

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

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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).

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.

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.

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 Nursing Home Oversight](#)

Embassy Manor at Edison Nursing and Rehabilitation (New Jersey)

Overmedicated: Two-star nursing home gives resident inappropriate psychoactive drugs for nearly two years.

The surveyor found that the nursing home gave psychoactive medication to a resident who exhibited no target behaviors appropriate for this type of medication. Further, in violation of facility policy and CMS guidelines, the nursing home failed to conduct a quarterly review to determine if the resident could be tapered off the medicine. Though the resident received unnecessary medication for nearly two years, the surveyor cited the violation as no harm.¹ The citation was based, in part, on the following findings from the [SoD](#):

- According to the citation, facility staff administered powerful psychoactive medication to a resident for alleged behavioral issues – to control the resident’s screaming and kicking.
- A psychiatrist prescribed the medication without documentation of the resident’s alleged behavior.
- The resident’s records did not show progress notes or evidence to show that resident screamed and kicked.
- **Note:** In a one-month period, the resident missed 12 doses of the medication (which was being administered inappropriately). Staff did not document any screaming and kicking during that period.

Each resident’s drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate monitoring.

- **Know Your Rights:** Dangerous drugging persists in nursing homes despite federal initiatives to reduce the inappropriate use of drugs. Federal standards are in place to protect nursing home residents from inappropriate drugging; based on a comprehensive assessment of a resident, facilities must ensure that residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. To learn more, check out [LTCCC's fact sheet on dementia care and psychotropic drugs](#).

Sandpiper Post Acute (South Carolina)

Check the use-by date: Three-star nursing home administers insulin after it expired.

The surveyor determined that the nursing home failed to provide residents with medications free from significant error. This failure was identified for four of the four resident records reviewed by the surveyor (i.e., 100% of resident records reviewed). According to the citation, the facility dispensed insulin after the 28-day use-by period. Although residents were at persistent and widespread risk of receiving medications with less efficacy and strength, 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, facility staff administered expired NovoLog (insulin injection) multiple times to four residents.
- An observation of a medication cart revealed one resident's NovoLog insulin pen was five days past its expiration date. That resident received nine injections after the expiration date.
- Another observation of a medication cart found a Novolog insulin pen eight days past the use-by date. Staff administered the insulin pen on that resident for a full week post-expiration.
- While observing medication administration of a third resident, surveyor witnessed that the RN did not check the expiration date on the medication. They were stopped prior to entering the resident's room and asked to check the expiration date. The RN then acknowledged that the medication had expired. Subsequent review of the resident's medical record revealed that expired insulin had been administered to that resident for a week.
- Review of medical records for a fourth resident, whose assessment indicated that they were "rarely or never understood" by nursing staff, indicated that they had received expired medicine twice a day for at least five days.
- In interviews, nursing staff acknowledged the expired insulin pens, and removed or disposed of the pens.
- Another interview revealed that staff should use a "back-up-box" of insulin if unexpired insulin is not available.
- **Know Your Rights:** Nursing homes are required to have sufficient nursing staff, with the appropriate competencies, to assure resident safety and maintain residents' highest practicable physical, mental, and psychosocial well-being. They are also required to ensure

Every resident has the right to receive the care and services they need to maintain their highest possible level of functioning and well-being.

that every individual resident is free of any significant medication error and that the facility's overall medication error rate is less than five percent. To learn more, check out [LTCCC's fact sheet on standards for nursing home services](#).

Windsor Chico Creek Care and Rehab Center (California)

'I am afraid': Understaffing at two-star nursing home leaves residents helpless.

The surveyor determined that the nursing home failed to protect residents from all types of neglect. According to the citation, staff failed to assist residents with basic hygiene, turning or repositioning, timely medication administration, and fall prevention. Though this deficient practice jeopardized residents' quality of life and quality of care, the surveyor cited the violation as no harm.³ The citation was based, in part, on the following findings from the [SoD](#):

Nursing homes residents are at a greater risk for falls when staff are not available to assess their risk, monitor, or provide assistance.

- An interview with a staff member revealed that a resident experienced an unwitnessed fall from her bed and staff found her dead on the floor. The staff member stated, "they are always short-staffed."
- According to the citation, residents often waited up to an hour for staff to respond to their call lights, causing feelings of anger and neglect for residents.
- Resident interviews revealed concerns about understaffing and fear about the staff's response in an emergency evacuation, with one resident stating, "I am afraid."
- Due to understaffing, residents stated staff may only help them out of bed once a day or not at all if the resident requires a two-person assist. Staff frequently canceled showers, and some residents stated they would go weeks without a shower.
- In an interview with a surveyor, the CNA stated that on a given night they were each overseeing 25 residents. This lack of sufficient staff led to infrequent checks, late medication administration, less assistance with showers, delayed response to call lights and delivering water, and delayed repositioning.
- **Note:** [Nursing home residents are at a greater risk for falls when staff are not available to assess their risk, monitor, or provide assistance](#). Common but preventable complications include back injuries, head injuries, bone fractures, severe cuts, bed sores, stress, and anxiety. Residents are also more prone to worsening pressure ulcers and infection when they are not turned and repositioned often or not given adequate nutrition. Both falls and infected ulcers may lead to hospitalization.
- **Know Your Rights:** Every resident has the right to receive the care and services they need to reach and maintain their highest possible level of functioning and well-being, including bathing, dressing, and grooming in accordance with the resident's preferences and customs. As noted in the previously discussed "no harm deficiency," nursing homes are required to have sufficient staffing to meet the care and quality of life needs of every resident. To learn more about standards of care, check out [LTCCC's fact sheet on fundamental requirements, resident care, and sufficient staffing levels](#).

