and used three color-coded tubes to control the television. The resident noted that staff only cleaned the device “about once a month.”
- The resident’s records did not include any staff direction regarding how the mouth-controlled device worked or on the cleaning and sanitization of the device. The facility’s housekeeper told the surveyor that she asked nursing staff how to clean the device but was not given an answer.
- The unit manager stated that she was not aware that the device was not listed on the resident’s care plan and that “cleaning was not being conducted/documented daily”
- **Note:** According to the World Health Organization ([WHO](#)), COVID-19 is known to cause respiratory infections in humans. The WHO indicates that the virus may live on surfaces for a few hours or even up to several days, adding that, “[i]f you think a surface may be infected, clean it with simple disinfectant to kill the virus and protect yourself and others.”

Dwelling Place at St Clares (New Jersey)

Five-star nursing home fails to change ventilator tubing for two residents after more than one month of use.

The surveyor determined that the nursing home failed to “change ventilator tubing according to facility policy in order to prevent infections for residents with tracheostomies and ventilators.”³ Although both residents’ ventilator tubes had not been changed in over a month, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- On December 30, 2019, the surveyor observed a resident who was connected to a ventilator machine to support his breathing. The blue tubing that went from the ventilator to an opening in the resident’s neck was dated 11/7/2019. The blue tubing for a portable ventilator on the resident’s nightstand was dated 11/3/2019.
- That same day, the surveyor observed a second resident also using a ventilator. The resident’s blue tubing was dated 11/7/2019. The resident’s care plan noted that she was at risk of developing an infection due to her dependence on the ventilator.
- The surveyor interviewed the respiratory therapist about the facility’s policies and procedures for changing ventilator tubing. The therapist told the surveyor that the tubes “were changed monthly by the respiratory therapy department.” A review of the facility’s ventilator standard of care policy showed that tubing was to be “changed when soiled or every thirty days.”
- **Note:** A new Medicare payment model for nursing home care incentivizes facilities to admit residents in need of ventilator services. Our organizations are concerned that this financial incentive may put residents at risk as more poorly-performing facilities admit these vulnerable residents. For more information, please read the Center’s alert, [“Medicare SNF Payment Model Creates Changes in Care and Admissions – What about Facility Assessments?”](#)

→ **Every facility must conduct and document a facility-wide assessment to determine what resources are necessary for daily operations and emergencies. This facility-assessment must be used in developing the infection prevention and control program.**

Hill View Retirement Center (Ohio)

Four-star nursing home fails to utilize personal protective equipment when providing care to a resident with isolation precautions.

The surveyor determined that the nursing home failed to “follow proper infection control procedures to prevent the potential spread of infection.”⁴ While the facility failed to follow isolation precautions, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- A resident was placed in isolation. The surveyor observed a cart in the resident’s room with personal protective equipment (PPE) but there was “no sign on the door alerting staff or visitors the resident had isolation precautions.” The surveyor observed staff deliver lunch to the resident without putting on PPE. The surveyor also observed staff conduct a dressing change for the resident’s wound without utilizing any PPE.
- A registered nurse acknowledged that “staff should utilize PPE, and there was not a sign on the door alerting the staff and/or visitors of the being on contact isolation.”
- **Note:** [CMS Guidance](#) directs nursing homes to place signage in a conspicuous place outside of a resident’s room to identify the CDC category of transmission-based precautions and instruct staff about the use of PPE. CMS Guidance also states that contact precautions require the use of PPE, including donning PPE upon entering a resident’s room and removing PPE before leaving the resident’s room.

→ A 2014 federal report found that one-third of Medicare beneficiaries experienced harm within about two weeks of entering a nursing home. Infections accounted for 43 percent of these events and most infections were deemed preventable.

Elderwood at Wheatfield (New York)

Four-star nursing home fails to provide proper incontinence care to a resident, risking the development and transmission of infections.

