

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 4, Issue 5

IN THIS ISSUE:

Lincoln Crawford Care Center (Ohio)	3
Empty-hearted: One-star nursing home overlooks resident’s cardiac condition.	
Accura Healthcare of Knoxville, LLC (Iowa)	3
‘Ouch, you’re hurting me’: Resident bruised after unsafe transfer at one-star nursing home.	
Good Samaritan Society – Larimore (North Dakota)	4
‘I can’t stand it anymore’: Understaffed one-star nursing home leaves residents unbathed.	
Aaron Manor Rehabilitation and Nursing Center (New York)	5
Out of breath: Four-star nursing home fails to provide safe respiratory care.	
Nspire Healthcare Plantation (Florida)	5
Risky business: Three-star nursing home fails to conduct quarterly fall assessments.	
Chestnut Hill Lodge Health and Rehab Ctr (Pennsylvania)	6
A resident out of motion: Two-star nursing home disregards care plans for maintaining mobility.	

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](#)

CMS and state survey agencies use the Scope and Severity Grid for rating the seriousness of nursing home deficiencies. For each deficiency identified, the surveyor is charged with indicating the level of harm to the resident(s) involved and the scope of the problem within the nursing home. The *Elder Justice* Newsletter covers “no harm” deficiencies cited from A-F on the grid. The following chart is from the [CMS Nursing Home Data Compendium 2015 Edition](#).

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is Not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

Lincoln Crawford Care Center (Ohio)

Empty-hearted: One-star nursing home overlooks resident's cardiac condition.

The surveyor determined that staff failed to provide appropriate treatment for a resident's heart condition. According to the citation, facility staff neglected to arrange for a resident to see a cardiologist, as ordered by a physician. Though the facility's failure to follow physician orders landed the resident in the hospital, 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, a physician ordered the resident to see a cardiologist for uncontrolled hypertension (high blood pressure).
- Review of the resident's records showed an order dated 11/30/21 for testing due to the resident's low heart rate. On 12/06/21, the physician ordered for the resident to see a cardiologist in January 2022.
- On 01/21/22, the resident appeared lethargic, had a low heart rate, and elevated blood pressure. The resident was not scheduled for a cardiology appointment as of that date, according to nursing progress notes.
- The nurse sent the resident to the hospital via emergency transport for evaluation.
- **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. To learn more, check out [LTCCC's fact sheet on standards for nursing home services](#).

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.

Accura Healthcare of Knoxville, LLC (Iowa)

'Ouch, you're hurting me': Resident bruised after unsafe transfer at one-star nursing home.

The surveyor determined that the nursing home failed to remove accident hazards and provide adequate supervision to prevent accidents. Although this deficient practice left a resident bruised, the surveyor cited the violation as no harm.² The citation was based, in part, on the following findings from the [SoD](#):

- The resident required assistance for transfers, according to the citation.
- In an interview, the resident stated that he fell while transferring himself to his wheelchair, but he was not hurt.
- The facility's policy stated that at no time would caregivers lift residents and further stated that caregivers should not use a gait belt to lift residents from the floor after a fall.

Nursing homes must ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision to prevent accidents.

- Staff interviews revealed CNA 1 found the resident on the floor following his fall and requested help from CNA 2. When they could not lift the resident themselves, CNA 1 retrieved a Hoyer lift (a type of mechanical lift) and brought in CNA 3 for assistance.
- CNA 3 disregarded facility policy and used her gait belt to lift the resident onto the bed herself.
- CNA 1 reported this inappropriate lift as it left the resident with bruising and a cut.
- Another staff interview revealed that during the gait lift, the resident stated “Ouch, you’re hurting me,” to which CNA 3 responded “No, I’m not hurting you.”
- **Know Your Rights:** Nursing homes are required to provide care to residents in a manner that helps promote quality of life. Facilities must ensure that the resident environment remains as free of accident hazards as is possible, and that each resident receives adequate supervision and assistance devices to prevent accidents. To learn more, [watch LTCCC’s September webinar on fall prevention](#).

Good Samaritan Society – Larimore (North Dakota)

‘I can’t stand it anymore’: Understaffed one-star nursing home leaves residents unbathed.

The surveyor determined that the nursing home failed to provide enough staff every day to meet resident needs and have a licensed nurse in charge on each shift. According to the citation, staff failed to assist 12 residents with bathing. Though this deficient practice adversely impacted residents’ dignity, 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](#):

- According to record review and interviews, the nursing home did not have enough staff to provide the residents with appropriate care.
- Records revealed staff failed to bathe one resident on nine of 12 scheduled days.
- In an interview, another resident stated that they had gone a month without a bath, and that the bath aide works on the floor when the facility is short-staffed.
- In another interview, a resident stated, “There isn’t enough staff. I’ve been trying to get my hair washed for two weeks. They say they are ‘always going to do it’ but don’t, they are using dry shampoo, but I can’t stand it anymore. I was okay with a bed bath, but I really want my hair washed.”
- **Note:** The federal data show that average nursing home staffing (3.62 Total Nurse Staff Hours Per Resident Day) is far below the levels needed to meet basic care needs for residents. Further, staffing levels are, too often, significantly lower on weekends. On Care Compare, the Good Samaritan Society in Larimore has a three-star rating for staffing.
 - See [LTCCC’s staffing report for Q1 2022](#) for user-friendly staffing data for nursing homes in every state.
- **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

“There isn’t enough staff. I’ve been trying to get my hair washed for two weeks. They say they are ‘always going to do it’ but don’t.”

bathing, dressing, and grooming in accordance with the resident's preferences and customs. To learn more about standards of care, check out [LTCCC's fact sheet on fundamental requirements, resident care, and sufficient staffing levels](#).

