

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 12

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How Do “No Harm” Violations Impact Nursing Home Quality & Safety?

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 nursing home residents are provided services that help them attain or maintain their “highest practicable physical, mental, and psychosocial well-being.” Nursing homes that fail to meet the federal requirements are subject to various penalties, based on the scope and severity of the violation(s).

Unfortunately, the overwhelming majority of health violations in nursing homes 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 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 substandard nursing home quality and safety.

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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 nursing home safety concerns in their communities and that every suspected case of resident harm is reported, investigated, and addressed.

Seneca Hill Manor Inc. (New York)

Five-star nursing home fails to ensure a resident was free from a physical restraint.

The surveyor determined that the nursing home failed to “ensure residents had the right to be free from physical restraints not required to treat the resident's medical symptoms.”¹ Although the resident was physically restrained without a physician's order, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A facility evaluation indicated that a seat belt used to secure a resident in a wheelchair, per the resident's request, was not considered a restraint. However, there was no documentation of a physician order.
- During an interview with a certified nurse aide (CNA), the CNA asked the resident if he could remove the seat belt. The resident stated that he could not reach it. The CNA asked the resident to take the seat belt off but the resident “shook their head no.”
- A licensed practical nurse (LPN) stated that she was “unsure what other interventions were tried prior to the buckle seat belt.” The LPN added that “she did not document on the seat belt, there were no parameters for usage, and she had not checked for proper placement of the seat belt.”
- The director of nursing noted that “[s]he expected if a resident could not remove the seat belt by them self it should to be care planned as a restraint on the CCP [comprehensive care plan] and care instructions.”
- **Note:** According to the Centers for Medicare & Medicaid Services (CMS), a physical restraint is anything that (1) is attached or adjacent to the resident's body, (2) that the resident cannot easily remove, and (3) which restricts the resident's freedom of movement or normal access to the body. To learn more, please read [LTCCC's fact sheet](#).

→ **Every facility must treat residents with respect and dignity. Each resident has the right to a dignified existence and self-determination.**

→ **Every resident has the right to be free from abuse, neglect, misappropriation of property, and exploitation.**

St. James Wellness Rehab Villas (Illinois)

Three-star nursing home fails to ensure that residents could easily access call lights, causing pain and discomfort.

The surveyor determined that the nursing home failed to “ensure call lights were accessible to four residents”² Although this failure resulted in residents experiencing pain and discomfort, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A resident was observed in bed wincing and grimacing in pain. When asked if he was in pain, the resident “responded by mouthing the word yes in a whispered voice.” The resident whispered that he wanted something for the pain. The surveyor asked the resident whether he could use his call light. The resident whispered yes and looked around for it. The surveyor noted that the “call light was found hanging down onto floor behind the bed, completely out of reach”
- A resident was observed in bed shaking the side rails, stating that she needed to get out of bed. When asked if she could use her call light, the resident “responded I can use it if I can find it, but they always hide it.” The surveyor noted that the call light was under the resident's pillow by her left shoulder. The resident was “unable to use her left arm/hand and could not access the call light with her right hand.”

- A resident was in bed and stated that her room was too hot. The resident wanted the privacy curtain pulled back “because she couldn’t breathe.” The surveyor noted that, at the time, the call light was on a chair next to the resident’s bed “[a]nd not within reach.”
- **Note:** Every resident has the right to be free from neglect. Federal regulation defines neglect as “the failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish, or emotional distress.” To learn more, please read [LTCCC’s fact sheet](#).

Wayne County Nursing Home (New York)

Three-star nursing home fails to provide safe and appropriate respiratory care.

