ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 3, Issue 10

IN THIS ISSUE:

Aaron Manor Rehabilitation and Nursing Center (New York) 2
Out of breath: Five-star facility fails to provide safe and appropriate respiratory care.
Springfield Health & Rehab (Vermont) 3
A black eye: Two-star facility fails to prevent physical abuse of resident.
Woodside Village (North Dakota).....4
'Please help me': Five-star facility fails to provide safe, appropriate pain management.
The Carrington (Mississippi) 5
Threatening a resident: Two-star facility fails to protect resident from verbal abuse by staff.
Kent Regency Center (Rhode Island) 6
Video violation: Five-star facility fails to protect a resident's right to personal privacy.
Sistersville Center (West Virginia) 6
Missing meds: Three-star facility fails to provide necessary medication to a resident.

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).

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 Care Compare website.

For many months during the COVID-19 pandemic, CMS restricted standard surveys and shifted oversight to infection control surveys. As of May 31, 2021, 71% of nursing homes have gone at least 16 months without a standard survey.[1] Even when surveys are conducted, they rarely identify harm and result in the imposition of a significant penalty, if any. Before the pandemic, surveyors cited 82% of nursing homes for infection control and prevention but did not issue penalties for 99% of deficiencies because they were designated "no-harm."[2] The nursing home survey system continuously fails to adequately protect residents, pandemic or not.

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.

Aaron Manor Rehabilitation and Nursing Center (New York)

Out of breath: Five-star facility fails to provide safe and appropriate respiratory care.

The surveyor determined that the facility neglected to provide respiratory care consistent with professional standards of practice and the resident's comprehensive care plan. According to the citation, the nursing home failed to consistently monitor a resident's oxygen according to physician orders. Though this deficient practice jeopardized the resident's health and safety, the surveyor cited the violation as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- The resident had a diagnosis that required constant oxygen therapy for shortness of breath.
- According to physician orders, the resident was to constantly receive oxygen via nasal cannula and a nurse was to check the resident's oxygen saturation levels once daily and to report any levels at or below 91%.
- A review of the resident's medical record revealed that facility staff failed to monitor the resident to ensure constant oxygen intake on 84 of 213 opportunities over a three-month period. Records further revealed that no oxygen saturation was documented from January 5 until April 23, 2021, despite a physician order requiring daily checks.
- A medical note dated April 27, 2021 revealed the resident had been reporting increased shortness of breath and continued chronic oxygen therapy.

- During an interview, the licensed practical nurse manager stressed the importance of checking the resident's oxygen flow as she noted the resident was fragile and their oxygen level drops quickly.
- **Know Your Rights:** Facilities are required to create and implement a baseline care plan within 48 hours and a comprehensive, person-centered care plan for each resident within seven days of the initial comprehensive assessment. It is important that care plans be implemented so that each resident can meet their mental, psychosocial, medical, and nursing needs. To learn more, please see LTCCC's fact sheet on resident care planning.

A resident's care plan "must describe… the services to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being…," and those services must be implemented.

Springfield Health & Rehab (Vermont)

A black eye: Two-star facility fails to prevent physical abuse of resident.

The surveyor determined that the nursing home failed to protect a resident from physical abuse by a staff member. Though a facility staff member struck the resident in the face and left the resident with a bruised eye, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- The resident was admitted to the facility and identified as exhibiting, or having the potential to exhibit, physically aggressive behaviors.
- The resident's care plan stated that staff were to approach the resident in a patient, calm, and unhurried manner and to reassure the resident as needed. If the resident became combative, staff were to postpone care and allow the resident time to regain composure.
- According to interviews and video surveillance, the resident was walking down a hallway and took an item off a staff member's medication cart. The staff member approached the resident from behind, reached over the top of the resident, and grabbed the item the resident took from the medication cart.
- At that point, the resident hit the staff member. The staff member took a step back and struck the resident in the face.
- The facility's investigation of the incident revealed that another staff member approached the resident after the incident. The resident was doubled over, had a bloody nose, and stated, "I didn't mean to."
- The director of nursing stated the incident was "definitely a situation of abuse."
- According to the citation, due to the facility taking corrective actions prior to the surveyor's onsite investigation, the citation is considered past noncompliance (see Note below).

