Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
What "No Harm" Really Means for Residents

Volume 1, Issue 5

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Introduction: What is a "No Harm" Deficiency?

Effective monitoring and oversight of nursing home care is critical to ensuring the safety and dignity of residents, as well as the integrity of the public programs which pay for a majority of nursing home care. Nevertheless, numerous studies over the years have indicated that, too often, the state agencies responsible for ensuring that nursing homes meet minimum standards of care fail to identify when residents experience substandard care, abuse, or neglect. Furthermore, CMS data indicate that, even when state surveyors *do* identify a health violation, they only identify the deficiency as having caused any harm to a resident about four percent (4%) of the time.

The failure to identify resident harm has pernicious implications at many levels. Fundamentally, it means that resident suffering and degradation–even death– go unaccounted for and are left unheard. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes that violate a resident's right to quality care and quality of life services rarely face financial penalties for "no harm" deficiencies. In our view, this leads to systemic under-enforcement.

Share your thoughts with us on Twitter using **#HarmMatters**.

For more information on the nursing home standards of care, please see LTCCC's **Issue Alerts**.

The purpose of this newsletter is to provide the public with examples of these "no harm" deficiencies, taken from Statements of Deficiencies (SoDs) on Nursing Home Compare. Surveyors classified all of them as "no harm," meaning that they determined that residents were neither harmed nor put into immediate jeopardy for their health or well-being. We encourage our readers to read these residents' stories and determine for themselves whether or not they agree with the "no harm" determination.

Wellbridge of Fenton, MI

Five-star facility’s failure to develop a baseline care plan results in improper catheter use and “bright red blood on the resident’s genitals”

The resident was cognitively impaired and needed extensive assistance with the activities of daily living (ADLs).[1] Additionally, the resident had an indwelling urinary catheter, which the resident had a tendency to pull on and, on at least one occasion, did pull out.

Surveyors observed the resident over the course of three days. On the first day, surveyors observed the resident receiving assistance with ADLs from two certified nursing assistants (CNAs). When the CNAs changed the resident’s incontinence brief, surveyors saw “bright red blood on the resident’s genitals.”

On the second day, surveyors watched as a CNA provided care to the resident. The CNA told surveyors that there was “dried blood . . . present in the resident’s brief.” Surveyors also saw that the catheter was hanging unsecured by the resident’s leg; this was also observed on the third day.

When surveyors reviewed the resident’s record, they found that the facility developed a care plan entitled “Use of Indwelling Catheter . . .” with the goal of having no acute complications. However, the care plan failed to identify “proper positioning of the catheter to prevent pulling, discomfort, bleeding and dislodgement . . . [and] did not include any mention of a urinary catheter securement device.”

Surveyors cited the facility for failing to develop a care plan with proper catheter interventions, which resulted in the staff not knowing to secure the resident’s catheter “to prevent serious side effects including trauma and bleeding to the urethral site.” Despite this finding, surveyors characterized the facility’s failure in care as having resulted in “no harm” to the resident.

Avon Nursing Home, NY

Three-star facility fails to provide ordered psychiatric services to resident who claimed battery acid was being poured onto his leg

An assessment of the resident showed that he suffered from delusions and expressed physical behaviors towards staff.[2] The resident’s record indicated that the resident had several psychiatric episodes, including “stating that a friend was paying someone to kill him . . . [and that] battery acid is being taken from cars in the parking lot and poured on his right leg. . . .”

A physician had previously ordered that the resident be given an antidepressant and that he have a psychiatric consultation. However, a month after the order, a social worker’s notes showed that the resident’s consultation was still incomplete and that psychiatric services were actually unavailable at the time.

The facility developed a seven-day behavior log to monitor the resident’s increased paranoid behaviors. However, surveyors found that the “documentation was incomplete for 12 of 26 opportunities.” The facility also developed a comprehensive care plan that included the resident’s potential for psychological and mood problems, but did not “address the resident’s behaviors, delusions and person-centered approaches as identified in the Comprehensive Assessment.” The physician later ordered that psychiatric evaluation be discontinued “until services were available in the facility.”

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The director of nursing acknowledged to surveyors that the physician should have been informed of psychiatric services being unavailable. The facility administrator noted that psychiatric services ended in June 2017 and that "when the order was written in August the physician should have been informed . . . ."

Surveyors determined that the facility "did not ensure that the resident received the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being . . . ." Nevertheless, surveyors cited the facility's failure as causing "no harm."

Northwest Florida Community Hospital (SNU), FL

Four-star facility places residents at risk of antibiotic-resistant infections because of improper medication administration

A resident at the facility was diagnosed with a urinary tract infection and was prescribed medication to be administered twice daily for three days, with a follow-up order to be administered for four days.[3] The resident's record indicated that the resident received the medication on three consecutive days, followed by a two-day gap, and then another four days.

Another resident at the facility was also prescribed antibiotics that were to be given twice daily for three days. The resident's record indicated that there was a follow-up order for another course of medication for four days. There was a four-day gap between when the first course of the medication ended and when the second course began.

