

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 3, Issue 3

IN THIS ISSUE:

Manhattanville Health Care Center (New York)	2
Speed over safety: Resident fractures hip as facility fails to follow transfer protocols.	
Maple Springs of Wasilla (Alaska)	3
What’s the plan? Absence of behavioral health interventions results in use of chemical restraints.	
Oceanside Skilled Nursing and Rehabilitation (New Hampshire)	3
Not worth the weight: Facility fails to monitor residents’ health and provide sufficient food.	
Southern Specialty Rehab & Nursing (Texas)	4
Locked up: Unsupervised resident leaves facility and spends evening in jail.	

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 most 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.

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.

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 [Care Compare](#) website.

The COVID-19 pandemic has had devastating consequences for residents in long-term care settings. This issue focuses on nursing home citations in the months leading up to the pandemic to illustrate the lack of accountability within the nursing home industry before the crisis hit. The absence of enforcement has cultivated an environment that has led to 100,000 COVID-19 deaths and 700,000 COVID-19 cases in long-term

care facilities through early December 2020,¹ in addition to immeasurable suffering from gross neglect, substandard care, loneliness, and “broken hearts.” As nursing home industry leaders lobby for legal immunity for resident abuse and neglect during the COVID-19 pandemic (and beyond!), consider that too many facilities, even under “normal” conditions, were failing to protect the basic rights of their residents – often with no penalty.

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. When state enforcement agencies and CMS fail to properly identify and penalize nursing homes for health violations, it is important for the public to be aware of nursing home safety concerns in their communities. Fundamentally, from our perspective, every suspected case of resident harm should be reported, investigated, and (as appropriate) addressed.

Manhattanville Health Care Center (New York)

Speed over safety: Resident fractures hip as facility fails to follow transfer protocols.

The surveyor determined that the facility failed to follow safety protocols when transferring a resident on a Hoyer lift. According to the citation, a Certified Nursing Assistant (CNA) conducted solo transfers of a resident despite the resident requiring two-person assists. Hours after a solo transfer, the resident reported significant pain and was later diagnosed with a fractured hip. Despite the serious injury, the surveyor cited the violation as no-harm.² The citation was based, in part, on the following findings from the [SoD](#):

- A resident was observed grimacing during hip movements while receiving incontinence care. Asked what happened, the resident stated through a staff interpreter that they didn’t know. The resident was later diagnosed with a hip fracture and transferred to the hospital.
- Earlier that day, the resident received a solo transfer from a CNA despite the resident requiring a two-person assist. In an interview, the CNA stated it was a safe transfer and denied any fall or accident/incident. The CNA admitted to conducting solo transfers with this resident in the past and stated it “was a poor judgement on her part,” according to the SoD.
- An investigation dated 12/29/19 – the day of the incident – documented there was reasonable cause to believe abuse, mistreatment, or neglect occurred. The Investigation Summary, written by the Director of Nursing (DON), documented the case was reported to the New York State Department of Health. The CNA was suspended for three days for transferring the resident with the Hoyer lift without assistance. Staff also received training on Hoyer lift transfers and Abuse Prevention and Prohibition.
- Exactly how or when the injury happened, we may never know. Regardless, the resident suffered serious harm. Nursing home facilities implement strict transfer rules in order to prevent injuries such as this one. To violate these rules multiple times is to violate a resident’s rights to be protected from preventable harm, injury, and death.
- **Protect from neglect:** Federal law states that residents “have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation.” Learn more about protecting residents from neglect by visiting [LTCCC’s Abuse, Neglect, and Crime Reporting Center](#).

→ *Every facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident’s individuality.*

Maple Springs of Wasilla (Alaska)

What's the plan? Absence of behavioral health interventions results in use of chemical restraints.

The surveyor determined that the facility failed to develop a resident's baseline care plan to include social service needs. According to the citation, the resident faced increased risk for unnecessary medications and experienced numerous adverse outcomes including anxiety, hallucinations, confusion, agitation, and violence. Still, the violation was cited as no-harm.³ The citation was based, in part, on the following findings from the [SoD](#):

- Record from the referring hospital indicated the resident had occasional episodes of agitation and worsening anxiety. However, the initial care plan, initiated 1/13/20, did not include any interventions for agitation or anxiety.
- In an interview on 2/5/20, the Administrator stated the resident was involved in an incident that included increased aggression and physical violence towards staff and resulted in emergency medication and hospitalization.
- The Administrator admitted in the interview that "the facility did not have psychiatric services and did not have a way to manage the Resident other than chemical restraints."
- The resident experienced numerous adverse behavioral outcomes prior to the incident, including anxiety, hallucinations, confusion, and agitation. The resident's care plan (revised 1/31/20) lacked interventions for behavioral health or non-pharmacological interventions.
- **Note:** Powerful antipsychotic drugs are being administered to approximately one in five nursing home residents, or 10 times the proportion of the population that will ever have a diagnosis recognized by CMS as qualifying for potentially appropriate use. Too often, these drugs are administered to resident inappropriately, as a chemical restraint, because the facility lacks sufficient staffing to provide appropriate care. Visit [LTCCC's Dementia Care & Antipsychotic Drugging page](#) for information on the antipsychotic drugging rates for all licensed nursing homes, by state, [for the fourth quarter of 2019](#). See LTCCC's [Dementia Care Advocacy Toolkit](#) for information and resources to help residents, families and those who work with them meet and overcome the challenges to accessing good care and life with dignity.