The surveyor determined that the nursing home failed to “ensure provision of a safe, sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections.”⁵ Although the facility did not follow infection control practices during incontinence care, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- A resident was on antibiotics for a urinary tract infection (UTI) and placed on contact precautions. While being observed, the resident become incontinent of urine and stool. A certified nurse aide (CNA #1) washed the resident but did not use the proper technique. A second CNA (CNA #2) intervened.
- CNA #1 removed the resident’s soiled brief, exposing visible stool between the resident’s legs. CNA #1 attempted to change the resident’s brief but the surveyor stopped him. CNA #1 then cleaned the stool but used a soiled washcloth in the process. After completing the resident’s incontinence care, CNA #1 removed his soiled PPE and, without washing his hands, “proceeded to transport the resident to the common area.”
- CNA #1 later entered the resident’s room and collected the soiled laundry using both hands but only one glove. He carried the contaminated linen to the utility room. Wearing two gloves, CNA #1 returned the soiled laundry to the resident’s room. He admitted to the surveyor that “[t]he proper way to dispose of dirty lines is to place them in the plastic bag in the resident's bathroom.”

- CNA #2 told the surveyor that “the incontinent care could have been better.” CNA #2 explained “[t]here was just too much cross contamination and it was just messy.”
- **Note:** Incontinence is a risk factor for developing pressure ulcers. [CMS Guidance](#) states that “[s]kin problems associated with incontinence and moisture can range from irritation to increased risk of skin breakdown.” For more information about pressure ulcers, please read [LTCCC’s fact sheet](#).

Should I Report Suspected Infection Control Violations?

YES! Anyone can report violations of the nursing home standards of care by contacting their state survey agency. **In light of the COVID-19 pandemic, our organizations encourage residents and families to immediately report any suspected infection control violations to help prevent a potentially deadly outbreak in their nursing home and in their community.** To file a complaint against a nursing home, please use [this resource](#) available at CMS’s Nursing Home Compare website. If you do not receive an adequate or appropriate response, [contact your CMS Regional Office](#).



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

Note: The overall star rating of any facility identified in this newsletter is subject to change. The star ratings are current up to the date of newsletter's drafting.

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 Central Park Rehabilitation and Nursing Center (Jan. 7, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335253&SURVEYDATE=01/07/2020&INSPTYPE=STD&profTab=1&Distn=6902.5&state=NY&lat=0&lng=0&name=CENTRAL%20PARK%20REHABILITATION%20AND%20NURSING%20CENTER>.

² Statement of Deficiencies for Medilodge of Frankenmuth (Dec. 12, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235175&SURVEYDATE=12/12/2019&INSPTYPE=STD&profTab=1&Distn=7380.3&state=MI&name=MEDILODGE%20OF%20FRANKENMUTH&lat=0&lng=0>. The unit manager’s gender was not identified. To make the newsletter more reader-friendly, we identify the unit manager as female.

³ Statement of Deficiencies for Dwelling Place at St Clares (Jan. 3, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=315019&SURVEYDATE=01/03/2020&INSPTYPE=STD&profTab=1&Distn=6771.1&state=NJ&lat=0&lng=0&name=DWELLING%20PLACE%20AT%20ST%20CLARES>. The residents’ genders were not identified. To make the newsletter more reader-friendly, we identify resident #1 as male and resident #2 as female.

⁴ Statement of Deficiencies for Hill View Retirement Center (Dec. 12, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=365444&SURVEYDATE=12/12/2019&INSPTYPE=STD&profTab=1&Distn=7300.7&state=OH&name=HILL%20VIEW%20RETIREMENT%20CENTER&lat=0&lng=0>.

⁵ Statement of Deficiencies for Elderwood at Wheatfield (Dec. 6, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335790&SURVEYDATE=12/06/2019&INSPTYPE=STD&profTab=1&Distn=7083.0&state=NY&name=ELDERWOOD%20AT%20WHEATFIELD&lat=0&lng=0>.