Virginia Beach Healthcare and Rehab Center (Virginia)

Skin breakdown: Two-star nursing home fails to provide daily wound care.

The surveyor determined that the nursing home's staff did not provide proper wound care to prevent a resident from developing new skin injuries. According to the citation, a resident went without skin treatments, repeatedly, over the course of two months. Despite the facility's failure to treat the resident's skin in accordance with the care plan, 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 physician order, staff were to apply medication to the resident's buttocks and rear thighs every day and evening shift, and to cover the area with a pad.
- A review of a resident's medical records over a two-month time period revealed that at least 30 skin treatments were skipped.
- In an interview, the resident stated that staff did not provide treatments to his backside twice a day as ordered.
- Skin treatments were necessary to prevent further skin breakdown and pressure ulcers.
- **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.

Central Park Rehabilitation and Nursing Center (New York)

A sticky situation: Brown and red substances cover the floors of four-star nursing home.

The surveyor determined that the nursing home failed to maintain a clean, safe, and homelike environment in each of its four units. Although residents were made to live in unclean conditions throughout the nursing home, the surveyor cited the violation as no harm.⁵ The citation was based, in part, on the following findings from the [SoD](#):

- According to the citation, the surveyor observed unclean floors, surfaces, privacy curtains, wheelchairs, and linens.
- Residents stated during a resident council meeting that their surrounding environments and rooms were unkept as well as their mobility equipment [wheelchairs], and they were not aware of a cleaning schedule.

Facilities are required to provide residents with a safe, clean, comfortable home-like environment, which includes maintaining a sanitary, orderly, and comfortable interior.

- The surveyor documented brown layered substances on a resident's floor, red circular stains on the floor in a dining area, pink and brown stains on floors and walls, and yellow and brown stains in residents' bathrooms.
- One resident's room had garbage on the floor for several days, according to the resident's family members. Another resident's room had spilled liquids on the floor.
- In an interview, the Administrator indicated that the facility was in the process of replacing the flooring as needed.
- When interviewed about the stains in residents' rooms, the housekeeping director stated, "that was how it always looked."
- **Know Your Rights:** Facilities are required to provide residents with a safe, clean, comfortable home-like environment, which includes maintaining a sanitary, orderly, and comfortable interior. For more information on the requirements for a safe and clean living environment, watch [LTCCC's webinar on nursing home resident rights](#).

Amie Holt Care Center (Wyoming)

42 days, no bath: Five-star nursing home fails to bathe residents.

The surveyor determined that the nursing home failed to promote and facilitate resident self-determination through supporting each resident's choice and preference for bathing. Though residents went without a bath for weeks – in one case, 42 days – the surveyor cited the violation as no harm.⁶ The citation was based, in part, on the following findings from the [SoD](#):

- In an interview, a resident stated that they receive only one shower or bath per week, and that they would prefer to bathe more often. Further, the resident stated that they have to wait until other residents were asleep for additional bathing requests.
- The resident's bathing records showed the resident went 42 days without documentation of bathing or resident refusal for bathing.
- A second resident also stated they receive only one shower or bath per week and prefer to bathe more often. That resident went 16 days without bathing, according to the resident's records.
- A third resident stated that they prefer to shower or bathe at least twice a week, but the resident's records showed only one per week over a three-month period.
- **Note:** It is the facility's responsibility to create and sustain an environment that humanizes and individualizes each resident's quality of life by ensuring that the care and services provided are person-centered, and honor and support each resident's preferences and choices. Facilities must treat each resident with respect and dignity. This includes bathing and grooming residents as they wish to be groomed.
- **Know Your Rights:** Nursing homes are required to assess of each resident's capacity, needs, and preferences. The assessment must include a wide range of resident needs and abilities, including customary routine, cognitive patterns, mood, ability and methods of communication,

Nursing homes must make assessments of residents' capacity, needs, and preferences to ensure residents receive appropriate care.

physical, dental, and nutritional status. To learn more, check out [LTCCC's fact sheet on resident assessment and care planning](#).

- **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 NursingHome411 staffing page](#) to learn more about nursing home staffing and to see staffing information for all licensed facilities in the U.S.

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 Statement of Deficiencies for Embassy Manor at Edison Nursing and Rehabilitation (February 26, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Embassy-Manor-at-Edison-Nursing-and-Rehabilitation.pdf>.

² Statement of Deficiencies for Sandpiper Post Acute (September 1, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Sandpiper-Post-Acute.pdf>.

³ Statement of Deficiencies for Windsor Chico Creek Care and Rehab Center (February 13, 2020). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Windsor-Chico-Creek-Care-and-Rehab-Center.pdf>.

⁴ Statement of Deficiencies for Virginia Beach Healthcare and Rehab Center (December 30, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Virginia-Beach-Healthcare-and-Rehab-Center.pdf>.

⁵ Statement of Deficiencies for Central Park Rehabilitation and Nursing Center (February 17, 2022). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Central-Park-Rehabilitation-and-Nursing-Center.pdf>.

⁶ Statement of Deficiencies for Amie Holt Care Center (February 3, 2022). Available at <https://nursinghome411.org/wp-content/uploads/2022/07/Amie-Holt-Care-Center.pdf>.