ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 5, Issue 2

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).

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

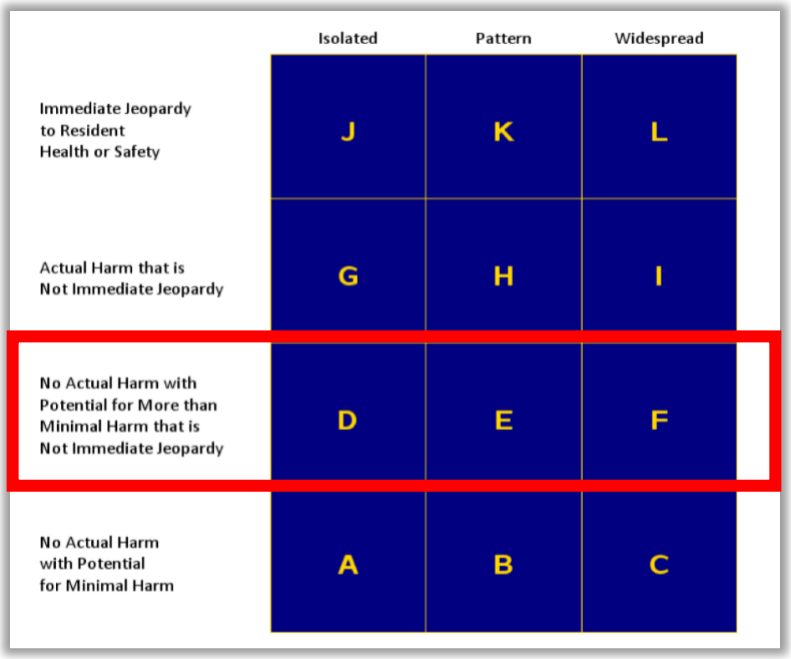
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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***

All licensed nursing homes are rated on a scale of one to five, with one being the lowest possible rating and five being the highest. While studies have shown that having a high rating does not necessarily mean that a nursing home is safe, substandard care in lower rated facilities has become a matter of increasing public concern. Star ratings included in this newsletter are current up to the date of newsletter's drafting.

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. This chart is from the CMS Nursing Home Data Compendium 2015 Edition.



Sanctuary at Wilmington Place (Ohio)

Pulling teeth: Resident goes without dental care despite cracked and missing teeth.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home failed to ensure a resident received necessary, routine dental care (F790). Though the resident's care plan indicated a potential for dental problems and a need for a dental consultation, 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, the resident's assessment revealed the resident had a "broken or loosely fitting full or partial denture that was chipped, cracked, uncleanable, or loose."
- The resident's care plan indicated orders for a dental consultation. However, a review of the resident's records revealed no dental visits between 3/26/21 and 12/19/22.
- The resident stated in an interview that he had not seen a dentist while living at the facility and that he had a desire to get dentures.
- According to observations, the resident had multiple missing teeth, broken teeth, and a brown color in his mouth.
- **Know Your Rights:** When left unaddressed for too long, dental problems can become serious issues. Nursing homes must assist residents in obtaining routine and 24-hour emergency dental care. Federal guidance defines "emergency dental services" to include "broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist." To learn more, check out LTCCC's fact sheet on dental services.

> Nursing homes must assist residents in obtaining routine and 24-hour emergency dental care.

Eastern Plumas Hospital – Portola Campus Dp/Snf (California)

"Who let you in here?": Resident verbally abused by staff.

Facility overall rating: ★★★★☆

The surveyor determined that the nursing home failed to prevent verbal abuse from staff to a resident (F557). Although a staff member screamed at a resident who then felt threatened by the staff member, the surveyor cited the violation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a resident self-propelled herself in her wheelchair from the activity room to her bathroom.

> Nursing homes must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of their quality of life, recognizing each resident's individuality.

- A CNA saw the resident and screamed at the resident for being in the hallway. The CNA shouted, "you are not to be in the hallway because this is a yellow zone. Who let you in here?"
- The resident stated in an interview that she felt scared when the CNA screamed at her and that, "she [the CNA] seemed really angry at me."
- An interview with a long-term care ombudsman revealed the incident had been investigated and the resident felt threatened when the incident occurred.
- **Know Your Rights:** Nursing home residents have the right to be free from abuse. Emotional abuse may include aggressive or hostile behavior/attitude towards a resident, staff speaking to residents with disrespect or contempt, and staff ignoring residents or leaving them socially isolated. To learn more, check out LTCCC's fact sheet on dignity and respect.

Alton Memorial Rehab & Therapy (Illinois)

Bladder and bowel: Staff fail to provide appropriate hygiene and incontinence care.

Facility overall rating: ★★★☆☆

The surveyor determined that the nursing home staff failed to provide timely and complete incontinence care for four residents (F690). Although the staff's failure to provide appropriate perineal care could lead to growth of bacteria, skin breakdown, and poor hygiene, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- According to the deficiency, the surveyor observed inappropriate hygiene care for four residents.
- The first resident's care plan indicated incontinence and a need for assistance with personal care.
- According to observations, a CNA wiped the resident's bottom after the resident used the toilet, but the CNA did not clean the resident's inner thighs and inner labia as required by the facility's perineal care policy.
- The surveyor observed a CNA assisting a second resident with toileting. The CNA removed a heavily soiled incontinence brief from the resident, and during the transfer to the toilet, the resident continued to urinate down her legs and onto the floor, soiling her elastic stockings.
- The CNA cleaned the resident's abdomen, inner thigh, and buttocks, and applied a clean brief and pants. However, the CNA did not clean the resident's lower leg or remove the resident's urine-soiled stockings.
- A third resident requiring incontinence care was assisted to his bed by two CNAs. One CNA opened the resident's incontinence brief, cleaned the peri area and sides of the scrotum, the left buttock and part of the right buttock. The CNA failed to properly clean the resident's entire right buttock.
- A CNA assisted a fourth resident while the resident was in a standing position. The CNA removed the resident's soiled incontinence brief, used a wet washcloth to wash the resident's buttocks, penis, scrotum, and dried the areas with a dry towel. However, the CNA did not use soap or any cleaner when providing perineal care.