Far too much resident abuse goes unreported, despite longstanding requirements for nursing homes to report allegations of abuse or neglect to the state survey agency.

- **Note:** Past noncompliance means a deficiency citation that meets all of the following three criteria: 1) the facility was not in compliance with the regulatory requirement at the time the situation occurred; 2) the noncompliance occurred after the exit date of the last standard survey and before the survey currently being conducted; and 3) there is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement.
- **Know Your Rights:** Nursing home residents retain all the rights of people who live outside of a facility. These rights include the right to live free of physical, emotional, verbal, and sexual abuse and the right to be treated with dignity. Far too much resident abuse goes unreported, despite longstanding requirements for nursing homes to report allegations of abuse or neglect to the state survey agency. To help address the problem, the Affordable Care Act established important requirements for the reporting of any reasonable suspicion of a crime against a nursing home resident. To learn more about these requirements and addressing abuse in nursing homes, check out LTCCC's Abuse, Neglect, and Crime Reporting Center.

Woodside Village (North Dakota)

'Please help me': Five-star facility fails to provide safe, appropriate pain management.

The surveyor determined that the nursing home failed to provide treatment and services in a manner to maintain a resident's highest practicable physical well-being. According to the citation, the facility failed to adequately control a resident's pressure ulcer pain. Although the facility's deficient practice resulted in the resident experiencing unnecessary pain and discomfort, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- A physician prescribed a resident medication for shortness of breath every hour as needed and pain medication two times a day, according to the resident's medical records.
- During a dressing change for the resident's pressure ulcer, the resident verbalized pain multiple times.
- The surveyor observed the resident calling out for help from her room several times throughout the day. During the morning, the resident was observed saying, "Please help me. I hurt. Please help the pain go away. Please come and help." Facility staff failed to enter the resident's room to address her needs.
- A review of the resident's medical records revealed the resident took all her pain medication as received, but only received the medication for shortness of breath once a day for nine of 16 days when the resident could have received the medication every hour as needed.
- According to the citation, the medical record lacked evidence of routine pain management and monitoring.

- The resident stated in an interview that she did not feel her pain was controlled and asked the surveyor to 'Please help me."
- **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 assessing and properly treating a resident's pain to ensure a good quality of life. To learn more, see LTCCC's fact sheet on resident care and well-being.

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.

- **Note:** Pressure ulcers are an important measure of quality of clinical care in nursing homes. Despite this, over 87,000 nursing home residents are suffering with pressure ulcers today. Facilities are required to ensure that residents with pressure ulcers receive necessary treatment and care consistent with professional standards of practice. For more information on pressure ulcers, please see LTCCC's fact sheet for standards you can use to support better care.

The Carrington (Mississippi)

Threatening a resident: Two-star facility fails to protect resident from verbal abuse by staff.

The surveyor determined that the facility failed to prevent the verbal abuse from staff to a resident. Though a staff member yelled obscenities and threatened to harm a resident, 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, two CNAs entered the resident's room with breakfast trays and one of the CNAs told the resident that his room "smelled like pee and sh**."
- After making this comment to the resident, the CNA attempted to hand the resident a cup of coffee. The resident, upset with the CNA's comment, hit the coffee out of the CNA's hand. A verbal exchange followed between the resident and the CNA.
- The CNA stepped outside of the resident's room and yelled for the supervisor stating, "Y'all better come and get this M***** F**** before I beat his M**** F**** a***."

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.

- An RN arrived at the resident's room and escorted the CNA down the hallway.
- The CNA involved was terminated and no longer allowed on the property.
- **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 Abuse, Neglect, and Crime Reporting Center.

Kent Regency Center (Rhode Island)

Video violation: Five-star facility fails to protect a resident's right to personal privacy.

