

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 8

IN THIS ISSUE:

Northern Manor Geriatric Center Inc (New York)	2
Three-star facility’s inadequate supervision results in a resident’s fractured femur.	
Pahrump Health and Rehabilitation Center (Nevada)	2
Two-star nursing home fails to provide sufficient food and fluids.	
York Nursing and Rehabilitation Center (Pennsylvania)	3
Two-star nursing home fails to provide appropriate treatment for a resident with suicidal ideation.	
Metron of Forest Hills (Michigan)	4
Five-star nursing home fails to prevent staff-to-resident abuse.	
The Brightonian, Inc (New York)	4
One-star nursing home fails to ensure safe and appropriate pain management.	

What is a “No Harm” Deficiency?

Nursing homes that voluntarily participate in the Medicare and Medicaid programs must adhere to minimum standards of care established by the federal Nursing Home Reform Law and its implementing regulations. These standards ensure that every nursing home resident is provided services that help attain and maintain his or her “highest practicable physical, mental, and psychosocial well-being.” Under the Reform Law, nursing homes that fail to meet the federal requirements are subject to various penalties, based on the scope and severity of the violation(s).

Centers for Medicare & Medicaid Services (CMS) [data](#) indicate that the majority of health violations (more than 95%) are cited as causing “no harm” to residents. The failure to recognize resident pain, suffering, and humiliation when it occurs too often means nursing homes are not being held accountable for violations through financial penalties. In the absence of a financial penalty, nursing homes may have little incentive to correct the underlying causes of resident abuse, neglect, and other forms of harm.

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How to Use this Newsletter

The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS’s [Nursing Home Compare](#) website. **Our organizations encourage residents, families, ombudsmen, law enforcement, and others to use these cases to help identify potential instances of resident harm in their own communities.** While CMS may fail to properly penalize nursing homes for health violations, it is important that the public is aware of safety concerns in nursing homes in their communities and that every suspected case of resident harm is reported, investigated, and addressed.

Northern Manor Geriatric Center Inc (New York)

Three-star facility's inadequate supervision results in a resident's fractured femur.

The surveyor determined that the nursing home failed to provide "safe and effective assistive devices" to transfer a resident out of bed to a wheelchair using a mechanical (Hoyer) lift.¹ The resident sustained a fracture of the left femur requiring surgery due to the fall, yet the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident's comprehensive care plan indicated he was at risk for falls "related to immobility and gait/balance problems" and that he required total assistance in most activities of daily living.
 - The resident's fall occurred after one of the hooks of the Hoyer lift's slings broke during a transfer from out of bed to his wheelchair. As a result, the resident sustained a fracture to his left hip and was transferred to a hospital where he underwent an open reduction and internal fixation (ORIF) procedure.
 - The investigation found that the Hoyer lift's sling was not laundered according to the manufacturer's standards and that staff were not trained on how to check the sling's functionality and durability before use. In a written statement, a facility housekeeper documented that he usually dried slings on the high setting for 15 to 25 minutes, though the instructions stated that the high temperature should not be used to tumble dry.
 - A second housekeeper stated that a nursing supervisor used to check all slings for malfunction three times weekly, but that inspections were discontinued when the supervisor stopped working at the facility. The director of nursing stated that prior to the incident, the facility did not have any procedures in place for checking if slings were intact.
- **Note:** Under federal law, nursing homes must have sufficient care staff to meet every resident's care, monitoring, and psycho-social needs. Unfortunately, many nursing homes are woefully understaffed and, as a result, their residents face increased risk of "[\[a\]dverse events such as falls and medication errors.](#)" For more information, see LTCCC's [Fact Sheet: Requirements for Nursing Home Care Staff & Administration for more information](#).

→ *Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical and/or mental harm.*

→ *Neglect is the failure to provide goods and services necessary to avoid physical and/or mental harm.*

Pahrump Health and Rehabilitation Center (Nevada)

Two-star nursing home fails to provide sufficient food and fluids.

The surveyor determined that the nursing home failed to "implement weight loss interventions and notify the physician of a significant weight loss" for two residents, including one whose weight declined 42 pounds in 30 days.² Although the resident's rapid weight decline was unaddressed for several weeks, the surveyor cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- A resident's medical record on August 1, 2018, revealed a significant weight loss of 42 pounds in 30 days (203.3 pounds to 161.9 pounds). A nutrition evaluation progress note on August 2nd did not note a significant weight loss and indicated "to continue giving formula feeding by bolus (by gravity) through the feeding tube."

- Staff identified the significant weight loss on August 22nd but the resident's medical record lacked documented evidence that it was addressed prior to that date. A registered dietitian acknowledged that the resident's significant weight loss was not immediately addressed on August 2nd because staff did not timely report the resident's weight.
 - Another resident who was at risk for altered nutrition and hydration experienced a 12-pound weight decline in 30 days according to a June 1, 2019, report. Though interventions were in place for the resident's weight loss, a June 12 physician's progress note documented that the resident was seen urgently due to poor appetite, not eating or drinking, and becoming lethargic and weak. A registered dietitian stated additional measures should have been taken, including additional supplementation, notification of the physician, an interdisciplinary team meeting, a conversation with the family member, and a care plan update.
- **Note:** Federal standards require that a resident's meals be healthy, appropriate for the individual, and appetizing. In addition, it is required that the dining experience fosters resident dignity. For more information on relevant regulatory standards, see [LTCCC's Primer: Nursing Home Quality Standards](#).

