

# LONG TERM CARE COMMUNITY COALITION

*Advancing Quality, Dignity & Justice*

## CHRONIC DEFICIENCIES IN CARE

The Persistence of Recurring Failures to Meet  
Minimum Safety & Dignity Standards in U.S.  
Nursing Homes



by

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Please visit [www.nursinghome411.org](http://www.nursinghome411.org) to access the data discussed in this report, including information on every nursing home in each state with triple repeat deficiencies. The website also provides a variety of free materials and resources on nursing home care and oversight, quality improvement and residents' rights.

### Acknowledgements

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## Executive Summary

Nursing homes provide vital care and living services to 1.3 million Americans every day. Because of the vulnerability of this population, and the fact that the public pays for the large majority of nursing home care, there are wide-ranging standards in place to ensure that residents are provided adequate care and are able to live with dignity. Unfortunately, widespread, often serious problems persist in too many nursing homes across the country.

There have been numerous efforts over the years to gain insights into and address the persistence of substandard care, abuse and neglect in U.S. nursing homes. For example, in response to the significant problem of so-called “yo-yo” compliance (in which a facility is found to be out of compliance with minimum standards, corrects the problem(s), but then soon relapses back into substandard care), the federal Centers for Medicare & Medicaid Services (CMS) developed the Special Focus Facility (SFF) Program. The SFF Program is aimed at identifying facilities that go in and out of compliance and targeting them for increased monitoring and oversight so that, within about two years, they either (1) implement enduring solutions to their problems or (2) are terminated from the Medicare/Medicaid system.

Unfortunately, the SFF Program has only been used on a fraction of the facilities that qualify and, to date, it has often not been effectively implemented by the states on those few facilities.<sup>1</sup> For example, there are numerous cases of facilities staying in the SFF Program for far longer than two years and, perhaps even worse, cases in which a facility had “graduated” from the SFF Program only to wind up back on it again. Both of these outcomes are the result of the persistence or reoccurrence of violations of minimum federal standards.

To help the public gain insights into the quality of care in the facilities in their communities and states, the federal government maintains the Nursing Home Compare (NH Compare) website at [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare). This website provides survey (inspection) results, quality, staffing and other relevant information on every licensed facility in the U.S.

The purpose of this report is to provide a brief framework for data that we are publishing on facilities that have what we call “Chronic Deficiencies in Care.” Specifically, we apply this term to facilities that have three (or more) citations for the same type of deficiency in the three years covered in the NH Compare database. All of these data have been derived directly from that database. To facilitate their usefulness, we are posting the data in a variety of forms. Individual state files list every nursing home that has three or more such deficiencies on NH Compare as of September 2016. For each of these facilities, we provide the F-tag (the number which represents the specific regulatory requirement that was violated), a short description of the regulatory requirement, the scope and severity code given to the violation (the surveyor’s finding of how many residents were affected and to what extent) and other relevant information. The files can be viewed and downloaded from our website, [www.nursinghome411.org](http://www.nursinghome411.org).

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<sup>1</sup> See, for example, CMS Memorandum S&C-10-32-NH, Subject: Special Focus Facilities (SFF) Procedures (September 17, 2010). The Memorandum notes that “[t]he number of nursing homes on the candidate list is based on 5 candidates for each SFF slot.”

## Introduction

### Background

US nursing homes provide care, support services and home to well over one million people every day. In addition to those individuals, their families and loved ones have a substantial personal stake in the quality of care and quality of life nursing homes provide. And with the aging of the “Baby Boomer” generations, these numbers will undoubtedly rise. As reported in *U.S. News and World Report*, “[a] majority of people over age 65 will require some type of long-term care services during their lifetime, and over 40 percent of people will need a period of care in a nursing home.”<sup>2</sup>

In addition to the personal stake many of us have – or will have – in nursing home care there is the financial stake which we all share. The average rate for nursing home care in the US is now well over \$200 per day.<sup>3</sup> The large share of these costs is paid by taxpayers through Medicaid and Medicare.

Over 40% of the population will need nursing home care at some point.

Despite the significant need for both long-term and short-term nursing home care, and the billions of dollars spent on this care every year, the data show that significant problems in resident care, quality of life and dignity are pervasive across the country. Our laws and regulatory standards are strong, with the goal of ensuring that each resident is treated with dignity and receives the care and services that he or she needs to attain, and maintain, his or her highest practicable physical, emotional and social well-being. The fact that the reality often falls short of this level of care is a result of the observable failure (in fact multiple failures, every day) to adequately enforce those legal standards and protections. In short, we conclude that nursing homes often have inadequate care staff and fail to provide appropriate care with dignity because the standards themselves, absent effective enforcement, will not alter conduct.

Last year we conducted a study on the effectiveness of nursing home citations across the country.<sup>4</sup> Specifically, based on data published on [www.medicare.gov](http://www.medicare.gov), we assessed the extent to which the State Survey Agencies (SAs, which are responsible for monitoring nursing homes and enforcing minimum standards) are fulfilling their obligation to ensure that all residents in licensed nursing homes receive appropriate and sufficient services twenty-four hours a day, seven days a week, 365 days a year.

That report provided, for the first time (to our knowledge), a review of nursing home quality assurance indicators that is centered on nursing home residents as individual people. Typically,

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<sup>2</sup> Mullin, Emily, U.S. News and World Report, *How to Pay For Nursing Home Costs* (February 26, 2013). Accessed February 2015 at <http://health.usnews.com/health-news/best-nursing-homes/articles/2013/02/26/how-to-pay-for-nursing-home-costs>.

<sup>3</sup> Genworth, *2016 Cost of Care Survey*. Accessed November 2016 at <https://www.genworth.com/corporate/about-genworth/industry-expertise/cost-of-care.html>.

<sup>4</sup> Mollot, Richard, JD, *Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance*, LTCCC (April 2015). Available at [www.nursinghome411.org](http://www.nursinghome411.org). Hereinafter *LTCCC State Survey Agency Review*.

oversight issues are looked at on a facility basis. For instance, the federal government’s Nursing Home Compare<sup>5</sup> and non-governmental resources like ProPublica’s Nursing Home Inspect<sup>6</sup> report on citations on a per facility basis. We endeavored to bring the assessment a bit closer to the resident by connecting relevant statistical data about quality and oversight to the individual level. Our goal, fundamentally, was to reflect the language and spirit of the requirements in the 1987 federal Nursing Home Reform Law which focus on the individual residents, not the individual businesses.

We concluded that, even with respect to significant quality problems, the SAs generally fail to adequately identify the extent to which an individual resident is harmed. For example, pressure ulcers (also known as bed sores) are a serious problem for nursing home residents. While some pressure ulcers are unavoidable, research and experience indicate that, “[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation.”<sup>7</sup> Yet our analysis of the data indicated that, though pressure ulcers are largely preventable, SAs cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer. Furthermore, even in those instances when SAs do cite a facility for failing to provide pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.<sup>8</sup>

In addition to the general persistence of substandard nursing home care, we and other resident advocates have identified nursing homes with citations for the same deficiency year after year.

### **This Report**

Neglect, abuse and substandard services are longstanding problems for residents in U.S. nursing homes. A Google internet search for the phrase “nursing home abuse” recently yielded “[a]bout 17,600,000 results.”<sup>9</sup> One entry which appeared on the first page of results was a 2001 ABC News story, “Elderly Abused at 1 in 3 Nursing Homes” which stated that “[r]eports of serious, physical, sexual and verbal abuse are “numerous” among the nation's nursing homes, according to a congressional report released today.”<sup>10</sup> Despite these and other reports over the years,<sup>11</sup>

<sup>5</sup> Centers for Medicare and Medicaid Services, Nursing Home Compare. Accessed February 2015 at <http://www.medicare.gov/nursinghomecompare/search.html>.

<sup>6</sup> Ornstein, C. and Groeger, L., ProPublica, Nursing Home Inspect. Accessed February 2015 at <http://projects.propublica.org/nursing-homes/>.

<sup>7</sup> Edsberg, L.; Langemo, D.; Baharestani, M.; Posthauer, M.; and Goldberg, M., “Unavoidable Pressure Injury: State of the Science and Consensus Outcomes,” *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313–334. Abstract accessed in March 2015 at [http://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable\\_Pressure\\_Injury\\_State\\_of\\_the\\_Science\\_6.aspx](http://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science_6.aspx).

<sup>8</sup> Data on pressure ulcer rates and other key indicators are provided in the report in charts that can be used to find out specific state information as well as compare states against each other and national averages. All of the charts are available as interactive Excel files at <http://www.nursinghome411.org/articles/?category=lawgovernment>.

<sup>9</sup> Search was conducted on December 1, 2016.

<sup>10</sup> Retrieved on September 25, 2015, from <http://abcnews.go.com/US/story?id=92689&page=1>. The ABC News story was reporting on the results of a study commissioned by Congress, *Abuse of Residents Is a Major Problem in*

substandard care, abuse and neglect are widespread and persistent. The average U.S. nursing home has seven (7) government citations per year for failing to meet minimum health standards.<sup>12</sup> This does not include any failures to meet federal Life Safety Code Standards or any state-specific standards which might exist (for instance, if a state has minimum staffing standards). Most importantly, this figure does not take into account instances of substandard care that the State Agencies simply have failed to identify – a longstanding problem affecting nursing home care<sup>13</sup> As a result of inadequate state oversight, we believe it is likely that there are many more violations occurring every day in our nursing homes, undetected by the State Agencies.<sup>14</sup>

In addition to the general persistence of substandard nursing home care, we and other resident advocates have identified nursing homes with citations for the same deficiency year after year. This prompted us to undertake the current data analysis, which identifies the extent to which facilities have three (or more) citations for the same deficiency in the three years of data published on the federal database, Nursing Home Compare.

We consider this a crucial issue for the public and for policymakers because repeated violations of the very same deficiency raise numerous serious concerns, including:

1. Are enforcement mechanisms sufficient – and sufficiently implemented – to prevent recidivism?
2. For repeat failures to meet standards that are narrow in scope, why is the facility being permitted to continue operations – and take in new residents – when it is failing to adequately address problems that have been repeatedly identified by state surveyors?
3. For repeat failures to meet standards that are broad in scope, why isn't the facility taking adequate and appropriate steps to ensure that it is learning from its citations and operationalizing corrective action system-wide?
4. To the extent that repeat deficiencies occur, why aren't the State Survey Agencies and CMS (both national and regional offices) tracking and using these data to more effectively ensure that residents are protected and that public funds are not spent on substandard or worthless services?

To assess the extent of this problem and to assist the public in identifying the nursing homes which have repeats of the same deficiencies year after year, in 2015 the Coalition for Quality Care<sup>15</sup> commissioned the development of an analytic program capable of evaluating the data

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*U.S. Nursing Homes* (2001). See Appendix I for a sampling of studies and reports on the persistence of abuse, neglect and substandard care in U.S. nursing homes.

