

Elder Justice

What “No Harm” Really Means for Residents

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Introduction: What is a “No Harm” Deficiency?

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

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

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

The failure to identify resident harm when it has occurred has pernicious implications on many levels.

Elderwood at Amherst, NY

[Four-star facility fails to prevent, address, and care for a resident’s pressure ulcer.](#)

The resident assessment showed that, although the resident did not have any pressure ulcers, she was at risk for developing them.¹ While observing the resident in her room, the surveyor saw the resident in bed with “an open bleeding area on the bridge of her right nostril.” When the certified nurse aide (CNA) came into the room to provide morning care, the surveyor was able to see that the resident’s pressure ulcer was the same size and shape as the nose pad on the resident’s glasses. According to the surveyor, the CNA did not “relay any information regarding skin problems [to the licensed practical nurse], stated her care was done and left.”

When subsequently interviewed, a registered nurse (RN) gave a summary of the resident’s problems but failed to report any skin conditions. The RN told the surveyor that the CNA had not reported any skin problems. During a later observation, the surveyor asked the RN to remove the resident’s glasses for a skin inspection. After seeing the resident’s damaged skin, she said that someone should have told her. The RN left the resident’s glasses on but said that she would “come up with a plan for the resident.”

The surveyor cited the facility for failing to “ensure that, a resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and . . . not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable.” Despite the resident’s having developed a pressure ulcer, the surveyor cited this failure as causing neither harm nor immediate jeopardy to the resident’s well-being.

Community Care Center, CA

[Five-star facility’s staff member spits on resident’s face during an argument.](#)

The assessment showed that the resident’s cognition was intact and that the resident did not exhibit behavioral issues, such as “hitting, pushing, threatening, and screaming.”² Nevertheless, the facility’s records indicated that the resident became angry after a certified nursing assistant (CNA) told her that she could not go into another resident’s room. During a subsequent argument between the resident and the CNA, the CNA reportedly spat on the resident’s face.

Two staff members witnessed the encounter between the resident and the CNA. Both staff members informed the facility’s investigator that the CNA did in fact spit on the resident’s face. The CNA was terminated from his position at the facility after spitting on the resident’s face. While speaking with the facility’s special treatment program counselor, the surveyor learned that the resident “felt mistreated” by the incident and believed that “it was not accident.”

Although the facility fired the CNA, the surveyor cited the facility for failing to ensure that the resident “was free from mistreatment.” Despite the resident’s stating that she felt violated, the surveyor still determined that this incident did not harm the resident.

Share your thoughts with us on Twitter using [#HarmMatters](#).

For more information on the nursing home standards of care, please see LTCCC’s [Issue Alerts](#).

The Manor of Farmington Hills, MI

[Four-star facility fails to report an allegation of neglect after a resident was left on top of his bed pan for an hour and a half.](#)

During the inspection, a resident told the surveyor that care at the facility was not good.³ The resident recalled that he had to call his wife three or four times to get him off his bed pan because he was on it for an hour and half. The resident explained that the wait times after hitting the call light have been as long as two hours on some occasions. He also told the surveyor that he requested “an x-ray after being left on the bed pan because it hurt so bad.”

A subsequent review of the resident’s clinical records showed that the resident complained of right buttock pain, with pain from his spine to his hip. The nurses’ notes indicated that an x-ray was ordered and the wound progress notes showed a “superficial excoriation on the coccyx area.” A later physician’s note detailed that the resident’s back pain improved but that the resident has a history of chronic pain “that became aggravated after prolonged sitting on [the] bed pan which caused increased low back and buttock pain.”

The surveyor spoke to the administrator, who acknowledged that not providing care to residents may lead to allegations of neglect. However, the administrator stated that the incident involving this resident was not reported because “during the investigation there was no abuse determined . . . I wouldn’t have reported that because it’s not abuse.” The administrator did not respond when asked whether the incident could have been considered an allegation of neglect.

