

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 2, Issue 7

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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

The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS’s [Nursing Home Compare](#) website. **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.

Newfane Rehab & Health Care Center (New York)

Two-star nursing home fails to maintain a resident's personal hygiene.

The surveyor determined that the nursing home failed to ensure a resident who was unable to carry out the activities of daily living (ADL) received “the necessary services to maintain personal hygiene”¹ Although a staff member failed to adhere to the facility's proper handwashing policies, which resulted in a resident having stool smeared on her, 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 handwashing policy required employees to wash their hands “after contact with body substance and between different tasks on the same resident.”
 - The surveyor observed that the resident was incontinent of a moderate amount of stool. Stool was visible on the resident's hands, including under her fingernails. Stool could also be seen on the resident's bed linens.
 - Two certified nurse aides (CNAs) donned gloves and assisted the resident. One CNA washed the resident's perineal area (the area “between [the] anus and genitalia”). The CNA then touched the resident's shoulder and thigh to hold the resident while the other CNA cleaned the resident's back.
 - While wearing the same gloves, the first CNA attempted to put a shirt on the resident and got “a smear of stool on the resident's left shoulder.” The CNA had visible stool on her left glove.
 - The registered nurse (RN) unit manager told the surveyor that the “CNA should have changed her gloves and washed her hands after providing bowel incontinence care.”
- **Note:** According to [CMS](#), **infections are the leading cause of illness and death among nursing home residents.** Between 1.6 and 3.8 million infections occur in nursing homes throughout the country every year, resulting in approximately 388,000 deaths. For more information about infection prevention and control, please see our [Issue Alert](#).

→ *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.*

Homestead Health Center (Kansas)

Two-star nursing home fails to ensure that anonymous grievances could be filed.

The surveyor determined that the nursing home failed to “ensure residents could file a grievance anonymously within the facility.”² Although the surveyor determined that the facility violated “the right of residents to file a grievance anonymously . . .,” the violation was cited as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- During an interview with the facility's resident council, the council told the surveyor that instructions for filing grievances anonymously were available on a long-term care ombudsman poster. However, the surveyor's observation of the facility failed to show any evidence of support.
- The social worker told the surveyor that residents, families, and staff report grievances to her and that she would then complete the grievance form. She explained that individuals could inform her if they wanted to

remain anonymous and that there was “no way to independently obtain a grievance form, complete it, and turn the form in anonymously.”

- **Note:** CMS has [proposed](#) to roll back current requirements for grievances. Most notably, CMS is proposing to create a distinction between so-called “feedback” (or complaints) and grievances. Nursing homes will be responsible for determining whether a resident’s concern is considered feedback or a grievance—only the latter would initiate the formal grievance process. To read our comments opposing this change, please visit LTCCC’s [Comments and Statements](#) webpage.

The Pines Genesis Eldercare (Maryland)

Two-star nursing home fails to protect a resident from verbal abuse.

The surveyor determined that the nursing home failed to protect a resident from abuse.³ Despite being the victim of verbal abuse, which resulted in a staff member being fired, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- A resident reported that the geriatric nursing assistant (GNA) told her she was “disgusting for laying in stool for several hours and should have put the call light on.”
- The resident explained that the call light was on and another staff member told her that the message would be relayed to the appropriate caregiver.
- The GNA was placed on administrative leave and was eventually terminated.

- **Note:** Under federal regulation, every resident has the right to be treated with dignity and respect. Staff must assist residents in maintaining or enhancing their self-esteem and self-worth. For more information, please see LTCCC’s [fact sheet](#).

→ *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.*

Regency at Livonia (Michigan)

Three-star nursing home fails to provide proper respiratory care to a resident.

The surveyor determined that the nursing home failed to provide wound care as ordered by a physician.⁴ While staff failed to follow the physician’s order when treating the resident’s wound, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- On September 9, 2019, the surveyor asked the resident whether he had any wounds. The resident told the surveyor that he had a wound on his left leg and that the dressing was not changed every day. The resident explained, “[t]hey don’t do anything here. They hardly answer the call lights.” The dressing on the resident’s leg indicated that it was last changed several days ago (dated 9/6/19).
- A nurse told the surveyor that the resident’s dressing was scheduled to be changed “as needed.” However, an inspection of the physician’s order showed the resident’s leg needed to be cleansed and dressed “every day shift every two days for pressure injury.”
- The director of nursing (DON) told the surveyor that the dressing was changed on 9/8/19 but that the nurse wrote down the wrong date because she was busy. The DON stated that the nurse put her initials, “REE,” on the dressing. The initials on the dressing were “GP.”

