Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
What "No Harm" Really Means for Residents

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In This Issue:

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.

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The failure to identify resident harm when it occurs 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**.

The Pines Healthcare & Rehab Centers Olean Campus, NY

One-star facility physically restrains a resident without a documented medical symptom and ongoing re-assessments.

The resident's care plan documented that the resident was at a high risk for falls.[1] The noted interventions included a bed alarm, a lowered bed, and "a positioning belt on in chair with instructions to release the belt every two hours for 15 minutes." However, the surveyor's review of the medical record and chart showed "no documented medical symptom for the use of the belt and there were no on-going re-assessments for the continued use of the seatbelt. Resident observations also "revealed that the belt was not released every two hours as planned."

Advocacy Tip: Every nursing home resident has the "right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."

For more information, please see LTCCC's new physical restraints **fact sheet**.

The director of therapy told the surveyor that "in this resident's case the seatbelt would be considered a restraint because the resident was not able to self-release [the] seat belt." The director of nursing (DON) stated that if the "resident can't release the belt on command it's a restraint or we need to justify that it is for positioning."

The surveyor cited the facility because "a thorough assessment and re-evaluation were not conducted to address the use of a self-release seatbelt while in the wheelchair that may restrict the resident's movement . . . ." Despite the resident being improperly restrained, the surveyor cited neither harm nor immediate jeopardy to the resident's well-being.

Southern Ocean Center, NJ

Four-star facility fails to implement a therapy referral, resulting in the resident losing improvements in ambulation.

During an interview, the resident indicated to the surveyor that he was at the facility because he was unable to walk.[2] The resident explained the he had been receiving therapy and was progressing but that his physical therapy had been terminated. In a follow-up interview, the resident "expressed the desire to continue physical therapy and resume walking."

Advocacy Tip: Medicare coverage "does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care."

For more information, please see the Center's *Jimmo v. Sebelius* **Checklist Toolkit**.

The resident was first referred to physical therapy after a decline in transfer ability. The resident's physical therapy lasted for nearly two months before being terminated. According to the director of rehabilitation, the resident "was able to walk about 50 feet with the rolling walker." The physical therapy discharge summary indicated that the resident was to transfer to a restorative nursing program (RNP) "with nursing to maintain and increase independence on the Long Term Care Unit." The unit manager acknowledged that she never received the referral from the therapy department to continue ambulation on the RNP. When the resident's therapy resumed the following day, the resident was only able to walk 32 feet.

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The surveyor cited the facility for failing “to provide restorative nursing services.” The facility’s failure to properly care for the resident resulted in the resident not only losing his ability to “perform activities of daily living” but also led to a physical decline, as his ability to ambulate for “about 50 feet” declined to 32 feet. Despite this outcome, the surveyor cited the deficiency as causing neither harm nor immediate jeopardy.

Lexington Park Nursing & Post Acute Center, KS

Five-star facility administers an antipsychotic drug to a resident without attempting non-pharmacological interventions first.

The physician’s order sheet documented that the resident received an antipsychotic intramuscular injection “one time daily for one day for agitation.”[3] A review of the nurse’s progress notes showed that the resident was agitated, spoke about two people being murdered, became resistive to care, and made a fist. As a result, the resident was “laid down” and given the antipsychotic drug.

The surveyor’s report documented that the drug had a “black box warning of increased mortality in elderly patients with [the] dementia-related [medical condition].” The surveyor also noted that the nurse’s progress notes lack a showing of staff attempting non-pharmacological interventions before administering the antipsychotic drug. The physician confirmed that staff were to “try non-pharmacological interventions before calling . . . for medication.”

Policy Alert: CMS placed an 18-month **moratorium** on the full enforcement of eight standards of care, including standards for “as needed” antipsychotic drugs. While the moratorium limits enforcement, every nursing home must still follow the prescribed standards of care required by federal law.

For more information about the antipsychotic drug standards, please see LTCCC’s Dementia Care & Psychotropic Drugs **fact sheet**.

The surveyor cited the facility for failing “to provide an environment free from chemical restraint . . . .” Although the facility gave the resident a potentially fatal antipsychotic drug without attempting at non-pharmacological interventions first, the surveyor still cited the deficiency as causing neither harm nor immediate jeopardy to the resident.

Daughters of Israel Pleasant Valley Home, NJ

Four-star facility alters a resident’s antipsychotic medication without proper monitoring, resulting in extreme fatigue and a lower quality of life.

The surveyor first observed the resident asleep at 10:30 a.m., while other residents were eating breakfast.[4] When the surveyor returned around 11:45 a.m., the resident was still sleeping. The following day the surveyor saw the resident sitting at a table with her breakfast tray untouched. A staff member tried to help the resident eat but the resident “could not keep . . . [her] eyes open.” On the third day, the surveyor again saw the resident asleep with her neck “hyperextended” and as she was “starting to slide from the wheelchair.” The surveyor witnessed a similar pattern over the course of three additional days.

A review of the resident's record showed that she was receiving 10 milligrams (mg) of an antipsychotic drug twice a day. However, the resident's order was changed to 20 mg every morning without "documentation in the clinical record to indicate the rationale for the change in the dose frequency." When interviewed, the unit manager told the surveyor that "the resident did not have any side effects from the medication." The medical director explained that the dose was altered because the "[i]nsurance company would not cover the current form ordered in divided dose."

Advocacy Tip: Every nursing home must ensure that residents who are on antipsychotic drugs receive gradual dose reductions, unless clinically contraindicated.

For more information, please see LTCCC's Antipsychotic Drugs **issue alert.**

The surveyor ultimately cited the facility for failing "to provide an environment that promotes and enhances a resident's quality of life." Although the facility altered the resident's dosage without proper monitoring and the resident experienced a lower quality of life as a result, the surveyor still cited the deficiency as causing neither harm nor immediate jeopardy to the resident.

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 more information about the nursing home standards of care, please see www.nursinghome411.org and www.medicareadvocacy.org.**

Tell Your Story

Your voice matters! Your experiences as a resident, family member, friend, ombudsman, or nursing home staff member play an invaluable role in shaping our advocacy, as well as informing federal and state governments about ways to improve resident care and quality of life. We encourage you to share your story using **LTCCC's user-friendly form**.

Our organizations will never divulge any identifiable information without your specific permission.

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 The Pines Healthcare & Rehab Centers Olean Campus, CMS (Nov. 30, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335357&SURVEYDATE=11/30/2018&INSPTYPE=STD.

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[2] Statement of Deficiencies for Southern Ocean Center, CMS (Nov. 16, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=315332&SURVEYDATE=11/16/2018&INSPTYPE=STD. The resident’s sex is not identified in the inspection report. To make the summary more user-friendly, we refer to the resident as being male.

[3] Statement of Deficiencies for Lexington Park Nursing & Post Acute Center, CMS (Nov. 5, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=175154&SURVEYDATE=11/05/2018&INSPTYPE=STD. The resident’s sex is not identified in the inspection report. To make the summary more user-friendly, we refer to the resident as being female.

[4] Statement of Deficiencies for Daughters of Israel Pleasant Valley Home, CMS (Nov. 1, 2018), https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=315029&SURVEYDATE=11/01/2018&INSPTYPE=STD. The resident’s sex is not identified in the inspection report. To make the summary more user-friendly, we refer to the resident as being female.

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