<sup>11</sup> As noted above, Appendix I provides a sample of studies and reports on the persistence of poor care.

<sup>12</sup> Nursing Home Compare states "Average number of health deficiencies in the United States: 7.2." Accessed December 1, 2016.

<sup>13</sup> See, for example, the findings in *LTCCC State Survey Agency Review* discussed in the Background section.

<sup>14</sup> See, *inter alia*, the list of studies and reports in Appendix I for data on the failure of State Survey Agencies to: conduct surveys at times that are not unanticipated by facilities, adequately respond to and substantiate complaints of abuse and neglect, etc....

<sup>15</sup> The Coalition for Quality Care is an umbrella organization of citizen advocacy groups of which LTCCC is a member. For more information, including all of the data discussed in this report, visit <http://coalitionqualitycare.org/>.

on Nursing Home Compare and isolating all of the facilities that have repeat citations for the same deficiencies three or more times in the three years covered by the Nursing Home Compare database.<sup>16</sup> In the fall of 2015, the Coalition published these data for the first time on its website, <http://www.coalitionqualitycare.org/>.

This report coincides with the publication of a one-year update on the data for the three years' worth of records published on Nursing Home Compare in the fall of 2016. These data are available on the Coalition for Quality Care's website and LTCCC's website, [www.nursinghome411.org](http://www.nursinghome411.org). The data are presented for the entire country and in separate files for every state, for both health and fire and safety citations. Each file provides the name of every nursing home with triple deficiencies and information about those deficiencies. The purpose of this report is to provide a brief narrative and discussion of the information provided to make it as useful as possible to consumers, policymakers and other stakeholders.

Notes on the data discussed in this report and presented on our website: The broader listings of nursing homes with triple deficiencies on Nursing Home Compare were derived from the Nursing Home Compare database at [data.medicare.gov](http://data.medicare.gov) in September 2016. The specific data have not been changed, but have been reformatted to facilitate use by the public. However, for certain files, such as the U.S. Composite Averages (with state and national average deficiencies) we have removed the data for Guam and the US Virgin Islands.

## Nursing Home Deficiencies 101

### Strong Structural Protections

State Survey Agencies (SAs) are the principal agencies responsible for overseeing care in nursing homes and responding effectively to complaints about care. SAs are paid under contracts with the federal government to ensure that every nursing home certified under Medicare and/or Medicaid meets or exceeds federal standards of care for all of its residents, including those whose care is paid for by other sources. The vast majority of U.S. nursing homes are certified by Medicare and/or Medicaid.

When resident neglect or abuse occurs – whenever a facility fails to ensure that each resident attains and maintains his or her highest practicable physical, emotional and social well-being – it is a failure to comply with the minimum legal and regulatory standards which the SA is charged with enforcing. Fundamentally, the persistent and widespread problems that exist in nursing homes across the country, including those that result in serious resident harm, are an outcome of failures to enforce minimum standards.<sup>17</sup>

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<sup>16</sup> Nursing Home Compare, [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare), is the federal website with quality, staffing, enforcement and other information on all U.S. nursing homes that participate in Medicare/Medicaid. Nursing home information is posted for the last three years, with additional data available in the underlying database on the website.

<sup>17</sup> It also follows that the use of public funds to pay for care that is deficient or substandard is financially wasteful. Hence the increasing attention being paid to False Claims Act cases alleging that nursing homes sought and received payment for “materially substandard nursing services that were so deficient that they were effectively worthless.” See, for example, the US Department of Justice’s news release, “Extendicare Health Services Inc. Agrees to Pay \$38 Million to Settle False Claims Act Allegations Relating to the Provision of Substandard Nursing Care and Medically Unnecessary Rehabilitation Therapy,” available at

Essentially, a state’s oversight of nursing home care boils down to two components: (1) its ability to identify when a failure to meet standards (i.e., a deficiency) exists and (2) its ability to appropriately rate the deficiencies it identifies in terms of their “scope and severity.” To help states *identify* deficiencies, CMS provides guidance on what surveyors are supposed to look for, the questions they are supposed to ask, etc. To help them *rate* deficiencies, CMS provides both guidance (instructions) and a scope and severity grid.<sup>18</sup>

The grid is crucial because it is used to classify how extensive the problem is in the facility (its “scope”) and its seriousness or “severity.” Is the identified deficiency a minor problem that did not affect any residents or was it a serious problem that could or did cause harm? If there was harm, was it limited to one resident or more widespread?

The rating of a deficiency in terms of its scope and severity is very important for two reasons: (1) it is a determining factor in whether or not the nursing home is penalized for the deficiency and (2) it affects the “star rating” for that facility on Nursing Home Compare and individual states’ nursing home information website (and, thus, public perceptions of the nursing home and the quality of care it provides).

### **Weak Implementation**

While this system provides a strong framework for ensuring quality care, we believe that significant problems with its implementation – by both CMS and the state agencies – greatly undermine its effectiveness. Generally speaking, nursing homes are not penalized for deficiencies unless they are rated as having caused harm to one or more residents. Thus, when a deficiency is not rated at a harm level it is extremely unlikely to result in improvements to resident safety (since such citations carry virtually no negative repercussions for the facility).

This is especially troubling when it comes to deficiencies that have been cited at no harm but which, in our view, relate to a resident having been harmed or put in immediate jeopardy. Two examples, discussed in our 2015 study, *LTCCC State Survey Agency Review*, are, we believe, illustrative:

- I. Citations for inadequate pressure ulcer care when a resident has a pressure ulcer. As detailed in our study,
  - (1) Pressure ulcers are a problem for over 86,000 nursing home residents.
  - (2) Though pressure ulcers are largely preventable, States cite nursing homes the equivalent of less than 3% of the time that a resident has a pressure ulcer.<sup>19</sup>

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<https://www.justice.gov/opa/pr/extendicare-health-services-inc-agrees-pay-38-million-settle-false-claims-act-allegations>.

<sup>18</sup> For more on certification and compliance, see <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>. The scope and severity grid can be found in Appendix II to this report.

<sup>19</sup> An average of 2,568 citations per year equals a citation rate of 2.9%.



(3) When States *do* cite a facility for inadequate pressure ulcer care or prevention, they only identify this as harmful to residents about 25% of the time.<sup>20</sup>

II. Citations for inappropriate antipsychotic drugging. Despite the FDA “black box” warning against using these drugs on elderly people with dementia, due to an “increased risk of death,” about one in five (20.6%) nursing home residents currently receive these drugs.<sup>21,22</sup> As our 2015 study noted, less than 2% of the population will ever have a diagnosis for a condition recognized by CMS as potentially appropriate in its risk-adjustment of the antipsychotic drugging rates. Despite this significant disparity, our study found that in 2015

[t]he average risk-adjusted state drugging rate is 18.95% while the average state citation rate is 0.31%.<sup>23</sup> This indicates that there is a significant amount of inappropriate antipsychotic drugging that is not being cited by the states.

[We examined] ...state citations for F-329<sup>24</sup> that were cited as having caused harm to one or more residents (G or higher on the scope and severity matrix). The data indicate that, on average, states only find two percent (2%) of all F-329 violations as having caused any harm to residents. Given the known significant dangers of these drugs, widely publicized since the FDA’s “Black Box Warning” ten years ago, we believe this is a striking and

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<sup>20</sup> LTCCC State Survey Agency Review at 21. Note that the data referenced in the quotation are from the 2015 study. As of 2016 Q3, pressure ulcers are a problem for over 92,000 nursing home residents (a 6.5% increase in the rate of residents with pressure ulcers since data collection for our 2015 report). These data, the latest available as of January 1, 2017, were obtained from CMS’s Minimum Data Set 3.0 Public Reports, available at <https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/Minimum-Data-Set-3-0-Public-Reports/index.html>.

<sup>21</sup> See <http://www.fda.gov/Drugs/DrugSafety/default.htm> for FDA warnings for both conventional and atypical antipsychotics due to their high risk of death. Numerous studies have indicated a strong association with other serious adverse events such as strokes, heart attacks and Parkinsonism. See our website, [www.nursinghome411.org](http://www.nursinghome411.org), for information and resources on the dangers antipsychotic drugging and national efforts to improve dementia care and reduce the use of antipsychotic drugs as chemical restraints.

<sup>22</sup> Data on antipsychotic drugging rates are for the 2016 Q3, obtained from the MDS Frequency Reports available at [www.cms.gov](http://www.cms.gov).

<sup>23</sup> Nursing Home Compare publishes the “risk-adjusted” rates for antipsychotic drug use. Specifically, these data are risk-adjusted to exclude certain populations for whom CMS has identified that antipsychotic drugs *may* be clinically beneficial, such as individuals with Schizophrenia, Tourette’s Syndrome and Huntington’s Disease. The rate cited in the previous paragraph, 20.6%, is the *non-risk-adjusted* rate based on what facilities report in the MDS (Minimum Data Set) resident assessments. Both numbers are important. The non-risk-adjusted data provide the cleanest information possible on drugging rates (subject to the accuracy of facility reporting) whereas the risk-adjusted data are what CMS uses in Nursing Home Compare and elsewhere. LTCCC (and other advocates) have long urged CMS to just use the non-risk-adjusted data to provide what we consider to be cleaner information and to avoid confusion.

<sup>24</sup> F-329 is the federal designation for citations for inappropriate drugging of nursing home residents.

troublesome finding. If giving residents drugs that are both highly dangerous and not clinically indicated is not harm, what is?<sup>25</sup>

## Chronic Deficiencies – What are we talking about?

As noted above, substandard care is common in U.S. nursing homes. The number of citations per facility varies greatly, with some nursing homes having zero citations and others having dozens (or more) citations. The average nursing home has seven (7) health deficiencies per year.<sup>26</sup> Importantly, it has been well-documented that state survey agencies often fail to identify abuse, neglect and substandard care. As one prominent report noted, “performance measurement models are better at identifying problem facilities than potentially good homes.”<sup>27</sup> In other words, a facility’s *published* citations may be just the tip of the iceberg with respect to the care that its residents are *actually* receiving on a day-to-day basis.

Thus, to gain further insights into the extent to which problems exist – and persist – in nursing homes, we have identified all nursing homes which have been cited for the same deficiency at least three times in the three years on Nursing Home Compare. This information can be useful to consumers, advocates and policymakers in numerous ways.

### Questions Raised by the Presence of Chronic Deficiencies

Following are some questions that we believe the presence of Chronic Deficiencies in Care raises for nursing home residents, families and those concerned about decent care:

1. Does my nursing home (or the nursing homes in my community) have chronic or persistent problems?
2. If yes, what are those problems?
3. What steps has the nursing home taken to address those problems?
4. What has worked? What hasn’t?
5. How are these problems being addressed by the facility’s leadership (owners/administrators) and its quality assurance (or QAPI) team?
6. How are these problems being addressed by the state Survey Agency, CMS and other enforcement agencies?
7. To what extent are the resident council, family council and LTC ombudsman aware of the problems and involved in the solutions?