- The DON asked the resident if his dressing was changed on 9/8/19. The resident stated, “[n]o, my dressing was changed on Friday and not Sunday.”
- **Note:** As of the date of publication, this facility has an abuse icon (a red circle with a white hand) on Nursing Home Compare. The icon is meant to alert consumers to facilities “that have been recently cited for resident harm or potential harm for abuse or neglect.” CMS is encouraging consumers “to ask the administrator or other staff about what they’re doing to keep residents safe from abuse, neglect, mistreatment, or exploitation.” For more information, please see CMS’s [“How can Nursing Home Compare help you?”](#) webpage.

Gowanda Rehabilitation and Nursing Center (New York)

Two-star facility fails to screen three employees before allowing them access to residents.

The surveyor determined that the nursing home failed to “implement written policies and procedures for screening employees that would prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.”⁵ Although the facility allowed three newly-hired employees to have access to residents before conducting screenings, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following facts from the [SoD](#):

- Employee #1 was hired on July 18, 2019, and the nurse aide registry verification sheet was dated August 21, 2019. A review of the employee’s work history showed that the employee began working at the facility on July 22nd and worked nine shifts before the nurse aide registry was checked.
- Employee #2 was also hired on July 18th but the nurse aide registry verification sheet was dated July 30th. A review of this employee’s work history showed that the employee worked three shifts before the nurse aide registry was checked.
- Employee #3 was hired on August 1st and the nurse aide registry verification sheet was dated August 8th. The employee’s work history showed that the employee began working at the facility on August 5th and worked two shifts before the nurse aide registry was checked.
- The administrator told the surveyor that she acted as the interim human resources coordinator while the position was vacant. She explained that she normally checks the nurse aide registry for all new employees before their start date “but these were missed.”
- **Note:** There is no federal requirement that facilities conduct comprehensive nationwide background checks of their employees. In regards to CNAs, Facilities are only required to check their state’s nurse aide registry and the registry of any other state the facility believes might have information about the individual.

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 Newfane Rehab & Health Care Center (Sept. 13, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335481&SURVEYDATE=09/13/2019&INSPTYPE=STD&profTab=1&Distn=7064.5&state=NY&lat=0&lng=0&name=NEWFANE%20REHAB%20%26%20HEALTH%20CARE%20CENTER>.

² Statement of Deficiencies for Homestead Health Center (Oct. 10, 2019). Available at <https://www.medicare.gov/nursinghomecompare/profile.html#profTab=1&ID=175487&Distn=8275.5&state=KS&lat=0&lng=0&name=HOMESTEAD%20HEALTH%20CENTER>.

³ Statement of Deficiencies for The Pines Genesis Eldercare (Oct. 25, 2018). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=215010&SURVEYDATE=10/25/2018&INSPTYPE=STD&profTab=1&Distn=6838.1&state=MD&lat=0&lng=0&name=THE%20PINES%20GENESIS%20ELDERCARE>. The resident's sex was not identified. For purposes of this newsletter, the resident was identified as being female.

⁴ Statement of Deficiencies for Regency at Livonia (Sept. 9, 2019). Available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235479&SURVEYDATE=09/09/2019&INSPTYPE=CMPL&profTab=1&Distn=7348.2&state=MI&lat=0&lng=0&name=REGENCY%20AT%20LIVONIA>. The resident's sex was not identified. For purposes of this newsletter, the resident was identified as being male.

⁵ Statement of Deficiencies for Gowanda Rehabilitation and Nursing Center (Oct. 4, 2019). Available at <https://www.medicare.gov/nursinghomecompare/profile.html#profTab=1&ID=335642&Distn=7069.3&state=NY&lat=0&lng=0&name=GOWANDA%20REHABILITATION%20AND%20NURSING%20CENTER>.