Surveyors spoke to the pharmacist at the facility's designated pharmacy. The pharmacist told surveyors that "antibiotics needed to be ordered and administered for 7 consecutive days in order for them to be effective in treating infections . . . ." According to the pharmacist, a gap in doses lasting longer than twenty-four hours required a new seven-day round of antibiotics. The pharmacist explained that ineffective use could lead to resistant organisms.

Surveyors cited the facility for failing "to establish an antibiotic stewardship program that included antibiotic use protocols and a system to monitor antibiotic use . . . ." Although the facility placed these residents at risk of developing resistant infections, surveyors determined that this deficiency did not cause harm to residents or put them in immediate jeopardy.

Valley View Nursing & Rehabilitation, ID

Four-star facility administers "as needed" antipsychotic drug to resident four days in a row without documented behavior monitoring or first attempting non-pharmacological approaches

A hospice physician ordered that the resident be administered a psychotropic drug "every 4 hours *as needed* (PRN) for anxiety and restlessness."[4] The resident's record demonstrated that the resident was then administered the drug, on a PRN basis, on four consecutive days.

The resident was administered the drug the day after the physician ordered PRN use for anxiety and restlessness; however, there was no description of whether or how the resident was anxious or restless. The resident was administered the drug again on the second day for restlessness and agitation; nursing notes indicated that the resident's legs and arms were "waving about."

On the third day, the resident was administered the drug for agitation based on his “moving his legs about and trying to grab onto things.” The resident was again administered the drug a fourth day for “anxiety/restlessness without further explanation.”

A review of the resident’s records showed that the facility had no documentation for behavior monitoring for the four days that the resident was being administered the drug. A social worker at the facility said that she “was not familiar with the behavior monitor documentation by nurses.” The director of nursing added that “no behaviors were documented and there was no evidence that non-pharmacological interventions were attempted prior to the administration” of the drug.

Surveyors cited the facility for failing to “ensure there was a clear indication for . . . medications and that non-pharmacological approaches were attempted prior to the use of these medications, unless contraindicated.” Although the resident was being administered an “as needed” psychotropic drug daily and without following appropriate guidelines, surveyors determined that this resulted in “no harm.”

A Note on This Month’s Deficiencies

On November 24, 2017, following requests from industry lobbyists for “burden reduction,” CMS issued new guidance announcing that violations of eight standards of care would not result in any financial penalty for the next 18 months. According to CMS, this time “will be used to educate facilities” about the standards.

Each of the “no harm” deficiencies highlighted in this month’s newsletter relates to one of the standards for which CMS announced it is delaying enforcement.

The standards for which CMS is delaying enforcement are:

- Baseline Care Plan, §483.21(a)(1)-(a)(3)
- Behavioral Health Services, §483.40
- Sufficient/Competent Direct Care/Access Staff-Behavioral Health, §483.40(a)(1)-(a)(2)
- Psychotropic Medications related to PRN Limitations, §483.45(e)(3)-(e)(5)
- Facility Assessment, §483.70(e)
- Antibiotic Stewardship Program, §483.80(a)(3)
- QAPI Program and Plan related to the development of the QAPI Plan, §483.75(a)(2)
- Smoking Policies, §483.90(i)(5)

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Further Reading from LTCCC & the Center:

1. LTCCC Alert: Special Focus & One-Star Nursing Homes in NY (March 2018)
2. LTCCC Issue Alert: Transfer & Discharge Requirements
3. Fact Sheet: The Foundations of Resident Rights
4. Elder Justice Alert: New York Times Publishes Article on Drug Use Among Older Adults

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[1] Statement of Deficiencies for Wellbridge of Fenton, CMS (Dec. 14, 2017), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235715&SURVEYDATE=12/14/2017&INSPTYPE=STD&profTab=1&state=MI&lat=0&lng=0&name=WELLBRIDGE%2520OF%2520FENTON&Distn=0.0.

[2] Statement of Deficiencies for Avon Nursing Home, CMS (Dec. 1, 2017), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335216&SURVEYDATE=12/01/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=AVON%2520NURSING%2520HOME&Distn=0.0.

[3] Statement of Deficiencies for Northwest Florida Community Hospital (SNU), CMS (Dec. 15, 2017), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=106055&SURVEYDATE=12/15/2017&INSPTYPE=STD&profTab=1&state=FL&lat=0&lng=0&name=NORTHWEST%2520FLORIDA%2520COMMUNITY%2520HOSPITAL%2520%2528SNU%2529&Distn=0.0.

[4] Statement of Deficiencies for Valley View Nursing & Rehabilitation, CMS (Dec. 18, 2017), available at https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=135098&SURVEYDATE=12/18/2017&INSPTYPE=STD&profTab=1&state=ID&lat=0&lng=0&name=VALLEY%2520VIEW%2520NURSING%2520%2526%2520REHABILITATION&Distn=0.0 (emphasis added).

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