ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 2, Issue 6

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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 nursing homes with four and 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.**

Sunharbor Manor (New York)

Four-star nursing home fails to ensure a resident's right to be free from abuse.

The surveyor determined that the nursing home failed to protect a resident's right to be from abuse.[1] Although a staff member inappropriately injected the resident with insulin and attempted to cover up the resulting fall, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the SoD:

- The resident's July 2015 comprehensive care plan indicated that the resident was easily agitated and loved his space. The care plan called on staff to "explain all procedures prior to care, allow time to calm down and protect patient and self from injury." A July 2017 care plan again called on staff to "identify self prior to providing care, explain all procedures to the resident prior to providing care and talk to the resident while giving care."
- Nurse progress notes from both the registered nurse (RN) and the licensed practical nurse (LPN), dated May 2019, documented that the resident fell to the floor after his wheelchair tilted while he was moving. However, video surveillance showed that the LPN appeared to have walked up to the resident from behind and injected him with an insulin pen through his shirt, causing the resident to become agitated. The resident appeared to have hit the LPN, after becoming agitated, which resulted in the LPN trying to push the resident away. After the resident's wheelchair fell over, the LPN attempted to pick up the wheelchair while the resident was still partially in it.

→ **Note:** A 2019 Government Accountability Office (GAO) report suggests that more than 1 in 5 nursing homes considered "above average" and "much above average" by CMS have been cited for abuse in a single year.

→ ***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.*

Corry Manor (Pennsylvania)

Four-star nursing home fails to have sufficient staff, causing pain and missed care.

The surveyor determined that the nursing home failed to "have sufficient staff with the appropriate skill sets to provide nursing services including timely medication administration . . . .[2] While the facility's failure to provide medications on time resulted in pain and interfered with care, the violation was cited as no-harm. The citation was based, in part, on the following facts from the SoD:

- The facility medication schedule documented that residents living on the right side of unit B's hallway would receive their morning medications at 8:00 A.M. and that those on the left side would receive their medications at 9:00 A.M. The nurse staffing sheets for August 6th showed that there were only three licensed nurse staff scheduled to administer medications in the four different units.

- Records indicated that residents did not receive their medications on time. For instance, one resident received 9:00 A.M. medication at 1:01 P.M. "(four hours, one minute past the scheduled time) . . . ."
- A resident told the surveyor during an interview that "We don't always get our morning medication in a timely fashion . . . Some of us are on insulins and stuff. I get a pain killer in morning and night. Sometimes get my pain pill late and then my bedtime one. When I get it late in the morning, I have pain, and can't do therapy."
- The nursing home administrator confirmed that "medications were given up to and over two hours late on some days."

→ **Note:** Federal law requires nursing homes to have 24-hour licensed nursing services that is sufficient to meet the nursing needs of all residents. Facilities must also have a registered nurse on duty eight hours a day, seven days a week. To learn more about nursing home staffing, please see LTCCC's fact sheet.

Good Samaritan Society – Algona (Iowa)

Four-star nursing home fails to recognize when unwanted care caused a resident's behavioral symptoms to escalate, resulting in a resident being physically abuse.

The surveyor determined that the nursing home failed to recognize that their persistence in providing unwanted care caused a resident's behavioral symptoms to escalate, resulting in a staff member grabbing the resident's "nose and squeezing it in retaliation."[3] Although a staff member abused the resident, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the SoD:

- A registered nurse (RN) reported that a certified nurse aide (CNA) grabbed the resident's nose and squeezed it. The RN explained that the resident was irritated because she did not want her brief changed but the CNA and another staffer persisted. The RN said she did not see what the resident did to the CNA but the CNA responded by "squeezing the resident's nose with all her might." The RN noted that the resident began to weep once they got her settled into bed.
- The CNA explained that the resident began hitting her and so she squeezed the resident's nose to stop her. The CNA acknowledged that the resident had dementia and could not control her behavior. The CNA also acknowledged that some residents have told her over the years that "she gets too rough." However, she said that "sometimes residents get a little too whiny and their complaints are not always legitimate."
- One staffer who occasionally worked with the CNA said the she yelled at residents but never saw her hit any of them. The staffer recalled another incident when a resident kicked them during care and how the CNA "yelled at the resident, grabbed her hand and held them tight."

→ ***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:** A 2019 Government Accountability Office (GAO) report found that the number of cited abuse deficiencies more than doubled between 2013 and 2017. The GAO stated that resident abuse was perpetrated by staff 58 percent of the time.

Rae Ann Suburban (Ohio)

Five-star nursing home fails to provide proper respiratory care to resident.

The surveyor determined that the nursing home failed "to provide respiratory care in accordance with the physician's order and consistent with the resident plan of care."[4] Although the resident suffered from poor respiratory care and told the surveyor that he did not feel well, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the SoD:

- The resident's record indicated the he had shortness of breath with exertion, as well as when lying and sitting. The physician's order called for "oxygen at two liters per minute to keep pulse oximetery (measurement of oxygen in the blood) above 92%." The resident's plan of care revealed he had "compromised respiratory status related to pneumonia with an intervention stating his respiratory status and lung sounds would be assessed every shift and the respiratory rate, character and depth of respirations as well as any cough would be documented."
- The surveyor observed the resident sitting in his wheelchair with the oxygen concentrator set at three liters per minute. The resident told the surveyor he had pneumonia and did not feel well. The surveyor noted that "[h]is congestion was audible when he spoke."
- A registered nurse (RN) confirmed that, while the oxygen concentrator was set to three liters per minute, the physician had ordered two liters. The RN told the surveyor that she had just given the resident breathing treatment but "had not assessed his pulse oximetery or breath sounds prior to or after the breathing treatment."

→ **Note:** Our organizations are concerned by Medicare's new reimbursement system for nursing homes. As a result of new financial incentives, nursing homes are changing their admissions practices. Facilities that previously denied admissions to people who use ventilators are now actively recruiting ventilator-dependent residents. Unfortunately, this includes facilities that may not actually have the resources to properly care for such residents. For more information, please read the Center's alert: Medicare's New Skilled Nursing Facility Payment System Alters Access to Care.

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.

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[1] Statement of Deficiencies for Sunharbor Manor (July 15, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335559&SURVEYDATE=07/15/2019&INSPTYPE=CMPL&profTab=1&Distn=6709.9&state=NY&lat=0&lng=0&name=SUNHARBOR%20MANOR.

[2] Statement of Deficiencies for Corry Manor (Aug. 16, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=395489&SURVEYDATE=08/16/2019&INSPTYPE=STD&profTab=1&Distn=7109.6&state=PA&lat=0&lng=0&name=CORRY%20MANOR.

[3] Statement of Deficiencies for Good Samaritan Society – Algona (Jul. 3, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=165190&SURVEYDATE=07/03/2019&INSPTYPE=CMPL&profTab=1&Distn=8040.4&state=IA&lat=0&lng=0&name=GOOD%20SAMARITAN%20SOCIETY%20-%20ALGONA#.

[4] Statement of Deficiencies for Rae Ann Suburban (Aug. 8, 2019). Available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=365845&SURVEYDATE=08/08/2019&INSPTYPE=STD&profTab=1&Distn=7252.6&state=OH&lat=0&lng=0&name=RAE%20ANN%20SUBURBAN.