ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 3, Issue 7

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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.

For many months during the COVID-19 pandemic, CMS restricted regular survey activities at nursing homes across the country. As a result, state agencies conducted only 8,999 complaint surveys in 2020, approximately half the amount from the previous year (16,662).[1] At a time when nursing home residents were most in need, too many facilities were operating without oversight.

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.

Brighton Manor (New York)

'He did not see it as abuse': One-star facility fails to appropriately address abuse allegations.

The surveyor determined that the facility failed to respond appropriately to two residents' allegations of abuse. According to the citation, the facility neither initiated nor completed a thorough investigation in response to two residents raising abuse concerns. Despite the facility's failure to address resident abuse allegations, the surveyor cited the violation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- In an interview, a resident said that they overheard a staff person refer to them as "a heifer." The resident said they reported the incident to the administrator.
- The administrator acknowledged the resident's report that the resident overheard the staff talking at the nurse's station but did not complete an investigation or have any documentation of the resident's report because 'he did not see it as abuse.'
- A second resident said that she was photographed by staff after staff removed her gown.
- The director of social work (DSW) said that the facility did not conduct an investigation into the resident's complaint because the incident had occurred two weeks prior to the date the resident reported it.
- The incident was called into a New York State nursing home hotline three days after the resident reported the incident.
- **Know Your Rights:** Nursing home residents retain all of the rights of people who live outside of a facility. These rights include the right to live free of physical, emotional, verbal, and sexual abuse and the right to be treated with dignity. Far too much resident abuse goes unreported, despite longstanding requirements for nursing homes to report allegations of abuse or neglect to the state survey agency. To help address the problem, the Affordable Care Act established important requirements for the reporting of any reasonable suspicion of a crime against a nursing home resident. To learn more about these requirements and addressing abuse in nursing homes, check out LTCCC's Abuse, Neglect, and Crime Reporting Center.

> Though nursing home residents live in an institutional setting, residents retain all of the rights of people who live outside of a facility, including the right to be treated with dignity.

North Hills Life Care and Rehab (Arkansas)

Privacy matters: Four-star facility fails to maintain and protect a resident's bodily privacy.

The surveyor determined that the facility neglected to treat a resident with dignity by failing to offer appropriate privacy while providing the resident care. Though this deficient practice jeopardized the resident's right to a dignified existence and privacy, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- Observations revealed a resident receiving care in his bed while wearing a t-shirt and an opened brief with his entire lower body exposed.

- The CNA did not close the window blinds or the privacy curtain, leaving the resident exposed to his roommate. The CNA closed the privacy curtain after the surveyor entered the room.
- An interview with the CNA revealed that she was aware of the policy and procedure to promote, maintain, and protect resident privacy during assistance with personal care.
- **Note:** No matter a resident's needs or abilities, facilities must treat each resident with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. This includes keeping residents sufficiently covered while providing care to protect the resident's right to privacy. Please see LTCCC's fact sheet on residents' rights to live with dignity.

Cedars Healthcare Center (Colorado)

Six pounds down: Two-star facility fails to assist and encourage resident with eating.

The surveyor determined that the facility failed to provide a resident encouragement, cueing, and assistance with eating. Though the resident experienced a recent six-pound weight loss and was observed not eating during a meal, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- The resident's assessment indicated cognitive impairment and revealed that the resident required limited assistance and encouragement with eating. The care plan identified the resident was at risk for not maintaining nutritional and hydration status.
- A CNA delivered the resident's meal, placed it on the overbed table, and left the room.
- The surveyor observed the resident looking around the room and eventually falling asleep. When the resident woke up, she took her fork and attempted to eat her dessert. She stopped eating after one bite but continued holding her fork.
- A nurse checked in on the resident after hearing her cough. The nurse told the resident to eat, then left the room without providing assistance, encouragement, or an offer for an alternative meal.
- The facility's dietitian stated in an interview that the resident had dementia and required encouragement to eat. The dietitian admitted that she was unsure whether the resident's recent six-pound weight loss was from the resident's medical condition or from not eating.
- **Note:** Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, facilities must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility providing encouragement and assistance to residents who require it to maintain a proper nutritional status. To learn more about the standards nursing homes are required to follow in order to ensure that residents receive appropriate care, check out LTCCC's fact sheet on resident care and well-being.

> Nursing homes must make assessments of resident's capacity, needs, and preferences, including nutritional status to ensure residents receive appropriate care.

Hillcreek Rehab and Care, LLC (Kentucky)

Attempted strangulation: Two-star facility fails to provide medically-related social services.

The surveyor determined that the nursing home failed to physically assess two residents and provide them the means to maintain or improve their mental and psychosocial needs. Though a resident attempted self-

strangulation, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- Records revealed the facility admitted two residents with known mental and psychosocial diagnoses.
- One resident's admission referral included a known communication issue as the resident spoke Napoli and required a translator.
- Within the first few days following admission, observations revealed the resident to be tearful, anxious, agitated, crying, and yelling. Staff documented 13 times that they were unable to communicate with the resident due to the language barrier.
- A review of progress notes revealed no documentation from the social service director (SSD) of a reassessment, interventions, or referrals.
- In interviews, the SSD stated she heard the resident yelling repeatedly as she walked past the resident's room but continued without interaction because an aide informed the SSD that the resident "just yelled all the time."
- Records revealed facility staff found the resident unresponsive and off the side of the bed with a call cord wrapped around their neck.
- The facility admitted a second resident whose initial assessment revealed no mood or behavioral issues or anxiety and depression as known diagnoses. However, the resident's medication list included antipsychotic medications and anxiety and depression medications.
- On the day of admission, the resident's behaviors included aggressive behavior, cursing, yelling, and refusal of care and services.
- The only note in the resident's record by the SSD revealed an attempt to transfer the resident, which occurred about one month after admission. The records revealed no other attempts to provide social services support to the resident.
- **Note:** Facilities are required to develop a baseline care plan within 48 hours of a resident's admission that include the minimum health care information necessary to properly care for a resident, including information about therapy services. If residents require rehabilitative services, such as services for mental disorders and intellectual disabilities, facilities must provide the required services or obtain the required services from an outside resource. To learn more, check out LTCCC's fact sheet.

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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 their state survey agency. 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] "Five-Star surveys: Changed forever?," McKnight's Long-Term Care News (February 8, 2021). Available at https://www.mcknights.com/blogs/guest-columns/five-star-surveys-changed-forever/

[2] Statement of Deficiencies for Brighton Manor (November 6, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/04/Brighton-Manor.pdf.

[3] Statement of Deficiencies for North Hills Life Care and Rehab (December 11, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/04/North-Hills-Life-Care-and-Rehab.pdf.

[4] Statement of Cedars Healthcare Center (December 3, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/04/Cedars-Healthcare-Center.pdf.

[5] Statement of Deficiencies for Hillcreek Rehab and Care, LLC (December 17, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/04/Hillcreek-Rehab.pdf.