The surveyor determined that the facility failed “to report an allegation of neglect to the State Agency . . . resulting in an allegation of neglect not being investigated . . . and the potential for unidentified and continued neglect.” Despite this finding, the surveyor cited the deficiency as causing neither harm nor immediate jeopardy to the resident’s health and safety.

Willow Crest Nursing Pavilion, IL

[One-star facility fails to identify bed rails as a physical restraint and to reassess use after a resident was found “wedged between the wall and her bed.”](#)

The facility’s incident log showed that the resident was found on the floor in her room.⁴ A second recorded incident showed that the resident was “wedged between the wall and her bed[,] with her head wedged between the upright side-rail and the mattress . . .” The record included that that the resident had some of her weight on her left knee but that “most of her weight was dangling, pulling on her neck.”

When the surveyor spoke to the resident’s roommate, the roommate noted that the resident attempted to get out of her bed often and that “she fell just the other evening trying to get out.” A certified nurse aide (CNA) told the surveyor that the resident’s dementia was getting worse and that the resident had two falls. The CNA explained that it was difficult to pull out the release knob to raise and lower the side rails and that there was “[n]o way” the resident could move these side rails.

The director of nursing (DON) told the surveyor that “side rail use should be assessed quarterly and prn (as needed).” The DON said that the resident’s recent incident was “definitely a prn situation and reassessing the

use of her bed rails is definitely necessary.” The DON added that “there has been no reassessment done and it is definitely a safety issue now”

The surveyor ultimately cited the facility for failing to “identify the use of bed rails as a restraint and fail[ing] to reassess their use after a resident attempted to climb over the bed rail.” Despite repeated incidents and the resident’s potential to strangle on the bed rails, the surveyor cited the violation as “no harm.”

A Note on Residents’ Rights

Under the federal Nursing Home Reform Law, every nursing home must provide each resident with services that help attain or maintain the resident’s “highest practicable physical, mental, and psychosocial well-being.” This federal law and its implementing regulations offer residents specific rights and protections to ensure quality of care and quality of life in nursing homes. While CMS’s enforcement of the nursing home standards of care may be lacking, the nursing home standards must still be followed. Our organizations encourage residents and families to remain vigilant, learn about resident protections, and continue advocating for the rights of their loved ones. **For more information about the nursing home standards of care, please see www.nursinghome411.org and www.medicareadvocacy.org.**

Further Reading from LTCCC & the Center:

1. [The New York Times Shows Nursing Homes Are Not Meeting Staffing Requirements](#)
2. [LTCCC’s Action Center: Speak Out in Support of Nursing Home Residents!](#)
3. [Fighting the Rollback of Nursing Home Protections](#)
4. [Nursing Home “In-House” Managed Care Plans May Harm Residents](#)
5. [Special Focus Facilities: Poor Care for Residents, Limited Consequences for Providers](#)

¹ Statement of Deficiencies for Elderwood at Amherst, CMS (April 4, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335056&SURVEYDATE=04/04/2018&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=ELDERWOOD%2520AT%2520AMHERST&Distn=0.0>.

² Statement of Deficiencies for Community Care Center, CMS (April 4, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=05A109&SURVEYDATE=04/04/2018&INSPTYPE=CMPL&profTab=1&Distn=0.0&state=CA&lat=0&lng=0&name=COMMUNITY%20CARE%20CENTER..>

³ Statement of Deficiencies for The Manor of Farmington Hills, CMS (April 19, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235508&SURVEYDATE=04/19/2018&INSPTYPE=STD&profTab=1&state=MI&lat=0&lng=0&name=THE%2520MANOR%2520OF%2520FARMINGTON%2520HILLS&Distn=0.0>.

⁴ Statement of Deficiencies for Willow Crest Nursing Pavilion, CMS (May 31, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=145712&SURVEYDATE=05/31/2018&INSPTYPE=CMPL&profTab=1&state=IL&lat=0&lng=0&name=WILLOW%2520CREST%2520NURSING%2520PAVILION&Distn=0.0>.