ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 5, Issue 3

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

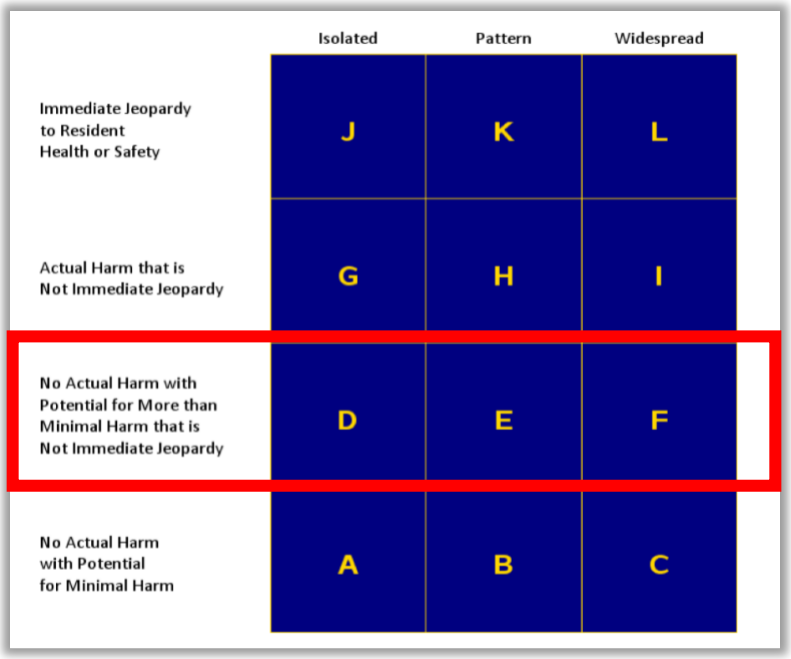
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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.



Note: Decades of extensive research shows that nursing homes with more nursing staff produce better quality measures, on-site survey scores, and resident outcome measures. Conversely, residents in understaffed nursing homes are more likely to suffer harm and experience negative outcomes.

This issue of the Elder Justice Newsletter is dedicated to nursing home residents suffering from neglect because of severe understaffing across the United States.

Cedar Ridge Health & Rehab Ctr (Illinois)

"Nobody came for over 11 hours": Residents wait all night to receive care.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home failed to provide adequate staffing to meet resident needs including bathing, incontinent care, and repositioning (F725). This deficient practice left one resident waiting over 11 hours for care. Nevertheless, 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 deficiency, 65 of the nursing home's 97 residents required assistance with bathing, 84 required assistance with dressing, and 70 required assistance with toileting.
- Multiple residents and staff stated that the nursing home was understaffed at night and on the weekends. One staff member told the surveyor there are usually only two CNAs in one hall to care for 26 residents.
- In an interview, the director of nursing said, "you will never find a CNA who does not state they think the facility is understaffed."
- One resident stated there was no one on his hall to assist him in repositioning in his bed. Due to his bilateral below-knee amputations, the resident was unable to adjust himself without assistance. Despite ringing his call light, nobody came until the next morning, more than 11 hours later.
- A second resident told the surveyor he has been requesting a shower, but staff consistently tell him there is not enough help. The resident had been without a shower for over two weeks.
- According to a third resident, there is often only one CNA on staff in her hall at night, and so the resident can lay soaked in urine all night long. The resident told the surveyor her skin gets raw and burned from lying in the wetness and that she uses wipes to clean herself up after being incontinent but struggles due to physical limitations from a stroke.
- A fourth resident reported not having a shower in a week and a half despite daily requests. The resident said he tries to keep himself clean but feels uncomfortable and embarrassed.

Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Unfortunately, inadequate nursing home staffing is a widespread and persistent problem. Some nursing homes provide good care, ensuring that their facilities have enough qualified staff. However, in the absence of limits on profits and administrative expenses, too many nursing homes fail to allocate the resources necessary to maintain sufficient staffing.

According to the resident, staff tell him they do not have time to shower him due to understaffing and the time-consuming process of transferring him to the shower bench.

