

Elder Justice

What “No Harm” Really Means for Residents

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Introduction: What is a “No Harm” Deficiency?

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 the deficiency as having caused any harm to a resident about four percent (4%) of the time.

The failure to identify resident harm when it has occurred has pernicious implications at many levels. Fundamentally, it signifies a lack of recognition of resident suffering, degradation and even, occasionally, death. Importantly, from a policy perspective, it means that there is likely no accountability because nursing homes rarely face financial or other penalties for “no harm” deficiencies. The absence of any penalty sends a message to nursing homes that such substandard care, abuse, and neglect will be tolerated.

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” determinations.**

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](#).

Mountainside Residential Care, NY

Five-star facility failed to secure a resident in her wheelchair, resulting in a hematoma, lack of oxygen, bodily pain, and bruising.

The resident was sitting in her wheelchair in the facility’s transport van.¹ When the van accelerated to go up a hill, the resident fell backwards and hit her head, resulting in a hematoma to the right side of her head. The facility’s nurse progress notes documented that the resident had ice applied to her injury and was given oxygen because her lips and finger tips took on a bluish color, indicating a lack of oxygen. After the resident returned from the hospital, the progress notes documented that the resident complained of right shoulder, torso, arms, hip, back, neck, and head pain. The notes also documented “a purple bruise to her chest . . . and [a] dark purple/yellow area . . . from the resident’s ear to her neck.”

The facility’s investigation summary showed that the wheelchair restraint belts that were to be used during vehicle transportations were not properly used as directed by the manufacturer’s instructions. When the surveyor interviewed the certified nurse assistant (CNA) who drove the van, he told the surveyor the he used the two rear wheelchair belts but not the two front belts. The CNA added that he “had not received education on proper wheelchair securement for transportation . . .” The director of nursing (DON) told the surveyor that there was “no documented evidence of wheelchair & occupant securement education for the transportation drivers.”

The surveyor cited the facility for “not ensur[ing] that the resident’s environment remained free from accident hazards. Specifically . . . the facility did not ensure that staff were trained on securing the four wheelchair restraint belts when transporting residents in the facility van.” Despite the resident’s injuries, the surveyor noted that the facility corrected the noncompliance before the survey and identified the deficiency as “no harm.”

Harrogate, NJ

Five-star facility fails “to ensure that an indwelling urinary catheter drainage bag was stored in a manner to prevent urinary tract infections.”

The surveyor first found a plastic bag in the resident’s bathroom with a used indwelling urinary catheter drainage bag, a urinal, and paper towels inside.² The surveyor noted that the tubing was not capped and was “in direct contact with the plastic bag.” When the surveyor was in the resident’s room a few days later, the surveyor observed the resident in bed with an indwelling urinary catheter in place. The surveyor noted that the tubing had “visible urine occupying the full length of the tubing . . .” On a follow-up visit, the surveyor again saw “clear, yellow urine occupying the indwelling catheter tubing . . . [and] was in direct contact with the safety floor mat . . .”

When the surveyor interviewed the certified nursing assistant (CNA), the CNA stated that the tubing at the end of the catheter drainage bad should be capped when stored and that “tubing should never be touching the floor in the resident’s room.” The licensed practical nurse (LPN) told the surveyor that, when the catheter drainage bag was not in use, “staff were required to clean it, place the catheter bag in a plastic bag and put a

cap at the end of the tubing.” The facility’s own policy and procedure warned staff that “[c]aution should be taken not to allow the end of the spout to touch anything that will contaminate it.”

The surveyor cited the facility for the deficiency, noting that the facility “failed to ensure that an indwelling urinary catheter drainage bag was stored in a manner to prevent urinary tract infections.” Despite this finding, the surveyor cited this failure as causing neither harm nor immediate jeopardy to the resident’s well-being.

Fitchburg Healthcare, MA

[Two-star facility fails to provide “appropriate care and services,” resulting in a resident developing a pressure ulcer.](#)

The resident’s record indicated that the resident had a moderate risk of developing pressure ulcers.³ Additional records also showed that the resident’s spine had a fragile area that was being cleaned with normal saline and being dressed with Allevyn (foam dressing). However, the resident’s initial care plan did not indicate “any additional interventions for the prevention of pressure ulcers.”

When the surveyor reviewed the nurse’s notes, the records showed that the resident developed an open wound on “the mid back.” The records noted that the pressure ulcer was being treated with the Allevyn dressing. The resident’s subsequent care plan provided that “the resident had a Stage II pressure ulcer on his/her spine related to immobility and a nutritional deficit.” The plan called for the resident to be turned and repositioned, in addition to other interventions. The surveyor later found that the additional interventions, like the use of an air mattress and pressure cushion for the resident’s chair, were not implemented until later.

