

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 3, Issue 6

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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.

For many months during the COVID-19 pandemic, CMS restricted regular survey activities at nursing homes across the country. As a result, state agencies conducted only 8,999 surveys in 2020, approximately half the amount from the previous year (16,662).¹ At a time when nursing home residents were most in need, too many facilities were operating without oversight.

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 Utica (New York)

Dental decay: One-star facility fails to assist resident in obtaining appropriate dental care.

The surveyor determined that the facility failed to ensure that a resident received routine dental services. According to the citation, the facility did not obtain the services of an outside dentist when a tooth extraction was recommended by the in-house dentist. Despite the facility's failure to address the resident's dental pain, the surveyor cited the violation as no harm.² The citation was based, in part, on the following findings from the [SoD](#):

- According to the resident's dental records, the in-house dentist documented decay on the resident's tooth and recommended sending the resident to an outside dentist for an extraction. The records also documented the resident stated that the tooth hurt and wanted the tooth extracted.
- Six months after the in-house dentist's recommendation for a tooth extraction, the resident saw an outside dentist who recommended an extraction at a follow-up appointment, scheduled for two days later. However, the facility canceled the follow-up appointment and failed to reschedule an appointment for the resident, according to an interview with the outside dentist.
- More than a year after the initial recommendation for tooth extraction, the facility had still not scheduled an appointment for the resident, according to an interview with the resident.
- **Know Your Rights:** Nursing homes are required to assist residents in obtaining routine and 24-hour emergency dental care. For more information on requirements for nursing home physician, rehab, and dental services, watch [LTCCC's webinar](#) or check out [LTCCC's consumer fact sheet](#).

Nursing homes must provide or obtain from an outside resource routine and emergency dental services to meet the needs of each resident.

Legacy Nursing and Rehabilitation of Franklin (Louisiana)

Out the window: One-star facility failed to ensure resident safety.

The surveyor determined that the facility neglected a resident's safety by failing to provide a window alarm and/or increase supervision for a resident with a history of elopements. Though this deficient practice jeopardized the resident's health and safety, the surveyor cited the violation as no harm.³ The citation was based, in part, on the following findings from the [SoD](#):

- A review of the resident's care plan revealed the resident's severe cognitive impairments and risk for elopement based on two previous elopements.
- According to an interview, the facility transferred the resident out of the secure unit for cleaning purposes, and into a room with other residents in the general population, and located outside the secure unit.
- Facility notes indicate that a few days after the transfer, a nurse could not locate the resident. The nurse noted that the resident's room window was open, the window blind was down, the window screen was torn, and a chair was located by the outside fence/gate.
- Shortly after this observation, facility staff found the resident walking on the road located 200 feet from the facility. The resident had no injuries and returned to the facility.

- An interview with the Director of Nursing (DON) revealed the resident's window did not have an alarm because the room was not located on the locked unit, and staff did not increase supervision because the DON did not think the resident would elope through the window and over the fence.
- **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 fact sheet on residents' rights to a safe environment](#) to use in supporting resident-centered advocacy for both safety and a good quality of life.

Goshen Healthcare Community (Wyoming)

Resident abuse: Three-star facility failed to protect two residents from sexual abuse by another resident.

The surveyor determined that the facility failed to protect multiple residents from abuse. Though the facility failed to protect two residents from sexual abuse from another resident, the surveyor cited the violation as no harm.⁴ The citation was based, in part, on the following findings from the [SoD](#):

- Observation and interviews revealed the facility failed to protect two residents from sexual abuse by another resident ("Resident A") whose care plan included close observation when in common areas and identification of physically or verbally inappropriate behavior.
- The first incident occurred when Resident A approached another resident, who was sleeping. Resident A slid their left hand into the other resident's pants while sliding their right hand under the other resident's shirt and grabbing her breast.
- A CNA who witnessed this occurrence reported the incident to an RN. The RN documented the incident but failed to report it to facility administration. According to a later interview with the facility administrator, the facility no longer employs the CNA and RN involved.
- In a separate incident, Resident A approached another resident and asked if the resident wanted to play. When the other resident replied that they did not, Resident A rubbed their hands over the other resident's breasts over their shirt and began reaching inside their shirt. The abused resident left and reported the behavior to facility staff.
- **Note:** Though nursing home residents live in an institutional setting, it is crucial to keep in mind that they retain all of the rights of people who live outside of a facility, including the right to live free of sexual abuse and the right to be treated with dignity. To learn more, check out [LTCCC's Abuse, Neglect, and Crime Reporting Center](#).

Nursing home residents have the right to live free of physical, emotional, verbal, and sexual abuse and the right to be treated with dignity.

The Laurels of Hendersonville (North Carolina)

Weeks without a shower: Understaffed four-star facility fails to bathe residents.

The surveyor determined that the nursing home failed to honor two residents' rights to self-determination through support of resident choice. Though two residents went several weeks without proper bathing, the surveyor cited the violation as no harm.⁵ The citation was based, in part, on the following findings from the [SoD](#):

- Review of one resident's bathing record indicated that the resident went 12 days without a shower and was only bathed after filing a grievance.
- In an interview, a nurse aide stated that the resident likely was not showered on a certain date because of insufficient staffing on that day, and indicated that "when staffing was short, showers were not always provided."
- Records revealed a second resident went 21 days without a shower. An interview with that resident revealed that after mentioning the lack of showers, staff stated "they would try to give her one if they had time."
- A nurse aide stated in an interview that she was unable to provide showers as scheduled due to short staffing.
- **Note:** Nursing home facilities must treat each resident with respect and dignity and care for each resident in a manner and environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. Please see [LTCCC's fact sheet on residents' rights to dignity and respect](#) to use in supporting resident-centered advocacy for a good quality of life.
- **Note:** Sufficient staffing is vital to a nursing home resident's quality of care and ability to live with dignity. Unfortunately, many nursing homes fail to comply with federal law requiring facilities to provide sufficient care staff. Check out [LTCCC's staffing page at NursingHome411](#) to learn more about nursing home staffing and to see staffing information for all licensed facilities in the U.S.

Nursing home residents have the right to be treated with respect and dignity, and in a manner that promotes maintenance or enhancement of their quality of life.

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 (Click on "Nursing Homes" and scroll down to "Learn how to file a complaint and find state agency contacts"). If you do not receive an adequate or appropriate response from your state agency, [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 "Five-Star surveys: Changed forever?," McKnight's Long-Term Care News (February 8, 2021). Available at <https://www.mcknights.com/blogs/guest-columns/five-star-surveys-changed-forever/>

² Statement of Deficiencies for The Grand Rehabilitation and Nursing at Utica (July 27, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/03/Grand-Rehab-and-Nursing-at-Utica.pdf>.

³ Statement of Deficiencies for Legacy Nursing and Rehabilitation of Franklin (June 23, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/03/Legacy-Nursing-and-Rehab-of-Franklin.pdf>.

⁴ Statement of Goshen Healthcare Community (August 13, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/03/Goshen-Healthcare-Community.pdf>.

⁵ Statement of Deficiencies for The Laurels of Hendersonville (March 5, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2021/03/Laurels-of-Hendersonville.pdf>.