ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 4, Issue 6

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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).

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***

CMS and state survey agencies use the Scope and Severity Grid for rating the seriousness of nursing home deficiencies. For each deficiency identified, the surveyor is charged with indicating the level of harm to the resident(s) involved and the scope of the problem within the nursing home. The Elder Justice Newsletter covers "no harm" deficiencies cited from D-F on the grid. The following chart is from the CMS Nursing Home Data Compendium 2015 Edition.

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is Not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

Beechtree Center for Rehabilitation and Nursing (New York)

Poisoned: Lack of staff supervision at one-star nursing home leads to resident's death.

The surveyor determined that staff failed to remove accident hazards and provide adequate supervision for a resident who died after ingesting dangerous vaping liquid (F689). Though the failure to prevent accidents and supervise a resident led to the resident's death, the surveyor cited the violation as no harm.[1] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a resident had vaping supplies including vaping liquid and a vaping device (a battery-powered vaporizer that heats vaping liquid), chewing tobacco, and THC-infused gummies in his possession at the nursing home.
- The resident's care plan documented cognitive impairment and chronic mental illness but did not include information related to the resident's use of a vaping device.
- On the morning of 6/8/2022, staff received a call from the resident's relative and were told the resident drank vape liquid.

> Nursing homes must ensure that the resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision to prevent accidents.

- When staff entered the resident's room, the resident was in bed, heavily perspiring, with an empty bottle of vape liquid on the bedside table. According to the investigation, the resident stated, "I just want to die" and had drunk the bottle of the liquid. The resident later died at the hospital from the overdose.
- In an interview, a CNA stated that the resident's possession of THC gummies and the vaping device was common knowledge among staff. The CNA had previously reported the resident's vaping device to an LPN.
- **Know Your Rights:** Nursing homes are responsible for ensuring the safest environment possible for residents in a manner that helps promote quality of life. Facilities must ensure that the resident environment remains as free of accident hazards as possible, and that each resident receives adequate supervision to prevent accidents. To learn more, check out LTCCC's fact sheet on fall and accident prevention in nursing homes.

Pearl City Nursing Home (Hawaii)

Moaning and yelling: Resident suffers excessive pain due to poor pain management.

The surveyor determined that the nursing home (a three-star facility) failed to provide adequate pain management services (F697). Although this deficient practice left a resident moaning and yelling in "excruciating" pain, the surveyor cited the violation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- The nursing home provided palliative care to a resident whose health records indicated Comfort Measures Only – medical treatment of a dying person that assures maximum comfort.[3]
- In an interview, staff stated that the resident had pain almost every day.
- On 6/15/2022, the resident was observed moaning and yelling in severe pain. After staff administered pain medications, the resident continued to experience "excruciating pain" for more than an hour.
- The next day (6/16), the resident was again observed moaning and yelling in severe pain. Though staff attended to the resident, he continued to experience excruciating pain for up to two hours.

Nursing homes must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

- Although the resident's care plan indicated several interventions to control the resident's pain, the resident continued to moan and yell in pain for long periods of time, according to the citation.
- **Know Your Rights:** Nursing homes must ensure that pain management is provided to residents who require such services. In order to help a resident attain or maintain his or her highest practicable level of well-being and to prevent or manage pain, as required by the federal rules, the facility must 1) recognize when the resident is experiencing pain and identify circumstances when pain can be anticipated; 2) evaluate the cause(s) of the resident's pain; and 3) manage or prevent pain, consistent with the resident's care plan, current professional standards of practice, and the resident's goals and preferences. To learn more, check out LTCCC's fact sheet on resident assessment and care planning.

Majestic Care of Livonia (Michigan)

91 degrees: One-star nursing home fails to provide safe living environment.

The surveyor determined that the nursing home did not honor its residents' right to live in a safe, clean, comfortable, and homelike environment (F584). Though residents were living in dangerous and uncomfortable conditions – rooms above 90 degrees, trash on the floor, etc... – the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- According to the survey conducted in August, seven residents voiced dissatisfaction with their living environment.
- Several residents stated their rooms were too hot. The maintenance supervisor found that two rooms were 91 degrees, and one room was 89 degrees.
- Observations for another resident's room revealed trash on the floor, a trash can in the bathtub, a food

Nursing homes must provide a safe, clean, comfortable, and homelike environment, allowing residents to use their personal belongings to the extent possible.

product bag by the door, and a plastic bag filled with trash behind the resident's door.
- Another resident who recently moved back into their room following a remodeling said that they were living out of the boxes and that they did not understand why no one had put their things back in the cabinets and wardrobe.
- The seventh resident to complain about their living environment said that their former roommate's belongings were still packed on the bed in clear plastic bags a week after that resident was discharged. In an interview, the resident said they "hated looking at that shit."
- **Know Your Rights:** Every resident has the right to a safe, clean, comfortable, and homelike environment. This includes providing housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior, and maintaining a temperature in a relatively narrow range that is comfortable for the residents. To learn more, see LTCCC's fact sheet on nursing home environments.

