

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

VOLUME 2, ISSUE 3

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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 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.**

Schenectady Center for Rehabilitation and Nursing (New York)

Nursing home fails to properly report an allegation of sexual abuse.

The surveyor determined that the nursing home failed to ensure that “all alleged violations involving abuse were reported immediately, but not later than 2 hours after the allegation was made”¹ Despite failing to report an allegation of sexual abuse within the mandated timeframe, the surveyor cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The facility’s investigation form documented that the resident reported an allegation of sexual abuse on November 14, 2018. The resident told staff, “a male caregiver had kissed her breast and made comments such as, I could stay on you all day.” The resident did not have a history of making allegations against staff.
 - The New York State Department of Health’s (DOH) record indicated that the allegation was reported on November 20th.
 - The registered nurse manager told the surveyor that she could not recall the incident but that, “when there was an allegation of abuse, it should be reported to the NYSDOH immediately.” The director of nursing noted that she was informed of the allegation on November 14th and that the allegation should have been reported sooner than November 20th. The administrator added that, under the federal requirements, the initial reporting of the sexual abuse allegation should have been made within the first two hours.
- **Note:** A June 2019 [federal report](#) found that **one in five** (20 percent) of high-risk Medicare claims for emergency room services in 2016 were the result of potential abuse or neglect. The report also found that nursing homes “failed to report many of these incidents to the Survey Agencies in accordance with applicable Federal requirements.”

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

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

Woodside Healthcare Center (California)

Nursing home fails to ensure that a resident is treated with respect and dignity.

The surveyor determined that the facility failed to ensure that a resident was treated with dignity and respect “when . . . [the resident was sitting] in a wheelchair tilted back on two wheels and was pulled backwards down a hallway.”² While the surveyor noted that the failure increased the potential for the resident to feel belittled and disrespected, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident told the surveyor that, during an argument with staff and other residents, a nurse “pulled me in my wheelchair backwards, tilted back, with the front wheels lifted off the ground, I was staring at the ceiling, down the hall, from the dining room to the north nurse’s station.” The resident added that the nurse had no right to do that and that she did not feel safe with the nurse. The surveyor documented that the resident cried while talking.
- The director of nursing stated that, in cases of resident altercations, staff were to find out what the resident wanted and have somebody else step in. The director told the surveyor that “tilting (the) wheelchair backwards down [the] hall is not okay.”

→ **Note:** Every nursing home resident has the right to be treated with respect and dignity. Facilities must ensure that care is provided in a manner that promotes the resident's quality of life. The loss of dignity may negatively impact a resident's physical, mental, and psychosocial well-being. For more information, please see our fact sheet: <https://nursinghome411.org/fact-sheet-resident-dignity-quality-of-life-standards/>.

South Campus Care Center (Florida)

Nursing home staff fail to implement proper hand hygiene during medication administrations.

The surveyor determined that the facility failed "to ensure staff implemented appropriate infection prevention and control practices during medication administration including hand hygiene, and injection safety . . ."³

While this failure placed residents at risk of developing infections, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The facility's hand hygiene policy documented that "this facility considers hand hygiene the primary means to prevent the spread of infections." However, the surveyor observed a licensed practical nurse (LPN) giving a resident an injection without wearing gloves. When interviewed, the LPN told that the surveyor that she does not wear gloves when giving insulin injections. The surveyor asked her if it was standard practice to wear gloves when giving injections, to which she responded "yes." The director of nursing confirmed that nurses must wear gloves when giving injections to residents.

→ *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.*

- A second LPN was observed walking into another resident's room to administer medications "without washing or sanitizing his hands." This LPN confirmed that he did not wash his hands when entering the resident's room. The director of nursing noted that it is standard practice, and the facilities policy, for nurses who are entering a resident's room to administer medication or perform a procedure to wash or sanitize their hands.

→ **Note:** According to the [Centers for Disease Control and Prevention](#), as many as 380,000 individuals die of infections in long-term care facilities each year. Infection prevention and control violations continue to be one of the most cited deficiencies in nursing homes. CMS's Deputy Director for the Nursing Home Division [noted last year](#) that poor hand washing was a key factor in such citations.

Regency Heights - Detroit (Michigan)

Nursing home fails to implement safety measures to protect a resident from falls.

The surveyor determined that the facility failed to implement safety measures for a resident, "resulting in a fall and for the potential for further falls and injuries to occur."⁴ Although the resident suffered from repeated falls, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- The resident's records indicated that staff had found her on the floor on two occasions. A bump was noted on her head after the second incident. Interventions included the use of a wing tip mattress and maintaining her bed at its lowest possible position.

- On April 4, 2019, the surveyor observed the resident in bed and asked a nurse whether the resident's bed was in the lowest position. The nurse acknowledged that it was not. The nurse also noted that a wing tip mattress was not being used.
- Another nurse told the surveyor that the resident recently had a low air mattress in place to support wound healing but that, because the wound had since healed, the air mattress was no longer necessary. The surveyor asked the nurse to provide documentation for when the air mattress was removed and the regular mattress was put in place. The documentation "revealed the low air loss mattress was removed on 3/18/19."

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](https://nursinghome411.org/learning-center/abuse-neglect-crime/) at <https://nursinghome411.org/learning-center/abuse-neglect-crime/>.**



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To learn more about Medicare and nursing home care, visit us online at
[MedicareAdvocacy.org](https://www.MedicareAdvocacy.org) & [NursingHome411.org](https://www.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 Schenectady Center for Rehabilitation and Nursing (Mar. 27, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=335014&SURVEYDATE=03/27/2019&INSPTYPE=CMPL>.

² Statement of Deficiencies for Woodside Healthcare Center (Mar. 21, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=555798&SURVEYDATE=03/21/2019&INSPTYPE=CMPL>. The resident's sex is not identified in the inspection report. To make the summary more user-friendly, we refer to the resident as being female.

³ Statement of Deficiencies for South Campus Care Center (Apr. 11, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=105375&SURVEYDATE=04/11/2019&INSPTYPE=SID>.

⁴ Statement of Deficiencies for Regency Heights – Detroit (Apr. 4, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.aspx?ID=235452&SURVEYDATE=04/04/2019&INSPTYPE=SID>.