

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 3, Issue 5

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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 their “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.

Onsite surveys at nursing homes serve a critical role in protecting residents from substandard care. While facilities are facing fewer onsite surveys during COVID-19, many residents are living in a constant state of danger, exacerbated by the lack of oversight. More than 130,000 long-term care residents and workers¹ have died from COVID-19, while tens of thousands more have “died prematurely of other causes.”² CMS said in

November regarding surveys that, “[w]e need to get back to the way things were prior to the pandemic,”³ but as demonstrated by the following four no harm SODS – from surveys conducted before the pandemic – nursing home residents deserve better than “the way things were.”

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.

The Grand Rehabilitation and Nursing at Mohawk (New York)

He thought they knew what they were doing: One-star facility fails to keep residents free from pressure ulcers.

The surveyor determined that the facility failed to ensure residents received care consistent with professional standards of practice to prevent pressure ulcers. According to the citation, a resident was found with a deep tissue injury (DTI) on his foot after receiving orthopedic surgery that same day. Still, the surveyor cited the violation as no harm.⁴ The citation was based, in part, on the following findings from the [SoD](#):

- According to a hospital discharge report, the resident fell at home and fractured the left tibia and fibula and was sent to the nursing facility with a plan to undergo outpatient orthopedic surgery, which took place one week later.
- During the resident’s surgery, the hospital discovered a black area on the ball of the resident’s foot. Upon readmission to the nursing home after surgery, there was no documentation in the medical record related to the black spot on the resident’s foot, and no treatment was put in place at that time.
- A physical therapist’s progress report from the day after the resident’s readmission documented the black area on the bottom of the resident’s foot, but there was no documentation that this was reported to nursing. The injury was also documented in a nursing progress note dated two days after the physical therapist’s report.
- In an interview, the resident stated that he had a splint type cast that was wrapped with an ACE bandage. After his surgery, he was readmitted to the facility where the ACE wrap remained on his leg.
- Four days after readmission, the Director of Nursing’s progress note documented that the hospital where the resident’s surgery took place discovered a black area on the ball of the resident’s foot during surgery. The area was unstageable (completely covered in dead tissue), dry, and black.
- The resident stated that no one at the nursing facility removed his dressing or checked his feet or circulation for 18 days until his follow up with the orthopedic surgeon. The resident stated that he did not say anything to staff because he “thought they knew what they were doing.”
- **Know Your Rights:** Pressure ulcers are an important measure of quality of clinical care in nursing homes. Despite this, over 87,000 nursing home residents are suffering with pressure ulcers today. For more information on pressure ulcers, please see [LTCCC’s webinar, Focus on Care & Outcomes: Pressure Ulcers and Infection Control & Prevention](#).

Facilities must ensure that “a resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.”

Ladera Center (New Mexico)

Six weeks too long: Two-star facility administered unauthorized medication.

The surveyor determined that the facility administered unauthorized medication to two residents. Though this deficient practice can affect a resident's health and safety, and contribute to opioid dependency, the surveyor cited the violation as no harm.⁵ The citation was based, in part, on the following findings about one of the residents from the [SoD](#):

- A resident's medical record revealed that he was admitted on Hospice with a medical history of stroke, abnormal body movements and tremors, chest pain, diabetes, and mild cognitive impairment.
- The resident was later discharged from Hospice services per his wife's request. The resident's Hospice Comprehensive Assessment and Plan of Care report indicated that he had been receiving an opioid pain reliever/narcotic but that it was discontinued.
- According to medication records, the resident continued to receive the opioid pain reliever/narcotic past the discontinued date. Records documented that the resident received the last dose of the medication on 9/15/19. However, according to the actual narcotic record sign-out sheet, the resident received an additional 16 doses, with the last dose recorded on 10/29/19.
- The facility administration determined that the resident continued to receive the medication for approximately six weeks past the discontinued date.
- **Note:** There are numerous strong standards to ensure that residents receive appropriate medications, free from medication errors, and are not administered antipsychotics (or any drugs) for the convenience of staff. Unfortunately, these requirements are poorly enforced by the state and federal oversight agencies. See [LTCCC's fact sheet on dementia care and drugging standards](#) for more information.

Palm Valley Rehab & Care Ctr (Arizona)

Sedated: Three-star facility failed to ensure that a resident's representative was informed of new medications prior to treatment.

