

# ELDER JUSTICE

## What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 3, Issue 2

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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 his or her “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).

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 being 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.

*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.*

### 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 [Nursing Home Compare](#) website.

**This issue focuses on nursing home citations in the months leading up to the COVID-19 pandemic, to highlight how facilities were not held accountable before the crisis hit.** About 70,000 people in long term care facilities have died from COVID-19 through August 20,<sup>1</sup> and countless more are suffering and dying from other causes: gross neglect, substandard care, loneliness, and “broken hearts.” As nursing home industry leaders lobby for legal immunity for resident abuse and neglect during the COVID-19 pandemic (and beyond!),

consider that too many facilities, even under “normal” conditions, were failing to protect the basic rights of their residents – often with no penalty.

**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 (as appropriate) addressed.

## Niagara Rehabilitation and Nursing Center (New York)

### Breakfast in a soiled bed: One-star facility fails to honor resident’s right to a dignified existence.

The surveyor determined that the facility did not provide treatment with dignity and care for a resident in a manner that promotes maintenance or enhancement of quality of life. According to the citation, a resident was observed sitting naked while eating from a tray placed on soiled linens. Despite the unsanitary conditions and the resident’s discomfort, the surveyor cited the violation as no-harm.<sup>2</sup> The citation was based, in part, on the following findings from the [SoD](#):

- A resident was heard yelling about not having pants or underwear and observed sitting naked from the waist down while eating from a tray placed directly on bed linens soiled with a brown substance. On the floor next to the resident was a soiled incontinence brief.
- In an interview, a Certified Nurse Aide (CNA) stated that after setting the breakfast tray down on the bed, he “went to go find a tray table, got distracted, and forgot about it.”
- According to the Minimum Data Set (MDS), the resident was cognitively impaired and required supervision while eating. The administrator stated that the resident should have been cleaned, dressed, and the meal tray should have been placed on an over the bed table.
- The facility was also cited for failing to maintain a sanitary environment for three resident units. The surveyor found that there were “soiled walls, damaged ceilings, soiled floors, a missing shower curtain, a soiled chair, soiled privacy curtains, dust-laden surfaces, damaged window sills, soiled and ripped floor mats and pads, a toilet tank missing its cover, wall-mounted night lights missing covers, improper garbage storage, and foul odors.”
- **COVID-19 Facts:** Niagara rehabilitation reported three COVID-19 resident deaths and 22 confirmed COVID-19 cases through July 26, according to CMS data.<sup>3</sup>
- **Know Your Rights:** There are many standards which nursing homes are required to follow to ensure that residents receive appropriate care, have a good quality of life, and are treated with dignity. Though some standards have been relaxed during the pandemic, all quality of care and dignity standards remain in effect. Read [LTCCC’s resident rights fact sheet](#) to learn how you can use these standards as a basis for advocating in your nursing home and community.

→ *Every facility 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 his or her quality of life, recognizing each resident’s individuality.*

## Cross Landings Health and Rehabilitation Center (Florida)

## Four-star facility fails to provide stop date for psychotropic medication.

The surveyor determined that the facility failed to indicate the duration for a dispense as needed (PRN) order of psychotropic medication for residents sampled for unnecessary medication. Despite the risks posed by the potentially life-threatening side-effects of psychotropics, the surveyor cited the violation as no-harm.<sup>4</sup> The citation was based, in part, on the following findings from the [SoD](#):

- The resident’s medical record – reviewed in February 2020 – documented an active order for medication three times a day, as needed, for agitation. The order, active for almost five months, did not list a stop date nor a rationale for a duration greater than 14 days.
- The Director of Nursing (DoN) stated that the pharmacy’s recommendation did include a recommendation indicating no stop date. The DoN confirmed that there needed to be a stop date with a rationale if the medication was to exceed 14 days.
- The surveyor documented a similar finding with another resident who was receiving PRN (as needed) antipsychotic medication for several months without justification for ongoing use in the medical record, and without a stop date on the order.
- **COVID-19 Facts:** Cross Landings has reported zero resident COVID-19 cases and three staff COVID-19 cases while reporting sufficient staffing levels and PPE supply throughout the pandemic, according to CMS data.<sup>5</sup>
- **Note:** Facilities must ensure that residents using psychotropic drugs receive gradual dose reductions, unless clinically contraindicated, in an effort to discontinue these drugs. For more information, please see [LTCCC’s Dementia Care & Antipsychotic Drug Basics fact sheet](#) and check out [the latest data](#) (fourth quarter 2019) on antipsychotic drugging.

- Residents have the right to be informed about the risks and benefits of any medication.
- Residents have the right to refuse a medication.
- It is against the law to give medications that do not benefit the resident, such as for convenience of staff.

## Heartland Health Care Center – Grosse Pointe Woods (Michigan)

### ‘I wanted to go home’: Four-star facility fails to provide sufficient staffing to meet residents’ needs.

The surveyor determined that the facility did not ensure that enough staff were available to meet planned interventions, incontinence care needs, and other activities of daily living (ADLs) for six residents. Still, the surveyor cited the violation as no-harm.<sup>6</sup> The citation was based, in part, on the following findings from the [SoD](#):

- In interviews with the surveyor, several residents spoke about how the facility’s understaffing resulted in unmet resident care needs and dissatisfaction with care. One resident stated, “I waited three hours to get my brief changed. I laid in a soiled brief.”
- Another resident stated that they waited over an hour for toileting assistance four times in a two-week span. The resident stated, “The CNA turns off the call light and walks out of the room. Two times I have wet myself ... I felt angry, helpless, it felt really bad.” That night, the resident laid in a wet brief for an hour while waiting for staff to answer the call light, the resident stated in an interview. “I felt frustrated and was afraid that I might get a bed sore, I wanted to go home, at least I don’t have to lay in pee at home.”
- Residents stated that the staffing shortage was worse on weekends and that this has resulted in delays in receiving pain medication and therapy.