York Nursing and Rehabilitation Center (Pennsylvania)

Two-star nursing home fails to provide appropriate treatment for a resident with suicidal ideation.

The surveyor determined that the nursing home failed to provide appropriate treatment and services for a resident with depression and suicidal ideation.³ The resident was observed cutting her wrist with a butter knife after previously expressing suicidal ideation. Although the cut resulted in open skin with bleeding and admission, by ambulance, into a psychiatric ward, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- A resident who had previously expressed suicidal ideation was observed with blood on her gown and "with a butter knife in her right hand, against her left wrist, causing open skin with bleeding." The resident was transported by ambulance and admitted to a psychiatric hospital.
- Clinical records indicated that the resident was "paranoid and defensive" and that her negative behavior was based on her poor vision and how she was approached by staff. However, a review of the resident's clinical record revealed no evidence that the facility provided services to the resident related to her difficulty coping with the loss of her vision and her change in living arrangements.
- In an interview, the resident's assigned social worker stated that the "social services department had not provided counseling and/or obtained outside services to address [the resident's] behaviors."
- Prior to the incident, the resident expressed suicidal ideation to a licensed practical nurse, stating "why can't I just shoot myself and die already?" Review of that nurse's orientation and training documents revealed no evidence that they had "the required skills and competencies to work effectively with residents with mental disorders and psychosocial disorders," according to the surveyor.

→ **Note:** Under federal regulation, every resident has the right to be treated with dignity and respect. Staff must assist residents in maintaining or enhancing their self-esteem and self-worth. For more information, please see LTCCC's [Fact Sheet: The Fundamentals of Resident Rights – Dignity & Respect](#).

→ *Abuse and/or neglect can include instances of inappropriate physical contact, inappropriate antipsychotic drugging, entrapment in a bed rail, falls, pressure ulcers, wandering, infections, malnutrition, isolation, crimes against residents, and other forms of resident harm.*

Metron of Forest Hills (Michigan)

Five-star nursing home fails to prevent staff-to-resident abuse.

The surveyor determined that the nursing home failed to protect a resident from physical and verbal abuse from a certified nursing assistant (CNA) who has since been terminated.⁴ Though the resident was “highly distressed” because of the altercation with the CNA, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The behavior care plan for a 47-year-old male resident with severe cognitive impairment stated “I have potential to demonstrate physical behaviors of becoming combative during attempted cares . . . If I am having a difficult time with you approach/intervention, please offer another staff person to assist, if available/needed ask male staff member to assist you.”
 - In a December 7, 2018, incident report, the resident alleged that a female certified nursing assistant shoved him and “tried to hit” him. A registered nurse (RN) who witnessed the altercation stated that the CNA “roughly tried to take his shirt off” while attempting to change the resident’s clothes and briefs against his will. After being kicked at by the resident, the CNA retaliated by kicking back without making contact.
 - The RN, who entered the room after hearing the CNA saying “someone help me!” stated that the resident “was in MUCH distress,” speaking angrily in his primary language (Bosnian), and spitting toward the CNA. The RN noted the CNA was angry and making sarcastic, inappropriate comments toward the resident, and had asked the CNA to leave the room both before the physical altercation.
 - According to the report, the RN went in between the CNA and the resident to calm the resident, and again asked CNA to leave the room. When the CNA headed for the door, the resident immediately calmed.
 - A December 8th status form change indicated the CNA was terminated due to resident abuse.
- **Note:** A 2019 Government Accountability Office (GAO) [report](#) found that the number of cited abuse deficiencies more than doubled between 2013 and 2017. The report indicated that more than 1 in 5 nursing homes considered “above average” and “much above average” by CMS have been cited for abuse in a single year. To learn more, please visit [LTCCC’s Abuse, Neglect, and Crime Reporting Center](#).

The Brightonian, Inc (New York)

One-star nursing home fails to ensure safe and appropriate pain management.

The surveyor determined that the nursing home did not provide appropriate pain management to a resident requiring such services.⁵ The facility failed to assess the resident for pain at admission, monitor the pain management plan’s effectiveness, notify the medical provider after resident’s continued complaints of pain, and use an adaptive cushion for comfort. Although the resident experienced severe pain, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident was admitted to the facility on November 29, 2018. A December 6th Minimum Data Set, indicated “no scheduled routine pain medications” received as needed pain medication. The MDS indicated spinal stenosis (narrowing of the spinal column), osteoarthritis, radiculopathy (pinched nerve), and complaints of “occasional mild pain.”
- On December 3rd, a physician ordered to change the medication plan to “routine” (Tylenol four times a day routinely, and 650 mg once per day as needed) after a skin exam revealed “a scabbed area on the left buttock and redness of both heels,” according to physician documentation. In a January 8th interview, the director of nursing said that an Admission Pain Assessment Flow Sheet should have been implemented

when the pain medication was changed to evaluate its effectiveness. However, there was no documentation that the resident's pain was being monitored consistently at this time.