- **Note:** The most recent staffing data indicates that this nursing home provides 3.24 hours per resident per day (HRPD) of total nurse staff time, including 0.42 RN HPRD. These staffing levels are well below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD, including 0.75 RN HPRD). This nursing home received a one-star overall rating and a one-star staffing rating from CMS.
- **Know Your Rights:** Every facility must have sufficient and competent nursing staff to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being.

Linden Grove Health Care Center (Washington)

"The ones that suffer the most": Insufficient staffing results in insufficient care.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home did not have sufficient staff to provide care and services (F725). Though the nursing home's low staffing levels left resident care needs unmet and put them at an increased risk of declining conditions, the surveyor still cited the violation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- Based on observations and interviews with residents and staff, the surveyor found that the facility lacked adequate staffing levels to timely respond to resident's call lights, provide showers, or appropriately prevent and care for pressure injuries.
- According to resident care instructions, staff were to check residents every two hours to determine if their brief needed to be changed. In an interview, a staff member stated that they were unable to complete this care when they were assigned 16 or 17 residents. The staff member told the surveyor that the facility management knew about the insufficient care and were very understanding of the staff challenges. Management told staff to inform the aide on the next shift about care that was not done.
- The nursing home admitted one resident with paralysis on the right side of the body and a stage III pressure injury near their tail bone. A March 24 provider's note documented the resident's wound no longer required treatment, but on March 28, the surveyor observed the resident lying on their side attempting to remove their wet brief. As staff assisted the resident in removal, the surveyor observed an open wound near the resident's tail bone.
- In an interview, a staff member stated that they sometimes prioritize residents who request to be changed. In response to a question about those that cannot ask, the staff member stated it was "sad because these were the ones that suffer the most."
- Several other residents stated they often had to wait longer than they'd like for call light responses and would be left wet in their briefs. The result can be increased risk of bed sores.

Pressure ulcers are serious medical conditions and one of the most important measures of the quality of clinical care in nursing homes.

- **Know Your Rights:** A resident with pressure ulcers has the right to receive care that is consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. To learn more, check out LTCCC's fact sheet on pressure ulcers.

Isabella Geriatric Center Inc (New York)

Pungent urine odor: Residents fend for themselves in filthy nursing home.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home failed to provide sufficient staff to timely and appropriately complete incontinence care, provide a clean living space, or adequately address the needs of residents (F725).[3] The citation was based, in part, on the following findings from the SoD:

- The surveyor determined that the facility was often severely understaffed, at times requiring one CNA to care for over 40 residents and leaving residents who require one-on-one supervision without a staff member.
- According to the deficiency, the surveyor observed residents with urine-stained pants and observed resident bathrooms with brown stains near the toilets and dried urine on the floors.
- The facility administrator told the surveyor they are aware that the resident bathrooms smelled like urine.
- In an interview, a CNA stated that the CNAs do their best to check resident bathrooms and report to housekeeping. However, the CNA stated there is no time to check if the rooms were cleaned because the CNAs have so many residents under their care.
- Several staff members stated the facility has a pattern of understaffing and that the staff do their best, even telling the surveyor they skip breaks and stay late to ensure assignments are completed.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.17 hours per resident per day (HRPD) of total nurse staff time, including 0.49 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD, including 0.75 RN HPRD). This nursing home received a one-star overall rating and a one-star staffing rating from CMS.
- **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.

The Waterview Pines LLC (Minnesota)

Urgent needs unmet: Facility maintains insufficient staff to assist with toileting.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to ensure there were enough nursing staff every day to meet the needs of every resident. It also determined the facility did not have a licensed nurse on each shift (F725). Although this deficient care infringed on the residents' right to dignity, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- The surveyor identified that staff could not complete appropriate care for residents when understaffed on a shift. Residents were left in bed past noon, sat in soiled briefs, and were not repositioned as needed.
- According to the citation, several residents stated the facility did not have enough staff to provide timely toileting and repositioning or provide residents with their preferred wakeups and bedtimes.
- A resident reported that she frequently had soiled briefs and had been left on the commode for over an hour due to understaffing.
- Another resident reported that she had daily accidents because there were not enough staff to answer her call light. This resident reported there were times she would go a week without a shower. According to her care plan, the resident's output record had been requested for the past four weeks, but the facility was unable to provide records of intake and output.
- **Know Your Rights:** Resident care plans must be based on resident assessments and implemented accordingly. In other words, care must be provided based on each resident's needs and goals, not on the services or staffing levels which the nursing home decides to provide based on its financial (or other) priorities. See LTCCC's fact sheet on resident assessments and care planning for more information.

