

Elder Justice

What “No Harm” Really Means for Residents

February 2018

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A Brief Introduction

Effective monitoring and oversight of nursing home care is critical to ensuring the safety and dignity of residents, as well as the integrity of the public programs which pay for a majority of nursing home care. Nevertheless, numerous studies over the years have indicated that, too often, the state agencies responsible for ensuring that nursing homes meet minimum standards of care fail to identify when residents experience substandard care, abuse or neglect. Furthermore, [CMS data](#) indicate that, even when state surveyors *do* identify a health violation, they only identify it as having caused any harm to a resident about four percent (4%) of the time.

The failure to identify resident harm has pernicious implications at many levels. Fundamentally, it means that resident suffering and degradation—even death—has gone unaccounted for and unheard. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes that violate a resident’s right to quality care and quality life rarely face financial penalties for “no harm” deficiencies. In our view, this leads to systemic under-enforcement.

The purpose of this newsletter is to provide the public with examples of these “no harm” deficiencies, taken from Statements of Deficiencies (SoDs) on [Nursing Home Compare](#). Surveyors classified all of them as “no harm,” meaning that they determined that residents were neither harmed nor put into immediate jeopardy for their health or well-being. We encourage our readers to read these residents’ stories and determine for themselves whether or not they agree with the no-harm” determination.

Washington Center for Comprehensive Rehabilitation, WA [Resident’s deep laceration described to the resident’s representative as a scratch](#)¹

The resident was admitted to the nursing home for care needs related to “debility [(physical weakness)] and protein malnutrition.” According to the resident assessment, the resident required the assistance of two staff members for most of the activities of daily living (ADLs). During a resident observation, it was discovered that the resident suffered from a skin laceration on the right abdomen that was “deeper than a skin tear or scratch.”

When surveyors interviewed the resident’s representative, the representative noted the facility’s failure to notify him/her about the extent of the resident’s injury. Apparently, a licensed practical nurse (LPN) told the representative that a certified

nursing assistant (CNA) discovered a scratch on the resident’s abdomen while providing care but did not provide a description of the injury, such as “length, depth, and the general appearance of the skin injury.”

The resident’s representative told state surveyors that, after returning from a Sunday church service, s/he requested to have a physical observation of the resident’s injury. The representative told surveyors that the injury was inconsistent with what the nursing home staff told him/her because there was a “deep skin laceration” and not a “scratch.”

During staff interviews, the LPN acknowledged that the resident’s injury was “not a minor scratch, but a deep laceration measuring 7cm.” The LPN told surveyors that s/he had not done a thorough skin assessment during the time s/he notified the resident’s representative.

The surveyors cited the nursing home for the deficiency. In fact, the surveyors noted that the nursing home’s “failure did not uphold the resident’s right to be informed, and prevented the resident’s legal representative to be involved in the resident’s care and treatment in a timely manner.” Despite the resident’s injury being more serious than reported to the resident’s representative, surveyors cited the deficiency as “no harm” (D) instead of actual harm or immediate jeopardy.

Prescott Nursing and Rehabilitation Community, WI

[Staff’s disregard of a resident’s care plan led to a broken femur and missing documentation²](#)

On October 14th, nursing home staff transferred a resident without following the resident’s care plan, leading to an injury. The care plan instructed staff to use a Hoyer lift (a lifting device) and to have two staff members assist whenever the resident had to be transferred. The nursing home’s nurses’ notes contained no documentation of the incident until the

following shift. The nursing home self-reported that the resident had a fracture that was discovered on October 15th.

When surveyors reviewed the resident’s record, they found that a registered nurse (RN) was informed on the 15th that the resident was “experiencing pain in her right leg” and that she had a “baseball sized lump.” The RN informed the doctor of the injury, who then ordered x-rays. When the x-rays showed that the resident had suffered a broken femur, she was sent to the emergency room.