- A January 3, 2019, pain assessment interview revealed the resident had occasional severe pain (8 out of 10) over the last five days. The Certified Nursing Assistant (CNA) Resident Care Card directed the use of a ROHO cushion (specialty pressure reducing cushion), but observations from January 7th indicated that the resident was sitting on a gel cushion – not a ROHO – and saying that her “bottom hurt.” The next day, the director of therapy, who recommended the ROHO cushion, said he did not know where the cushion went. Minutes later, he returned to the unit with a “Harmony cushion (a foam cushion with [an] egg crate on top)” and placed it in the resident's chair, saying that if the resident continues to complain of pain, “she should not be on her butt that much.”
 - During an observation with a registered nurse later that morning, the resident said it hurt to stand and complained of pain when she was touched on the spine near the tailbone. The resident reported a pain level of 10 at the worst, saying she “cannot go to the bathroom by herself, relies on staff, and does not go back to bed during the day,” according to the report.
 - A registered nurse (RN) said the Pain Admission Flow Sheet – not initiated until January 8th – should have been completed within three days of admission, adding that the initial pain assessment should have been reviewed by an RN and brought “to the attention of medical to determine a plan for pain management.”
 - In a January 4th interview, a Licensed Practical Nurse (LPN) Manager said she visited the resident frequently to talk about her pain. When interviewed on January 9th, the LPN Manager said she knew the resident had pain but did not notify the medical team.
- **Note:** An Office of the Inspector General (OIG) report, [*Adverse Events in Skilled Nursing Facilities*](#), found that an astounding one-third of people who turn to a nursing home for Medicare rehab are harmed within an average of about two weeks. The report identified that “59 percent of these . . . events were clearly or likely preventable,” and attributed much of the preventable harm to “substandard treatment, inadequate resident monitoring, and failure or delay of necessary care.”

Can I Report Resident Harm?

YES! Federal laws and regulations require nursing homes and certain individuals (such as owners, staff, and contractors) to report suspected cases of resident abuse, neglect, and/or crime within a specified amount of time. Nevertheless, residents and families should not wait to report harm when it occurs. Anyone can report suspected cases of resident harm to the state survey agency, local law enforcement, and other appropriate agencies. **For more information about the federal reporting requirements and to access free resources, please visit LTCCC's [Abuse, Neglect, and Crime Reporting Center](#).**



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To learn more about nursing home and assisted living care, visit us online at
[MedicareAdvocacy.org](https://www.MedicareAdvocacy.org) & [NursingHome411.org](https://www.NursingHome411.org).

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

¹ Statement of Deficiencies for Northern Manor Geriatric Center Inc (Jan. 9, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335046&SURVEYDATE=01/09/2019&INSPTYPE=STD>. An unredacted version of this inspection report, provided by ProPublica, is available for download in the Region II file at https://s3.amazonaws.com/propublica/projects/nursing-homes/nursing-homes-unredacted-April2019.zip?_ga=2.222370971.1231082905.1580319745-1716579264.1574889280.

² Statement of Deficiencies for Pahrump Health and Rehabilitation Center (June 21, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=295075&SURVEYDATE=06/21/2019&INSPTYPE=STD&profTab=1&Distn=9561.1&state=NV&lat=0&lng=0&name=PAHRUMP%20HEALTH%20AND%20REHABILITATION%20CENTER>.

³ Statement of Deficiencies for York Nursing and Rehabilitation Center (June 7, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=395687&SURVEYDATE=06/07/2019&INSPTYPE=STD&profTab=1&Distn=6795.1&state=PA&lat=0&lng=0&name=YORK%20NURSING%20AND%20REHABILITATION%20CENTER>.

⁴ Statement of Deficiencies for Metron of Forest Hills (Jan. 7, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235366&SURVEYDATE=01/07/2019&INSPTYPE=CMPL&Inspn=HEALTH&profTab=1&Distn=7492.3&state=MI&lat=0&lng=0&name=METRON%20OF%20FOREST%20HILLS>. An unredacted version of this inspection report, provided by ProPublica, is available for download in the Region V file at https://s3.amazonaws.com/propublica/projects/nursing-homes/nursing-homes-unredacted-April2019.zip?_ga=2.222370971.1231082905.1580319745-1716579264.1574889280.

⁵ Statement of Deficiencies for The Brightonian, Inc (Jan. 9, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335046&SURVEYDATE=01/09/2019&INSPTYPE=STD>. An unredacted version of this inspection report, provided by ProPublica, is available for download in the Region II file at https://s3.amazonaws.com/propublica/projects/nursing-homes/nursing-homes-unredacted-April2019.zip?_ga=2.222370971.1231082905.1580319745-1716579264.1574889280.