ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 3, Issue 9

IN THIS ISSUE:

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

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.

homes may have little incentive to correct the underlying causes of resident abuse, neglect, and other forms of harm.

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.

As of May 31, 2021, 71% of nursing homes have gone at least 16 months without a standard survey.[1] Even when surveys are conducted, harm to residents or the probability of harm rarely leads to a significant penalty, if any. For many months during the COVID-19 pandemic, CMS restricted standard surveys and shifted oversight to infection control surveys. Before the pandemic, surveyors cited 82 percent of nursing homes for infection control and prevention yet did not issue penalties for 99 percent of deficiencies because they were designated "no-harm."[2] The nursing home survey system continuously fails to adequately protect residents, pandemic or not.

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 (if confirmed), appropriately sanctioned.

Richmond Center for Rehab and Specialty Healthcare (New York)

Fire prevention: Two-star facility fails to develop a person-centered care plan for a resident with a known smoking history.

The surveyor determined that the facility neglected to create a person-centered care plan for a resident with a known history of smoking. According to the citation, an incident of the resident's smoking unsupervised led to a fire at the facility. Despite the facility's failure to implement its own policies which put the resident and others in immediate danger of serious harm, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- The resident was identified upon admission to the facility as a known smoker who smoked over ten cigarettes in the morning, afternoon, and evening but required assistance to do so.
- According to documents, the resident was transferred to the hospital from another facility after being found in bed with the pillow on fire and a lit cigarette.
- Per the facility's smoking policy, a safe smoking evaluation was to be completed by a nurse or another team member, and the resident's smoking materials were to be stored and locked by facility staff.

- Facility staff smelled smoke from the resident's room and searched the room, finding six packs of cigarettes and a box of matches. The cigarettes were confiscated and placed in a secure area for safety reasons, and staff were informed to monitor the resident.
- In a separate incident, there was a fire in the resident's closet, activating the smoke alarm and sprinklers and damaging the resident's closet and belongings.
- An interview revealed that a smoking care plan was created for the resident only after the fire in the resident's closet and several months after admission.
- **Note:** Facilities are required to provide residents with a safe, clean, comfortable home-like environment, including but not limited to receiving treatment and support for safe daily living. To learn more, please see LTCCC's fact sheet on safe environment.

> Ensuring that the nursing home is a safe environment for residents is fundamentally important, yet failure to do so is a persistent problem.

- **Know Your Rights:** Facilities are required to create and implement a baseline care plan within 48 hours and a comprehensive, person-centered care plan for each resident within 7 days of the initial comprehensive assessment. Care plans should be developed in consultation with each resident to meet their mental, psychosocial, medical, and nursing needs. To learn more, please see LTCCC's fact sheet on resident care planning.

Auburn Village (Indiana)

Bit off part of his tongue: Two-star facility fails to keep resident safe after significant medication errors.

The surveyor determined that the facility neglected to provide the resident with medication as prescribed. The citation states that the facility failed to provide the resident with the proper medication three times, which led to the resident biting off part of his tongue. Though this deficient practice jeopardized the resident's health safety and led to injury, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- The resident was admitted with hospital orders for an anti-convulsant medication for seizures.
- Following three missed doses of medicine, the resident was found with blood coming out of his mouth. The resident's teeth were clenched, and facility staff were unable to open the resident's mouth.
- After administering an anti-anxiety medication, staff opened the resident's mouth and found that the resident had bitten off part of his tongue.

> *"After missing 3 doses of medication, the resident experienced a seizure that resulted in injury."*

- An interview with the director of nursing revealed that the resident had not been given his medication because it was unavailable from the pharmacy and was not included in the facility's emergency drug kit.

- **Note:** There are numerous strong standards to ensure that residents receive appropriate medications and are free from medication errors, yet a 2017 systematic review published in the Journal of the American Geriatrics Society found that 16 to 27 percent of residents in studies were victims of medication errors. To learn more about the standards nursing homes are required to follow, check out LTCCC's Primer: Nursing Home Quality Standards.

