ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 3, Issue 4

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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 their "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 most 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.

In the absence of a financial penalty, nursing homes may have little incentive to correct the underlying causes of substandard nursing home quality and safety.

How to Use this Newsletter

The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified 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 Care Compare website.

This issue of the newsletter aims to underscore the lack of accountability and proper oversight that plagued facilities even before the COVID-19 pandemic struck. This issue includes four "no-harm" SODs from February 2020 which illustrate residents being robbed of their rights to **1)** Following an advance directive; **2)** Proper oxygen therapy; **3)** Gender pronoun preferences; and **4)** Appropriate blood pressure medication.

More than 100,000 people in long term care facilities have died from COVID-19,[1] but the harm of the pandemic extends far beyond cases and fatalities. Due to limited government oversight and restricted visitation, residents are facing heightened risk of abuse, neglect, and substandard care. As nursing home industry leaders lobby for legal immunity for resident abuse and neglect during the COVID-19 pandemic (and beyond!), consider that too many facilities, even under "normal" conditions, were failing to protect the basic rights of their residents – often with no penalty.

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. When state enforcement agencies and CMS fail to properly identify and penalize nursing homes for health violations, it is important for the public to be aware of nursing home safety concerns in their communities. Fundamentally, from our perspective, every suspected case of resident harm should be reported, investigated, and (as appropriate) addressed.

Absolut Ctr for Nursing & Rehab Three Rivers LLC (New York)

Disregarded DNR: One-star facility fails to honor resident's advance directive.

The surveyor determined that the facility failed to adhere to a resident's advance directive. According to the citation, the facility initiated Cardio-Pulmonary Resuscitation (CPR) on a resident whose care plan indicated "Do Not Resuscitate" (DNR). Still, the surveyor cited the violation as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- A resident became non-responsive and pulseless after returning from physical therapy, according to nursing progress notes. The resident received CPR and became responsive after multiple sets of compressions and breaths. The resident was then transported to the hospital and into the intensive care unit.
- The resident was documented as a DNR and the care plan for advance directives indicated that the resident's wishes would be honored. The resident's interventions included that a DNR band would be worn on the wrist.
- Facility policy indicates that residents who wish to be resuscitated wear a *blue* wrist or ankle band. A facility investigation found that the resident was wearing a blue identification bracelet with the word "RED" written on the bracelet. After completion of the investigation, the facility was unable to determine who was responsible for the bracelet mistake.
- **Know Your Rights:** Facilities are required to develop and implement comprehensive person-centered care plans for each resident that are consistent with resident rights, including the right to refuse treatment. For more information on comprehensive care plans, please see LTCCC's Resident Assessment & Care Planning fact sheet.

→ *The comprehensive care plan must describe any services that would otherwise be required… but are not provided due to the resident's exercise of rights…, including the right to refuse treatment…*

Augusta Place, A Prospera Community (North Dakota)

Right to breathe: Four-star facility fails to provide appropriate respiratory care for residents.

The surveyor determined that the facility failed to ensure oxygen was administered and provided as ordered for two residents. Though the residents faced increased risk of shortness of breath and respiratory problems, the surveyor cited the violation as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- A resident's medical record documented an active order for continuous oxygen therapy through every shift. The resident stated that she becomes short of breath without oxygen therapy.
- On several occasions over a three-day period, the surveyor observed the resident without the nasal cannula in her nose or with an empty oxygen tank.
- The surveyor documented a similar finding with a second resident whose medical record also ordered continuous oxygen for every shift. This resident's medical record indicated increased risk of altered cardiopulmonary function, respiratory distress, diabetes, wheezing, and occasional shortness of breath.
- The resident's medical record included continuous oxygen therapy, but the resident was only receiving oxygen at night, according to an interview with a staff nurse. "Yes she has oxygen, she only wears it at night, we do not give it during the day time," the nurse said.
- **Note:** There are many standards nursing homes are required to follow to ensure that residents receive appropriate care and that they have a good quality of life. To learn more, please read LTCCC's fact sheet on resident care and well-being.

