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 9

In This Issue:

Introduction: What is a "No Harm" Deficiency?

Effective monitoring and oversight of nursing home care are 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 when it has occurred has pernicious implications on many levels.

The failure to identify resident harm when it has occurred has pernicious implications on many levels. Fundamentally, it signifies a lack of recognition of resident suffering, degradation and even, occasionally, death. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes rarely face financial or other penalties for "no harm" deficiencies. The absence of any penalty sends a message to nursing homes that such substandard care, abuse, and neglect will be tolerated.

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 the deficiencies discussed here 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" determinations**.

St. Ann's Community, NY

Four-star facility leaves resident sitting in feces and fails to follow infection control procedures.

The resident assessment showed that the resident needed help with toileting and the comprehensive care plan required staff to provide assistance with incontinence care as need.[1] While observing the resident, the surveyor saw that "the resident was lying in bed and was incontinent of a large amount of liquid feces that had overflowed his incontinence brief and was pooled between his legs." Between 12:18 P.M. and 2:24 P.M., staff came in and out of the resident's room but did not provide incontinence care.

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 surveyor approached a certified nursing assistant (CNA) to question her about incontinence care. The CNA told the surveyor that she was finished and was leaving to go home. The CNA also noted that she checked the resident's "incontinence brief just a few minutes ago." When both the surveyor and the CNA entered the resident's room, the CNA admitted that she "had not checked on the resident." The CNA then put on gloves and cleaned the resident. While wearing the same gloves and without washing her hands, the CNA applied a new brief and then wet a washcloth. When the CNA approached the resident with the wet washcloth, the surveyor intervened and told her to remove her gloves. The CNA acknowledged that she should have "removed her gloves after cleaning the feces but she was rushing to finish so she could go home."

The surveyor cited the facility for failing to "ensure that proper infection control procedures were followed. Specifically, there was lack of glove changes and handwashing following incontinence care." Despite the resident's having to sit in his own feces for hours and the CNA failing to perform adequate hand hygiene, the surveyor cited this failure as causing neither harm nor immediate jeopardy to the resident's well-being.

Evergreen Bakersfield Post Acute Care, CA

One-star facility violates a resident's right to refuse treatment, resulting in staff grabbing the resident's wrist to perform care.

The certified nursing assistant (CNA) told the surveyor that he found the resident in her room with a soiled adult brief.[2] The CNA noted that he explained to the resident that he would be changing her brief; however, the resident yelled and scratched him. The CNA told the surveyor that he had to hold her hand because "she was scratching when I turned her." When the surveyor spoke to the resident, she stated that she woke up to a "man . . . at my bedside, he grabbed my wrists."

The director of nursing (DON) explained that, when residents refuse care, staff are expected to "[b]ack off, re-approach later and get help." The administrator added that staff needed to "stop and get assistance. If the resident still does not allow care to be given, wait a little bit and try again later." The surveyor later asked the director of staff developer (DSD) for policies and procedures regarding resident rights. The DSD indicated that "[w]e do not have a policy on [r]esident [r]ights." Instead, the DSD provided the surveyor with a resident rights handout that is provided to staff at the time of hire and annually. The surveyor examined a document entitled "Your Rights and Protections as a Nursing Home Resident," which explained that federal and state law provide

residents with rights and protections. The document noted that residents have “the right to be treated with dignity and respect” and “[t]o participate in decisions that affect[] . . . care.”

The surveyor ultimately determined that the “facility failed to respect the rights” of the resident, which had the potential to cause emotional distress. Despite a violation of the resident’s right to refuse treatment, the surveyor cited this deficiency as “no harm.”

Tacoma Nursing and Rehabilitation Center, WA

Five-star facility turns off heaters over the weekend, causing pain and displacement.

Multiple residents stated that staff turned off the heat in the facility.[3] One resident explained that the heat was intentionally shut off for “about two days” because some residents had items near the baseboard heaters. The resident noted that the facility should have just turned off the heat in the rooms that posed a problem, adding “I was freezing. I have . . . [a medical condition] [t]hat caused me to clench up all my muscles and caused pain.”

Another resident told the surveyor that the heat was turned off for a weekend. The resident said that he needs warmth or his “left arm and hand start cramping and hurting.” The resident’s progress notes indicated that the resident slept in his vehicle throughout the night . . . [and had] not come into [the] facility for meds or his IV.”

In an interview, the facility’s maintenance supervisor (MS), he stated that the heaters were shut off Friday afternoon through Monday “due to multiple residents having too much clutter near the baseboard heaters.” The MS told the surveyor the plan was to turn off the heat until the items could be removed. The MS noted that he was aware that one of the residents slept in his car when the heaters were off but was not “aware it was for two nights.” The administrator told the surveyor that the “facility ensured there were enough blankets until the following Monday when the heaters were turned back on.”

