ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 7, Issue 1

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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***

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 up to the date of 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

This issue of the *Elder Justice Newsletter* highlights the expectations and failures associated with facilities that have received a five-star rating from the Centers for Medicare & Medicaid Services.

Nursing homes with five-star ratings are held up as models of high-quality care. However, even in these top-rated facilities, issues such as neglect, abuse, and inadequate care occur. Behind the stellar ratings, some facilities still struggle with issues that put residents at risk. This issue is a reminder that a higher CMS rating does not guarantee a safe environment, and ongoing vigilance and advocacy are essential to ensure residents receive the safe, respectful care they deserve.

Greenville Nursing and Rehabilitation (Kentucky)

Neglected smiles: Five-star facility fails to ensure timely dental care.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to ensure timely dental care for a resident, resulting in unmet oral health needs (F791). Although the deficient practice resulted in the resident feeling self-conscious about their teeth and appearance, the violation was cited as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- The surveyor noted that a resident was admitted to the facility with a care plan identifying decayed and missing teeth. The care plan directed staff to arrange necessary dental care and monitor the resident for any additional oral health concerns.
- According to the citation, the facility failed to schedule any dental appointments for the resident. Additionally, social services records showed no documentation of any dental referrals over several months.
- During an interview, the resident expressed a desire for top dentures as they had no teeth on top and severely decayed bottom teeth.
- Interviews with various staff members revealed awareness of the resident's dental concerns but records showed a lack of action. Although the resident had signed a consent form for dental services upon admission, they were not placed on the dentist’s list.
- A family member of the resident stated that the resident had not seen a dentist since admission to the facility, despite health concerns and concerns about their appearance due to missing teeth.
- Interviews with the director of nursing services and executive director confirmed that residents should receive a dental assessment upon admission and, if they signed a consent form, they should be referred for routine dental care every three months. Both confirmed that the resident should have had at least one routine dental visit since admission and that staff were expected to follow proper referral and care procedures.
- **Know Your Rights:** When left unaddressed for too long, dental problems can become serious issues. Nursing homes must assist residents in obtaining routine and 24-hour

emergency dental care. Federal guidance defines "emergency dental services" to include "broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist." To learn more, check out LTCCC's fact sheet on dental services.

Riverside Behavioral Healthcare Center (California)

Unresolved altercation: Resident injured in physical abuse.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to protect residents from all types of abuse such as physical, mental, sexual abuse, and physical punishment (F600). Specifically, the facility failed to protect a resident from physical abuse during a reported altercation with a program counselor. Although the altercation resulted in injuries to the resident's face, the incident was cited as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- According to the citation, an altercation occurred during which a resident and a program coordinator engaged in physical contact.
- Multiple staff members, including a CNA and an RN, observed and intervened during the incident. The altercation involved both parties swinging their arms and hitting each other.
- During interviews, staff confirmed that the program counselor failed to de-escalate the situation and instead attempted to retaliate against the resident.
- The resident sustained visible injuries, including scratches on the face and forehead redness, as well as reported dizziness after the altercation.
- The facility's "Professional Assault Crisis Training" (Pro-Act) mandates de-escalation techniques to manage challenging resident behaviors. The director of nursing confirmed that the program coordinator did not follow this protocol.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including physical and emotional abuse. Physical abuse may involve intentional acts such as hitting, pushing, or other physical aggression towards a resident, as well as the use of unnecessary force during care. Both state and federal laws mandate that any suspected or confirmed abuse must be reported immediately to the appropriate authorities. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Moravian Hall Square Health and Wellness Center (Pennsylvania)

Inconsistent care: Pressure ulcer risk increased.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to ensure appropriate pressure ulcer prevention and care for a resident (F686). Despite the resident having a pressure ulcer and discrepancies in the documentation and reporting, the violation was classified as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- A resident was diagnosed with generalized muscle weakness, arthritis of the right knee, and a pressure ulcer on the left heel.
- The care plan noted the resident's risk for skin breakdown due to immobility and required the use of boots with a cushioned bottom to prevent pressure on both feet.
- The surveyor observed the resident on two different occasions seated in a wheelchair with only a pressure-relieving boot on the left foot, while the right foot had only a sock and was in contact with the wheelchair footrest. A second pressure-relieving boot was later located in the resident's closet.
- During an interview, the resident stated that staff did not consistently apply the right boot despite availability and denied refusing its use.
- A nurse aide incorrectly reported that the resident had an order for a boot on the left foot only and claimed the resident owned only one boot. This contradicted observations of the second boot in the resident's closet.
- The failure to consistently apply prescribed pressure-relieving devices placed the resident at increased risk of further skin breakdown.
- **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.

