ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition — Volume 6, Issue 2

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This issue of the Elder Justice Newsletter focuses on the injustices occurring in facilities that have received a one-star rating from the Centers for Medicare & Medicaid Services.

Nursing homes with these lowest possible one-star ratings often fail to meet basic care standards, putting residents at risk. These facilities struggle with issues like chronic understaffing, poor management, medication errors, and unsafe conditions, leading to neglect, inadequate medical care, and even abuse.

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 Nursing Home Oversight***

All licensed nursing homes are rated on a scale of one to five, with one being the lowest possible rating and five being the highest. While studies have shown that having a high rating does not necessarily mean that a nursing home is safe, substandard care in lower rated facilities has become a matter of increasing public concern. Star ratings included in this newsletter are current as of the date of the newsletter's drafting.

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 D-F on the grid. This 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

Laconia Nursing Home (New York)

Increased risk: One-star nursing home physically restrains residents.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home failed to ensure residents remained free from physical restraints (F604). Although the deficient practice violated the residents' right to be free from physical restraints, the violation was cited as no- harm.[1] The citation was based, in part, on the following findings from the SoD:

- One resident had a lap tray in place while seated in a recliner without proper assessment or medical justification. The resident was unable to release the tray independently, and there was no comprehensive care plan or ongoing monitoring documented.
- Three other residents had bilateral upper half siderails raised while in bed, but no assessment or justification for their use was documented. All three residents had cognitive impairments and were unable to lower the siderails independently.
    - **Note:** The use of bed rails is associated with an increased risk of preventable harm and death for nursing home residents. Residents' attempts to leave their bed by going around or through the bed rail can lead to falls or entrapment, which occurs when a resident becomes caught in the bed rail or between the mattress and the bed rail. To learn more, see LTCCC's fact sheet on bed rail standards.

The use of bed rails is associated with an increased risk of preventable harm and death for nursing home residents.

- During interviews, nursing staff reported that the siderails were used for turning and positioning, but no assessments or care plans were in place to support their use as enablers rather than restraints.
- The facility's policy on physical restraints requires comprehensive assessments, family discussions, and individualized care plans for any restraint use. Despite these requirements, assessments and care plans were missing for all four residents in question.
- **Know Your Rights:** According to CMS's interpretive guidance, a physical restraint is any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: 1) is attached or adjacent to the resident's body; 2) cannot be removed easily by the resident; and 3) restricts the resident's freedom of movement or normal access to their body. To learn more, check out LTCCC's fact sheet on physical restraints.

Aliya On 87th (Illinois)

Insufficient CNA staffing on weekends: Resident care delayed.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to ensure sufficient certified nursing assistant (CNA) staff on weekends to meet the care needs of its residents (F725). This staffing shortage led to delays in personal care and medication administration, particularly on weekend shifts, but the violation was cited by the surveyor as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- A resident reported experiencing prolonged wait times for assistance with personal care needs, including using the toilet, as well as delays in receiving necessary medications.
- These delays were especially common on weekends, when CNA shortages were most prevalent, impacting the level of care provided.
- During interviews, residents and staff, including CNAs, confirmed concerns about staffing shortages. Staff noted that while their workload was typically manageable, the absence of even one CNA during a shift would cause significant disruptions in care delivery.
- In discussions with the surveyor, the director of nursing and the facility administrator acknowledged ongoing efforts to improve staffing levels but confirmed that they were still actively recruiting for CNA positions.
- **Note:** The most recent staffing data indicate that this nursing home provides 2.90 hours per resident per day (HRPD) of total nurse staff time, including 0.36 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.1 Total Nurse Staff HPRD, including 0.75 RN HPRD). This nursing home received a one-star overall rating and a one-star staffing rating from CMS.
- **Know Your Rights:** Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Every facility must have sufficient and competent nursing staff to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. To see the latest staffing levels in your nursing home, check out LTCCC's nursing home staffing data.

Golden Modesto Care Center (California)

Double dose: One-star nursing home provides incorrect pain medication dosage.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home did not administer pain medications according to physician orders (F697). Despite the incorrect medication dose leading to unnecessary sedation and confusion with potential for long-term harm, the surveyor classified the violation as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- According to the surveyor, the facility failed to provide pain management that met professional standards of practice.
- A record review revealed the resident had two orders for pain management, morphine and methadone, and specific doses for each.
- During an interview, the director of nursing revealed that a resident had been given double the prescribed dose of morphine, which went against the physician's orders. This error put the resident at risk of serious adverse effects, including severe sedation and potentially life-threatening breathing complications.
- According to professional references from the National Library of Medicine (MedlinePlus), both morphine and methadone carry significant risks, especially in older adults or those with respiratory conditions like COPD. These medications can be habit-forming and may cause life-threatening breathing problems if misused.
- **Know Your Rights:** Every resident has the right to receive medication safely and in accordance with professional standards. Medication errors in nursing homes can have serious or even fatal consequences. That is why regulations exist to ensure medication administration follows prescribed orders, manufacturer instructions, and professional care standards. To learn more, see LTCCC's fact sheet on medication errors in nursing homes.