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<sup>25</sup> LTCCC State Survey Agency Review at 18.

<sup>26</sup> Nursing homes are inspected for compliance with two categories of standards, (1) health and (2) fire and safety. The average cited here is for health deficiencies only, as reported on [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare) (accessed January 2, 2017). According to the latest edition of the *Nursing Home Data Compendium*, the mean number of health deficiencies for 2014 (the last year for which data were available) was 5.7 per facility. *Nursing Home Data Compendium*, Centers for Medicare and Medicaid Services (March 2015). Available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>.

<sup>27</sup> Phillips, Charles D., Hawes, Catherine, Lieberman, Trudy and Koren, Mary Jane, Where should Momma go? Current nursing home performance measurement strategies and a less ambitious approach *BMC Health Serv Res.* 2007; 7: 93 (June 2007). Accessed December 1, 2016 at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1920506/>.

## Chronic Deficiencies – Who are we talking about?

As noted earlier, deficiencies in care in nursing homes are, unfortunately, quite common, with an average citation rate of seven (7) deficiencies identified and substantiated per nursing home per year.<sup>28</sup> The data we are presenting on our website, [www.nursinghome411.org](http://www.nursinghome411.org), and discussing in this brief report essentially digs deeper. These are facilities that have three or more citations **for the very same deficiency** in the three years' worth of records published on Nursing Home Compare. In other words, facilities that “just” have deficiencies three times in the three years covered on Nursing Home Compare are not necessarily included here.

The data indicate that 42% of all U.S. nursing homes have what we are calling Chronic Deficiencies in Care (citations for the same deficiency category three times in the three years covered on Nursing Home Compare).<sup>29</sup> From a consumer perspective, we consider this an astonishing number. Fundamentally, we find it hard to understand how a 42% rate of substantiated failures three years in a row can be acceptable for any nursing home entrusted with caring for frail elderly individuals. In fact, these data also indicate something that is, overall, far worse: a 42% failure rate year after year after year for the very same regulatory requirements. Though regulations can vary substantially (in terms of the extent to which they impact a resident's well-being, whether they are broadly or narrowly defined, etc...), in general they pertain to a well-defined subject. Given the persistence of nursing home problems in general, this high rate of recidivism is troubling.

Fundamentally, we find it hard to understand how a 42% rate of substantiated failures three years in a row can be acceptable for any nursing home entrusted with caring for frail elderly individuals.

This year, for the first time, we are posting information on each facility's Nursing Home Compare 5-Star ratings for all of the rating categories that comprise the 5-Star system: survey (inspection) results, staffing, quality measures and overall.<sup>30</sup> As one might expect, the average star rating of nursing homes with Chronic Deficiencies in Care (CDCs) is well below average (2.11) when it comes to the survey star category.<sup>31</sup> However, we were surprised to find that the average quality measure and staffing star ratings for CDC nursing homes were above average.<sup>32</sup> We believe this may be explained by the fact that, in 2016, both the staffing and quality measure information posted on Nursing Home Compare were self-reported by facilities and unaudited for veracity by either the State Agencies or CMS. Since CMS began implementing

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<sup>28</sup> NH Compare data accessed fall 2016 indicated that this average persisted for each of the three years covered in the database.

<sup>29</sup> See US Composite file on the data page at [www.nursinghome411.org](http://www.nursinghome411.org).

<sup>30</sup> Nursing homes are rated from one to five stars for each of these categories. According to CMS, “Nursing homes with 5 stars are considered to have much above average quality and nursing homes with 1 star are considered to have quality much below average.” Nursing homes with three stars are labelled as “average” on Nursing Home Compare. For details on the 5-Star rating system's components and how ratings are calculated see <https://www.cms.gov/medicare/provider-enrollment-and-certification/certificationandcompliance/fsgrs.html>.

<sup>31</sup> This is, in our opinion, an expected outcome because, in order to be included, a facility must have multiple citations.

<sup>32</sup> The average staffing rating for CDC facilities was 3.16 and the average quality rating was 3.19.

significant improvements to both reported staffing and quality measures in late 2016, we expect that these data will provide more accurate information (and, therefore, more useful insights) in late 2017 and beyond, as the effects of these improvements are reflected on Nursing Home Compare.

### Chronic Deficiencies – What does it mean?

The federal Centers for Medicare and Medicaid Services (CMS) has recognized that the chronic failure to comply with minimum care standards is a serious problem in the nursing home industry and has taken steps to address it, most prominently through the Special Focus Facility Program. According to CMS:

The Special Focus Facility program (SFF) focuses on nursing homes that have a track record of substandard quality of care. Although such facilities have sometimes incorporated enough improvement in the presenting problems to pass one survey, they have frequently manifested many problems on the next survey, often for many of the same problems as before. Such facilities with a “yo-yo” compliance history rarely addressed the underlying systemic problems that were giving rise to repeated cycles of serious deficiencies.<sup>33</sup>

The SFF Program sets forth strong parameters within which the state survey agencies (SAs) are supposed to hold SFFs accountable. SAs are required to survey these facilities at least two times per year and apply “progressively stronger enforcement actions in the event of continued failure to meet Medicare and/or Medicaid participation requirements.”<sup>34</sup> The timing of these

“...the clear message of the SFF Program is that facilities... need to either get their act together or get out of the nursing home business.”

surveys “must be as **unpredictable** as possible. Each enforcement authority (SA or RO<sup>35</sup>), must impose an immediate remedy on each SFF that fails to achieve and maintain significant improvements in correcting deficiencies on the first and each subsequent standard survey after a facility becomes a SFF.”<sup>36</sup>

Most importantly, within a two year period, the SFF is supposed to have either developed and implemented enduring, systemic corrections to their problems or, if they have failed to do this, the facility is to be terminated from Medicare/Medicaid participation. Most nursing homes which are terminated from Medicare/Medicaid close or are sold. Thus, the clear message of the SFF Program is that facilities which are not able to consistently provide decent care need to either get their act together or get out of the nursing home business.

<sup>33</sup> CMS Memorandum: Special Focus Facilities (SFF) Procedures, S&C-10-32-NH (September 2010). Accessed December 2, 2016 at [https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter10\\_32.pdf](https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter10_32.pdf). Hereinafter SFF Memo.

<sup>34</sup> *Id.*

<sup>35</sup> Regional Office of CMS.

<sup>36</sup> SFF Memo. Emphasis in original.

## Case Studies

The United States has over 15,000 nursing homes which provide care for well over one million Americans every day. Nursing homes are paid to know each of their residents and to provide appropriate care and services to meet their medical and psycho-social needs as individuals in a manner that protects and fosters their dignity. Due to the individualized nature of nursing home services, no two citations for violating a standard of care will be the same. Nor, in our opinion, should they be; residents are individuals, not objects produced on an assembly line.

The survey system is not perfect but, through regulatory language and guidelines, we believe it provides a strong framework for (1) recognizing appropriate care standards and practices, (2) identifying cases of substandard care and abuse (i.e., violations of those standards) and (3) addressing violations so that facilities operate, by and large, in compliance with minimum standards (so that residents are safe and able to lead decent lives).

Because surveyors only inspect a facility for compliance about once a year, it is imperative that when a facility corrects a deficiency, it does so in a manner that not only addresses the immediate problem identified by the State Agency, but related issues as well, so that similar problems do not occur in the future. It is our belief that the fundamental integrity of the nursing home system is predicated on facilities understanding the nature of an identified deficiency and operationalizing corrective action throughout the facility, to the extent necessary to ensure that the deficiency (whether broad or narrow in scope) will not reoccur.

In the following two case studies, we look at how this “plays out” in two nursing homes with Chronic Deficiencies in Care: one with repeated failures to achieve a standard that is relatively broad and the other with repeated failures to achieve a standard that is more narrow in scope.

### Editor’s notes:

1. These case studies were selected randomly from among the facilities with triple deficiencies on Nursing Home Compare in our home state of New York. They are presented as a vehicle to provide insights into how triple repeat deficiencies may “play out” with a narrow requirement vs. a broad requirement, not as dispositive examples. With over a million individuals who rely on nursing home care every day and a range of standards to ensure that they receive adequate care and services, no two situations are alike. However, nursing homes agree – and are paid – to ensure that residents are monitored, cared for and safe 24 hours a day seven days a week.
2. Emphases added in the quotations below.

Because surveyors only inspect a facility for compliance about once a year, it is imperative that when a facility corrects a deficiency, it does so in a manner that not only addresses the immediate problem identified by the State Agency, but related issues as well, so that similar problems do not occur in the future.

## Case Study 1: Repeat of a Deficiency That is Broad in Scope

**Standard of Care:** Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents. (42 CFR §483.25(h))

### Description of the Facility

Brighton Manor nursing home in Rochester, NY was one of the facilities identified as having Chronic Deficiencies in Care in our fall 2016 data run. According to its listing on Nursing Home Compare, **Brighton Manor is a one star facility** (overall rating) owned by a for-profit corporation, Blossom Health Care Center, Inc.<sup>37</sup> A Rochester *Democrat & Chronicle* article published on November 12, 2013 reported that

Brighton Manor is the new name for Blossom Health Care Center, 989 Blossom Road, according to owner Gerald Wood.

Wood said he instituted a new management team at Brighton Manor, improved the staff by having registered nurses rather than licensed practical nurses as unit managers, and he plans to refurbish residents' rooms.<sup>38</sup>

Though Brighton Manor has a three-star (average) rating for staffing, according to Nursing Home Compare, its registered nurse (RN) and nurse aide (CNA) staffing ratios are both below both state and federal averages. Its licensed practical nurse staffing is slightly above average. According to Nursing Home Compare, Brighton Manor has received no federal fines in the last three years.<sup>39</sup>

### Description and Discussion of the Repeat Deficiencies

Brighton Manor had four citations on Nursing Home Compare for the standard we selected to examine as one that is broad in scope: F-323, **the facility must ensure that the nursing home area is free from accident hazards and risks and provide supervision to prevent avoidable accidents**. These citations occurred in January 2014, August 2014, August 2015 and June 2016. The January 2014 citation was imposed during a complaint survey, while the others were imposed during the facility's standard (annual) surveys.

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<sup>37</sup> Nursing Home Compare listing for Brighton Manor. Accessed on January 3, 2017 at

[www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare).

<sup>38</sup> "Blossom Health Care Center changes name," *Democrat & Chronicle* (November 12, 2013) (no author listed, filed under "Staff reports"). Accessed on January 3, 2017 at

<http://www.democratandchronicle.com/story/money/business/2013/11/12/blossom-health-care-center-changes-name/3510589/>.

<sup>39</sup> Nursing Home Compare listing for Brighton Manor. Accessed on January 3, 2017 at

[www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare). Note, in respect to fines, that states can impose state fines and other penalties for deficiencies. For this report, we looked only at what was posted on Nursing Home Compare.