A nurse told the surveyor that “no care plan to prevent pressure ulcers had been implemented prior to . . .” that later date. The facility’s dietician noted that she had not been aware of the resident’s pressure ulcer and that she “had not been informed as indicated in the facility policy for skin integrity.”

The surveyor ultimately cited the facility for the deficiency. The surveyor noted that the “facility staff failed to implement adequate interventions to prevent a pressure area from developing.” Also, stating that the facility “failed to provide appropriate care and services to prevent pressure ulcers from developing . . .” Although the resident’s skin was not properly cared for, resulting in a pressure ulcer, the surveyor only cited the deficiency as “no harm.”

Humboldt Nursing and Rehabilitation Center, TN

[Three-star facility fails to follow care plan’s instructions for minimizing potential infections for a resident who was at risk.](#)

The resident’s care plan showed that the resident was at risk of developing infections, had a history of infection, and had frequent urinary tract infections (UTIs).⁴ The plan called on staff to mitigate risks by “always wip[ing] front to back, assur[ing] perineal area is thoroughly clean after each BM (bowel movement).”

While the surveyor was observing the resident in her room, the surveyor watched as the certified nursing assistant (CNA) and a licensed practical nurse (LPN) cleaned the resident after she had a bowel movement. The LPN turned the resident to her side and the CNA began wiping back to front. The CNA also applied barrier

cream to the resident’s buttocks, “leaving a large amount of BM in the perineal area.” The CNA then put a clean incontinence brief on the resident.

The surveyor stopped the CNA and ask if the resident was properly cleaned. The CNA stated “Yes” but the surveyor asked the CNA to remove the brief, which showed “a large amount of stool in the perineal area.” The CNA acknowledged that the resident was not clean and began wiping the resident again from back to front. The LPN told the CNA to wipe from front to back.

The surveyor cited the facility for this deficiency, writing that the facility failed to follow care plan interventions for . . . [the resident] reviewed for urinary tract infections.” Although the CNA did not follow long-established protocols to minimize the risk of an infection, the surveyor cited the deficiency as resulting in neither harm nor immediate jeopardy to the resident’s well-being.

A Note on Elder Abuse

[World Elder Abuse Awareness Day](#) takes place every year on June 15th. While June 15th was chosen as the day for reflection, elder abuse affects older adults every single day. According to the [Administration for Community Living](#) (ACL), about five million—one in ten—older adults are abused, neglected, or exploited every year. Elder abuse can take many forms and may even be committed by those who are paid by publically-funded programs, such as Medicare and Medicaid, to ensure the health and safety of their patients. Sadly, as our newsletter may indicate, abuse in nursing homes may all too often be a reality for some residents.

Irrespective of the weaknesses in enforcement of minimum safety and care standards, all residents are entitled to advocate for themselves and to exercise their rights. Our organizations encourage readers to acknowledge World Elder Abuse Awareness Day this year by learning about the many residents’ rights and protections currently in place to ensure quality care and quality of life. To learn more, please visit LTCCC’s homepage: www.nursinghome411.com. To speak out in support of nursing home residents, please visit our [Action Center](#) and send a [free message](#) to your political leaders.

Further Reading from LTCCC & the Center:

1. [LTCCC’s Timeline on Antipsychotic Drugging in America’s Nursing Homes: 1987 - 2018](#)
2. [LTCCC’s Congressional Briefing Materials \(June 2018\)](#)
3. [LTCCC’s Issue Alert: Baseline Care Plan](#)
4. [Center’s Comments on Proposed Reimbursement for Skilled Nursing Facilities](#)
5. [Resident advocates publish issue briefs on the rollback of nursing home protections](#)

¹ Statement of Deficiencies for Mountainside Residential Care, CMS (Feb. 8, 2018), <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335339&SURVEYDATE=02/08/2018&INSPTYPE=CMPL&profTab=1&state=NY&lat=0&lng=0&name=MOUNTAINSIDE%2520RESIDENTIAL%2520CARE&Distn=0.0>.

² Statement of Deficiencies for Harrogate, CMS (Mar. 26, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=315262&SURVEYDATE=03/26/2018&INSPTYPE=STD&profTab=1&state=NJ&lat=0&lng=0&name=HARROGATE&Distn=0.0>.

³ Statement of Deficiencies for Fitchburg Healthcare, CMS (Feb. 21, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=225216&SURVEYDATE=02/21/2018&INSPTYPE=STD&profTab=1&state=MA&lat=0&lng=0&name=FITCHBURG%2520HEALTHCARE&Distn=0.0>.

⁴ Statement of Deficiencies for Humboldt Nursing Home and Rehabilitation Center, CMS (Apr. 11, 2018),

<https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=445441&SURVEYDATE=04/11/2018&INSPTYPE=STD&profTab=1&state=TN&lat=0&lng=0&name=HUMBOLDT%2520NURSING%2520AND%2520REHABILITATION%2520CENTER&Distn=0.0>.