Oasis at Pearland (Texas)

Missing the mark: The importance of informed consent in antipsychotic drug use.

Facility overall rating: ★☆☆☆☆

The surveyor found that the facility failed to obtain informed consent before administering an antipsychotic medication to a resident. This violates residents' right to be informed and make decisions regarding their treatment, resulting in a citation (F552). Although the facility violated the resident's right, the surveyor classified this violation as no-harm.[4] The citation was based, in part, on the following findings from the SoD:

- The surveyor documented that this facility failed to obtain informed consent for administering the antipsychotic medication, Olanzapine, to a resident with dementia and a mood disorder.
- Despite receiving the medication daily for seven days, there was no signed consent by the resident or appropriate diagnosis on file, which is required under informed consent policies.

- Interviews with staff confirmed that the failure to obtain consent placed the resident at risk of receiving treatment without proper authorization or understanding.
- The facility's director of nursing and psychiatric provider both acknowledged the oversight, and the risks posed to residents when receiving antipsychotic medications without proper diagnosis and consent.
- The facility's policy on administering psychotropic medications was outdated and did not include a protocol for informed consent, further exacerbating the issue.
- **Know Your Rights:** Every resident has the right to informed consent when it comes to their care and treatment. This means that they or their representative must be fully informed of their health status and any risks or benefits of the proposed treatment, as well as alternative treatments, before it is provided. Informed consent is critical in respect to dementia care and the use of antipsychotic medications, due to the fact that these medications are dangerous and generally not clinically appropriate for people with dementia. To learn more, see LTCCC's fact sheet on informed consent.

Stone Bridge Center for Health & Rehabilitation (Connecticut)

Freedom from abuse: A right ignored by nursing homes.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the nursing home failed to protect a resident's freedom from abuse and neglect (F600). Although there was a confirmed incident of abuse and a failure to report it within the required timeframe, the surveyor still classified this violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- According to the citation, the facility failed to prevent staff-to-resident physical abuse for a resident who was diagnosed with dementia and other conditions.
- A nurse's note stated the resident was screaming in pain and holding their chest while eating dinner in the dining room. The resident was brought to their room and upon assessment, was found to have a bruise and pain in the right upper quadrant, without a known cause.
- The resident was sent to the emergency department, but no acute injury was found. A nurse aide (NA) reported witnessing a licensed practical nurse (LPN) on top of the resident on 10/31/23, but the NA did not initially report the incident.
- The director of nursing was informed on 11/2/23, after which the LPN was placed on administrative leave. Interviews with the resident indicated that the resident identified the LPN as the perpetrator.
- **Know Your Rights:** Nursing home residents have the right to be free from abuse, neglect, misappropriation of resident property, and exploitation. Furthermore, there are both state and federal requirements for reporting abuse or neglect. Nevertheless, far too much resident abuse goes unreported. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Healthsource Saginaw, Inc (Michigan)

Neglected: Resident waits over a month for CT scan.

Facility overall rating: ★☆☆☆☆

The surveyor found that the facility failed to provide treatment and care according to orders. This oversight ultimately led to the resident being transferred without the required treatment, compromising continuity of care and resulting in a citation (F684). Despite this, the violation was cited as no-harm.[6] The citation was based, in part, on the following findings from the Statement of Deficiencies (SoD):

- According to the surveyor, a neurosurgeon requested a CT scan for a resident on 6/26/2023. The facility did not schedule the imaging appointment before the resident's discharge on 7/27/2023, resulting in a delay of care for over a month.
- The nurse manager reported difficulties with the scheduling process, stating issues with insurance preauthorization initially delayed the appointment.
- Staff confirmed that no preauthorization was required for the CT scan, yet the scan was still not scheduled before the resident's transfer on 7/27/2023.
- The discharge summary did not mention the need for a CT scan, despite the original physician order and its importance in managing the resident's health status.
- Staff interviews and document reviews confirmed procedural gaps, as the resident's transition to a new facility was finalized without addressing or communicating the required follow-up imaging.
- **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. This includes timely medical care, such as necessary tests and scans, as well as personal support like bathing, dressing, grooming, and oral hygiene, in accordance with the resident's preferences and customs. To learn more, see LTCCC's fact sheet on resident care and well-being.

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to report resident harm or neglect. 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 as of the date of the newsletter's drafting.

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[1] Statement of Deficiencies for Laconia Nursing Home (January 23, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Laconia-Nursing-Home-F604.pdf.
[2] Statement of Deficiencies for Aliya on 87th (March 10, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Aliya-on-87th-F725.pdf.
[3] Statement of Deficiencies for Golden Modesto Care Center (January 24, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Golden-Modesto-Care-Center-F697.pdf.
[4] Statement of Deficiencies for Oasis at Pearland (April 28, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Oasis-at-Pearland-F552.pdf.
[5] Statement of Deficiencies for Stone Bridge Center for Health Rehabilitation (November 6, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Stone-Bridge-Center-for-Health-Rehabilitation-F600.pdf.
[6] Statement of Deficiencies for Healthsource Saginaw Inc (August 15, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/11/Healthsource-Saginaw-Inc-F684.pdf.