### Citation 1: January 2014

A resident's care plan indicated a **risk for falls**, exhibiting of **wandering behaviors** and a **high risk for elopement**. On January 15, 2014, **the resident was found in a stairwell in between units** of the nursing home. Investigation found that the alarm on the door to resident's floor was not set. In light of this, the facility's corrective action plan included installation of a new security system by January 17.

On January 30, 2014 at 11:30 a.m., the resident was escorted to the dining room off of which there is an open stairwell. At 12:00 p.m., housekeeping staff heard the first floor outside door alarm go off but did not see anyone there. The resident was found above the 3<sup>rd</sup> floor at a locked door to the roof of the building. The housekeeping staff person returned the resident to her unit. Neither the LPN nor the RN supervisor were aware that the resident had been missing.

**Citation level.** This deficiency was cited as **not** causing harm or immediate jeopardy to a resident's well-being.<sup>40</sup>

### Citation 2: August 2014

On July 29, 2014 **hot water temperatures in numerous residents' rooms was found to be between 123° - 131° Fahrenheit**. According to the U.S. Consumer Product Safety Commission, "a thermostat setting of 120 degrees Fahrenheit... may be necessary for residential water heaters to reduce or eliminate the risk of most tap water scald injuries." The Commission warns that **burns will occur "...with a thirty second exposure to 130 degree water**. Even if the temperature is 120 degrees, a five minute exposure could result in third-degree burns."<sup>41</sup>

The facility log for June and July indicated no temperature greater than 113.5°. However, no testing times were indicated in the facility log.

This citation indicated a second deficiency: a **resident with a risk of falling** had an assessment indicating that siderails were being provided to enable and promote independence. However, **the surveyor found that these siderails were, in fact, extremely loose and wobbly**.

The surveyor interviewed the resident and staff and found the following:

- a. At 1:41 p.m., the resident stated that he has told numerous staff members that his siderail has been loose since it was put on but was told it was fine. He added that he did not feel it was safe and tried not to use it.
- b. At 2:00 p.m., the Licensed Practical Nurse Manager stated that she went down to check the resident's siderail and did find it very wobbly and immediately notified maintenance.

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<sup>40</sup> CMS defines "Immediate Jeopardy" as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." State Operations Manual, Appendix Q - Guidelines for Determining Immediate Jeopardy - (Rev. 1, 05-21-04). Accessed on January 26, 2017 at [https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap\\_q\\_immedjeopardy.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_q_immedjeopardy.pdf).

<sup>41</sup> Quotations in this paragraph are from the U.S. Consumer Product Safety Commission Safety Alert, Publication 5098 009611 032012. Accessed on January 26, 2017 at <https://www.cpsc.gov/s3fs-public/5098.pdf>.

She added that they do monthly siderail audits that include observing staff to ensure they are using it as ordered. **The audits do not include checking the siderail to ensure a tight fit and no gaps.**<sup>42</sup>

**Citation level.** These deficiencies were cited as *not* causing either harm or immediate jeopardy to a resident's well-being.

#### Citation 3: August 2015

Surveyors found that a portion of the carport ceiling at the main entrance to the building was damaged. The maintenance tech stated that it did not look like it was going to fall down but should be addressed. The owner stated that someone came to look at it and determined that the structure was safe, but should be fixed. The facility did not provide any documentation to support these determinations.

**Citation level.** This deficiency was cited as *not* causing harm or immediate jeopardy to a resident's well-being.

#### Citation 4: June 2016

Surveyors "...determined that for two of six residents and two of two residential units reviewed for accidents, the facility did not provide adequate supervision of residents to prevent avoidable accidents, and the residents' environment remained as free of accident hazards as possible. Issues involved the **lack of safety assessment and adequate monitoring of smoking paraphernalia** belonging to residents known as smokers living in this nonsmoking facility, and the **lack of monitoring of hot water temperatures** at varied times within 24 hours per day."

In respect to the hot water monitoring deficiency, the surveyor found that hot water in resident areas exceeded 120° in several areas in two days of testing. The surveyor noted that

On 5/26/16 at approximately 3:50 p.m., the Acting Director of Maintenance took the water temperature in the sink of Resident Room #217 with the surveyor. The surveyor found the temperature to be 125°F with Taylor model 9842 digital thermometer. The **Acting Director of Maintenance stated that it was hard to read between the lines with his dial type... thermometer unless you have real good eyesight** and stated it looked like his thermometer read 122°F.

**Citation level.** These deficiencies were cited as *not* causing either harm or immediate jeopardy to a resident's well-being.

#### Discussion

We identified this as a broad deficiency category, since "accidents and risks" could potentially relate to a variety of issues. It encompasses both environmental safety for the physical facility as well as care and monitoring provided by staff to the residents. Despite the broadness of this category, however, in the four times for which Brighton Manor was cited for this deficiency in a

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<sup>42</sup> See Appendix 3 for full citation.



three year period, we believe that one can see how there can be strong connections between environmental safety and safe care and monitoring.

In the first deficiency (1/14), the facility failed to properly monitor a resident who was at a risk for wandering and who wound up wandering in places which posed a high risk of danger (a stairwell). Her direct caregivers were unaware that she had wandered into a dangerous area. In two other citations (8/14 and 8/16), surveyors determined that the facility failed to ensure that water temperatures in residents' rooms were at safe levels (to prevent scalding). All three of these problems relate to ensuring, through monitoring of the environment and residents, that they are safe and, in essence, out of harm's way. In the 8/14 citations, the facility was also determined to have failed to ensure a safe environment for another resident at risk for falling (the bed rails that he was supposed to use were wobbly).

In all of these cases (unsafe hot water temperatures twice in three years, inadequate monitoring and environmental precautions for residents at risk for falls twice in three years) one can see, we believe, both specific repeat problems and a pattern which this broad citation category is meant to address: the critical need to monitor both residents and their environment (particularly the fixtures and facilities they use) to ensure safety for a population that is generally quite vulnerable. This was the nature of the deficiencies identified in 2014 and was still the nature of the deficiencies identified in 2016.<sup>43</sup>

**Importantly, from our perspective, the fundamental question is: if the nursing home had fully operationalized its corrections to the deficiencies cited in earlier surveys across its systems and facilities, would that have been likely to avoid or ameliorate future occurrences of deficiencies for this citation?**

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<sup>43</sup> There were two other problems identified in the four citations reviewed: a damaged carport at the front entrance and failure to adequately assess and monitor residents who smoke. A damaged carport is a singular event, though we are nevertheless concerned that there was, evidently, a potentially hazardous environmental issue for which the facility did not have documentation to support its claim that residents, workers and their visitors were not at risk. Likewise, the failure to have an effective system for monitoring residents who smoke and maintain a non-smoking facility (as the nursing home claims) is troubling and another indication of a persistent failure to provide appropriate monitoring of residents and record-keeping that substantiates the facility's ability to meet or exceed minimum standards.

## Case Study 2: Repeat of a Deficiency That is Narrow in Scope

### Standard of Care: Pressure Sores

Based on the comprehensive assessment of a resident, the facility must ensure that--

- (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
- (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. (§483.25(c)).

### Description of the Facility

Hilaire Rehab & Nursing in Huntington, NY was one of the facilities identified as having Chronic Deficiencies in Care in our fall 2016 data run. According to its listing on Nursing Home Compare, **Hilaire is a one-star facility** overall, with one star for health inspections (surveys), three stars for staffing and four stars for quality measures. Hilaire's Nursing Home Compare listing indicates that the nursing home has not received any federal fines in the last three years.<sup>44</sup>

### Description and Discussion of the Repeat Deficiencies

**Hilaire had three citations on Nursing Home Compare for the standard we selected to examine as one that is narrow in scope: F-314**, which relates to the provision of adequate care and monitoring to prevent and/or treat pressure ulcers.

#### Citation 1: May 2014

The surveyors found that **the facility did not monitor a resident's skin for timely identification of changes**. The facility identified a new pressure ulcer on a resident's right hip on 5/8/14 (during the facility's survey) when it was a Stage 3.<sup>45</sup>

The resident's care plan in this case indicated that she was, *inter alia*, non-ambulatory, at risk for falls and at risk for pressure ulcers. Her care plan included interventions to turn and reposition her every 2-4 hours. According to the wound nurse, "the nurses are supposed to do weekly body check during shower days and the Certified Nurses [sic] Assistant (CNA) check the body daily including during incontinence care."

According to the medical record, **the facility identified this pressure ulcer as having been the result of the resident's hospital stay. However, the surveyor conducted interviews with several CNAs who had provided care to the resident in the nursing home for the three days**

<sup>44</sup> All information is from the Nursing Home Compare listing for Hilaire Rehab and Nursing accessed on January 30, 2017 at [www.medicare.gov/nursinghomecompare](http://www.medicare.gov/nursinghomecompare). Note, in respect to fines, that states can impose state fines and other penalties for deficiencies. For this report, we looked only at what was posted on Nursing Home Compare.

<sup>45</sup> There are, essentially, six categories of pressure ulcers including four stages with each higher stage indicating a higher level of severity. For more information, see the National Pressure Ulcer Advisory Panel's staging/categorization guide at <http://www.npuap.org/wp-content/uploads/2012/01/NPUAP-Pressure-Ulcer-Stages-Categories.pdf>.

**prior to identification of a Stage 3 pressure ulcer. All of the CNAs stated that they did not see any problem with the resident's skin in the days before identification of the Stage 3 pressure ulcer except for one CNA who stated that she saw a "bright red mark" and alerted the nurse the morning before it was discovered.**

**Citation level.** This deficiency was cited as *not* causing either harm or immediate jeopardy to a resident's well-being.

#### **Citation 2: May 2015**

In this case, a resident came in to the facility at risk for developing pressure ulcers and with two serious pressure ulcers (one Stage 4 and the other "unstageable"). The **resident's care plan** and the **physician's orders** referenced by the surveyors **describe several treatment protocols.** However, according to the Statement of Deficiency (SoD), reviews of the Treatment Administration Record (TAR) and the nurses' notes revealed that **"there was no documentation that the... treatment was done between 4/8/15 through 4/10/15."** In addition, **the facility's written record** on 4/29/15 indicated that there was a pressure ulcer measuring 1.5 cm x 1.0 cm. **The next morning the surveyor observed** the nurse conducting a wound dressing change. At that time, **the wound was measured to be double the size** (3.0 cm x 1.5 cm) that the nurse had written the day before.

**Citation level.** This deficiency was cited as *not* causing either harm or immediate jeopardy to a resident's well-being.

#### **Citation 3: April 2016**

In this case, a resident came in to the facility at risk for developing pressure ulcers and with pressure ulcers in three areas as well as areas of eschar in two areas.<sup>46</sup> The facility received a citation because there was **no documented evidence that treatment was provided to one of the pressure ulcers or for the areas with eschar for the five month period between the resident's admission (with documented skin conditions) in November and the April 2016 survey.**

**Citation level.** This deficiency was cited as *not* causing either harm or immediate jeopardy to a resident's well-being.

