

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 11

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How Do “No Harm” Staffing Violations Impact Nursing Home Quality and Safety?

Sufficient staffing is one of the most important indicators of nursing home quality and safety. Federal law and regulations require nursing homes to have 24-hour licensed nursing services that are sufficient to meet resident care needs, in addition to having a registered nurse on duty every day. Unfortunately, too many nursing home residents across the country continue to experience harm because of insufficient staffing. While a landmark 2001 federal study indicated that 4.1 of total care staff hours per resident per day are needed to ensure residents receive basic clinical care, the latest data ([2019Q3](#)) demonstrate that U.S. nursing homes only provide an average of 3.37 hours of care per resident per day.

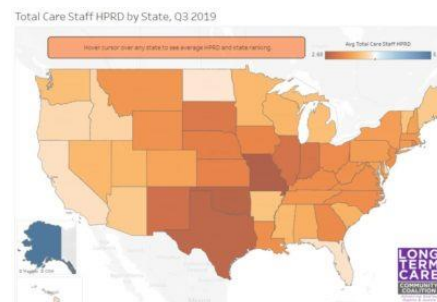
In the absence of a financial penalty, nursing homes may have little incentive to improve deficiencies in staffing.

The failure to maintain sufficient staffing levels has significant consequences for residents. For example, a [2014 federal study](#) found that one-third of short-stay Medicare beneficiaries were harmed within approximately two weeks of entering a nursing home. The study determined that almost 60 percent of these events were attributed to “substandard treatment, inadequate resident monitoring, and failing to provide treatments.” Similarly, a [2019 federal study](#) found that the number of cited abuse violations more than doubled from 2013 to 2017. A related stakeholder discussion noted that “nursing homes with insufficient staffing, inadequate staff training, and inadequate staff screening may be at risk for abuse.”

Despite persistent and widespread deficiencies in staffing, the overwhelming majority of violations are identified as causing “no harm” to residents. The failure to recognize resident pain, suffering, and humiliation when it occurs means nursing homes are likely not being held accountable for violations through financial penalties. In the absence of a financial penalty, nursing homes may have little incentive to improve deficiencies in staffing.

Purpose of this Newsletter

This issue of the *Elder Justice* newsletter focuses specifically on staffing 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 [Nursing Home Compare](#) website. While CMS may fail to properly penalize nursing homes for deficiencies in staffing, it is important that the public is aware of safety concerns affecting members of their community. To learn more about staffing levels for nursing homes in your community, please visit [LTCCC's Staffing webpage](#).



[Map of State Staffing Averages for Q3 2019.](#)

Onondaga Center for Rehabilitation & Nursing (New York)

One-star facility fails to have sufficient staff to meet resident needs, including activities of daily living (ADLs), meals, medications, treatments, and activities.

The surveyor determined that the nursing home did not “ensure sufficient nursing staff to provide nursing services to attain or maintain the highest practicable physical, mental and psychosocial well-being for all 76 residents in the facility.”¹ Specifically, the surveyor documented that the facility did not have sufficient staff to meet the needs of residents, “including activities of daily living (ADLs), meals, medications, treatments and activities.” Despite this conclusion, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A certified nurse aide (CNA) told the surveyor that “most day shift[s] they would work with only 3 CNA's for 35- 40 residents and typically only 1-2 CNA's for the evening shift. They were not able to get residents up in the morning and they would have to wait to get up late, showers did not get done as there was not enough time, there was no turning and positioning and they were not able to get residents toileted at times or not timely.”
- A registered nurse (RN) noted that “some treatments on residents were not being completed on multiple occasions as there was one nurse passing medication to 40 residents.” A licensed practical nurse (LPN) added that she “worked every weekend and frequently worked with just herself passing medications to 40 residents. Sometimes there was no time to get treatments done as she was busy getting all the medications passed.”
- The surveyor’s review of the daily staffing sheet showed that the facility failed to have an RN in the building for nearly two days in February.
- **Note:** The most recent staffing data ([2019Q3](#)) indicates that this facility provides 3.9 hours per resident per day (HPRD) of total care staff time and 0.5 HPRD for registered nurse care time. Both of these figures are below safety thresholds identified in a landmark 2001 federal study. To learn more about the federal staffing requirements, please see LTCCC’s [fact sheet](#) and [issue alert](#).

→ **Every facility must have sufficient and competent nursing staff to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being.**

Jacob Health Care Center (California)

Three-star nursing home fails to have sufficient staff to respond to resident needs in a timely manner.

The surveyor determined that the nursing home failed to “provide sufficient staffing to answer call lights and provide care in a timely manner”² Although the surveyor documented that this failure had the potential to result in physical and psychosocial harm, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- One resident told the surveyor that he frequently had uncontrollable muscle spasms which moved his entire body. The resident indicated that “on the day of his fall, when he had spasms, he felt his body start to drift too close to the edge of the bed.” Sadly, staff did not respond to his call light in a timely manner, causing him to fall over the side of the bed. The resident noted that he spent five minutes on the floor before staff finally answered his call light.
- A family member reported to the surveyor that she often visited her husband and has had to ask staff to provide frequent hydration. She stated that “her husband's lips would be dry and cracked.” She also expressed her belief that “staff were too busy to help her husband.”
- Interviews with residents elicited the following feedback about their experiences with care staff: (1) Licensed nurses did not help the nurse aides with answering call lights; (2) Wait times of 2-3 hours for help; (3) Staff come in quickly and turn off a resident’s call light, and then they never come back; and (4) “It feels like a game.”
- **Note:** The most recent staffing data ([2019Q3](#)) indicates that this facility provides 4.7 hours per resident per day (HPRD) of total care staff time and 1.0 HPRD for registered nurse care time. Both of these figures are above minimum safety thresholds identified in a landmark 2001 federal study. [Note: Federal staffing requirements are not based on this study; they require that facilities have “sufficient” staff to meet their residents clinical, psycho-social, and dignity needs.] To learn more about the federal staffing requirements, please see LTCCC’s [fact sheet](#) and [issue alert](#).