- Residents have the right to be informed about the risks and benefits of any medication.
- Residents have the right to refuse a medication.
- It is against the law to give medications that do not benefit the resident, such as for convenience of staff.

Oceanside Skilled Nursing and Rehabilitation (New Hampshire)

Not worth the weight: Facility fails to monitor residents' health and provide sufficient food.

The surveyor determined that the facility failed to monitor weight loss and follow dietary protocols for several residents. Two residents experienced significant weight loss while another who required a special diabetic diet was instead given a regular diet. Nonetheless, the surveyor cited the violation as no-harm.⁴ The citation was based, in part, on the following findings from the [SoD](#):

- A resident's care plan included weekly weight monitoring, but records indicated that staff failed to follow through with this intervention. The resident experienced rapid weight loss under the facility's care, losing 9.6 pounds (5.2% of their body weight) over a 14-day period and later losing 17 pounds (9.6%) over a 21-day period.
- The facility also failed to monitor the weight of a different resident who lost 31.6 pounds (15%) in six months. A staff member recommended weekly weight monitoring after observing significant weight loss, but the weight summary sheet indicated that the facility failed to follow through.
- A resident who required a special diabetic diet was receiving sugary desserts. The resident stated that they did not eat those desserts, but "also did not like the temptation." In an interview, the Food Service Supervisor confirmed that the kitchen staff have been serving the resident a regular diet instead of the prescribed diet.
- **Note:** [Federal law \[§483.60\]](#) requires facilities to "provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident."

A resident lost **9.6 pounds over a 14-day period** and later lost **17 pounds over a 21-day period**. Still, the violation was cited as no-harm.

Southern Specialty Rehab & Nursing (Texas)

Locked up: Unsupervised resident leaves facility and spends evening in jail.

The surveyor determined that the facility failed to provide adequate supervision to a resident to prevent accidents. This deficiency resulted in an unsupervised resident leaving the facility and ending up in a local jail. Still, the violation was cited as neither causing harm nor putting the resident in immediate jeopardy.⁵ The citation was based, in part, on the following findings from the [SoD](#):

- An unsupervised resident left the facility late at night and was stopped by police and arrested on a warrant, according to the Administrator.
- Staff learned the resident was missing the next morning after seeing his untouched breakfast tray. Following a search inside and outside the facility, the social worker checked the jail roster and discovered the resident was in Lubbock County Jail. The resident had been arrested and booked into the jail at 9:19 PM the night before.
- A CNA had documented that the resident had a large bowel movement between 10-11 PM the night of the arrest despite the resident being in the county jail at that time. According to the administrator, the CNA said the resident "usually has a bowel movement around that time so she had documented it," then stated she had not seen the resident all night.
- In an interview, the DON stated the facility does not have a policy on supervision of residents, but staff are expected to make rounds and locate the residents every two hours. The DON stated that not all staff completed their rounds that night.
- In an interview, a Licensed Vocational Nurse (LVN) stated that she gave the resident his medication and a cigarette to go smoke that evening. The LVN stated she was in the resident's room a lot that night because his roommate required a lot of care, and that she should have looked for him upon realizing he wasn't there, but relies on the CNA to report if they cannot find a resident.
- **Know Your Rights:** There are many standards which nursing homes are required to follow to ensure that residents receive appropriate care, have a good quality of life, and are treated with dignity. Though some standards have been relaxed during the pandemic, all quality of care and dignity standards remain in

effect. Read [LTCCC's resident rights fact sheet](#) to learn how you can use these standards as a basis for advocating in your nursing home and community.

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 Care 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 "State Data and Policy Actions to Address Coronavirus," Kaiser Family Foundation (December 9, 2020). Available at <https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>.

² Statement of Deficiencies for Manhattanville Health Care Center (February 27, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2020/12/Manhattanville.335695.2020-02-27.pdf>.

³ Statement of Deficiencies for Maple Springs of Wasilla (February 11, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2020/12/Maple.025038.2020-02-11.pdf>.

⁴ Statement of Deficiencies for Oceanside Skilled Nursing and Rehabilitation (January 27, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2020/12/Oceanside.305055.2020-12-09.pdf>.

⁵ Statement of Deficiencies for Southern Specialty Rehab & Nursing (March 3, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2020/12/Southern.676028.2020-03-03.pdf>.