

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 4, Issue 2

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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 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.

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 (if confirmed), appropriately sanctioned.

“Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?”

– [Broken Promises: An Assessment of Federal Data on Nursing Home Oversight](#)

Glens Falls Center for Rehabilitation and Nursing (New York)

Medication mix-up: One-star nursing home’s medication error leads resident to ER.

The surveyor determined that the nursing home failed to ensure that residents were safe from any significant medication errors. According to the citation, nursing home staff administered medications including antidepressants, insulin, a narcotic pain medication, and a blood thinner to the wrong resident. Although the resident was transferred to the emergency room due to the significant medication error, the surveyor cited the violation as no harm.¹ The citation was based, in part, on the following findings from the [SoD](#):

- A review of a resident’s chart showed that a resident received someone else’s morning medications instead of their own.
- The resident was found minimally responsive, unable to stay awake or answer questions. The resident’s breathing was shallow and irregular at times.
- According to documents, the resident had been sedated due to receiving medications that were not prescribed for the resident.
- Due to the resident’s advanced age and the amount of medication administered, the nursing home sent the resident to the emergency room for evaluation.
- Upon further investigation, the nurse who administered the incorrect medications stated that they had confused two residents who look similar and go by the same name, leading to the medication error. The error was reported by the nurse who administered the medication.
- **Know Your Rights:** Nursing homes are required to have sufficient nursing staff with the appropriate skills and competencies to ensure resident safety and maintain residents’

Nursing homes must ensure that residents are free of any significant medication errors.

highest practicable physical, mental, and psychosocial well-being. They are also required to ensure that every individual resident is free of any significant medication error and that the facility as a whole has a medication error rate of less than 5%. To learn more, check out [LTCCC's Fact Sheet on Standards for Nursing Home Services](#) and our [Primer on Nursing Home Quality Standards](#).

Country Village Center, Genesis Healthcare (New Hampshire)

Pressure's on: Timely and appropriate pressure ulcer care not provided at five-star nursing home.

The surveyor determined that the nursing home failed to provide a resident with appropriate pressure ulcer treatment and services in a timely manner. According to the citation, one resident's pressure ulcer dressing was not changed as scheduled, leading to a worsening of the affected area. Despite this, 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 citation, a resident acquired a pressure ulcer to both heels while at the nursing home, requiring a set regimen of appropriate pressure ulcer care every three days.
- The resident's left heel appeared to have a significant drainage on the pressure ulcer dressing. Further examination of the resident's heel revealed a newly macerated area surrounding the wound.
- A review of the resident's treatment administration record found that the resident was due to have their dressing changed three days prior, but that the dressing was unchanged.
- An interview with the unit manager confirmed that the dressings were not changed as scheduled, and that the last known dressing change occurred nearly six days prior.
- **Know Your Rights:** A resident with pressure ulcers has the right to receive care that is consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. To learn more, check out [LTCCC's Fact Sheet on Pressure Ulcers](#).

Pressure ulcers are serious medical conditions and one of the most important measures of the quality of clinical care in nursing homes.

Monroeville Rehabilitation and Wellness Center (Pennsylvania)

Unplanned weight loss: Two-star nursing home fails to properly monitor resident nutrition.

The surveyor determined that the nursing home failed to provide proper nutrition and weight monitoring to maintain a resident's highest practicable well-being. According to the citation, the nursing home failed to ensure that the residents maintained acceptable parameters of nutritional status, leading to significant unplanned weight loss. Despite this, the surveyor cited

the violation as no harm.³ The citation was based, in part, on the following findings from the [SoD](#):

- According to the deficiency, the nursing home’s nutrition policy indicates that all residents should receive care that allows them to maintain acceptable parameters of nutritional status including body weight. Unacceptable parameters of nutritional status include unplanned weight loss.
- A review of one resident’s records revealed a 5.4% weight loss over 30 days.
- Review of the resident’s treatment record revealed no weight documentation for four weeks between July through September, despite the requirement for weekly weight checks in the resident’s care plan.
- A second resident’s nutrition note indicated a 20% weight loss over a 180-day period.
- Despite orders to monitor weight in the resident’s care plan, the second resident’s record did not include weekly weight checks for three weeks in one month.
- An interview with the nursing home’s registered dietitian confirmed that the nursing home failed to obtain weights according to orders for both residents and that both residents had experienced significant weight loss.
- **Know Your Rights:** Every resident has the right to receive the care and services they need to maintain their highest possible level of functioning and well-being. To learn more, check out [LTCCC’s fact sheet on Standards of Care for Resident Well-Being](#).

Nursing homes must provide care and services for activities of daily living, including hygiene care – bathing, dressing, grooming, and oral care.

Aloha Nursing and Rehab Centre (Hawaii)

‘There’s just no time for those things’: Residents’ personal care neglected due to understaffing at five-star nursing home.

The surveyor determined that the nursing home failed to treat residents with respect and dignity by not providing care in a way that maintains their quality of life. One resident did not receive appropriate personal care, while another resident was denied time to participate in crafts that he enjoyed. Despite this failure to promote residents’ quality of life, the surveyor cited the violation as no harm.⁴ The citation was based, in part, on the following findings from the [SoD](#):

- The surveyor observed a resident lying on his bed in a gown that “was bunched up in a wad on his chest.” The resident’s hair was not clean and there were excoriations on his lower leg.
- Additional observations over the next two days showed that the resident was still in the same hospital gown, with hair and skin still unkempt and ungroomed.
- In interviews, nursing home staff stated that due to understaffing, staff could not provide residents with personal care. “[T]here’s just no time for those things.”
- Observations of a second resident found the resident asleep after breakfast with the TV on.