→ **Every facility must conduct and document a facility-wide assessment to determine what resources are necessary for daily operations and emergencies. This facility-assessment must account for nursing staff and other personnel.**

The Oaks-Athens Skilled Nursing (Georgia)

Two-star nursing home fails to have sufficient care staff to respond to call lights and provide restorative services.

The surveyor determined that the nursing home failed to “provide sufficient nursing staff to address activity of daily living (ADL) needs . . . restorative services . . . and timely meal tray delivery and call light response”³ Despite this failure, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A review of the facility’s grievances showed that one family member complained that she turned on the call light and nobody responded even after two and half hours. The family member had to transfer the resident to a recliner and take the resident to the bathroom.
- One resident told the surveyor that, on the night she was admitted to the nursing home, “she pressed her call light for assistance to use the restroom, but nobody came so she just waited until the next morning to ask again.” The resident stated that, on the following night, staff put her on a bedpan but spilled the urine

while removing it. The resident added that “instead of changing the wet sheets on her bed, the staff just put a dry pad over the wet sheet, and a family member changed the sheets the next morning.”

- A unit manager told the surveyor that CNAs “don't do a very good job providing care for the residents because they are so overworked. She stated that she has made complaints to Director of Health Services about staff being overworked, and she has also talked to the Administrator about the CNA's being overworked.”
- **Note:** The most recent staffing data ([2019Q3](#)) indicates that this facility provides 3.6 hours per resident per day (HPRD) of total care staff time and 0.2 HPRD for registered nurse care time. Both of these figures are well below safety thresholds identified in a landmark 2001 federal study. To learn more about the federal staffing requirements, please see LTCCC's [fact sheet](#) and [issue alert](#).

Newton Wellesley Center for Alzheimer's Care (Massachusetts)

Five-star nursing home fails to have sufficient nurse staffing to provide basic supervision and sustain resident dignity.

The surveyor determined that the nursing home failed to “provide adequate staffing to provide supervision, care and activity support to residents residing . . . [in the] specialized dementia care unit during meal preparation and activities programming.”⁴ While the nursing home failed to provide adequate staffing for resident needs, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- The surveyor observed a resident who was incontinent and dripping fluid through the wheelchair. The surveyor noted that a puddle had formed underneath the resident's wheelchair. The surveyor also observed another resident “rocking back and forth, gripping the arm rest of the wheel chair firmly and releasing in a rapid sequence and then attempting to stand, only to be stopped by their seat belt and then repeating the same motions.”
- The surveyor observed 33 residents in the dining/recreation room. Two residents were crying, two residents were yelling, and one resident appeared to be asleep. Only one staff member—the activities assistant—was in the room at the time. The number of residents in the dining/recreation room grew to 35. One nurse and two aides were in the room but “the aides were walking in and out and at times assisting residents in the room and wandering on the unit.” The survey noted that during this time, “[o]ne resident was saying help, one resident was roughly scratching himself/herself and crying, and another resident was yelling loudly, go go go, which disturbed the other residents at his/her table. No staff intervened, redirected, or attempted to assist these three residents.”
- Later that day, the surveyor observed a resident screaming loudly in the corner of the room. The activities assistant was occupied and the “nurse turned to look at the resident and shrugged her shoulders. Neither staff person addressed or acknowledged the resident.”
- **Note:** The most recent staffing data ([2019Q3](#)) indicates that this facility provides 3.1 hours per resident per day (HPRD) of total care staff time and 0.3 HPRD for registered nurse care time. Both of these figures are

→ *When a facility accepts a resident, it is **affirming** that it has both enough staff to meet the care and service needs of that individual and that the staff it hires and retains are appropriately trained to carry out this promise. When a facility lacks sufficient staff to meet the needs of its residents, it is **breaking** that promise and violating its agreement with the federal government.*

well below safety thresholds identified in a landmark 2001 federal study. To learn more about the federal staffing requirements, please see LTCCC's [fact sheet](#) and [issue alert](#).

Should I Report Insufficient Staffing?

YES! Residents and families should not wait for annual health inspections to detect insufficient staffing.

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](#).



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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 Onondaga Center for Rehabilitation & Nursing (Feb. 9, 2018), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335548&INSPTYPE=STD&SURVEYDATE=02/09/2018>.

² Statement of Deficiencies for Jacob Health Care Center, LLC (Sept. 17, 2018), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=055508&SURVEYDATE=09/17/2018&INSPTYPE=STD>.

³ Statement of Deficiencies for Oaks – Athens Skilled Nursing (Mar. 15, 2015), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=115419&SURVEYDATE=03/15/2018&INSPTYPE=STD>.

⁴ Statement of Deficiencies for Newton Wellesley Center for Alzheimer's Care (Sept. 16, 2016), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=225222&SURVEYDATE=09/16/2016&INSPTYPE=STD>.