Aaron Manor Rehabilitation and Nursing Center (New York)

Out of breath: Four-star nursing home fails to provide safe respiratory care.

The surveyor determined that the nursing home failed to provide safe and necessary respiratory care for a resident. Specifically, staff did not consistently monitor the resident's oxygen flow or saturation levels. Despite the facility's failure to provide care in accordance with the resident's care plan, the surveyor cited the violation as no harm.⁴ The citation was based, in part, on the following findings from the [SoD](#):

- A physician ordered staff to supply the resident with constant oxygen for shortness of breath, according to the citation. Staff were directed to check oxygen saturation levels once daily for COVID-19 screening and report levels at 91% or lower.
- Though staff were to monitor and document the resident's oxygen cannula on every shift, a review of the medical records revealed missing documentation on nearly half of the opportunities from March 1-May 10, 2021.
- Staff further failed to document any oxygen saturation for over three months.
- The resident's medical record noted the resident increasingly reported shortness of breath.
- **Know Your Rights:** Specialized rehabilitative services, which includes respiratory therapy, must be provided by qualified personnel. They are "specialized" in that they are provided based on each resident's individualized assessed rehabilitation needs, as included in their comprehensive care plan. Learn more from [LTCCC's fact sheet on pressure ulcers](#).

Nursing homes are required to provide specialized rehabilitative services, including respiratory therapy, and these services must be delivered by qualified personnel.

Nspire Healthcare Plantation (Florida)

Risky business: Three-star nursing home fails to conduct quarterly fall assessments.

The surveyor determined that the nursing home failed to provide adequate supervision to prevent accidents. Despite the nursing home's failure to conduct risk assessments for a fall-prone resident, 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 facility was to monitor a resident with a high fall risk and follow the facility's fall protocol.
- Although the fall protocol states that residents should have quarterly risk assessments, the facility neglected to evaluate this resident for nearly two years.

- According to records, it was only after the resident fell when attempting to get out of bed that the facility conducted an evaluation.
- When asked how she fell, the resident stated that her doctor increased her pain medication which caused her to feel dizzy and she fell over while trying to get out of bed.
- **Know Your Rights:** Each year, more than half of nursing home residents experience a fall while one in three residents will experience multiple falls. These incidents can lead to serious harm including functional decline, injury, reduced quality of life, and death. For more information, check out LTCCC's [fact sheet on fall prevention and mobility](#).

Chestnut Hill Lodge Health and Rehab Ctr (Pennsylvania)

A resident out of motion...: Two-star nursing home disregards care plans for maintaining mobility.

The surveyor determined that the nursing home failed to provide restorative nursing services to maintain range of motion for residents. Although the facility ignored the physical therapist and physician care plans leading to the failure to maintain residents' range of motion, the surveyor cited the violation as no harm.⁶ The citation was based, in part, on the following findings from the [SoD](#):

- Based on the citation, one resident required two-person assistance when changing positions from seated to standing and moving from the bed to a chair or a wheelchair. The resident had one-sided functional limitations on the upper and lower extremities.
- According to the physical therapist's (PT) care plan, the resident required restorative therapy to maintain joint integrity. The PT further recommended active range of motion exercises of upper and lower extremities and bed mobility rolling.
- As reported in interviews, staff failed to implement the restorative therapy services for the resident for four months.
- A second resident required one-person assistance while walking and transferring from the bed to a chair or a wheelchair. The physician ordered restorative therapy for this resident five to seven times per week.
- Based on the citation and interviews with staff, the facility failed to provide restorative therapy services for three months.
- In an interview, the resident told the surveyor that they were not routinely ambulating or exercising independently or with staff supervision and assistances.
- **Know Your Rights:** Nursing homes must ensure that residents who enter facilities without limited range of motion do not experience a reduction in range of motion unless the resident's clinical condition demonstrates that a reduction is unavoidable. A resident with limited range of motion must receive appropriate treatment and services to increase range of motion and/or to prevent further decrease. To learn more, check out [LTCCC's fact sheet on resident assessment and care planning](#).

Residents with limited range of motion must receive appropriate treatment and services to increase range of motion and/or to prevent further decrease.

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](#).



Elder Justice Volume 4, Issue 5

© 2022 Center for Medicare Advocacy & Long Term Care Community Coalition.

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 Lincoln Crawford Care Center (February 17, 2022). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Lincoln-Crawford-Care-Center.pdf>.

² Statement of Deficiencies for Accura Healthcare of Knoxville, LLC (July 1, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Accura-Healthcare-of-Knoxville-LLC.pdf>.

³ Statement of Deficiencies for Good Samaritan Society – Larimore (October 21, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Good-Samaritan-Society-Larimore.pdf>.

⁴ Statement of Deficiencies for Aaron Manor Rehabilitation and Nursing Center (May 11, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Aaron-Manor-Rehabilitation-and-Nursing-Center.pdf>.

⁵ Nspire Healthcare Plantation (February 16, 2022). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Nspire-Healthcare-Plantation.pdf>.

⁶ Statement of Deficiencies for Chestnut Hill Lodge Health and Rehab Ctr (April 30, 2021). Available at <https://nursinghome411.org/wp-content/uploads/2022/08/Chestnut-Hill-Lodge-Health-and-Rehab-Ctr.pdf>.