El Jen Skilled Care (Nevada)

Unkempt, messy, greasy: A surveyor's description of unbathed residents.

The surveyor determined that the one-star nursing home failed to provide care and assistance to perform activities of daily living for residents who are unable to perform these activities themselves (F677). Despite the nursing home's failure to bathe and groom two residents, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- According to the citation, staff failed to provide showers for two residents.
- The surveyor observed one resident in bed watching television. The resident's hair was unkempt and messy, and his face was unshaved.
- In an interview on 6/14/22, the resident stated that staff had not offered or helped them shave since they arrived at the facility on 6/7/22. The resident further stated they would like to feel clean when going out to the clinic.
- A second resident, observed on 6/14/22, had "messy, greasy," hair and did not appear to have been washed, according to the surveyor.
- The resident stated that staff had not offered a shower or washed their hair since their arrival on 6/9/22. Though the resident requested a shower, staff did not provide the resident with the necessary assistance.
- The director of nursing indicated the CNAs were expected to provide showers or bed baths twice a week. However, during an interview, a CNA stated they were "busy and forgot to provide the shower."
- **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 fundamental requirements, resident care, and sufficient staffing levels.

Life Care Center of Skagit Valley (Washington)

Avoidable accident: Resident falls after being left unattended on toilet.

The surveyor determined that the four-star nursing home failed to provide adequate supervision and monitoring to prevent a resident's fall (F689). Although the lack of supervision led to an avoidable fall, the surveyor cited the violation as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- A resident with a significant fall history required two-person physical assist for toilet use, according to the citation. This resident also had cognitive impairment, dementia, impaired safety awareness, confusion, seizures, Raynaud's syndrome, gait, and balance problems.
- Despite the resident's high fall risk (which the facility had documented in the resident's care plan), staff placed the resident on the toilet at 1:55pm and did not return until 2:15pm. During that time, the resident tried standing and fell to the floor.
- Staff members found the resident sitting on her buttocks with her legs bent after leaving her alone on the toilet for 20 minutes.
- The resident's daughter reported to the surveyor that the emergency department found a "compression fracture of L4 (lumbar, lower back region)."
- **Know Your Rights:** Each year, more than half of nursing home residents experience a fall while one in three residents experiences multiple falls. These incidents can lead to serious harm including functional decline, injury, reduced quality of life, and death. For more information, check out LTCCC's fact sheet on fall and accident prevention and watch LTCCC's webinar on fall prevention.

> Nursing homes must implement comprehensive, resident-centered fall prevention plans for each resident at risk for falls or with a history of falls and must also closely observe those with high fall risk.

Mesa Verde Post Acute Care Center (California)

"Severe sadness": One-star nursing home fails to provide appropriate medication.

The surveyor determined that the nursing home failed to provide the necessary care and services to maintain a resident's highest physical well-being (F684). Specifically, staff discontinued a resident's antidepressant medication without a physician's orders. Though the discontinuation had the potential to lead to severe complications, the surveyor cited the violation as no harm.[7] The citation was based, in part, on the following findings from the SoD:

- According to the citation, the resident had verbalized severe sadness due to multiple health issues.
- The resident's records had an active order dated 10/19/21 to administer medication to treat depression every day at bedtime.
- On 3/1/22, interviews and records revealed nursing home staff had discontinued the resident's medication without an order by the physician.

- The resident did not receive any of their prescribed antidepressant medication during the month of February.
- Abruptly stopping antidepressants can lead to withdrawal and cause symptoms including anxiety, insomnia or vivid dreams, headaches, dizziness, tiredness, irritability, flu-like symptoms, and nausea.[8]
- **Know Your Rights:** Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, residents' person-centered plan, and residents' choices. Learn more from LTCCC's fact sheet on standards of care.

According to federal regulations, the drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.

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 Care 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 6

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 Beechtree Center for Rehabilitation and Nursing (July 7, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/Beechtree-Center-for-Rehabilitation-and-Nursing.pdf.
[2] Statement of Deficiencies for Pearl City Nursing Home (June 17, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/Pearl-City-Nursing-Home.pdf.
[3] Comfort Measures Only, Specifications Manual for Joint Commission National Quality Measures (v2015A). Available at https://manual.jointcommission.org/releases/TJC2015A/DataElem0031.html.
[4] Statement of Deficiencies for Majestic Care of Livonia (August 4, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/Majestic-Care-of-Livonia.pdf.
[5] Statement of Deficiencies for El Jen Skilled Care (June 21, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/El-Jen-Skilled-Care.pdf.
[6] Statement of Deficiencies for Life Care Center of Skagit Valley (March 24, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/Life-Care-Center-of-Skagit-Valley.pdf.
[7] Statement of Deficiencies for Mesa Verde Post Acute Care Center (March 1, 2022). Available at https://nursinghome411.org/wp-content/uploads/2022/10/Mesa-Verde-Post-Acute-Care-Center.pdf.
[8] "Antidepressant withdrawal: Is there such a thing?" Mayo Clinic. Available at https://www.mayoclinic.org/diseases-conditions/depression/expert-answers/antidepressant-withdrawal/faq-20058133.