ELDER JUSTICE

What "No Harm" Really Means for Residents

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

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Note: In honor of Memorial Day, this Elder Justice newsletter is dedicated to those living in Veterans' homes across the United States.

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).

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.

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 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.

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.

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.

> *"Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?"*
> – ***Broken Promises: An Assessment of Nursing Home Oversight***

Western New York State Veterans Home (New York)

Pronounced dead: Staff fail to verify resident's CPR status at four-star nursing home.

The surveyor determined that the nursing home failed to provide basic life support per the resident's advance directive. Though the staff's failure to verify the resident's advance directive led to the resident's dying without receiving CPR, the surveyor cited the violation as no harm.[1] The citation was based, in part, on the following findings from the SoD:

- Records showed the resident signed a Medical Order for Life Sustaining Treatment (MOLST) which directed staff to attempt CPR in the event it was necessary.
- According to staff statements, a CNA was in the resident's room to transport the resident's roommate out of the room. During this time, the CNA heard the resident gurgling, and commented to another aide that the resident sounded terrible.
- The CNA returned to the resident's room to check on him and found him to be gray in color. She informed the Assistant Director of Nursing, who told the CNA to ask a nurse to enter the room.

> Facilities must have sufficient nursing staff with the *appropriate competencies and skills sets* to provide nursing and related services to *assure resident safety*…

- According to the nurse, the resident wore a wristband indicating that the resident wished to forgo CPR. After the nurse assessed the resident, she pronounced the resident dead.
- A review of the resident's advance directive revealed the resident wished to be resuscitated. The resident's wristband had an incorrect code status.
- After the nurse learned of the resident's wishes to be resuscitated, she returned to the resident's room to find the resident completely purple.
- **Know Your Rights:** Nursing homes must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population. To learn more about requirements for nursing home care staff and administration, check out LTCCC's fact sheet.

Lebanon Veterans Home (Oregon)

Unquenched thirst: Dehydration lands resident in hospital at three-star facility.

The surveyor determined that the nursing home staff failed to keep a resident properly hydrated. According to the citation, staff did not assist the resident with hydration needs even though the resident's care plan documented his need for total assistance with meals. Despite the resident's arriving at the hospital extremely dehydrated, 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 instructed staff to provide total assist with meals, and a dietary assessment revealed the resident was at risk for dehydration and entirely dependent on caregivers for eating and drinking.
- Shortly after the resident's admission to the nursing home, the resident's wife contacted the facility about concerns relating to the resident's fluid intake.
- Progress notes indicated the resident could not safely swallow medications, and when staff attempted to provide fluids, the fluids ran out of the resident's mouth.
- Medical records indicated the resident had a critically high sodium value and a water deficit.
- Several months after admission, the facility transferred the resident to the hospital where it was noted that that resident was extremely dehydrated.
- According to an interview with a family member, facility staff were unaware that the resident was unable to hold a cup.
- **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.

Every resident has the right to receive the care and services they need to maintain their highest possible level of functioning and well-being.

- **Note:** This nursing home has been cited for abuse, according to CMS's Care Compare website. Visit LTCCC's Abuse, Neglect, and Crime Reporting Center for a selection of resources that are free to use and share.

Spokane Veterans Home (Washington)

Sexual harassment: Residents at risk for unwanted and inappropriate touching at three-star facility.

The surveyor determined that the nursing home neglected to adequately supervise a resident reviewed for behaviors that put other residents at risk for abuse. The citation states that the facility failed to keep all residents safe from sexually inappropriate behavior by another resident. Though this deficient practice jeopardized residents' quality of life, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- According to an assessment, Resident 1 had the potential to be physically or sexually inappropriate with staff and/or peers, and was to have one-on-one monitoring, as needed.
- An interview with Resident 2 revealed an instance of Resident 2's waking up to Resident 1's playing with Resident 2's genitals.
- Another instance revealed Resident 1 in the dining room reaching over to another resident and grabbing that resident in the groin area. Staff immediately removed Resident 1 from the dining room and placed the resident under one-on-one supervision for a period of time.
- Shortly after removal of the supervision, Resident 1 was again found reaching toward another resident's groin, but staff separated the residents before there was inappropriate touching.
- Review of a facility investigation revealed the facility removed the one-on-one supervision of Resident 1 due to understaffing. While unsupervised, Resident 1 entered two residents' rooms and grabbed their genitals.
- **Note:** For more information on resident-to-resident incidents, listen to LTCCC's NursingHome411 Podcast, 'A Story of Neglect'.
- **Note:** This nursing home has been cited for abuse, according to CMS's Care Compare website. Visit LTCCC's Abuse, Neglect, and Crime Reporting Center for a selection of resources that are free to use, share, and adapt.

> Nursing homes are responsible for protecting residents from all forms of abuse, including resident to resident abuse.

Veterans Victory House (South Carolina)

'I will make the rest of your time here miserable': Nursing home administrator verbally abuses resident at four-star facility.