- Review of staffing records found that during a weekend afternoon shift, the facility had only one nursing assistant on each floor. One of those nursing assistants was also assigned to be a resident's sitter but worked the floor rather than providing for one-to-one monitoring.
- The resident who required one-to-one monitoring stated that staff do not check on them and that "Nobody moved me in bed yesterday or today." The resident stated that call light response times varied, but they had waited up to an hour for assistance.
- A review of confidential resident group meeting notes revealed that staffing is a longstanding problem at the facility. The document included notes about nurses not liking to work, complaining, taking too long, and shutting off call lights with no help.
- **Note:** Research on U.S. nursing homes has shown that higher staffing levels are associated with more favorable COVID-19 outcomes.<sup>7</sup> Unfortunately, [too many facilities were severely understaffed](#) in the months leading up to the pandemic. Visit [LTCCC's staffing page](#) to access the latest staffing data and information.
- **COVID-19 Facts:** Heartland Health Care staff experienced a COVID-19 outbreak that resulted in 19 confirmed COVID-19 cases and nine suspected cases, according to CMS data. Among residents, the facility reported 10 suspected COVID-19 cases, one confirmed COVID-19 case, and one COVID-19 death.

*"I wanted to go home, at least I don't have to lay in pee at home."*

## Kingston Healthcare Center, LLC (California)

### One of 25: Facility's failure to provide appropriate skin care results in Stage 3 Pressure Ulcer.

The surveyor determined that the nursing home failed to provide a resident with appropriate pressure ulcer care and prevent new ulcers from developing. Though the resident developed a pressure injury "as a result of intense and/or prolonged pressure," the surveyor cited the violation as no-harm.<sup>8</sup> The citation was one of 25 deficiencies included in a November 2019 inspection report, all of which were categorized as no-harm. It was based, in part, on the following findings from the [SoD](#):

- A resident developed a pressure injury resulting in on the right posterior thigh that resulted in full thickness skin loss, but staff failed to identify the injury until it advanced to Stage 3 and was discovered on 10/15/19.
- According to the surveyor, the facility was not providing daily assessments of the resident's condition as it should have.
- In an interview, a nurse stated that staff should "document in the shower sheets, and report any new change in skin condition to the charge nurse." However, a nurse stated there were no shower sheets for the resident on 10/10 or 10/14.
- The resident's thigh injury went unreported as staff was treating a separate pressure injury near the thigh on the back part of the hip bone.
- **COVID-19 Facts:** Kingston Healthcare reported 33 total COVID-19 resident deaths and a combined 163 resident and staff cases, according to data from CMS and the facility website.<sup>9 10</sup> Kingston Healthcare, a Special Focus Facility, has been identified by CMS as having an extremely poor record of resident care.
- **Note:** Pressure ulcers occur when there is damage to a resident's skin or underlying tissue and are generally localized to areas of the body with boney prominences such as elbows, hips, heels, and shoulders. Though some pressure ulcers are unavoidable, according to experts, "[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation."<sup>11</sup> To learn more, please read [LTCCC's pressure ulcer fact sheet](#).

## 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](#).



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To learn more about nursing home and assisted living care, visit us online at  
[MedicareAdvocacy.org](https://www.MedicareAdvocacy.org) & [NursingHome411.org](https://www.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.

<sup>1</sup> "State Data and Policy Actions to Address Coronavirus," Kaiser Family Foundation (Aug. 20, 2020). Available at <https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>.

<sup>2</sup> Statement of Deficiencies for Niagara Rehabilitation and Nursing Center (February 28, 2020). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335742&SURVEYDATE=02/28/2020&INSPTYPE=STD>.

<sup>3</sup> Facility Level COVID Data based on CMS nursing home dataset updated Aug. 6, 2020. Available at <https://nursinghome411.org/facility-level-covid-data/>.

<sup>4</sup> Statement of Deficiencies for Cross Landings Health and Rehabilitation Center (Florida) (Feb. 27, 2020). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=105802&SURVEYDATE=02/27/2020&INSPTYPE=STD>.

<sup>5</sup> Facility Level COVID Data (CMS).

<sup>6</sup> Statement of Deficiencies for Heartland Health Care Center – Grosse Pointe Woods (Feb. 27, 2020). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235109&SURVEYDATE=02/27/2020&INSPTYPE=STD>.

<sup>7</sup> See, for example, Li, Y. "COVID-19 infections and deaths among Connecticut nursing home residents: facility correlates," *Journal of the American Geriatrics Society* (June 18, 2020), available at <https://doi.org/10.1111/jgs.16689>.

<sup>8</sup> Statement of Deficiencies for Kingston Healthcare Center LLC (Nov. 7, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=555336&SURVEYDATE=11/07/2019&INSPTYPE=STD&profTab=1&Distn=9787.4&state=CA&lat=0&lng=0&name=KINGSTON%20HEALTHCARE%20CENTER%2C%20LLC>.

<sup>9</sup> Facility Level COVID Data (CMS).

<sup>10</sup> Kingston Healthcare Center COVID-19 Update (Aug. 3, 2020) available at <http://kingstonbakersfield.com/news/covid-19/>.

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<sup>11</sup> Edsberg, Laura E.; Langemo, Diane; Baharestani, Mona Mylene; Posthauer, Mary Ellen; and Goldberg, Margaret, "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy and Continence Nursing* (July/August 2014). Available at [https://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable\\_Pressure\\_Injury\\_State\\_of\\_the\\_Science.6.aspx](https://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science.6.aspx).