A certified nursing assistant’s (CNA) statement regarding the incident indicated that the CNA attempted to transfer the resident alone because the two “other aides were busy.” While in the process of transferring the resident, the resident “lunged forward and began to slide out of her chair.” The CNA stated that she called out for help and a licensed practical nurse (LPN) came in to assist with transferring the resident to her bed. The nursing home administrator’s statement provided a similar recounting of the incident. In both statements, the staff noted that the resident complained of pain after the incident.

During staff interviews, surveyors asked another RN to provide documentation regarding the incident on October 14th. The RN reported that no documentation could be found until the following day. The nursing home was also not able to provide surveyors with the falls incident report.

When the surveyors spoke to the LPN, she told surveyors that “she had never been a nurse for an incident like this so [she] did not know what to do.” The LPN also told surveyors that she did not document the incident in the electronic medical record. The director of nursing stated that she expected events to be documented in the medical record.

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The surveyors cited the nursing home for the deficiency. According to the surveyors, the “facility did not ensure that 1 of 4 records reviewed had accurate and complete documentation of resident conditions.” Although the staff’s failure to follow the resident’s care plan resulted in the resident suffering a broken femur and missing documentation, the surveyors determined the incident resulted in “no harm” (D).

Premier Genesee Center for Nursing and Rehabilitation, NY

[Staff member allegedly verbally abused a resident and records showed a failure to conduct a timely review of prospective employees³](#)

State surveyors interviewed a resident who told them that she “witnessed a male staff member yell at another resident in the hall and take away the doll the resident was holding.” She told surveyors that she reported what she saw but could not remember who she spoke to about the incident.

During staff interviews, the licensed practical nurse (LPN)/nurse manager told surveyors that a resident reported the incident to her but that she did not tell the administration. The LPN clarified that she “should have told someone else like the Assistant Director of Nursing or the Director of Nursing (DON).” The DON told surveyors that she expected any resident complaint to be reported to a supervisor.

In reviewing five employee files, surveyors further discovered that the New York State Nurse Aide Registry checks for these employees were not completed until October 25th—months after most of the employees were hired. The nursing home administrator told surveyors that the nursing home self-identified the missing checks and that “miscommunication was the reason for the missed Nurse Aide Registry checks.”

The surveyors cited the nursing home for the deficiency. Surveyors noted that the “facility did not complete an investigation to rule out abuse, neglect, or mistreatment.” Surveyors also noted that “for five of five employees files reviewed for abuse screening, the facility did not conduct an abuse review of prospective employees through the Nurse Aide Registry prior to employment.” Although a staff member seemingly abused a resident and the nursing home failed to complete abuse checks for five employees, surveyors found that the deficiency was “no harm” (E).

Crowell Memorial Home, NE

[Nursing home physically restrained a resident in a wheelchair without an assessment⁴](#)

During resident observations at 10:43 A.M., surveyors saw the resident in his room. The television was on and the resident’s wheelchair was “tilted back into a reclining position, bringing [his] knees up above [his] chest.” Surveyors observed the resident trying to lean forward but being “unable to lean forward due to the tilting position.”

At 1:09 P.M., the resident was observed sitting in the middle of the hall, in front of the nursing station. The resident’s knees again were higher than his chest. The resident had been given a “Busy Box” (items to play with), which sat on a tray table. The box was sitting at the same height as the resident’s knees and he was unable to lean forward to reach the items. At 3:43 P.M., the resident was seen again sleeping while in the tilted wheelchair.

While interviewing the nursing home staff, a nursing assistant (NA) told surveyors that the resident was “in the tilted wheelchair for his and others safety.” The NA said that the resident would slide forward when in a recliner. The NA told surveyors that the resident is unable to lean forward and fall. A licensed practical nurse (LPN) acknowledged that the resident was in a tilted wheelchair “to prevent falls.”

