

ELDER JUSTICE

What “No Harm” Really Means for Residents

CENTER FOR MEDICARE ADVOCACY & LONG TERM CARE COMMUNITY COALITION

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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

In this issue, we focus on “top performing” nursing homes with five-star ratings on [Nursing Home Compare](#) (NHC). Following are examples of violations taken directly from Statement of Deficiencies (SoDs) on NHC that have been classified 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 communities. While CMS may fail to properly penalize nursing homes for health violations, **it is important that the public is aware of safety concerns in nursing homes in their communities and that every suspected case of resident harm is reported, investigated, and addressed.**

Brothers of Mercy Nursing & Rehabilitation Center (New York)

Nursing home fails to ensure that a resident receives proper pressure ulcer care.

The surveyor determined that the nursing home failed to ensure a resident with a pressure ulcer received “necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing”¹ Despite the resident’s developing a pressure ulcer that was not properly assessed, the surveyor cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident’s record indicated that the resident had a Stage II pressure ulcer that was facility-acquired. The resident’s care plan documented that the resident developed the pressure ulcer “due to ill-fitting shoes and a contracture of the left lower extremity.”
- A registered nurse told the surveyor that the resident developed the pressure ulcer from “a shoe that was too tight . . . [and that] the wound team all agreed the wound was still a Stage II based on the facility’s policy” The wound team later agreed that the wound declined to a Stage III pressure ulcer.
- The director of nursing stated she was informed that the resident’s pressure ulcer “had some slough but there was still some healthy tissue present on the wound bed, thus it was assessed as a Stage II.” The director of nursing later noted that policy had a typo in it, and that a Stage II pressure ulcer does not contain slough . . . [t]hus the assessments were incorrect.”

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

Montclair Manor Care Center (California)

Nursing home fails to report an allegation of resident abuse.

The surveyor determined that the nursing home failed to report an allegation of resident abuse.² Although the resident might have experienced abuse at the hands of facility staff, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident stated that, when the certified nursing assistant (CNA) pulled up her adult brief, the brief pinched her. The CNA became “annoyed, threw the adult brief out of the bathroom across the room, and immediately left the resident’s room.” The resident noted that she told the licensed vocational nurse (LVN) about the incident.
- The facility’s subsequent investigation contained a statement from the CNA explaining that the resident was “mad because I left the diaper in the trash can so I went to get it . . . there was no throwing of a diaper.” Irrespective of the conflicting accounts, the facility’s documentation did not indicate that the facility reported the incident to the proper authorities.
- When interviewed, the director of nursing confirmed that the facility did not report the allegation of abuse to local authorities or the “local licensing and certification office within 24 hours of the resident’s complaint.”
- **Note:** The Reform Law and its implementing regulations require facilities to report an allegation of abuse and/or neglect within two hours if there is serious bodily injury, otherwise within 24 hours. See LTCCC’s [fact sheet](#) for more information.

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

Carriage Hill Bethesda (Maryland)

Nursing home fails to properly implement baseline care plans for two residents.

The surveyor determined that the facility failed “to develop and implement a baseline care plan within 48 hours of a resident's admission.”³ While both residents identified in the SoD were at risk of experiencing unmet care needs, 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 medical record indicated that a nutrition care plan was not established until four days after the resident’s admission. The admission nurse told the surveyor that a registered dietician was responsible for each resident’s care plan but that the dietician only worked at the facility three times a week.
- The second resident’s record showed that the resident was admitted to the facility for rehabilitation after surgery. Unfortunately, “the baseline care plan did not address the potential for pain/discomfort, potential for post-operative infection or other concerns specific to the medical condition”
- **Note:** In a [2014 report](#), the HHS Office of the Inspector General found that one-third of Medicare beneficiaries were harmed within, on average, 15.5 days of entering a nursing home. Nursing homes are now required to create a [baseline care plan](#) within 48 hours to safeguard against any harm that may occur immediately after admission.

→ *Abuse and/or neglect can include instances of inappropriate physical contact, inappropriate antipsychotic drugging, entrapment in a bed rail, falls, pressure ulcers, wandering, infections, malnutrition, isolation, crimes against residents, and other forms of resident harm.*

Roubal Care and Rehab Center (Michigan)

Nursing home fails to properly transfer a resident.

The surveyor determined that the nursing home failed to properly transfer a resident, which “contributed to a fall with minor injury”⁴ Although the resident suffered an injury from her fall, the surveyor determined that the violation was no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident’s care plan documented a history of falls and required at least the assistance of one person for the weight-bearing activities of daily living. A subsequent accident report showed that the resident fell while being transferred from the toilet to her wheelchair. She hit her head and “received a hematoma with a small laceration to the left side of her head.”
- The certified nursing assistant’s written statement noted that the resident was unsteady at the time of the fall and the resident’s left knee buckled causing her to fall. A licensed practical nurse added that the resident “was assist of 1 at the time, and we thought after, maybe she should be assist of 2.” The director of nursing told the surveyor that the CNA should have sat the resident down and “gotten help instead of transferring her.”

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 Brothers of Mercy Nursing & Rehabilitation Center (Jun. 5, 2018). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335112&SURVEYDATE=06/05/2018&INSPTYPE=STD/>.

² Statement of Deficiencies for Montclair Care Center (Jan. 12, 2018). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=055718&SURVEYDATE=01/12/2018&INSPTYPE=STD/>.

³ Statement of Deficiencies for Carriage Hill Bethesda (Jan. 7, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=215234&SURVEYDATE=01/07/2019&INSPTYPE=STD/>.

⁴ State of Deficiencies for Roubal Care and Rehab Center (Jun. 22, 2018). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235591&SURVEYDATE=06/22/2018&INSPTYPE=STD/>.