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

The Gardens (Oklahoma)

Hygiene heartache: Resident comfort neglected due to staffing shortage.

Facility overall rating: ★★★☆☆

The surveyor determined that the nursing home failed to provide sufficient nursing staff to meet every resident's needs, specifically those related to hygiene (F725). Although some residents went 30 days with only one or two showers, 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 administrator identified 10 residents dependent on staff for bathing. The surveyor reviewed the bathing records for three of those residents, finding deficient care in each case.
- One resident's records revealed she had had one bath in the last 30 days even though her shower schedule indicated Monday and Thursday showers.
- A second resident told the surveyor she had not had a shower in two weeks. She stated she needed staff to wash her hair and "could not keep herself clean with paper towels and soap in the sink."
- A third resident told the surveyor the facility did not have enough staff to give baths according to resident preferences.
- Several staff members told the surveyor the residents did not receive baths as scheduled because there were not enough staff members to provide showers and daily care.
- **Know Your Rights:** It is important to remember: quality of life and quality of care cannot be separated – they are related and interdependent. No matter what a resident's needs are, or how their abilities have been diminished, everyone wants to live with dignity and have control of their lives, even if a person's health necessitates limitations. To learn more, check out LTCCC's fact sheet on resident dignity and quality of life standards.

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

Avenue at Broadview Heights (Ohio)

Wet and forgotten: Resident left saturated in urine due to understaffing.

Facility overall rating: ★★★☆☆

The surveyor determined that the nursing home failed to ensure sufficient staff to provide timely resident care (F725). Despite several residents being left disheveled and sitting in soiled briefs, the surveyor cited the violation as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- According to observations, one resident was seen with large chunks of white debris in his beard and white flakes throughout his "greasy and matted" hair. This resident was non-verbal and had not received showers or bed baths as scheduled due to understaffing.
- The surveyor found another resident with white debris in his hair. He was incontinent of stool, had a condom catheter in place for incontinence of urine, and his groin area had a "strong pungent odor and a thick mucus type discharge…"
- Observations of a third resident revealed the resident was "saturated with urine that had soaked through to her mattress pad."

Facilities must ensure that residents who are incontinent of bladder and bowel on admission receive services and assistance to maintain continence unless their clinical condition is or becomes such that continence is not possible to maintain.

- **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 report resident harm or neglect. 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 5, 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 Cedar Ridge Health & Rehab Ctr (March 24, 2023). Available at https://nursinghome411.org/wp-content/uploads/2023/08/Cedar-Ridge-Health-Rehab-Ctr.pdf.
[2] Statement of Deficiencies for Linden Grove Health Care Center (March 30, 2023). Available at https://nursinghome411.org/wp-content/uploads/2023/08/Linden-Grove-Health-Care-Center.pdf.
[3] Statement of Deficiencies for Isabella Geriatric Center Inc (December 16, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/08/Isabella-Geriatric-Center-Inc.pdf.
[4] Statement of Deficiencies for The Waterview Pines LLC (January 7, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/08/The-Waterview-Pines-LLC.pdf.

[5] Statement of Deficiencies for The Gardens (January 12, 2022). Available at https://nursinghome411.org/wp-content/uploads/2023/08/The-Gardens.pdf.
[6] Statement of Deficiencies for Avenue at Broadview Heights (March 30, 2023). Available at https://nursinghome411.org/wp-content/uploads/2023/08/Avenue-at-Broadview-Heights.pdf.