# ELDER JUSTICE

## What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 3, Issue 8


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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 surveys in 2020, approximately half the number 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.

## Van Duyn Center for Rehabilitation and Nursing (New York)

### Death by asphyxiation: One-star facility fails to implement a resident's care plan.

The surveyor determined that facility staff failed to review and properly implement a resident's care plan. According to the citation, staff did not assist the resident in walking to the bathroom even though the resident's care plan documented a high risk of falls. Despite the facility's failure to keep the resident safe from a fall that resulted in the resident's death, the surveyor cited the violation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- The resident's care plan documented a high risk for falling. Interventions included proper footwear, proper lighting, education on mobility and transfers, and supervision for all activities of daily living.
- Progress notes indicate the resident began physical therapy (PT) after at least two falls. Following discharge from PT, the resident's care plan documented that she could not safely walk on her own, and that she needed extensive assistance.
- Upon entering the resident's room, staff found the resident in her bathroom on the floor where she died after the tie of her gown caught on the door handle. According to the autopsy summary, the scene suggested that the resident's fall caused her tie to tighten around her neck and act as a noose, cutting off oxygen to her brain.

**Note:** To read more about this citation and the facility's history of poor care, read "Left on her own in notorious Syracuse nursing home, elderly woman dies horrible death."

- James T. Mulder, syracuse.com

- Interviews with staff revealed that they were aware that the resident often walked on her own to get to and from the bathroom, even though the resident's care plan indicated she needed assistance with walking. Interviews further revealed staff had not conducted daily reviews of the resident's care plan as required.
- **Note:** Facilities are required to develop **and implement** comprehensive person-centered care plans for each resident that are consistent with resident rights. For more information on comprehensive care plans, please see LTCCC's Resident Assessment & Care Planning fact sheet.

> *"This sends a terrible message to nursing homes, that they can get away with grossly substandard care, even when it leads to a resident's death. What a horrific way to die, and what an abject dereliction of duty on the part of the department of health."*
>
> – LTCCC Executive Director, Richard Mollot, quoted in syracuse.com report.

## Manorcare Health Services – Pike Creek (Delaware)

### A wound unhealed: Two-star facility fails to provide resident with appropriate pressure ulcer care.

The surveyor determined that the facility neglected to properly treat a resident's pressure ulcer. The citation states that the facility failed to follow standard recommended interventions of frequent turning and repositioning to promote healing. Though this deficient practice jeopardized the resident's health and safety, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- The resident's care plan documented an unhealed stage 3 pressure ulcer, which occurs when the skin develops an open, sunken hole called a crater with damage to the tissue below the skin. The skin assessment directed use of pressure ulcer reducing devices, ointments, nutrition, and hydration interventions.
- Five days after the resident's admission, the wound care staff, through a telehealth evaluation, noted an increase in size of the wound. The facility was then ordered to complete a body audit every day shift to observe the resident's skin.
- The facility's skin practice guide indicated that frequent repositioning shifts can help prevent pressure ulcers. However, there was no documentation of turning or repositioning of this resident, according to review of the CNA's task report.
- Due to COVID precautions, the resident's wound evaluations were conducted by telehealth. The wound care nurse did not have photographs of the wounds or access to the facility to assess the wound in person.

**What are the different stages of pressure ulcers?** Check out LTCCC's webinar, Focus on Care & Outcomes: Pressure Ulcers and infection Control & Prevention.

- An interview with the director of the facility confirmed that the resident's wound was not visually assessed by a wound care nurse and that the employee responsible for monitoring the resident's wound no longer worked at the facility by the time of the survey.
- The resident was admitted to the hospital one month after admission to the facility and did not return to the facility.
- **Know Your Rights:** Pressure ulcers are an important measure of quality of clinical care in nursing homes. Despite this, over 87,000 nursing home residents are suffering with pressure ulcers today. For more information on pressure ulcers, please see LTCCC's fact sheet for standards you can use to support better care.

## Medford Multicare Center for Living (New York)

### Dining during COVID: Three-star facility ignores Department of Health requirement to discontinue communal dining.

The surveyor determined that the facility did not establish and maintain an infection prevention and control program. According to the citation, the facility failed to discontinue communal dining upon discovering a COVID positive resident, as required by the NY State Department of Health (DOH). Despite the facility's failure to provide a safe, sanitary, and comfortable environment and to help prevent the spread of COVID-19, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- DOH issued a health advisory in March 2020 requiring facilities to cancel group activities and communal dining if there is a positive COVID-19 case within the facility.
- According to records, the facility documented a positive COVID-19 resident on April 20, 2020.
- On May 13, 2020, observations revealed 27 residents seated in the dining room. Most were within six feet of each other and not wearing masks.
- When interviewed, the unit's RN supervisor stated she did not know why the residents were in the dining room together and acknowledged that they should not have been.

Sufficiently staffed facilities are more prepared to stop the spread of COVID-19. Unfortunately, facilities continuously fail to meet the minimum staffing threshold.

- The RN on the unit also stated that he did not know why there were so many residents in the dining room. He further stated that he was the only nurse working on the unit and it was "difficult to keep on top of everything."
- **Note:** Sufficiently staffed nursing homes are better prepared to stop the spread of COVID-19. Unfortunately, facilities continuously fail to meet the minimum staffing threshold (4.10 total care staff hours per resident day (HPRD), including 0.75 RN HPRD) indicated by a landmark 2001 federal study. Visit the Nursing Home 411 Data Center for more information on staffing.

## San Juan Living Center (Colorado)

### A 20 percent weight loss: Four-star facility fails to meet nutritional and hydration needs for a resident.

The surveyor determined that the nursing home failed to assist a dependent resident with eating and drinking to meet his nutritional needs. Though the resident lost one-fifth of their body weight in three months, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- Records showed the resident needed extensive assistance with eating because of a swallowing disorder.
- Observations revealed the resident appeared thin, weak, and soft spoken. The resident required visible effort and energy to speak the words "yes" or "no" and to lift his head from his pillow.
- In an interview, the resident stated that he did not receive enough assistance from staff and that he would like to be checked on more often.
- Facility staff indicated that residents were monitored every two to four hours. Other staff members revealed the facility was insufficiently staffed to ensure that dependent residents were assisted with eating.
- The facility's administrator said that they were unaware that the resident had stated he was not receiving adequate assistance with eating and drinking.
- The resident's care plan documented a 19.2% significant weight loss in 90 days.
- **Note:** Inadequate oral food and fluid intake is a serious yet common problem among nursing home residents. Facilities must provide 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.

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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 Van Duyn Center for Rehabilitation and Nursing (January 5, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/05/Van-Duyn-Center-for-Rehabilitation-and-Nursing.pdf.
[3] Statement of Deficiencies for Manorcare Health Services – Pike Creek (September 28, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/05/Manorcare-Health-Services-Pike-Creek.pdf.
[4] Statement of Deficiencies for Medford Multicare Center for Living (May 14, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/05/Medford-Multicare-Center-for-Living.pdf.
[5] Statement of Deficiencies for San Juan Living Center (December 1, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/05/San-Juan-Living-Center.pdf.