- An LPN stated in an interview that she would expect staff to appropriately clean all areas of incontinence on residents, including removing any soiled linens from the residents and cleaning their wheelchair seats if needed.
- **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. This includes appropriate hygiene care of bathing, dressing, grooming, and oral care, in accordance with the resident's preferences and customs. To learn more, see LTCCC's fact sheet on resident care and well-being.

Azria Health Gretna (Nebraska)

Going hungry: Resident left slumped over uneaten food.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to ensure that staff assisted a resident with eating (F677). Although the resident was at risk for weight loss, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- A review of a resident's assessment and nutrition care plan revealed the resident was at risk for weight loss and required physical assistance with eating.
- The surveyor observed the resident slumped over in their recliner chair in their room with their eyes closed. The resident's lunch tray sat in front of them, uneaten.
- According to the citation, the resident sat slumped over with an uneaten meal tray for over 20 minutes without assistance.
- The director of nursing confirmed to the surveyor that the resident needed assistance with eating.

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

- **Know Your Rights:** 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 nursing home standards for care and nutrition, check out LTCCC's fact sheet on food, nutrition, and dietary services or watch our webinar on resident-centered dining.

St Joseph Chateau (Missouri)

No money, more problems: Facility operator withholds residents' personal funds.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility operator failed to ensure that residents had access to their personal funds (F567). Though this prevented residents from purchasing Christmas gifts in a timely manner and making vending machine purchases, 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, the facility operator withheld personal funds from five residents.
- Four of the five residents did not have access to their own personal funds to buy Christmas gifts for their family members and loved ones in a timely manner. These residents stated the lack of access to their own money made them feel sad and angry.
- A fifth resident stated they did not have access to the money in their account to purchase vending machine items for a month. The resident stated they believed it was mismanagement from the new operating company and not the administrator's fault.
- In an interview, the business office manager stated the residents' money was in the resident trust fund, as federally required, but the facility did not have access to the money to give to the residents because the new operator did not make the funds available.
- **Know Your Rights:** Nursing home residents have the right to manage their own financial affairs, including the right to know, in advance, what charges a facility may impose against a resident's personal funds. The facility must not require residents to deposit their funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility.
- **Note:** Congress has not raised the Medicaid personal needs allowance (PNA) in decades leaving hundreds of thousands of nursing home residents to survive on as little as $30 per month.

According to federal regulations and guidance, residents have the right to manager their financial affairs.

Thornapple Manor (Michigan)

Rip off the band-aid: Facility fails to assess and monitor resident's skin condition.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to provide appropriate treatment and care according to orders, resident's preferences, and goals (F684). Despite the failure to properly assess and monitor a resident's skin condition, resulting in the potential for worsening of condition and delay of treatment, the surveyor cited the violation as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- According to the deficiency, the surveyor observed a resident with a band-aid on her forehead.
- On 12/6/2022, a CNA stated that she was not sure why the band-aid was there and that it had been there for a couple months.
- In an interview with a registered nurse, the nurse stated she believed the scabbed area had been there for a while, but

Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents.

she could not find any documentation in the resident's record regarding the skin condition.

- A physician's note dated 12/7/2022 revealed the scabbed area had increased in size and included a referral to dermatology.
- On 12/8/2022, the assistant director of nursing noted that the skin condition was noted as dry skin on the resident's skin assessment dated 8/7/2022, but that there was no documentation that the skin condition had been evaluated or addressed since then.
- **Know Your Rights:** Nursing homes must place priority on identifying what each resident's highest practicable well-being is in each of the areas of physical, mental, and psychosocial health. Each resident's care plan must reflect person-centered care, and include resident choices, preferences, goals, concerns/needs, and describe the services and care that is to be furnished to attain or maintain, or improve the resident's highest practicable physical, mental, and psychosocial well-being. To learn more, check out LTCCC's fact sheet on resident assessment and care planning.

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
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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] Statement of Deficiencies for Sanctuary at Wilmington Place (December 27, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/Sanctuary-at-Wilmington-Place-OH.pdf.
[2] Statement of Deficiencies for Eastern Plumas Hospital – Portola Campus Dp/Snf (November 28, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/Eastern-Plumas-Hospital-Portola-Campus-DpSnf-CA.pdf.
[3] Statement of Deficiencies for Alton Memorial Rehab & Therapy (December 1, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/Alton-Memorial-Rehab-Therapy-IL.pdf.
[4] Statement of Deficiencies for Azria Health Gretna (December 15, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/Azria-Health-Gretna-NE.pdf.
[5] Statement of Deficiencies for St Joseph Chateau (December 21, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/St-Joseph-Chateau-MO.pdf.
[6] Statement of Deficiencies for Thornapple Manor (December 8, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/04/Thornapple-Manor-MI.pdf.