- In an interview, the resident stated that he enjoyed making decorative objects out of wire but that his tools to create his crafts were locked away. Staff stated that he is unable to use those tools without supervision.
- A review of the resident records showed that there were no activities documented for this resident for an entire month. An interview revealed that the nursing home had difficulty finding time to supervise this resident due to understaffing.
 - **Note:** Though staff members stated in interviews that they did not have enough time to provide each resident with appropriate hygiene care, this nursing home received a four-star rating for staffing on [CMS' Care Compare website](#).
- **Know Your Rights:** Quality of life is a fundamental principle that applies to all care and services provided to nursing home residents. Nursing home care staff should encourage and assist residents to dress in their own clothes appropriate to the time of day, activity, and individual preferences. To learn more, check out [LTCCC's fact sheet on resident dignity and quality of life standards](#).
- **Note:** Nursing homes averaged 3.62 Total Nurse Staff hours per resident day (HPRD) according to the [most recent staffing data \(Q3 2021\)](#). This falls well below the minimum staffing threshold (4.10 total care staff HPRD, 0.75 RN HPRD) indicated by a landmark 2001 federal study.

Quality of life is a fundamental principle that applies to all care and services provided to nursing home residents.

Alden Estates of Countryside (Wisconsin)

Falling on deaf ears: Resident and family member grievances unresolved at two-star nursing home.

The surveyor determined that the nursing home did not promptly or adequately resolve grievances for three residents. Despite this failure to address grievances, the surveyor cited the violation as no harm.⁵ The citation was based, in part, on the following findings from the [SoD](#):

- A resident was discharged and transferred to another nursing home, which reported that there were feces in the resident's clothing upon arrival. Upon notification, the resident's family member filed a grievance.
- After further investigation, the surveyor determined that the nursing home failed to investigate the details surrounding the incident to adequately resolve the grievance.
- A second resident stated to the occupational therapist that her weight had not been documented, and her legs were not being wrapped as required to decrease swelling to her legs due to the resident's condition.
- An interview with the Director of Nursing revealed that the complaints expressed by the resident to the

Nursing homes are required to establish grievance policies that ensure the prompt resolution of all grievances regarding the resident's rights.

occupational therapist had not been officially written as a formal grievance and was thus not resolved by the nursing home.

- A third resident filed a grievance about delayed responses to call lights.
- The Director of Nursing spoke with the resident and the resident verbalized an understanding of other residents' needs.
- The surveyor concluded that the nursing home did not determine if there was a problem with the call light response time, nor did they put in place measures to monitor the situation.
- **Know Your Rights:** Nursing homes are required to establish grievance policies that ensure the prompt resolution of all grievances regarding the resident's rights. To learn more, check out [LTCCC's Fact Sheet on Resident Grievances & Complaints](#).

Menig Nursing Home (Vermont)

Seven falls in 3 months: Resident care plan requirements go unenforced at five-star nursing home.

The surveyor determined that the nursing home failed to review and revise the care plan for two residents, leading to preventable falls. According to the citation, no changes were made to accommodate a resident's fall prevention needs despite frequent falls under the current fall prevention plan. Despite this failure in care planning, the surveyor cited the violation as no harm.⁶ This citation was based, in part, on the following findings from the [SoD](#):

- A review of one resident's record showed that the resident had fallen seven times in three months.
- Despite the resident's frequent falls, no new measures were in place to prevent future falls.
- A review of a second resident's record showed that the resident had fallen six times in eight weeks.
- After the most recent fall, which resulted in the second resident hitting their head and complaining of pain in the right hip, knee, shoulders, and neck, the resident was sent to the emergency room for evaluation.
- An investigation found that despite the second resident's frequent falls, the nursing home had no measures in place to revise the resident's fall prevention care plan.
- An interview confirmed that the care plans for these residents were not revised at the appropriate intervals.
- **Know Your Rights:** Nursing homes are required to develop and implement a comprehensive person-centered care plan for each resident to meet their medical, nursing, mental, and psychosocial needs. To learn more, check out [LTCCC's Fact Sheet on Resident Care Planning](#).

Person-centered care plans are critical to nursing home residents' care and safety.

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 on the Medicare.gov website. 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 Statement of Deficiencies for Glens Falls Center for Rehabilitation and Nursing (August 18, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Glens-Falls-Center-for-Rehabilitation-and-Nursing.pdf>.

² Statement of Deficiencies for Country Village Center, Genesis Healthcare (August 12, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Country-Village-Center-Genesis-Healthcare-.pdf>.

³ Statement of Deficiencies for Monroeville Rehabilitation and Wellness Center (September 20, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Monroeville-Rehabilitation-and-Wellness-Center.pdf>.

⁴ Statement of Deficiencies for Aloha Nursing & Rehab Centre (August 12, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Aloha-Nursing-Rehab-Centre.pdf>.

⁵ Statement of Deficiencies for Alden Estates of Countryside (February 2, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Alden-Estates-of-Countryside-Inc..pdf>.

⁶ Statement of Deficiencies for Menig Nursing Home (August 26, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/03/Menig-Nursing-Home.pdf>.