#### **Discussion**

We identified this as a narrow deficiency category, since pressure ulcers are a specific condition and clearly relate to some of the most critical components of good nursing home care: the employment of direct care staff at sufficient numbers and with sufficient skills to ensure that residents are able to attain, and maintain, their highest practicable well-being; appropriate clinical monitoring and care on a 24-hour basis to meet the needs of residents, etc. While pressure ulcers can develop in different ways, with some individuals being more prone to developing them than others, good pressure ulcer care, including (especially) care and monitoring to avoid the development of pressure ulcers, is widely recognized as an important

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<sup>46</sup> Healthline.com provides a succinct definition of Eschar: "...dead tissue that sheds or falls off from healthy skin. It's caused by burns and also occurs in pressure wounds (bedsores)." <http://www.healthline.com/symptom/eschar>.

component of nursing home care. In fact, research indicates that, “[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer (PU) formation.”<sup>47</sup> Too often, as we see throughout these three years of citations, deficient pressure ulcer care manifests itself in a lack of evidence that treatment was provided as called for by the care plan (or other facility documentation); that monitoring of resident skin conditions was (according to facility documentation) absent or slipshod; and/or that there is a lack of agreement between the various care planning and clinical records, statements of caregivers and physical evidence.

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<sup>47</sup> Edsberg, L.; Langemo, D.; Baharestani, M.; Posthauer, M.; and Goldberg, M., “Unavoidable Pressure Injury: State of the Science and Consensus Outcomes,” *Journal of Wound, Ostomy & Continence Nursing*: July/August 2014 - Volume 41 - Issue 4 - p 313–334. Abstract accessed in February 2017 at [http://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable\\_Pressure\\_Injury\\_State\\_of\\_the\\_Science.6.aspx](http://journals.lww.com/jwoconline/Abstract/2014/07000/Unavoidable_Pressure_Injury_State_of_the_Science.6.aspx).

## Appendix I: Selected Reports on Care and Oversight in U.S. Nursing Homes

Note: The majority of the following reports and articles were prepared by Janet C. Wells for the Centers for Medicare and Medicaid Services Survey Executives Training Institute, Baltimore, MD, April 9, 2014. Please note that all links provided were accurate as of February 2017.

1. Five-star ratings for sub-par service: Evidence of inflation in nursing home ratings (December 2016). <https://www.brookings.edu/research/five-star-ratings-for-sub-par-service-evidence-of-inflation-in-nursing-home-ratings/>
2. Nursing Home Quality: CMS Should Continue to Improve Data and Oversight (GAO-16-33): October 2015. <http://www.gao.gov/assets/680/673480.pdf>
3. Adverse Events in Skilled Nursing Facilities: National Incidence Among Medicare Beneficiaries (OEI-06-11-00370): February 2014. <https://oig.hhs.gov/oei/reports/oei-06-11-00370.pdf>
4. Examining Inappropriate Use of Antipsychotic Drugs: How Surveyors Describe How, When and Why They Cite Antipsychotic Drug Deficiencies: Toby Edelman and Dean Lerner, 2013. <http://www.medicareadvocacy.org/cma-report-examining-inappropriate-use-of-antipsychotic-drugs-in-nursing-facilities/>
5. Medicare Nursing Home Resident Hospitalization Rates Merit Additional Monitoring (OEI-06-11-00040): November 18, 2013. <https://oig.hhs.gov/oei/reports/oei-06-11-00040.asp>
6. [CMS Should Improve Efforts to Monitor Implementation of the Quality Indicator Survey](http://www.gao.gov/products/GAO-12-214) (GAO-12-214): March 9, 2012. <http://www.gao.gov/products/GAO-12-214>
7. [Private Investment Homes Sometimes Differed from Others in Deficiencies, Staffing, and Financial Performance](http://www.gao.gov/products/GAO-11-571) (GAO-11-571): July 15, 2011. <http://www.gao.gov/products/GAO-11-571>
8. Overmedication of Nursing Home Patients Troubling May 9, 2011. [http://oig.hhs.gov/newsroom/testimony-and-speeches/levinson\\_051011.asp](http://oig.hhs.gov/newsroom/testimony-and-speeches/levinson_051011.asp)
9. Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents (OEI-07-08-00150): April 7, 2011. <http://oig.hhs.gov/oei/reports/oei-07-08-00150.asp>
10. [More Reliable Data and Consistent Guidance Would Improve CMS Oversight of State Complaint Investigations](http://www.gao.gov/products/GAO-11-280) (GAO-11-280): April 7, 2011. <http://www.gao.gov/products/GAO-11-280>
11. [Implementation of the Quality Indicator Survey](http://www.gao.gov/products/GAO-11-403R) (GAO-11-403R): Apr 6, 2011. <http://www.gao.gov/products/GAO-11-403R>
12. Complexity of Private Investment Purchases Demonstrates Need for CMS to Improve the Usability and Completeness of Ownership Data (GAO-10-710): September 30, 2010. <http://www.gao.gov/products/GAO-10-710>

13. [Some Improvement Seen in Understatement of Serious Deficiencies, but Implications for the Longer-Term Trend Are Unclear](http://www.gao.gov/products/GAO-10-434R) (GAO-10-434R): April 28, 2010. <http://www.gao.gov/products/GAO-10-434R>
14. [Addressing the Factors Underlying Understatement of Serious Care Problems Requires Sustained CMS and State Commitment](http://www.gao.gov/products/GAO-10-70) (GAO-10-70): November 24, 2009. <http://www.gao.gov/products/GAO-10-70>
15. [Responses from Two Web-based questionnaires to Nursing Home Surveyors and State Agency Directors \(GAO-10-74SP\), an e-supplement to GAO-10-70](http://www.gao.gov/products/GAO-10-74SP) GAO-10-74SP: November 24, 2009. <http://www.gao.gov/products/GAO-10-74SP>
16. [Opportunities Exist to Facilitate the Use of the Temporary Management Sanction](http://www.gao.gov/products/GAO-10-37R) (GAO-10-37R): November 20, 2009. <http://www.gao.gov/products/GAO-10-37R>
17. [CMS's Special Focus Facility Methodology Should Better Target the Most Poorly Performing Homes, Which Tended to Be Chain Affiliated and For-Profit](http://www.gao.gov/products/GAO-09-689) (GAO-09-689): August 28, 2009. <http://www.gao.gov/products/GAO-09-689>
18. Nursing Home Corporations Under Quality of Care Corporate Integrity Agreements (OEI-06-06-00570): April 2009. <https://oig.hhs.gov/oei/reports/oei-06-06-00570.pdf>
19. [CMS Needs to Reexamine Its Approach for Funding State Oversight of Health Care Facilities](http://www.gao.gov/products/GAO-09-64) (GAO-09-64): February 13, 2009. <http://www.gao.gov/products/GAO-09-64>
20. Memorandum Report: Trends in Nursing Home Deficiencies and Complaints (OEI-02-08-00140): September 2008. <http://oig.hhs.gov/oei/reports/oei-02-08-00140.pdf>
21. Nursing Home Enforcement: Processing Denials of Medicare Payment (OEI-06-03-00390): May 2008. <http://oig.hhs.gov/oei/reports/oei-06-03-00390.pdf>
22. [Federal Monitoring Surveys Demonstrate Continued Understatement of Serious Care Problems and CMS Oversight Weaknesses](http://www.gao.gov/products/GAO-08-517) (GAO-08-517): May 9, 2008. <http://www.gao.gov/products/GAO-08-517>
23. [Federal Actions Needed to Improve Targeting and Evaluation of Assistance by Quality Improvement Organizations](http://www.gao.gov/products/GAO-07-373) (GAO-07-373): May 29, 2007. <http://www.gao.gov/products/GAO-07-373>
24. [Continued Attention Is Needed to Improve Quality of Care in Small but Significant Share of Homes](http://www.gao.gov/products/GAO-07-794T) (GAO-07-794T): May 2, 2007. <http://www.gao.gov/products/GAO-07-794T>
25. [Efforts to Strengthen Federal Enforcement Have Not Deterred Some Homes from Repeatedly Harming Residents](http://www.gao.gov/products/GAO-07-241) (GAO-07-241): March 26, 2007. <http://www.gao.gov/products/GAO-07-241>
26. Nursing Home Complaint Investigations (OEI-01-04-00340): July 2006. <http://oig.hhs.gov/oei/reports/oei-01-04-00340.pdf>
27. Nursing Home Enforcement: Application of Mandatory Remedies (OEI-06-03-00410): May 2006. <http://oig.hhs.gov/oei/reports/oei-06-03-00410.pdf>

28. [Information on Residents Who Are Registered Sex Offenders or Are Paroled for Other Crimes](http://www.gao.gov/products/GAO-06-326) (GAO-06-326): March 31, 2006. <http://www.gao.gov/products/GAO-06-326>
29. [Despite Increased Oversight, Challenges Remain in Ensuring High-Quality Care and Resident Safety](http://www.gao.gov/products/GAO-06-117) (GAO-06-117): December 28, 2005. <http://www.gao.gov/products/GAO-06-117>.
30. State Referral of Nursing Home Enforcement Cases (OEI-06-03-00400): December 2005. <http://oig.hhs.gov/oei/reports/oei-06-03-00400.pdf>.
31. Nursing Home Enforcement: The Use of Civil Money Penalties (OEI-06-02-00720): April 2005. <http://oig.hhs.gov/oei/reports/oei-06-02-00720.pdf>.
32. [Arkansas Coroner Referrals Confirm Weaknesses in State and Federal Oversight of Quality of Care](http://www.gao.gov/products/GAO-05-78) (GAO-05-78): November 12, 2004. <http://www.gao.gov/products/GAO-05-78>.
33. Inspection Results on Nursing Home Compare: Completeness and Accuracy (OEI -01-03-00130): June 2004. <http://oig.hhs.gov/oei/reports/oei-01-03-00130.pdf>.
34. Survey of Physical and Sexual Abuse in Alabama Nursing Homes (A-04-03-07027): June 2004. <https://oig.hhs.gov/oas/reports/region4/40307027.pdf>.
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## Appendix II: Scope and Severity Matrix

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	<b>J</b>	<b>K</b>	<b>L</b>
Actual Harm that is Not Immediate Jeopardy	<b>G</b>	<b>H</b>	<b>I</b>
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	<b>D</b>	<b>E</b>	<b>F</b>
No Actual Harm with Potential for Minimal Harm	<b>A</b>	<b>B</b>	<b>C</b>

### Appendix III: Excerpts from Deficiency Citations that are Broad in Scope

Following are excerpts from the four Statements of Deficiencies ( SoD, aka CMS Form 2567) discussed in Case Study 1. The excerpts include all of the language relating to the repeat deficiency citation for F-323 in each SoD, copied directly from the SoDs as they appear on Nursing Home Compare (accessed December 2, 2016). The original (PDF) of the SoDs are available from [www.medicare.gov](http://www.medicare.gov) or, upon request, from LTCCC.