The surveyor determined that “for two of four residents reviewed for respiratory care and oxygen, the facility did not provide proper care and treatment in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choice.”³ Despite this failure, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A resident’s comprehensive care plan called for the use of oxygen and for oxygen saturation to be at or above 93 percent at all times until the next review. The certified nursing assistant (CNA) assignment included 2 liters of oxygen at bedtime and throughout the day as needed.
- A review of records showed that the oxygen tubing and humidifier bottle were noted as being changed and cleaned on December 17, 2019. Resident observations in January showed that the concentrator and tubing were not clean. The registered nurse (RN) manager acknowledged that the “the concentrator was filthy and needed cleaning.” The RN manager told the surveyor that the tubing and filter needed to be changed every two weeks.
- **Note:** A new Medicare payment model for nursing home care incentivizes facilities to admit residents in need of ventilator services. Our organizations are concerned that this financial incentive may put residents who need respiratory care at risk as more poorly-performing facilities admit these vulnerable residents. For more information, please read the Center’s alert, [“Medicare SNF Payment Model Creates Changes in Care and Admissions – What about Facility Assessments?”](#)

→ *Every facility must ensure residents can exercise their rights as nursing home residents and citizens/residents of the United States without interference, coercion, discrimination, or reprisal from the facility.*

Montgomery Place Nursing Center (Kansas)

Four-star nursing home fails to ensure door alarms functioned properly, creating an elopement risk.

The surveyor determined that the nursing home failed to identify that the door alarms were not functioning.⁴ According to the surveyor, the failure had the potential to “allow the seven confused and mobile residents to exit the building without staff being aware.” Despite the potential for resident elopement, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A licensed nurse confirmed that a door alarm did not sound when the south hall exit door was opened. The door was held open for one minute and the alarm still did not sound. Other staff also confirmed that that door alarms for the north hall exit and west entrance did not sound. An administrative nurse acknowledged that door alarms were supposed to sound after the door is held open for 15 seconds.

- The facility's records indicated that the door alarms worked on previous days but failed to note whether the door alarms were checked on the morning of the survey. The surveyor noted that "[t]he facility lacked any type of log or a system to evidence staff checked the exit doors on a consistent basis, the results of those checks, which doors staff checked and measures taken if staff identified a problem."
- Ultimately, the surveyor concluded that the nursing home failed to "maintain an ongoing system to ensure the functioning of door alarms to alert staff when the exit doors open."
- **Note:** CMS Interpretative Guidelines indicates that elopement occurs when a resident leaves the facility or a safe area without authorization or necessary supervision. CMS states that a resident "who leaves a safe area may be at risk of (or has the potential to experience) heat or cold exposure, dehydration and/or other medical complications, drowning, or being struck by a motor vehicle."

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to detect resident harm. Anyone can report violations of the nursing home standards of care by contacting their state survey agency. To file a complaint against a nursing home, please use [this resource](#) available at CMS's Nursing Home Compare website. If you do not receive an adequate or appropriate response, [contact your CMS Regional Office](#).



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

Note: The overall star rating of any facility identified in this newsletter is subject to change. The star ratings are current up to the date of newsletter's drafting.

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 Seneca Hill Manor Inc. (Jan. 16, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335815&SURVEYDATE=01/16/2020&INSPTYPE=STD&profTab=1&Distn=6927.0&state=NY&lat=0&lng=0&name=SENECA%20HILL%20MANOR%20INC>. The resident's sex was not identified. For purposes of this newsletter, the resident was identified as being male.

² Statement of Deficiencies for St. James Wellness Rehab Villas (Feb. 6, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=145611&SURVEYDATE=02/06/2020&INSPTYPE=STD&profTab=1&Distn=7616.5&state=IL&lat=0&lng=0&name=ST%20JAMES%20WELLNESS%20REHAB%20VILLAS>.

³ Statement of Deficiencies for Wayne County Nursing Home (Jan. 15, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335406&SURVEYDATE=01/15/2020&INSPTYPE=STD&profTab=1&Distn=6957.8&state=NY&lat=0&lng=0&name=WAYNE%20COUNTY%20NURSING%20HOME>.

⁴ Statement of Deficiencies for Montgomery Place Nursing Center (Feb. 12, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=175511&SURVEYDATE=02/12/2020&INSPTYPE=STD&profTab=1&Distn=8165.3&state=KS&lat=0&lng=0&name=MONTGOMERY%20PLACE%20NURSING%20CENTER>.