The surveyor determined that the facility failed to prevent verbal abuse of a resident by a staff member. Despite the resident's filing a grievance regarding the abuse, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- An interview with the resident revealed an allegation of verbal abuse.
- The resident stated that, while in the cafeteria, the Administrator and Assistant Administrator were serving food without hairnets. Upon seeing that, the resident told the staff she was going to report them for a health violation.
- According to the resident, the Administrator thereafter wheeled the resident out of the cafeteria and told him, "Don't ever embarrass me like that again or I will make the rest of your time here miserable."
- The resident stated to the surveyor that two other staff members witnessed this incident but were fired a week after the incident.
- In an interview, the Administrator stated that they arrived in the dining room after staff had served all the residents, and that they did not wear a hairnet because they were not serving food.
- The Administrator stated that the resident arrived in the area very agitated, yelling, and aggressively waving his arms. In response, the Administrator asked the resident to leave the area, but when the resident did not, the Administrator approached the resident and said, "Don't ever speak to me like that again. I have never spoken to you disrespectfully and I don't expect you to talk to me that way."
- Records revealed the facility reported the alleged verbal abuse several days after the incident. During the investigation, the Administrator was placed on leave and re-educated on abuse and neglect.
- **Know Your Rights:** Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Visit LTCCC's staffing page to access the latest staffing data and information.
- **Note:** This nursing home has been cited for abuse, according to CMS's Care Compare website. Visit LTCCC's Abuse, Neglect, and Crime Reporting Center for a selection of resources that are free to use, share, and adapt.

Nursing home residents have the right to be free from any type of abuse.

Ussery Roan Texas State Veterans Home (Texas)

Out of time: Staff at four-star facility fail to assist resident with basic hygiene services.

The surveyor determined that the nursing home failed to assist a dependent resident with the necessary services to maintain good personal hygiene. Though this deficient practice can lead to psychosocial harm and a decline in hygiene, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- The resident's care plan indicated that he required assistance with bathing and showering.
- In an interview, the resident stated that he did not receive a shave or shower when he was supposed to, and that he does not like going without his shower.

- According to the director of nursing, CNAs were responsible for giving and logging resident showers, and residents are expected to be showered three times a week unless they refuse.
- In an interview, a CNA stated that she ran out of time to give the resident a shower, and that the resident would get a shower the next day. The resident's shower log revealed that he did not shower the next day.
- Although the residents were scheduled for three showers per week, a review of this resident's shower log showed his last shower had been nine days prior.

Nursing homes must provide care and services for good hygiene including bathing, dressing, grooming, and oral care.

- **Know Your Rights:** Every resident has the right to receive the care and services they need to reach and maintain their highest possible level of functioning and well-being, including bathing, dressing, and grooming in accordance with the resident's preferences and customs. To learn more about standards of care, check out LTCCC's fact sheet on resident care and well-being.

New Jersey Veterans Memorial Home Menlo (New Jersey)

In the dark: Two-star facility fails to notify family members of significant change.

The surveyor determined that the nursing home failed to notify the family and/or responsible party of a resident's change in condition. Though the resident's family was not notified until after the doctor pronounced the resident dead, the surveyor cited the violation as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- Records revealed that after a resident indicated a temperature of 100.7 degrees, facility staff called a doctor to assess the resident. The doctor ordered an X-ray among other tests.
- The resident's X-ray showed an issue in the left lung, and the doctor prescribed an antibiotic for 10 days.
- Further records revealed the medication nurse walked to the resident's bedside to provide evening medications and found the resident not breathing.
- Upon this observation, the nurse supervisor called the doctor, and the resident was pronounced dead. At this time, staff notified the resident's family.
- A review of the resident's notes did not indicate any communication with the family upon finding that the resident had a fever and required an X-ray.
- In an interview, the Director of Nursing stated that the resident's family should have been notified about the change in the resident's condition.
- **Know Your Rights:** Nursing homes are required to immediately inform the resident, consult with the resident's physician, and notify the resident's family of any significant situations, including injury and decline that affect the resident or may require a change in treatment.

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
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
Volume 4, Issue 3

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] Statement of Deficiencies for Western New York State Veterans Home (September 17, 2019). Available at https://nursinghome411.org/wp-content/uploads/2022/04/Western-New-York-State-Veterans-Home-NY.pdf.
[2] Statement of Deficiencies for Lebanon Veterans Home (July 21, 2021). Available at https://nursinghome411.org/wp-content/uploads/2022/04/Lebanon-Veterans-Home-OR.pdf.
[3] Statement of Deficiencies for Spokane Veterans Home (September 2, 2021). Available at https://nursinghome411.org/wp-content/uploads/2022/04/Spokane-Veterans-Home-WA.pdf.
[4] Statement of Deficiencies for Veterans Victory House (July 14, 2021). Available at https://nursinghome411.org/wp-content/uploads/2022/04/Veterans-Victory-House-SC.pdf.
[5] Statement of Deficiencies for Ussery Roan Texas State Veterans Home (June 24, 2021). Available at https://nursinghome411.org/wp-content/uploads/2022/04/Ussery-Roan-Texas-State-Veterans-Home-TX.pdf.
[6] Statement of Deficiencies for New Jersey Veterans Memorial Home Menlo (June 16, 2021). Available at https://nursinghome411.org/wp-content/uploads/2022/04/New-Jersey-Veterans-Memorial-Home-Menlo-NJ.pdf.