#### **Brighton Manor, Rochester, NY, January 2014 (Complaint Survey)**

F 0323

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Few

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on observations, record reviews, and interviews conducted during an Abbreviated Survey (complaint #NY 732) completed on 1/31/14, it was determined that for one (Resident #1) of three residents reviewed for accident hazards, the facility did not ensure that the residents' environment remained as free of accident hazards as possible. Specifically Resident #1, who was identified as an elopement risk, was found by staff alone in an unalarmed stairwell at the door to the roof. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy, and is evidenced by the following:

Resident #1 has a [DIAGNOSES REDACTED].

The Comprehensive Care Plan, dated 12/31/13, revealed that the resident was at risk for falls and exhibits wandering behaviors throughout the unit. Approaches include a Wanderguard system. An elopement risk assessment, dated 5/17/13 and reviewed on 1/15/14, revealed the resident was considered a high risk for elopement.

Review of the medical record revealed the following:

a. An Investigation Report, dated 1/15/14, included that on 1/10/14 at approximately 8:00 p.m., Resident #1 (who lived on the third floor) was found by a housekeeping staff in the stairwell between units. The exit door on the first floor was alarming, which had brought the staff member to the stairwell. The summary of the investigation determined that the third floor door was unalarmed by a staff member who failed to reset the alarm.

b. A statement of the incident, dated 1/14/14 taken by the Director of Nursing (DON) via a phone conversation with the LPN team leader on duty on the evening shift of 1/10/14, revealed that when the resident was brought back to the unit, the east end stairwell doors on the third floor was found unlocked and unalarmed. Also, the Registered Nurse (RN) Supervisor was not notified that the resident had gone into the stairwell. The doors were realarmed, and the floor staff were told not to use the stairwell doors unless they realarmed them. She added that nothing else was done at that time.

c. A statement, dated 1/14/14 and signed by the RN Supervisor on duty on 1/10/14 evening, revealed that the resident was found in the stairwell, that she had no injuries, and that actions taken included walking the resident around the unit to tire her out so she could go to bed.

d. A Corrective Action attachment to the 1/15/14 investigation included that when it was brought to the attention of administration on 1/14/14, staff were told not to use the stairwells until further notice, and, in addition, all Wanderguard residents were reassessed. The plan included to install a new security system to the doors by 1/17/14. Observations made on 1/30/14 included the following:

a. At 8:30 a.m., the resident was in her room eating breakfast at the side of her bed.

The resident was wearing a Wanderguard bracelet on her right ankle and was alert but very confused.

b. At 9:15 a.m., the third floor east end stairwell door was observed with the DON and the RN/ Nurse Manager (NM). A new key pad system had been installed after this incident to reset automatically after being disarmed following access.

c. At 11:30 a.m. during a review of the Wanderguard system, Resident #1 (wearing her Wanderguard bracelet and assisted by staff) ambulated down the elevator, into the dining room, and into the back hallway where the kitchen and staff break room (coffee and utensils available) are. The Wanderguard did not sound. Off the dining room is an open stairwell accessible to residents. When asked at that time if this resident should have access to the stairwell off the dining room or the staff breakroom, the DON stated, No, she should not.

Interviews on 1/30/14 included the following:

a. At 8:30 a.m., 10:00 a.m., and again at 12:30 p.m., the DON stated that the stairwell on the third floor was alarmed by use of a toggle switch that staff had to reset everytime it was used. The DON stated that they felt the new security system had corrected the problem. At that time, the whole Wanderguard system was checked for proper functioning and was found to be functioning properly. The DON said that the elevators are not Wanderguard alarmed, but the area by the front door is, including the two hallways on the first floor leading to the dining room and administration wing. Also, the system is checked daily by the Maintenance Department, and the breakroom and dining room are not locked at night.

b. At 11:15 a.m., the Director of Maintenance stated that he checks the Wanderguard system daily. He said the only area that is not Wanderguard alarmed is the back hall towards the kitchen area, and everyone is aware of this. He also stated that he thought the dining room hallway was Wanderguarded and did not know why it was not currently working.

c. At 12:00 p.m., the housekeeping staff stated that she heard the first floor outside door alarm go off at approximately 7:30 p.m. but found no one there. In checking the stairwell, she found Resident #1 above the third floor at the locked door to the roof. She returned the resident to her unit, where the LPN and RN Supervisor were unaware that the resident was missing.

d. At 1:45 p.m., the Administrator stated that they were aware that the Wanderguard system did not work in the back hallway (leading to the kitchen and break room) but was informed that it did work in the hallway leading to the dining room and that it would be

fixed immediately.

Review of the facility's policy, dated 2/12/12, Wanderguard Door Alarm Response, included that code alert sensors are installed on the sides of the main lobby entrance inside the doors. It does not include any information regarding the remaining three hallways on the first floor.

### **Brighton Manor, Rochester, NY, August 2014**

F 0323

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on observations, interviews, and record reviews, it was determined that for two of two residential units reviewed for hot water temperatures and for one (Resident #117) of four residents reviewed for accidents, the facility did not ensure residents were free of potential accident hazards and that each resident receives adequate supervision and assistance devices to prevent accidents. The issues involved unsafe hot water temperatures in residential areas and a loose siderail. This resulted in a pattern of no actual harm with potential for more than minimal harm that is not immediate jeopardy, and is evidenced by, but not limited to, the following:

1. Measurements of hot water temperatures in resident room sinks on 7/29/14 included the following:

- a. At 9:44 a.m., in Room #217, the hot water temperature was 130.1 degrees (\*) Fahrenheit (F). At 1:18 p.m., the hot water temperature was 123.4°F.
- b. At 9:51 a.m., in Room #211, the hot water temperature was 127.9°F. At 1:00 p.m., the hot water temperature was 131°F.
- c. At 9:53 a.m., in Room #205 the hot water temperature was 124.7°F. At 1:16 p.m., the hot water temperature was 125.1°F.
- d. At 10:12 a.m., in Room #319, the hot water temperature was 125.2°F.
- e. At 10:21 a.m., in Room #303, the hot water temperature was 123.3°F.

Interviews on 7/29/14 included the following:

- a. At 10:29 a.m., the Director of Maintenance (DOM) reported that maintenance staff are checking water temperatures in resident rooms on each floor daily.
- b. At 10:52 a.m., the surveyor and the DOM checked the hot water temperature in Resident Room #211. The surveyor's thermometer read the temperature at 125.8°F, and the DOM's thermometer read the temperature at 125.3°F.
- c. At 11:21 a.m., the DOM stated that there is no written policy for water temperature monitoring.
- d. At 12:15 p.m., the DOM stated that the water temperatures are taken daily between 8:00

a.m. and 9:00 a.m. They have never noticed any high temperatures during their monitoring. If they had a temperature that was too high, they would call the plumber. The DOM said that they should probably vary the times that they are taking the temperatures. Review of the water temperature monitoring logs at that time for the months of June 2014 and July 2014 revealed no temperatures greater than 113.5°F. No times were listed for any of the water temperatures listed on the temperature logs.

Additionally, hot water temperatures on 7/29/14 at 1:13 p.m. included the following:

- a. At 1:02 p.m., in Room #213, the hot water temperature was 131.0°F.
- b. At 1:13 p.m., in Room #207, the hot water temperature was 127.3°F.
- c. At 1:13 p.m., in Room #215, the hot water temperature was 127.9°F.

In an interview on 7/29/14 at 3:30 p.m., a plumber explained that he believed that the mixing valve is not functioning properly. The mixing valve was installed in 2011 and is due to be rebuilt. If the mixing valve is turned all the way to cold, the temperature on the gauge at the mixing valve should show a drastic change in temperature. The plumber then turned the valve to cold and the temperature on the gauge continued to read 124.3°F. The plumber stated that the mixing valve was malfunctioning and he would rebuild it but had to go get parts.

2. Resident #117 was admitted to the facility on [DATE] for rehabilitation with [DIAGNOSES REDACTED]. Per staff, the resident is alert and oriented. A Comprehensive Care Plan, dated 7/15/14, included that the resident was at risk for falls related to impaired mobility, a history of falls at home, and required assist of staff for all activities of daily living. An undated Certified Nursing Assistant Assignment Sheet included that the resident has two quarter siderails to aide in bed mobility.

Review of the medical record included the following:

- a. An undated risk assessment for falls included a score of 14, indicating that the resident is at high risk for falls.
- b. A siderail assessment, dated 7/18/14, included that the resident is using bilateral siderails to enable and promote independence, and included education of siderail risks and benefits.
- c. A siderail usage audit tool, dated 7/18/14, included that the resident's record was reviewed for all necessary forms related to siderail use. This form does not include information to verify the siderail was properly attached.

During an observation on 7/29/14 at 1:51 p.m. and again on 7/30/14 at 1:00 p.m., the resident's left siderail was in the up position and extremely loose and wobbly.

Interviews on 7/30/14 included the following:

- a. At 1:41 p.m., the resident stated that he has told numerous staff members that his siderail has been loose since it was put on but was told it was fine. He added that he did not feel it was safe and tried not to use it.
- b. At 2:00 p.m., the Licensed Practical Nurse Manager stated that she went down to check the resident's siderail and did find it very wobbly and immediately notified maintenance. She added that they do monthly siderail audits that include observing staff to ensure they are using it as ordered. The audits do not include checking the siderail to ensure a tight fit and no gaps.

In an interview on 7/31/14 at 9:30 a.m., the DOM stated that the resident's siderail was loose and that he changed out the resident's whole bed with attached siderails that were more appropriate to handle the resident's weight. Also, the new bed was designed to be used for residents who are care planned for siderails.

**Brighton Manor, Rochester, NY, August 2015**

F 0323

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

Based on observations and interviews, it was determined that for one of one building, the facility did not maintain an environment free of accident hazards. Specifically, a portion of the carport ceiling at the main entrance was damaged. This is evidenced by the following:

Observation on 8/6/15 at approximately 11:22 a.m. revealed that the ceiling pan of the front entrance carport was bowed down in the front approximately 2 inches. There were visible concrete pieces laying on the top side of the ceiling pan. Also, metal supports in the center of the carport were extending approximately 1 inch below the bottom of the carport frame. Towards the sides of the carport, metal supports were flush with the bottom side of the carport frame. At that time, the Maintenance Technician stated that he is not an engineer, but it does not look like the ceiling would fall down, however, it needs to be addressed. When viewed from under the carport, the white ceiling had staining in the area where the damage has occurred.

On 8/6/15 at approximately 12:20 p.m., the facility's owner stated that the damage occurred when a contractor hit the carport. He stated that someone had come in to look at the damage and determined it to be safe, but they should look into getting it fixed. The facility did not provide any supportive documentation to validate this determination.