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A registered nurse (RN) confirmed that the nursing home did not conduct an assessment as to whether the tilt wheelchair constituted a restraint device. The RN further told surveyors that the “interdisciplinary team had not met to review or assess a least restrictive device” The RN also provided that the tilt wheelchair was not in the resident’s plan of care. Subsequently, the director of nursing (DON) admitted that the tilt wheelchair “does meet the restraint criteria, and was being used to keep [the] Resident . . . confined in the wheelchair.”

The surveyors cited the nursing home for the deficiency. The surveyors noted that the nursing home “failed to evaluate a reclining wheelchair as a potential restraint” Despite the resident’s being restrained for at least several hours during the time of the observation, the surveyors determined that this failure was “no harm” (D).

Closing Note

On February 14th, [Senate Democrats sent a letter](#) to HHS Secretary Alex Azar and CMS Administrator Seema Verma to express their concerns about CMS’s recent rollback of nursing home resident protections. The Senators argue that these rollbacks will “inevitably weaken the safety of our nation’s nursing homes and put patients . . . at greater risk.” The Senators further state that “when patients are harmed . . . there must be a wide range of strong enforcement actions available to ensure that these adverse events are not repeated . . . and most importantly, lives are not lost.”

Unfortunately, the Trump Administration is continuing its effort to weaken nursing home protections through deregulation and harmful sub-regulatory guidance. In the President’s fiscal year

2019 budget proposal, [the Administration proposes](#) to authorize the HHS Secretary to “adjust statutorily required survey frequencies for top-performing skilled nursing facilities and reinvest resources to strengthen oversight and quality improvement for poor performing facilities.” This policy would directly result in fewer inspections for most nursing homes and would allow violations of resident rights to go unnoticed and unpunished.

Nursing home residents deserve and are entitled to quality care and quality life. Under-enforcement of the nursing home standards not only means that the rights of many nursing home residents are not realized but also results in residents suffering in silence. The Trump Administration and CMS should listen to and act on the concerns that the Senators expressed in their February 14th letter.

Further Reading From LTCCC & The Center:

1. [Winter 2018 LTC Journal](#)
2. [LTCCC Media Alert March 2018: New Data on Nursing Home Staffing](#)
3. [Fact Sheet: The Foundations of Resident Rights](#)
4. [Medicare Skilled Nursing Coverage and *Jimmo v. Sebelius* Toolkit](#)
5. [Hospitalists Continue to Oppose Observation Status and Call for Significant Change](#)

Please share your thoughts with us on Twitter using [#HarmMatters](#). For more information on the nursing home standards of care, please see LTCCC’s [Issue Alerts](#).

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¹ Statement of Deficiencies for Washington Center for Comprehe, CMS (Nov. 27, 2017), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=505017&SURVEYDATE=11/27/2017&INSPTYPE=CMPL&profTab=1&state=WA&lat=0&lng=0&name=WASHINGTON%2520CENTER%2520FOR%2520COMPREHE&Distn=0.0>.

² Statement of Deficiencies for Prescott Nursing and Rehabilitation Community, CMS (Nov. 21, 2017), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=525398&SURVEYDATE=11/21/2017&INSPTYPE=CMPL&profTab=1&state=WI&lat=0&lng=0&name=PRESCOTT%2520NURSING%2520AND%2520REHAB%2520COMMUNITY&Distn=0.0>.

³ Statement of Deficiencies for Premier Genesee Center for Nursing and Rehabilitation, CMS (Nov. 17, 2017), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335423&SURVEYDATE=11/17/2017&INSPTYPE=STD&profTab=1&state=NY&lat=0&lng=0&name=PREMIER%2520GENESEEE%2520CENTER%2520FOR%2520NURSING%2520AND%2520REHAB&Distn=0.0>.

⁴ Statement of Deficiencies for Crowell Memorial Home, CMS (Nov. 22, 2017), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=285210&SURVEYDATE=11/22/2017&INSPTYPE=STD&profTab=1&state=NE&lat=0&lng=0&name=CROWELL%2520MEMORIAL%2520HOME&Distn=0.0>.

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