The surveyor determined that the nursing home failed to keep a resident's personal and medical records private and confidential. According to the citation, a facility staff member posted an inappropriate video of the resident to the staff member's social media account. Despite this violation of privacy, the surveyor cited the violation as no harm.[7] The citation was based, in part, on the following findings from the SoD:

- According to a facility incident report, a CNA posted an inappropriate video of a resident on their social media.
- A review of a copy of the social media video revealed the resident lying on the floor with the top of their body on a mattress and the lower part of their body on the floor wearing only a brief. The video panned from the resident's feet up to their head showing the resident's entire backside.
- Over the video, the CNA posted the words, "it be sh*t like this that pisses me off."
- Interviews revealed the CNA admitted to posting the video, was told to remove it, and was terminated by the facility.

> Facilities must treat each resident with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement of their quality of life.

- **Know Your Rights:** No matter a resident's needs or abilities, facilities must treat each resident with respect, dignity, and care in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life. This includes refraining from practices that could be demeaning to residents. Please see LTCCC's fact sheet and LTCCC's webinar on residents' rights to live with dignity and respect.

Sistersville Center (West Virginia)

Missing meds: Three-star facility fails to provide necessary medication to a resident.

The surveyor determined that the facility failed to provide appropriate care for a resident with a urinary tract infection (UTI). The citation stated that the facility failed to ensure a resident diagnosed with a UTI received an antibiotic as directed by a physician because the facility did not have the medication on hand. Though the lapse in communication resulted in the resident receiving untimely treatment for the UTI, the surveyor cited the violation as no harm.[8] This citation was based, in part, on the following findings from the SoD:

- According to a hospital discharge plan, the resident was treated for a urinary tract infectious disease and septic shock that was present upon admission to the hospital.

    - The resident was initially sent to the hospital after being found by facility staff pale, unresponsive, and foaming at the mouth. The hospital then diagnosed the resident with a UTI.
- The resident returned from the hospital to the facility with a five-day prescription to treat the resident's UTI.
- According to a nurse's note, the facility did not receive the medication from the pharmacy.
- There were no records to indicate that facility staff contacted the resident's physician when the medication was unavailable and no records to indicate that the physician discontinued the medication for the resident.
- According to the deficiency, the above observations were discussed with the facility administrator, but no further information was provided to the surveyor.

Infection prevention and control programs protect residents from preventable harm, injury, and death. Sadly, despite strong regulatory requirements, infections continue to be a leading cause of death, needless suffering, and expense among nursing home residents.

- **Know Your Rights:** The federal Nursing Home Reform Law requires each nursing home to "establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection." To learn more, see LTCCC's issue alert on infection control and prevention.
- **Note:** Facilities are required to ensure that residents are free of any significant medication errors that could jeopardize their health and safety. For more information on nursing home quality standards, read LTCCC's primer for residents, families, ombudsmen, and advocates.

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.

Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
Volume 3, Issue 10

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] "States' Backlogs of Standard Surveys of Nursing Homes Grew Substantially During the COVID-19 Pandemic," Office of Inspector General (July 27, 2021). Available at https://oig.hhs.gov/oei/reports/OEI-01-20-00431.asp.
[2] "Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic," U.S. Government Accountability Office (May 20, 2020). Available at https://www.gao.gov/products/gao-20-576r.
[3] Statement of Deficiencies for Aaron Manor Rehabilitation and Nursing Center (May 11, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/10/Aaron-Manor-Rehabilitation-and-Nursing-Center-NY.pdf.
[4] Statement of Deficiencies for Springfield Health & Rehab (August 19, 2020). Available at https://nursinghome411.org/wp-content/uploads/2021/10/Springfield-Health-Rehab-VT.pdf.
[5] Statement of Deficiencies for Woodside Village (June 10, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/10/Woodside-Village-ND.pdf.
[6] Statement of Deficiencies for The Carrington (May 12, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/10/The-Carrington-MS.pdf.
[7] Statement of Deficiencies for Kent Regency Center (February 18, 2021). Available at https://nursinghome411.org/wp-content/uploads/2021/10/Kent-Regency-Center-RI.pdf.
[8] Statement of Deficiencies for Sistersville Center (March 31, 2021). Available at: https://nursinghome411.org/wp-content/uploads/2021/10/Sistersville-Center-WV.pdf.