The surveyor determined that the facility failed to ensure that a resident's representative was informed of the risks and benefits of treatment with medications prior to treatment. Though the failure to inform the resident's representative of the medications resulted in a violation of the resident's right to informed consent, the surveyor cited the violation as no harm.⁶ The citation was based, in part, on the following findings from the [SoD](#):

- Review of the clinical record revealed undated psychoactive medication consent forms for two medications. Further review of the clinical record did not reveal any evidence that the resident or his representative was provided information about the risks or benefits of the medications prior to treatment.
- According to a physician's orders, the resident was to receive medication three times a day for anxiety to keep the resident from pulling at life-sustaining devices.
- An interview with the Behavioral Health Clinical Liaison confirmed that no consent forms were found for these medications.

Nursing homes must inform the resident, or the resident's representative, of any proposed treatment. Residents (or their representatives) have the right to refuse treatment.

- **Note:** According to the [SoD](#), this resident later died after pulling out his life-sustaining device while unsupervised. Although it was documented that a sitter was to remain at the resident's bedside full-time, the sitter was found to be negligent in monitoring the resident for 45 minutes. This deficiency – failure to provide adequate behavioral supervision – was cited as causing actual harm.
- **Note:** Inappropriate antipsychotic drugging is a longstanding, pervasive problem in US nursing homes. Each week, almost 300,000 nursing home residents receive antipsychotic drugs, largely without clinical justification. Studies have shown that inappropriate drugging can damage social and emotional well-being while increasing risks of stroke, heart attack, diabetes, Parkinsonism, and falls. To learn more, check out [LTCCC's Nursing Home Update: Inappropriate Antipsychotics Pervasive in U.S. Nursing Homes](#).

Arizona State Veteran Home-Phx (Arizona)

A bloody knee: Four-star facility fails to provide appropriate supervision to prevent elopement.

The surveyor determined that the nursing home failed to ensure adequate supervision of a resident known to elope. Though the resident was outside the facility on his own and eventually returned to the facility with a bloody knee, the surveyor cited the violation as no harm.⁷ The citation was based, in part, on the following findings from the [SoD](#):

- According to a nursing progress note, the resident was angry after waking up and realizing his wheelchair was gone. The note further indicated that the resident's wheelchair was out for repairs.
- In an interview, the director of social services stated that she was with the resident on the day of the elopement. According to the interview, the director brought the resident outside to calm him down because he was upset and agitated, and that after their meeting, she brought the resident back inside and put him by the TV in the dayroom. After going upstairs to make a call, the director returned to the first floor and the resident was no longer in the dayroom.
- After staff was unable to locate the resident, the facility's head of security initiated a Code Yellow, and the resident was found outside the facility on the corner.
- According to a clinical record, the resident was seen by a social service staff while she was in her personal vehicle during her lunch break. The resident at that time was being assisted by a Good Samaritan who was helping to fix the resident's wheelchair. The resident was bleeding from his right knee when he returned to the facility.
- **Note:** Federal nursing home standards include provisions to ensure resident safety as well as the ability of residents to live comfortably, in an environment that is as home-like as possible. Please see [LTCCC's Consumer Factsheet: Safe Environment](#) to use in supporting resident-centered advocacy for both safety and a good quality of life.

Ensuring that the nursing home is a safe environment for residents is fundamentally important.

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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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 Chidambaram, P., Garfield, R., & Neuman, T. "COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff," *Kaiser Family Foundation* (November 25, 2020), available at <https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/>.

² Sedensky, M., & Condon, B. "Not just COVID: Nursing home neglect deaths surge in shadows," *Associated Press* (November 19, 2020), available at <https://apnews.com/article/nursing-homes-neglect-death-surge-3b74a2202140c5a6b5cf05cdf0ea4f32>

³ Brown, D. "Regular surveys resume at nursing homes, but CMS treads carefully with enforcement penalties," *McKnights Long-Term Care News* (November 20, 2020), available at <https://www.mcknights.com/news/regular-surveys-resume-at-nursing-homes-but-cms-treads-carefully-with-enforcement-penalties/#:~:text=State%20survey%20agencies%20have%20already,for%20Medicare%20%26%20Medicaid%20Services%20official>

⁴ Statement of Deficiencies for The Grand Rehabilitation and Nursing at Mohawk (Feb. 28, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/01/Grand-Rehab-and-Nursing-of-Mohawk.pdf>.

⁵ Statement of Deficiencies for Ladera Center (Feb. 17, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/01/Ladera-Center.pdf>.

⁶ Statement of Palm Valley Rehab & Care Ctr (Feb. 13, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/01/Palm-Valley-Rehab-Care-Ctr.pdf>.

⁷ Statement of Deficiencies for Arizona State Veteran Home-Phx (Jan. 31, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/01/Arizona-State-Veteran-Home-Phx-AZ.pdf>.