Accel at Crystal Park (Oklahoma)

Neglected wounds: Two-star facility fails to keep five residents free from pressure ulcers.

The surveyor identified five residents in the facility with pressure ulcers and determined that the nursing home failed to conduct thorough and necessary skin assessments for two of those residents. The citation states that two residents with stages II and III pressure ulcers who were supposed to receive weekly skin assessments had no skin assessments or wound measurements conducted or documented for two weeks. Despite the facility's failure to provide proper pressure ulcer care to these residents, the surveyor cited the violation as no harm. This citation was based, in part, on the following findings from the SoD:

- Resident 1 was admitted to the facility with a known pressure ulcer. The resident's care plan required a head-to-toe skin inspection each week.
- Records revealed that no skin assessments or wound measurements were conducted or documented for 14 days.
- An interview with the director of nursing confirmed that Resident 1 was admitted to the facility with a known pressure ulcer and that the resident should have received two skin assessments and wound measurements over those 14 days for the stage III pressure ulcer.
- In a separate incident, no skin assessments or wound measurements were conducted over the course of 15 days for Resident 2, whose care plan included weekly treatment documentation for the stage II pressure ulcer.
- An interview with the wound nurse confirmed that there were no skin assessments or wound measurements documented in the medical record over the course of those 15 days.

> While some pressure ulcers are unavoidable, "[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."
>
> - Journal of Wound, Ostomy & Continence Nursing

- **Know Your Rights:** Pressure ulcers are an important measure of care quality in nursing homes. Facilities are required to ensure that residents with pressure ulcers receive necessary treatment and care consistent with professional standards of practice. For more information on pressure ulcers and pressure ulcer care, please watch LTCCC's webinar on Pressure Ulcers & Infection Control.

Magnolia Place – Greenville (South Carolina)

Smeared feces: Two-star facility fails to provide a safe, clean, comfortable, homelike environment.

The surveyor determined that the nursing home failed to provide the resident with a safe, clean, comfortable, and homelike environment. According to the citation, there was no trash can in the resident's bathroom and a chair in the resident's room was smeared with a dried, brown substance. Despite this unsanitary living environment, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- During an observation and interview with the resident, the resident asked the surveyor to look at the chair in their room. Under two bath towels the surveyor found dried feces smeared all over the seat of the chair.
- The resident stated that the chair had been covered in the feces for two weeks and, despite reporting this to nursing staff and housekeeping staff, nothing had been done to clean it.
- Observation of the resident's bathroom revealed a wash basin without a liner, but no trash can for the resident's use.
- The resident stated that they never had a trash can in the bathroom even though they had been asking staff for one.
- During an interview, the housekeeping manager confirmed the dried, brown substance on the chair, but stated that housekeeping cleans the resident's room daily and "must not have gotten to the room yet."
- When asked if the substance had been on the chair for long, the housekeeping manager stated, "maybe since last night," contrary to the resident's statement that it had been there for two weeks.
- **Know Your Rights:** Facilities are required to provide residents with a safe, clean, comfortable home-like environment, which includes maintaining a sanitary, orderly, and comfortable interior. For more information on the requirements for a safe and clean living environment, watch LTCCC's webinar on nursing home resident rights.

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Pinnacle Health & Rehab at N Berwick (Maine)

Confined alone in the shower: Two-star facility uses involuntary seclusion on resident.

The surveyor determined that the nursing home failed to ensure a resident was free from involuntary seclusion. Though the resident was intentionally left alone without access to a call bell or ability to leave the shower, leaving the resident at a significant risk for injury, the surveyor cited the violation as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- A review of the resident's clinical record revealed the resident had severe cognitive impairment and required extensive two-person assistance for bed mobility, transfers, and personal hygiene, and required use of a wheelchair for movement.
- Records showed a CNA placed a resident in the shower room and closed the door where the resident remained for at least 15 minutes without access to a call bell.
- During the 15 minutes that the resident was locked in the shower room, the resident screamed for someone to open the door.
- The CNA confirmed in a written statement that they had placed the resident alone in the shower room because the resident was "screaming."