**Brighton Manor, Rochester, NY, June 2016**

F 0323

Level of harm - Minimal harm or potential for actual harm

Residents Affected - Some

Make sure that the nursing home area is free from accident hazards and risks and provides supervision to prevent avoidable accidents

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on observations, interviews, and record reviews, it was determined that for two (Residents #46 and #10) of six residents and two of two residential units reviewed for

accidents, the facility did not provide adequate supervision of residents to prevent avoidable accidents, and the residents' environment remained as free of accident hazards as possible. Issues involved the lack of safety assessment and adequate monitoring of smoking paraphernalia belonging to residents known as smokers living in this nonsmoking facility, and the lack of monitoring of hot water temperatures at varied times within 24 hours per day. This is evidenced by, but not limited to, the following:

1. Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of the Minimum Data Set (MDS) Assessment, dated 3/25/16, and the Care Plan Activity Report, dated 3/28/16, both revealed that the resident's cognitive skills were impaired. Review of a medical record revealed that on 5/7/16 at 8:12 p.m. a Licensed Practical Nurse (LPN) documented smelling cigarette smoke coming from the resident's room at 8:09 p.m. The resident admitted to smoking in the bathroom and turned in one cigarette and a lighter. The corresponding Incident/Accident (I/A) Report, dated 5/7/16, revealed that the resident admitted to smoking in the facility and relinquished a cigarette and lighter. In a note dated 5/10/16, the Social Worker (SW) documented that the resident is not able to make his own healthcare decisions. The SW spoke with the family who reported that they had been successful in weaning the resident of smoking in the past. In a progress note, dated 5/11/16 at 11:34 a.m., a Licensed Practical Nurse (LPN) documented that the resident declined to use nicotine patches to help with smoking cessation. The resident told the SW that he he forgot this was a non-smoking facility and would not smoke in the building again. At that time, there were no revisions to the resident's plan of care or a smoking assessment completed. In a progress note, dated 5/16/16 at 3:10 p.m., a LPN documented smelling cigarette smoke coming from the resident's room. The resident did not have any cigarettes on his person at that time. Staff reported that the resident was in the bathroom when they smelled smoke. The note indicated the Administrator and LPN spoke to the resident and searched for smoking materials. The resident denied smoking. The care plan, dated effective 5/16/16, indicated the resident was at risk for unsafe behavior that included smoking in the facility. The interventions included 15-minute checks. The corresponding I/A Report, dated 5/16/16, documented the incident of a cigarette smell coming from the resident's room. The resident denied smoking, and the immediate action included that the resident was checked for paraphernalia. Contributing factors listed cognitive impairment. In a note dated 5/19/16 at 3:21 p.m., the SW documented speaking to the family about the second smoking incident. The note indicated the family was not aware of where the tobacco products were coming from. The note indicated the resident's roommate had promised the family he would not supply the resident with cigarettes. Documentation in a medical note, dated 5/25/16, did not address awareness of the resident's smoking in the facility. In a note dated 5/29/16 at 9:59 p.m., a LPN documented that at 8:15 p.m. the resident was observed leaving the community bathroom at the same time she smelled heavy smoke in the area. The LPN observed black ashes in the toilet bowl at that time. The LPN asked the resident for any cigarettes and lighter and he declined. Review of the corresponding I/A Report, dated 5/29/16, revealed that a lighter was found



in the bathroom, and cigarettes and rolling papers were found in the resident's room. The immediate action included confiscating the smoking materials.

A care plan entry, dated effective 5/31/16, indicated a problem with smoking. The goals included the resident will understand and accept facility policy on smoking. Interventions included to review the smoking policy with the resident and family on admission and as needed and check clothing regularly for signs of unsafe smoking.

Observations included the following:

a. On 5/27/16 at 8:52 a.m., the resident was ambulating in his room and conversing with his roommate.

b. On 5/31/16 at 9:12 a.m., resident was ambulating in his room and closed the door.

Interviews included the following:

a. On 5/27/16 at 2:14 p.m., the Acting Administrator stated this is a non-smoking facility. She stated there was not a list of smokers, but she knew who they were. The Acting Administrator stated the assumption is made that the residents do not have smoking materials, as this is a no-smoking facility. She stated a list of smokers would be beneficial for staff, and staff on the units should know who the smokers are.

b. On 6/1/16 at 10:50 a.m., the LPN Nurse Manager (NM) stated she had developed an unsafe smoking care plan and added checking resident's clothes. The NM stated there were four known smokers residing on the second floor. She stated a list is not kept. The NM stated staff would be told who the known smokers are and are responsible for checking residents' clothing for smoking materials when they return from outings, removing the smoking materials, and locking them up.

c. On 6/1/16 at 10:57 a.m., a Certified Nursing Assistant (CNA) stated she thought there was only one known smoker on the unit, and she knew because she had seen nursing staff take the resident out to smoke. The CNA stated nothing had been shared with her as far as her role or responsibilities regarding residents that smoke. She stated that when a smoker returns to the facility, the nurse takes any cigarettes and lighters from the resident.

d. On 6/1/16 at 11:05 a.m., the SW stated the resident was sent to the Psychiatric emergency roianom on [DATE]. She stated the resident would probably return to the facility. The SW said the hospital will stabilize the resident, and he would come back with orders so the facility would not have to cope with the resident's smoking. The SW indicated the orders would assist the resident in understanding the no smoking policy. The SW stated the resident had personality changes in the last week. The SW stated nicotine dependence is identified on admission. Residents are aware it is a non-smoking facility when a bed offer is made, and paperwork is signed that there is no smoking on the grounds. She said they did not have to monitor smoking, as it has not been an issue until lately. The SW stated she had never included smoking on the care plan prior to this resident. She stated there was never a need to monitor smoking or the possession of smoking materials because clearly they are a non-smoking facility.

Review of the facility's smoking policy, undated, revealed that smoking is prohibited in all enclosed areas of the nursing home. The form included that a resident will not smoke on the campus. The form has lines for signatures by the resident and/or designated representative if the resident is unable to sign. A signed copy by this resident and/or representative could not be located in the medical record.

2. Resident #10 has [DIAGNOSES REDACTED].

A Comprehensive Care Plan (CP) for smoking, dated 5/11/15, revealed that the resident is a known smoker and continues to smoke with family off facility property. He states he understands and agrees to follow the policy and will not smoke on facility grounds.

Review of the MDS Assessment, dated 4/5/16, described the resident as cognitively intact and as a smoker.

During an interview in the resident's room on 5/25/16 at 11:06 a.m., Resident #10 opened the drawer to his bedside stand. The drawer was not locked, but a key was hanging from the lock. Cigarettes were observed in the drawer. When asked if he also had a lighter in the drawer, he said, Why? I smoke when my family takes me out. He quickly shut the drawer.

An I/A Report, dated 5/25/16 at 8:00 p.m., revealed the resident notified a housekeeping manager that he had smoking paraphernalia in his bedside stand. A staff statement, at that time, revealed the resident had cigarettes and a lighter in the drawer of his bedside stand. The resident voluntarily participated in room and person search and was re-educated.

A CP revision, dated 5/27/16, for smoking, includes goals that the resident will understand the dangers of smoking and will understand and accept the facility policy on smoking. Interventions include to review smoking policy with resident and family and after leave of absence the resident will be asked to surrender any smoking paraphernalia and voluntarily submit to a room and person search. A CP Note revealed that on 5/25/16, the resident voluntarily allowed a person and room search after he had made statements of having smoking paraphernalia in his room. There was no evidence of smoking paraphernalia. The resident was reeducated on the facility's non-smoking policy.

Interviews conducted on 5/27/16 included the following:

- a. At 11:02 a.m., CNA #1 said she does not check the resident's room for smoking supplies. She said he goes out with his family most evenings to smoke. CNA #1 said the resident is not supposed to have smoking materials in his room and is supposed to turn them into the nurses.
  - b. At 11:48 a.m., a nursing secretary (working at reception desk/lobby) said, There aren't any smoking supplies kept at the reception desk because we do not have any smokers. She said a list of smokers was not available.
  - c. At 1:01 p.m., a SW said she has seen Resident #10 smoking off grounds. The SW said residents cannot go outside to smoke by themselves. The SW said, to her knowledge, Resident #10 has not been found smoking on the unit. She said she had spoken with the family of Resident #10 to review the facility smoking policy. The SW said that when a resident wants to go out, they are to sign off the unit. She said the receptionist is aware of return, and at the time they go back to the unit, staff are to check for smoking materials.
  - d. At 1:43 p.m., LPN #1 and LPN #2 said Resident #10 is the only one who smokes on their unit. LPN #1 said the resident can go outside with a supervising staff member to smoke. LPN #2 said, This is a smoke free facility. How can he go out with staff? When asked their role when the resident returns from smoking, both LPNs said, We don't do anything.
- During an interview on 5/31/16 at 1:26 p.m. and 2:09 p.m., LPN #3/Unit Manager said Resident #10 did not have a smoking assessment done, in chart, anywhere, because residents are not allowed to smoke. She said she had revised his CP for smoking on 5/27/16.

3. Observations on 5/25/16 between approximately 11:24 a.m. and 2:23 p.m. revealed the following:

a. In Resident Rooms #305 and #315, the hot water temperature in the sinks were found to be approximately 122.5 degrees Fahrenheit (\*F).

b. In Resident Room #307, the hot water temperature in the sink was found to be approximately 123.8\*F.

An observation on 5/26/15 at approximately 1:37 p.m. revealed the temperature reading on the inline gauge after the domestic water mixing valve was 130\*F. In an interview at that time, the Acting Director of Maintenance stated that he takes temperatures every morning between 7:00 a.m. and 9:00 a.m., and that if a temperature is 120\*F on the floor, then he checks the mixing valve. If temperatures are too high, he takes the room out of service and then if he cannot get the temperature down, he calls Ryan (Plumbing Contractor).

Water temperatures taken with Taylor model 9842 digital thermometer on 5/26/15 between 12:58 p.m. and 1:20 p.m. revealed the following:

Second floor

a. In the sink in the shower room across from Resident Room #213, the water temperature was approximately 125.1\*F.

b. In the sink in Resident Room #215, the water temperature was approximately 127.1\*F.

Third Floor

a. In the sink in Resident Room #309, the water temperature was approximately 124.3\*F.

b. In the sink in Resident Room #313, the water temperature was approximately 125.2\*F.

c. In the bathroom on the third floor, the water temperature in the sink was approximately 122.3\*F.

On 5/26/16 at approximately 3:50 p.m., the Acting Director of Maintenance took the water temperature in the sink of Resident Room #217 with the surveyor. The surveyor found the temperature to be 125\*F with Taylor model 9842 digital thermometer. The Acting Director of Maintenance stated that it was hard to read between the lines with his dial type (bimetalic stem thermometer) thermometer unless you have real good eyesight and stated it looked like his thermometer read 122\*F.

## Appendix IV: Excerpts from Deficiency Citations that are Narrow in Scope

Following are excerpts from the three Statements of Deficiencies ( SoD, aka CMS Form 2567) discussed in Case Study 2. The excerpts include all of the language relating to the repeat deficiency citation for F-314 in each SoD, copied directly from the SoDs as they appear on Nursing Home Compare (accessed December 2, 2016). The original (PDF) of the SoDs are available from [www.medicare.gov](http://www.medicare.gov) or, upon request, from LTCCC.