The surveyor cited the facility for failing to identify and report “situations of potential abuse, neglect or mistreatment . . . .” The surveyor added that the facility failed to maintain an adequate temperature when the utilities (heat) was shut off facility-wide for an extended period of time . . . .” Despite findings of resident pain and displacement as a result of the heater being turned off for an entire weekend, the surveyor cited the violation as “no harm.”

Pruitthealth - Old Capitol, GA

Three-star facility fails to properly address the results of an x-ray for several days before finally sending the resident to the hospital.

The resident’s record showed that the resident was found “lying on the floor in his room.” [4] Staff assessed the resident, noting no visible injuries and that the resident was able to move without complaining about pain. However, shortly after, the resident stated that he could not move his left leg and yelled out in pain when a nurse attempted to move his leg. As a result, the nurse practitioner (NP) ordered an x-ray of the resident’s left knee and hip.

The x-ray showed that the resident was suffering from "an acute left intertrochanteric fracture." The x-ray was stamped with "Alert" and faxed to the facility that same day. However, the record showed a handwritten note stating that the NP reviewed the x-ray several days later. When the surveyor interviewed the NP, she stated that she did not receive the results of the x-ray until several days later, at which point she gave the order to send the resident to the hospital. The director of health services (DHS) acknowledged that the NP did not see the results until days after the order because "the charge nurse at the facility had incorrectly read the x-ray results as normal."

The surveyor cited the facility for failing "to notify the physician of an abnormal x-ray result . . . ." Although the resident complained of pain and had suffered an injury that was not properly addressed for several days, the surveyor cited the deficiency as "no harm."

A Note on Residents' Rights

Under the federal Nursing Home Reform Law, every nursing home must provide each resident with services that help attain or maintain the resident's "highest practicable physical, mental, and psychosocial well-being." This federal law and its implementing regulations offer residents specific rights and protections to ensure quality of care and quality of life in nursing homes. While CMS's enforcement of the nursing home standards of care may be lacking, the nursing home standards must still be followed. Our organizations encourage residents and families to remain vigilant, learn about resident protections, and continue advocating for the rights of their loved ones. For assistance with solving issues impacting quality of care or quality of life, please contact your state's Long Term Care Ombudsman Program (LTCOP). To file a complaint against a nursing home, please contact your state survey agency. **For more information about the nursing home standards of care, please see www.nursinghome411.org and www.medicareadvocacy.org.**

Further Reading from LTCCC & the Center:

1. Medical Loss Ratios for Nursing Homes: Protecting Residents and Public Funds
2. House Committee Holds Hearing on Nursing Home Quality Issues
3. *The LTC Journal* (Summer 2018)
4. LTCCC's Family & Ombudsman Resource Center (NEW)
5. Special Focus Nursing Facilities that "Have Not Improved:" Poor Care for Residents, Overall Ratings Artificially Boosted by 5-Star Ratings in Self-Reported Quality Measures

[1] Statement of Deficiencies for St. Ann's Community, CMS (Jun. 20, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335081&SURVEYDATE=06/20/2018&INSPTYPE=STD&profTab=1&Distn=0.0&state=NY&lat=0&lng=0&name=ST%20ANNS%20COMMUNITY.

[2] Statement of Deficiencies for Evergreen Bakersfield Post Acute Care, CMS (Jun. 29, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=555260&SURVEYDATE=06/29/2018&INSPTYPE=CMPL&profTab=1&state=CA&lat=0&lng=0&name=EVERGREEN%2520BAKERSFIELD%2520POST%2520ACUTE%2520CARE&Distn=0.0.

Elder Justice: What "No Harm" Really Means for Residents is a newsletter published by the Center for Medicare Advocacy and the Long Term Care Community Coalition. The purpose of the newsletter is to provide residents, families, friends, and advocates information on what exactly a "no harm" deficiency is and what "no harm" actually means to residents.

[3] Statement of Deficiencies for Tacoma Nursing and Rehabilitation Center, CMS (Jun. 28, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=505154&SURVEYDATE=06/28/2018&INSPTYPE=STD&profTab=1&state=WA&lat=0&lng=0&name=TACOMA%2520NURSING%2520AND%2520REHABILITATION%2520CENTER&Distn=0.0.

[4] Statement of Deficiencies for Pruitthealth - Old Capitol, CMS (Jun. 8, 2018), https://www.medicare.gov/nursinghomecompare/profile.html#profTab=0&ID=115681&state=GA&lat=0&lng=0&name=PRUITTHEALTH%2520-%2520OLD%2520CAPITOL&Distn=0.0.