

## Elder Justice

# What “No Harm” Really Means for Residents

Volume 1, Issue 10

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

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

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

## Oceanside Care Center Inc., NY

### [Five-star facility’s staff member doesn’t follow a resident’s care plan and drops the resident to the floor.](#)

The resident’s comprehensive care plan documented that the resident needed to be transferred using a mechanical lift with the assistance of two staff members.<sup>1</sup> During a complaint inspection, the surveyor reviewed the facility’s investigation summary, which showed that the resident was observed lying on top of the mechanical lift’s legs. The lift pad was still attached to the machine but “one strap [was] not connected to the left lower side of the strap attachment.” While conducting a post-fall assessment of the resident, staff spotted an “abrasion to her right elbow . . . .”

The certified nursing assistance (CNA) stated that she attempted to transfer the resident without the assistance of another staff member.

During the transfer, “[t]he strap of the sling (pad) came off and the resident slipped out of the pad onto the base of the mechanical lift.”

When interviewed, the CNA explained to the surveyor that one of the straps did not hook in properly. The CNA acknowledged that “it’s my job

to see if the strap is hooked properly, I was rushing.” The CNA was ultimately suspended for not following the resident’s care plan and not properly securing the resident.

The surveyor cited the facility for failing to “ensure resident rights for one of three residents reviewed for neglect.” Although the facility’s deficient care resulted in the resident being put at serious risk and injuring her elbow, the surveyor cited this failure as causing neither harm nor immediate jeopardy to the resident’s well-being.

## Crestwood Manor, NJ

### [Five-star facility fails to properly address the resident council’s grievances, affecting residents’ self-esteem and self-worth.](#)

The surveyor took part in a resident council meeting at the facility. During the meeting, some of the residents expressed concern with certified nursing assistants (CNAs) who would “not allow the residents to have a say in how their care was provided.”<sup>2</sup> The residents explained that the CNAs, both those employed by the facility and those employed by a staffing agency, would tell residents “I’m doing it my way.”

Several of the residents told the surveyor that they required the assistance of staff to use the bathroom. The residents complained that they would press the call button and some staff members would tell them that they needed to wait. Residents stated that “by the time the CNAs are done talking to the residents about having to wait, they could have assisted them into the bathroom and on to the toilet.” One resident

**Policy Alert:** The Department of Labor issued a proposed rule to allow 16 and 17 year-olds to operate resident lifts and hoists without the supervision of a trained adult staff member.

The Center and LTCCC have submitted [comments](#) opposing this proposal.

**Advocacy Tip:** Resident councils are protected under the federal Nursing Home Reform Law and its implementing regulations.

For more information, please see [LTCCC’s Resident & Family Council Issue Alert.](#)

also complained that a “CNA made grunting sounds as she pushed the resident down the hallway in a wheelchair. The resident explained that she felt embarrassed by the CNA’s actions.”

Lastly, residents also expressed concern about another resident who would wander into other residents’ rooms. The resident stated that this particular resident would touch them and their belongings. One resident told the surveyor that the wandering resident broke one of her belongings. Another resident told the surveyor that she was once scared to find the wandering resident sitting next to her bed when she woke up.

The surveyor ultimately determined that the “facility failed to address all residents in a manner that maintained their self esteem and self worth.” Despite the facility’s failure to address these residents’ concerns and the negative impacts this had on resident autonomy, dignity and privacy, the surveyor cited this deficiency as “no harm.”

## Helen Newberry Joy Hospital LTCU, MI

### [Five-star facility leaves a resident unsupervised, resulting in another resident with dementia being sexually assaulted.](#)

The facility’s incident report showed that a resident sexually assaulted another resident in front of a certified nursing assistant (CNA).<sup>3</sup> The CNA observed the resident slide his hand between the victim’s legs. The CNA separated the residents and went to get help. The resident’s care plan specified that he needed one-on-one supervision. The resident was first observed eating before getting up and leaving the dining room. The CNA in the dining room did not follow the resident because she assumed the CNA at the door would provide the required supervision. The CNA in the dining room admitted “I guess you learn you shouldn’t assume things.”