Courage Kenny Rehabilitation Institutes Trp (Minnesota)

Verbal abuse ignored: Nursing home failed to report incident on time.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to protect residents from abuse (F609). Although an allegation of verbal abuse was made, the facility failed to report it to the state agency within the required two-hour timeframe. Still, the surveyor classified the citation as no-harm.[4] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a nursing assistant allegedly verbally abused a resident by referring to the resident as a "piece of shit."
- The facility initiated an investigation into the incident and removed the nursing assistant from the schedule while the investigation was underway. However, the facility failed to report the allegation to the state agency within the required timeframe, waiting over 10 hours after the incident occurred.
- While the facility did report the incident, it failed to do so promptly. During the investigation, the nursing assistant denied the allegation, and the facility ultimately determined that the claim of abuse was unfounded.
- During an interview, the administrator acknowledged receiving the report via email but did not receive it immediately, as required by the facility's policy.

- The administrator stated that the abuse policy would be updated to ensure that staff are re-educated on the requirement to report allegations of abuse immediately
- **Know Your Rights:** Nursing home residents have the right to be free from abuse. Emotional abuse may include aggressive or hostile behavior/attitude towards a resident, staff speaking to residents with disrespect or contempt, and staff ignoring residents or leaving them socially isolated. 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.

Belleair Health Care Center (Florida)

Residents at risk: Failure to implement proper wound care protocols.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to provide proper treatment and care for two residents in accordance with physician orders and professional standards of care (F684). Despite the presence of skin injuries and outdated dressings on both residents, the surveyor cited the violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- One resident had a central catheter line inserted in his right upper arm. On May 1, the surveyor observed the dressing dated April 21. Facility staff failed to change the dressing weekly as required by a physician's orders.
- A skin tear was noted on the resident's left arm. The resident stated that the wound happened about a week and a half prior when a nurse attempted to lift the resident and improperly removed a skin dressing. This exposed a raw, wet area, and there was no documentation of the required dressing change.
- Additionally, the facility failed to follow physician orders for medication and dressing changes, did not maintain sterile dressing protocols, and missed required dressing changes.
- A second resident had a skin tear on the left elbow, but the facility did not document any dressing changes during the month of May. The surveyor found the dressing outdated, with a raw area underneath. Physician orders were in place for skin tear care but were not implemented according to the prescribed schedule.
- Additionally, through observation and interviews, it was noted that a nurse removed dressings from both residents with bare hands, increasing the risk of infection.
- In an interview, the director of nursing stated that dressings were removed improperly by staff members without gloves, indicating that the facility failed to maintain proper sterile dressing protocols as per established standards.
- **Know Your Rights:** Nursing home residents have the right to proper and timely care for wounds and medication lines. Failure to change the dressing every week and to wash hands before handling the line can lead to harm and infection. To learn more, see LTCCC's fact sheet on resident care and well-being.

New York Center For Rehabilitation & Nursing (New York)

Silent fall: Facility fails to report critical injury.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to report an injury of unknown source to the New York State Department of Health (NYSDOH) within the required two-hour timeframe (F609). Although the resident was found lying on the floor with a bump on their forehead and a fractured neck, the surveyor cited the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- A resident with a diagnosis of dementia and reduced mobility was admitted to the facility and later found on the floor with swelling on the forehead. The resident was diagnosed with a cervical spine fracture following the fall, which was unwitnessed, and the resident was unable to communicate how the fall occurred.
- Federal regulations require nursing homes to report any “injuries of unknown source” to the facility administrator and relevant state agencies. According to the citation, the facility failed to report the unwitnessed fall to NYSDOH within two hours of their awareness as required because of the injury sustained.
- Additionally, there was no documented evidence in the resident’s medical chart that the facility reported the injury.
- During interviews, both the director of nursing and assistant director of nursing acknowledged that this injury should have been reported.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including neglect and failure to report injuries. Any injury, especially one of unknown source, must be reported immediately to the facility administrator and relevant state agencies within 2 hours of the incident. The failure to report injuries not only violates state and federal regulations but also jeopardizes the safety and well-being of the resident. To learn more, see LTCCC’s fact sheet on requirements for nursing homes to protect residents.

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 Location (formerly known as 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.

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[1] Statement of Deficiencies for Greenville Nursing and Rehabilitation (June 20, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Greenville-Nursing-and-Rehabilitation-F791.pdf.

[2] Statement of Deficiencies for Riverside Behavioral Healthcare Center (July 11, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Riverside-Behavioral-Healthcare-Center-F600.pdf.

[3] Statement of Deficiencies for Moravian Hall Square Health and Wellness Center (April 20, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Moravian-Hall-Square-Health-and-Wellness-Center-F686.pdf.

[4] Statement of Deficiencies for Courage Kenny Rehabilitation Institutes Trp (January 11, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Courage-Kenny-Rehabilitation-Institutes-Trp-F609.pdf.

[5] Statement of Deficiencies for Belleair Health Care Center (May 1, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Belleair-Health-Care-Center-F684.pdf.

[6] Statement of Deficiencies for New York Center for Rehabilitation & Nursing (April 24, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/New-York-Center-for-Rehabilitation-Nursing-F609.pdf.