Life Care Center of Reno (Nevada)

Say my name: Four-star facility ignores resident's gender identity.

The surveyor determined that the facility failed to support a resident's gender identity as transgender. The resident was continuously addressed with incorrect pronouns and did not receive offers for treatment options or community support. Though the failure to honor the resident's right to self-determination resulted in "frustration and embarrassment," the surveyor cited the violation as no-harm.[4] The citation was based, in part, on the following findings from the SoD:

- In interviews with the surveyor, the resident expressed frustration and embarrassment about being addressed with incorrect pronouns and about having an opposite-sex roommate.
- The surveyor found that signage on the resident's door did not accurately reflect the resident's preferred name or gender identity.
- According to the Licensed Social Worker (LSW), the facility lacked specialized training for meeting the needs of gender variant residents. The resident's care plan failed to include goals or interventions to meet the resident's needs, according to the surveyor.
- **Note:** A 2020 research brief on Lesbian, Gay, Bisexual, and Transgender (LGBT) elders indicates that there are nearly three million LGBT people age 50 and older, and that these individuals are at high risk for discrimination and mistreatment. "It is imperative with all who interface with LGBT older adults respect the person's gender identity and gender

> *"It is **imperative** that all who interface with LGBT older adults respect the person's gender identity and gender expression…"*

expression by using the name and pronoun (e.g. he, she, they) used by the older adult, *regardless of legal identification or body configuration.*" [5]

Transitions Healthcare Capitol City (District of Columbia)

'Left off the list': Two-star facility fails to administer proper medication per resident's care plan.

The surveyor determined that the nursing home failed to administer hypertensive medications for a resident's elevated blood pressure. Though the resident had previously suffered a stroke due to high blood pressure, the surveyor cited the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

> *"The last time my blood pressure was that high, I had a stroke."*

- A resident with hypertension receives daily blood pressure measurements. In an interview, the resident stated that he always requests to review the numbers.
- After observing elevated blood pressure (189/111), the resident asked to see the nurse practitioner (NP). The NP told the resident that his blood pressure medication was "left off the list."
- "The last time my blood pressure was that high, I had a stroke," the resident said.
- The resident's medical record revealed medication for hypertension with a discontinue date of January 1, 2020. A nurse practitioner's note dated January 20 indicated that the resident had elevated blood pressure (BP), but that there was no BP medication listed on the resident's medical record. In interviews, the Director of Nursing and the Unit Manager acknowledged the findings that the facility's nursing staff failed to administer the resident's hypertensive medication for 19 days.
- **Note:** Facilities are required to ensure that residents are free of any significant medication errors that could jeopardize their health and safety. For more information on nursing home quality standards, read LTCCC's primer for residents, families, ombudsmen, and advocates.

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to detect resident harm. Anyone can report violations of the nursing home standards of care by contacting the state survey agency. To file a complaint against a nursing home, please use this resource available at CMS's Care 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] "State Data and Policy Actions to Address Coronavirus," Kaiser Family Foundation (Nov. 6, 2020). Available at https://www.kff.org/coronavirus-covid-19/issue-brief/state-covid-19-data-and-policy-actions/.

[2] Statement of Deficiencies for Absolut Ctr for Nursing & Rehab Three Rivers LLC (Feb. 25, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/01/Absolut-Ctr.pdf.

[3] Statement of Deficiencies for Augusta Place, A Prospera Community (Feb. 27, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/01/Augusta-Place.pdf.

[4] Statement of Deficiencies for Life Care Center of Reno (Feb. 21, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/01/Life-Care-Center-of-Reno.pdf.

[5] "Research Brief: Mistreatment of Lesbian, Gay, Bisexual, and Transgender (LGBT) Elders" (October 2020). Available at: http://eldermistreatment.usc.edu/wp-content/uploads/2020/10/NCEA_RB_LGBT2020.pdf.

[6] Statement of Deficiencies for Transitions Healthcare Capitol City (Feb. 20, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/01/Transitions-Healthcare.pdf.