> Nursing home residents have the right to be free from corporal punishment, involuntary seclusion, and any physical or chemical restraint not required to treat the resident's medical symptoms.

- **Know Your Rights:** Each resident has the right to be free from involuntary seclusion, which is defined as separation of a resident from other residents or from her/his room or confinement to her/his room against the resident's will. To learn more, see LTCCC's fact sheet on physical restraints.
- **Note:** This nursing home has been cited for abuse. For more information, please see LTCCC's alert about facilities with a history of abuse.

Provo Rehabilitation and Nursing (Utah)

Failure to report: Two-star facility fails to prevent and promptly report resident-to-resident abuse.

The surveyor determined that the nursing home failed to timely report altercations between residents on two occasions to the state survey agency or notify adult protective services. According to the citation, the director of nursing completed the reports but neglected to submit the reports in a timely manner. Although the facility failed to report the incidents as required, the surveyor cited the violation as no harm.[7] The citation was based, in part, on the following findings from the SoD:

- Records revealed that a resident was observed being hit by another resident in the hallway after lunch.
- A week after the incident, the facility reported it to the state survey agency, but there was no documentation that adult protective services was notified, and no investigation reported within five working days as required.
- According to interviews, the director of nursing prepared the report and "thought he had submitted the report."
- In a separate incident, a resident was observed hurrying back to his room after a nurse saw another resident nearby falling down.
- The incident was reported to the state survey agency the day following the incident, but no investigation report was reported within five days.

- **Know Your Rights:** Facilities are required to report, to the state survey agency, alleged violations of abuse immediately but not later than two hours after an allegation is made if the events involved abuse or resulted in serious bodily injury, or no later than 24 hours if the events did not involve abuse and did not result in serious bodily injury. Further, the results of all investigations into the allegation are to be reported to the state survey agency within five working days of the incident.
- In addition, everyone who works in a nursing home (including care staff, administrative staff, and contractors) is required to report any suspicion of a crime against a resident. If the crime involves serious bodily injury to any resident, the report must be made immediately but not later than two hours after forming the suspicion. In the absence of serious bodily injury, the report must be made within 24 hours.
- **Note:** Resident-to-resident incidents can have devastating consequences for the residents involved as well as their families. But why do these incidents happen? Check out LTCCC's podcast to hear gerontologist Eilon Caspi, PhD discuss the causes of resident-to-resident incidents, how these incidents relate to neglect, and more. For resources, see LTCCC's Abuse, Neglect, and Crime Reporting Center.

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.

Center for Medicare Advocacy
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LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

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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] "States' Backlogs of Standard Surveys of Nursing Homes Grew Substantially During the COVID-19 Pandemic," Office of Inspector General (July 27, 2021). Available at https://oig.hhs.gov/oei/reports/OEI-01-20-00431.asp.
[2] "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic," U.S. Government Accountability Office (May 20, 2020). Available at https://www.gao.gov/products/gao-20-576r.
[3] Statement of Deficiencies for Richmond Ctr for Rehab and Specialty Healthcare (December 7, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/08/Richmond-Ctr-for-Rehab-and-Specialty-Healthcare-NY.pdf.
[4] Statement of Deficiencies for Auburn Village (June 8, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/08/Auburn-Village-IN.pdf.
[5] Statement of Deficiencies for Magnolia Place (March 22, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/08/Magnolia-Place-Greenville-SC.pdf.
[6] Statement of Deficiencies for Pinnacle Health Rehab at N Berwick (February 17, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/08/Pinnacle-Health-Rehab-at-N-Berwick-ME.pdf.
[7] Statement of Deficiencies for Provo Rehabilitation and Nursing (January 6, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/08/Provo-Rehabilitation-and-Nursing-UT.pdf.