

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, 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 his or her “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 the majority of 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 being 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.

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How to Use this Newsletter

Following are examples of “no harm” health violations taken directly from Statement of Deficiencies (SoDs) on CMS’s [Nursing Home Compare](#) website. State surveyors classified all of these violations as causing neither harm nor immediate jeopardy to resident health, safety, or well-being. 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 lives. While CMS may fail to properly penalize nursing homes for health violations, **it is important that every suspected case of resident harm be reported and investigated.**

The Pines at Poughkeepsie Center for Nursing & Rehab (New York)

Nursing home fails to provide necessary interventions to prevent a resident's repeated falls.

The surveyor determined that the nursing home failed to provide a resident with “the necessary supervision and assistive device to prevent recurrent falls.”¹ Despite the resident experiencing repeated falls, the surveyor cited the violation as “no harm.” The citation was based, in part, on the following facts from the [SoD](#):

- The resident’s care plan documented a risk for falls and provided interventions to minimize this risk, including checking on her frequently, as well as using an anti-rollback device and a no-slip mat on her wheelchair. However, the facility did not properly implement all of these interventions and resident’s record indicated that she experienced several falls.
- The surveyor’s review of the nursing notes showed that some of the falls were the result of her falling out of her wheelchair. For instance, on one occasion, the resident fell out of her wheelchair and hit her head, resulting in a bruise on her forehead. The resident was sent to the hospital. The accident report made no mention about the use of the no-slip mat.
- A registered nurse (RN) told the the surveyor that she did not know whether the no-slip mat was being used and “did not indicate any new interventions after the four falls . . .” A physical therapist added that several other interventions were considered but rejected.

→ *Abuse is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical and/or mental harm.*

Beavercreek Health and Rehab (Ohio)

Nursing home fails to provide appropriate care to monitor and prevent pressure ulcers.

The surveyor determined that the facility failed “to ensure two residents at risk for pressure ulcers were receiving appropriate care and monitoring and had interventions in place to prevent the development of pressure ulcers.”² The residents both suffered from pressure ulcers but the surveyor still cited the violation as “no harm.” The citation was based, in part, on the following facts from the [SoD](#):

- One resident’s pressure ulcer care plan noted that skin inspections were to be completed weekly. However, the resident’s record did not provide documentation that the staff completed the weekly inspections over several months.
- A note in that resident’s record showed that the resident had a Stage II pressure ulcer. The surveyor noted that the National Pressure Ulcer Advisory Panel defines a Stage II pressure ulcer “as partial thickness loss of dermis presenting as a shallow open ulcer with a red pink wound bed, without slough.”
- A nurse acknowledged that the resident’s weekly skin inspections were not completed.

→ *Neglect is the failure to provide goods and services necessary to avoid physical and/or mental harm.*

The Orchard – Post Acute Care (California)

Nursing home fails to assess a resident before using bed rails.

The surveyor determined that the nursing home failed to ensure a resident was “assessed for the risk of entrapment before using bilateral bed rails.”³ According to the surveyor, “[t]his had the potential risk for injury from using these bed rails.” Although the resident was at risk for serious injury, the surveyor cited the violation as “no harm.” The citation was based, in part, on the following facts from the [SoD](#):

- The surveyor observed the resident asleep in bed. The bed was lowered to the floor with floor mats on both sides. Nevertheless, the resident's bed had quarter bilateral rails in the up position.
- The director of nursing told the surveyor that "there was no assessment for the risk of entrapment from the use of the bed rails." While the facility conducted an assessment to determine whether the bed rails acted as a physical restraint, the director acknowledged that a determination as to whether the bed rail posed a risk for entrapment was not part of the assessment.
- **Note:** Without a proper assessment, bed rails may place residents in immediate risk of serious injury and even death. Residents may harm themselves (e.g., be strangled) when attempting to climb over, under, through, or around bed rails. See LTCCC's [fact sheet](#) for more information.

Fairview Nursing and Rehabilitation Center (Pennsylvania)

Nursing home fails to identify and report alleged resident neglect after a resident suffers bruising around his right eye.

The surveyor found that the facility failed to ensure that the resident was free from staff neglect. The surveyor noted that "[t]he facility failed to conduct complete and thorough investigations to rule out resident neglect and failed to report this allegation to the State Survey Agency as required."⁴ While the resident suffered bruising around his right eye as a result of this failure, the surveyor cited the violation as "no harm." The citation was based, in part, on the following facts from the [SoD](#):

- The resident's care plan documented that he needed one-on-one supervision "at all times." The resident was observed with bruising around his right eye. Facility documentation determined that staff failed to maintain supervision of the resident when the resident's injury occurred. Additionally, facility documentation provided no indication that this failure was identified as neglect and reported to the state survey agency.
- The assistant director of nursing told the surveyor that the nurse who was assigned to watch the resident "left the resident unattended when he was asleep in bed, the resident got out of bed, fell to the floor, and sustained a bruise to the head." The assistant director acknowledged that the failure to maintain one-on-one supervision was not identified as neglect nor reported to the state survey agency.

→ *Abuse and/or neglect may result in inappropriate physical contact, inappropriate antipsychotic drugging, entrapment, falls, pressure ulcers, wandering, infections, malnutrition, isolation, crimes against residents, and other forms of resident harm.*

Can I Report Resident Harm?

YES! Federal laws and regulations require nursing homes and certain individuals (such as owners, staff, and contractors) to report suspected cases of resident abuse, neglect, and/or crime within a specified amount of time. Nevertheless, residents and families should not wait to report harm when it occurs. Anyone can report suspected cases of resident harm to the state survey agency, local law enforcement, and other appropriate agencies. **For more information about the federal reporting requirements and to access free resources, please visit LTCCC's [Abuse, Neglect, and Crime Reporting Center](#).**



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To learn more about nursing home and assisted living care, visit us online at
MedicareAdvocacy.org & NursingHome411.org.

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 The Pines at Poughkeepsie Center for Nursing & Rehab (Dec. 6, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335440&SURVEYDATE=12/06/2018&INSPTYPE=STD>.

² Statement of Deficiencies for Beaver Creek Health & Rehab (Dec. 11, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=366400&SURVEYDATE=12/11/2018&INSPTYPE=STD>.

³ Statement of Deficiencies for The Orchard – Post Acute Care (Dec. 21, 2018). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=055706&SURVEYDATE=12/21/2018&INSPTYPE=STD>.

⁴ Statement of Deficiencies for Fairview Nursing and Rehabilitation Center (Jan. 22, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=395782&SURVEYDATE=01/22/2018&INSPTYPE=STD>.