### **Hilaire Rehab & Nursing, Huntington, NY, May 2014**

F 0314

Level of harm – Minimal harm or potential for actual harm

Residents Affected – Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on observations, staff interviews and record review during a Recertification survey, the facility did not ensure that a resident who is without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was noted for one (Resident #33) out of 2 reviewed for pressure ulcers in a total of 33 sampled residents. Specifically, for Resident #33, the facility did not monitor the resident's skin for timely identification of changes. The facility identified a new pressure ulcer on Resident # 33's right hip on 5/8/14, when it was a Stage 3. This resulted in no actual harm with a potential for more than minimal harm which is not an immediate jeopardy.

The finding is:

Resident #33 was re admitted to the facility on [DATE] with [DIAGNOSES REDACTED].

Resident # 33's Comprehensive Care Plan (CCP) initiated since 2013 documented that the resident is non ambulatory, alert, disoriented, cannot follow directions, totally incontinent, at risk for falls, aspiration, and pressure ulcer.

A Braden Scale ( Pressure Ulcer Risk Assessment) dated 4/5/14, documented a score of 14 (a total score of 12 or less indicates high risk).

A CCP for skin integrity, dated 1/21/14 included interventions to turn and position 2-4 hrs, wheel chair gel cushion and alternating air mattress.

A CCP for total incontinence of Bowel and Bladder dated 12/16/13 and updated through 3/6/14, documented to check and change.

In an interview with the unit Charge Licensed Practical Nurse (LPN) on 5/8/14 at 8:30 AM, she stated that a new Stage 3 pressure ulcer was discovered on the right hip of the resident this morning.

In an interview with the Wound Registered Nurse (RN) Assistant Director of Nursing on 5/9/14 at 10:26 AM she stated that yesterday morning she was called for a redness on Resident # 33's right hip. She stated that it was a pressure ulcer discovered at a stage 3, peri wound is dry with no drainage with the opening in the center. She stated that an investigation has been started due to the Nosocomial development of the pressure ulcer. The Wound RN stated that the nurses are supposed to do weekly body check during shower days and the Certified Nurses Assistant (CNA) check the body daily including during incontinence care.

The Treatment sheets and the CNA Accountability sheets for May 2014 were noted to have documented that the Nurses checked the body on shower day (Thursday, May 1st) and the CNAs checked the body daily as instructed in their CNA Accountability record, and on the last shower day (Sunday, May 4th).

An observation was held on 5/9/14 at 12:15 PM. The observation revealed a Stage 3 pressure ulcer to the right hip. The center of the wound was a dime size white area, the surrounding tissue was a bright red excoriated area.

The 7:00 AM-3:00 PM shift CNA assigned to the resident on 5/5, 5/6 and 5/8/14 was interviewed 5/9/14 at 11:40 AM. The CNA stated she did not see anything on 5/5 and 5/6 but saw a big red mark on right hip on 5/8/14 at 7:20 AM and told the nurse.

The 7:00 AM-3:00 PM shift CNA assigned to the resident on 5/7/14 was interviewed on 5/9/14 at 1:02 PM and stated that she is a float. She stated that she did not see any change on the resident's skin during her shift.

The 3:00 PM-11:00 PM shift CNA assigned to the resident on 5/5 and 5/7/14 was interviewed on 5/9/14 at 2:00 PM. She stated that if she had seen anything unusual on the residents skin she would have reported it to the nurse.

The 11:00 PM-7:00 AM shift CNA assigned to the resident on 5/7 and 5/8/14 could not be reached.

A Nosocomial Pressure ulcer Investigation was completed by the facility on 5/12/14. It was concluded that the pressure ulcer was unavoidable.

The resident's Physician was interviewed on 5/12/14 at 11:10 AM. She stated that the resident is medically compromised and has had pressure ulcers in the past that have healed.

### **Hilaire Rehab & Nursing, Huntington, NY, May 2015**

F 0314

Level of harm – Minimal harm or potential for actual harm

Residents Affected – Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on observation, record review, and staff interviews during the recertification survey, the facility did not ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This was evident in 1 of 3 residents reviewed for pressure ulcer (P/U) in a total of 26 Stage 2 sampled residents. Specifically, Resident #62 had a physician's orders [REDACTED]. This resulted in no actual harm with the potential for more than minimal harm that is not immediate jeopardy.

The finding is:

Resident #62 has [DIAGNOSES REDACTED]. The resident was admitted to the facility on [DATE].

The Minimum Data Set (MDS) Quarterly assessment dated [DATE] documented that the resident was at risk for developing P/U, and had one Stage IV and one unstageable P/Us.

The Braden Scale dated 1/16/15 and dated 4/9/15 documented a score of 17 and score of 15, respectively, that indicated that the resident was low risk of developing P/U.

The Comprehensive Care Plan (CCP) dated 3/27/15 documented that the sacral area had reopened and measured 0.7 centimeter (cm) x 0.6 cm x 0.1 cm and was treated with Normal Saline (NS) cleansing and Hydrogel daily and as needed (PRN). The CCP was updated on 4/8/15 and documented sacral wound (measured at 4 cm x 2 cm x undetermined depth in cm, macerated) and was treated with Silver Alginate and to be covered Opsite dressing. An update on 4/22/15 documented that the sacral P/U (measured 2.5 cm x 1 cm x 0.1 cm with 100% granulation) was treated with Hydrogel and Calcium Alginate and to be covered with a dressing.

The physician's orders [REDACTED]. A new order was in place to cleanse sacral wound with soap/water. Then apply Silver Alginate daily and to cover with Opsite or [MEDICATION NAME] to be done by 7-3 shift.

The Treatment Administration Record (TAR) dated 4/8/15 documented to cleanse sacrum with NS and apply with CDD daily and PRN order was discontinued.

The TAR for April 2015 also documented to cleanse sacral wound with soap/water. Then apply Silver Alginate daily and cover with Opsite or [MEDICATION NAME] (by 7-3 shift). The treatment was documented from 4/11/15 through 4/27/15.

Review of the TAR revealed that from 4/8/15 through 4/10/15 the resident did not have treatment administered to the sacral P/U as ordered.

Review of the Nurses Notes from 4/8/15 through 4/10/15 revealed that the sacral P/U treatment was not addressed.

The facility's Wound Report dated 4/29/15 documented that the sacral P/U measured 1.5 cm x 1.0 cm x undetermined depth in cm and was at Stage III level.

A sacral wound dressing change observation with the Licensed Practical Nurse (LPN) Treatment Nurse was conducted on 4/30/15 at 9:20 AM. The sacral P/U measured 3.0 cm x 1.5 cm x 0.1 cm and at Stage III category.

An interview with the LPN Treatment Nurse was conducted on 4/30/15 on 10:00 AM. The LPN stated that the treatment was not done and that she might have missed the order as written.

An interview with the Assistant Director of Nursing Services (ADNS)/Wound Nurse was conducted on 4/30/15 on 10:15 AM. The ADNS stated that there was no documentation that the sacral treatment was done between 4/8/15 through 4/10/15. The ADNS also added that she could not explain as to why the LPN missed it.

An interview with the Attending Physician was conducted on 5/4/15 at 9:45 AM. The Attending Physician stated that he would have expected that the order would have been followed and treated the sacral P/U timely as per the physician's orders [REDACTED].>The facility's policy and procedure dated 4/2013 titled Transcription of medical orders documented that . All orders for medical treatment . be transcribed and implemented by a licensed nurse.

### **Hilaire Rehab & Nursing, Huntington, NY, April 2016**

F 0314

Level of harm – Minimal harm or potential for actual harm

Residents Affected - Few

Give residents proper treatment to prevent new bed (pressure) sores or heal existing bed sores.

**\*\*NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY\*\***

Based on record review and staff interview during the recertification survey the facility did not ensure that residents having pressure ulcers receive the necessary treatment and services to promote healing and prevent infection for 1 of 5 residents reviewed for Pressure Ulcers from a total of 33 Stage 2 sampled residents. Specifically, Resident #18 entered the facility with pressure ulcers assessed to the right and left ankles and left lateral knee, and areas of eschar to the left dorsal foot and right anterior foot. There is no documented evidence that treatment was provided to the left lateral knee wound or for the areas of eschar. There were physician's orders [REDACTED].

The finding is:

Resident #18 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The resident was discharged home on[DATE].

The Admission Minimum Data Set (MDS) assessment, dated 12/2/2015, documented that the resident had a Brief Interview of Mental Status (BIMS) score of 10, indicating that the resident had moderate cognitive impairment. The resident required extensive assistance for Activities of Daily Living (ADLs) and total assistance for transfers. There were no pressure ulcers documented in the MDS; however, there were two venous/arterial ulcers documented.

The Nursing admission note, dated 11/25/2015, documented the following skin conditions:

--Right lateral knee redness.

--Left lateral knee Stage 2, 1 centimeter (cm) x 1 cm x 0 cm.

--Left dorsal foot eschar, 1 cm x 0.5 cm with surrounding redness.

--Left ankle Stage 2, 2 cm x 2 cm x 0 cm.

--Right ankle Stage 2 with deep tissue injury to periwound and surrounding redness.

--Right anterior foot eschar (three areas)-0.5 cm x 0.5 cm, 0.8 cm x 0.3 cm, and 1 cm x 0.5 cm.

The Body/Skin Checklist, dated 11/25/2015, documented the same skin findings. physician's orders [REDACTED].

Left and Right ankle Stage 2 pressure ulcers, cleanse with normal saline, apply [MEDICATION NAME] daily, cover with [MEDICATION NAME] dressing, pad with gauze, then wrap with cling.

There was no evidence of Physician's treatment orders to the left lateral knee Stage 2 ulcer or for the areas of eschar on the feet.

A Comprehensive Care Plan (CCP) for Impaired Skin Integrity, dated 11/30/2015 and last updated 12/14/2015, documented the right and left ankle pressure ulcers and progress of those wounds. There was no documentation regarding the left lateral knee Stage 2 ulcer or for the areas of eschar on the feet.

Physician Wound Reports, dated 11/30/2015, 12/7/2015, and 12/14/2015, documented the right and left ankle wounds and the progress of those wounds. There was no documentation in these reports of the left lateral knee Stage 2 ulcer or for the areas of eschar on the feet.

On 4/22/2016 at 12:45 PM the Director of Nursing Services (DNS) was interviewed. She reviewed the chart and could not find any treatments or care plans for the left lateral knee Stage 2 ulcer or for the areas of eschar on the feet.

On 4/26/2016 at 1:00 PM the DNS was re-interviewed. She stated that the nurse that did the assessment and admission note on 11/25/2015 was the former DNS and was no longer employed at the facility. No further information was provided regarding the left lateral knee Stage 2 ulcer or for the areas of eschar on the feet.