The CNA who stopped the sexual assault noted that the victim was “blocked, couldn’t move away . . . [her] eyes were big.” The CNA stated that she was upset by the situation because the resident “shouldn’t have been left alone with that many staff around.” According to the CNA, there were “two sitting in the activity room, one in the dining room, one at the door, and a nurse.”

The director of nursing (DON) told the surveyor that the resident was previously caught placing his hand on another resident’s breast and that is why he was placed on one-on-one supervision. The DON stated that the CNA “that was doing the 1:1 observed [the resident] go out toward [the] door [and] assumed the other CNA was going to take over. . . .”

The surveyor cited the facility for failing “to prevent a resident to resident sexual abuse,” which resulted in a resident “sexually touching” another resident with dementia while unsupervised. Although one of the facility’s residents was sexually assaulted as a result of the facility’s failure, the surveyor cited the violation as “no harm.”

**Advocacy Tip:** Every nursing home resident has the right to be free from abuse. Facilities must report any “reasonable suspicion” that a crime has been committed against a resident within a specified timeframe.

For more information, please see LTCCC’s Requirements for Nursing Homes to Protect Residents from Abuse, Neglect & Exploitation [fact sheet](#).

## Warm Beach Health Care Center, WA

### [Two-star facility’s improper medication management puts a resident at risk of experiencing adverse side effects from antipsychotic medication.](#)

The resident’s medication administration and treatment records indicated that the facility’s antipsychotic medication adverse side-effect (ASE) monitoring “was ineffective because staff were not following the document instructions on the order.”<sup>4</sup> According to the surveyor’s inspection report, staff were to document “Y” for yes if ASEs were monitored but none was observed and “N” for no if ASEs were monitored and observed. Further review of the resident’s record revealed that day staff were mostly documenting “Y” and night staff were mostly documenting “N.” As a result, staff made “it impossible to determine if the resident was or was not having adverse side effects related to the antipsychotic medication.” The director of nursing services admitted that the facility needed to “find a better way to do it.”

**Advocacy Tip:** Every nursing home resident’s drug regimen must be reviewed at least once a month by a licensed pharmacist.

For more information, please see LTCCC’s Dementia Care & Psychotropic Drugs [fact sheet](#).

The resident’s record also showed that the resident was prescribed two different medications on the same order. The order listed the medication names noting “5-10 mg (milligrams)” and to give one “capsule by mouth two times a day.” The surveyor highlighted that the 5-10 mg dosage appeared to have been “written as a range, without parameters.” The registered nurse (RN) told the surveyor that the order didn’t make sense to the nurses but they were told by another staff member to give 15 mg. Another staff member did note that the order was 5 mg for one medication and 10 mg for the other.

Based on these deficiencies and other related violations, the surveyor cited the facility for failing “to ensure accurate pharmaceutical procedures were in place for five of five residents . . . reviewed for pharmacy services.” Specifically, the surveyor stated that the “[f]ailure to have procedures in place to periodically review and reconcile medication orders, to have clear and understandable medication orders, to administer medications as ordered and to have consistent . . . medication adverse side effect monitoring placed the residents at risk for medication errors and medication-related complications.” Despite these medication errors, the surveyor cited the deficiency at the “no harm” level.

## 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](http://www.nursinghome411.org) and [www.medicareadvocacy.org](http://www.medicareadvocacy.org).**

### Tell Your Story

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

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

**Note:** This document is the work of the LTCCC. It does not necessarily reflect the views of the Department of Health, nor has the Department verified the accuracy of its content.

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<sup>1</sup> Statement of Deficiencies for Oceanside Care Center Inc, CMS (Aug. 6, 2018), <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335158&SURVEYDATE=08/06/2018&INSPTYPE=CMPL>.

<sup>2</sup> Statement of Deficiencies for Crestwood Manor, CMS (Sept. 10, 2018), <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=315298&SURVEYDATE=09/10/2018&INSPTYPE=ST>.

<sup>3</sup> Statement of Deficiencies for Helen Newberry Joy Hospital LTCU, CMS (Sept. 6, 2018), <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235705&SURVEYDATE=09/06/2018&INSPTYPE=ST>.

<sup>4</sup> Statement of Deficiencies for Warm Beach Health Care Center (CMS (Aug. 30, 2018), <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=505405&SURVEYDATE=08/30/2018&INSPTYPE=ST>.