

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 3, 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 most 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.

In the absence of a financial penalty, nursing homes may have little incentive to correct the underlying causes of substandard nursing home quality and safety.

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.

This newsletter focuses on nursing homes that experienced COVID-19 outbreaks to highlight how pre-existing problems may have exacerbated the pandemic’s devastating toll. More than 52,000 people in long term care facilities have died from COVID-19 through July 6.¹ It is likely that many of the fatalities were preventable. In fact, numerous studies have found that facilities with better staffing and infection control experienced more favorable COVID-19 outcomes.²

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. When state enforcement agencies and CMS fail to properly identify and penalize nursing homes for health violations, it is important for the public to be aware of nursing home safety concerns in their communities. Fundamentally, from our perspective, every suspected case of resident harm should be reported, investigated, and (as appropriate) addressed.

ShorePointe Nursing Center (Michigan)

'It can be frightening': Care needs delayed and unmet at understaffed five-star facility.

The surveyor determined that the nursing home's failure to provide sufficient staffing resulted in dissatisfaction with care, likely unmet care needs, and a delay in care provision. Numerous residents complained of lengthy response times and lack of assistance, including one who called the situation "frightening." Despite widespread evidence of delayed and unmet care, the surveyor cited the staffing violation as no-harm.³ The citation was based, in part, on the following findings from the [SoD](#):

- According to the surveyor, the facility failed to provide timely call light response and adequate staffing to provide care for 14 residents.
- One resident stated that after using the call light, the "[staff would] come in, turn it off and say I'll be back, but never come back." Another stated, "I always get cold breakfasts."
- The surveyor found that numerous residents requiring toileting assistance did not receive timely responses after activating their call lights. One resident said that she went to the bathroom by herself because nobody responded to her call. The resident said that staff finally came in after hearing noise while she was on the way back to the bathroom and said they screamed at her, "that I shouldn't be out of my bed by myself."
- Residents stated that the understaffing at the facility was worse at certain times, including nights and weekends. "For the last couple weeks there has only been two people at night," one resident said in an interview. "I have had a [medical condition]. It can be frightening...."
- **Note:** Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Unfortunately, inadequate nursing home staffing is a widespread and persistent problem. Visit [LTCCC's staffing page](#) to access the latest staffing data and information.
- **COVID-19 Facts:** ShorePointe reported 32 COVID-19 resident deaths through July 2 and had a shortage of nursing staff during the outbreak, according to CMS data.⁴

→ *Every facility must ensure residents can exercise their rights as nursing home residents and citizens/residents of the United States without interference, coercion, discrimination, or reprisal from the facility.*

Andover Subacute and Rehab II (New Jersey)

A slap on the wrist: Facility fails to respond appropriately to all alleged violations.

The surveyor determined that the facility "failed to investigate an allegation of resident to resident abuse" and follow facility policy for reporting incidents and accidents.⁵ An altercation between residents resulted in one resident allegedly being slapped and punched, but the surveyor found that there was no investigation conducted by the facility. Though residents are entitled to be free from abuse and know that allegations will be investigated and, if necessary, addressed, the violation was cited as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A resident (A) alleged to have been slapped in the hand four times and punched in the abdomen by another resident (B), according to an Interdisciplinary Progress Note (IPN).
- In an interview, a Licensed Practical Nurse (LPN) first stated that she did not remember any altercations between the residents but in a follow-up interview recalled Resident A taking food off a cart and Resident B moving Resident's A hand away. The LPN stated that Resident A reported the allegations to her that same day.
- Resident A's primary physician was notified about the allegations the day of the incident, though the allegations were not investigated or documented in the resident's medical record, according to the surveyor.
- The LPN stated an incident report should have been created and investigated. The Director of Nursing stated that she was unable to locate an incident report, and the Incident Coordinator (IC) stated the incident was not investigated as per facility's protocol.
- **COVID-19 Facts:** Andover Subacute and Rehab was the subject of a disturbing [New York Times report](#)⁶ revealing that 17 bodies were piled inside the nursing home in a small morgue. The facility reported 105 COVID-19 resident fatalities and suffered one of the deadliest COVID-19 outbreaks in the U.S., according to CMS.⁷
- **Note:** Researchers have found that “[r]esident-to-resident incidents (RRI) in long-term care (LTC) homes are a prevalent, concerning but underrecognized phenomenon.”⁸

Catholic Eldercare on Main (Minnesota)

‘Forgot to report it’: Three-star facility fails to provide adequate supervision to prevent accidents.

The surveyor determined that the nursing home “failed to investigate causal factors related to falls and comprehensively reassess and implement additional fall interventions” for four residents, including one whose fall resulted in a possible clavicle fracture.⁹ Despite the facility's repeated failure to prevent falls, the surveyor still cited the violation as no-harm. The citation was based, in part, on the following findings from the [SoD](#):

- A resident was found on the floor reading a book at 5:10 AM on 07/30/19 following an unwitnessed fall that resulted in a possible clavicle fracture. A fall event report indicated that the resident presented with confusion and unable to explain what happened. However, it did not indicate any injury (such as the possible clavicle fracture) or immediate interventions taken to address it.
- A family member stated that they were notified that the resident had a large shoulder bruise and swollen right hand after the incident. On 08/11/19, the family member found a “blue purplish bruise” around the resident's left forearm and expressed concerns about new bruises located on right anterior chest.
- A registered nurse attributed the chest bruise to the 07/30 fall though other staff offered different explanations about the injury's origin. One nurse stated that the nursing assistant who worked with the resident saw the bruise but “forgot to report it.”
- In a 08/12 interview, the family member said she was upset because she had warned staff about the resident's tendency to self-transfer and felt that the facility failed to implement interventions to prevent the injury.
- **COVID-19 Facts:** Catholic Eldercare reported six COVID-19 resident deaths and two staff COVID-19 deaths, according to CMS.¹⁰ The facility failed to pass a quality assurance check at the height of the outbreak on May 24.
- **Know your rights:** There are many standards which nursing homes are required to follow to ensure that residents receive appropriate care, have a good quality of life, and are treated with dignity. Read [LTCCC's](#)

[resident rights fact sheet](#) to learn how you can use these standards as a basis for advocating in your nursing home and community.

Terence Cardinal Cooke Health Care Center (New York)

Inappropriate drugging: Three-star facility fails to provide safe pain management.

The surveyor determined that the nursing home's pain management was inconsistent with professional standards of practice and did not meet the resident's goals and preferences.¹¹ The facility's substandard pain management resulted in a resident receiving an inappropriate dosage of opioid pain medication. Nevertheless, the surveyor cited the violation as neither causing harm nor putting the resident in immediate jeopardy. The citation was based, in part, on the following findings from the [SoD](#):

- The surveyor found that on multiple occasions, the facility administered the wrong dosage of pain medication to a resident experiencing foot and knee pain. The physician's orders indicated that the resident should receive stronger pain medication when reporting a pain level at 6 or above out of 10; however, the resident received the stronger medication on January 28 when reporting 4 out of 10 pain, and again on January 29 when reporting 2 out of 10 pain, according to the Medication Administration Record (MAR).
- The facility also failed to assess the resident's pain before and after administration of medication, according to the surveyor. The resident received medication PRN (to be given as needed) 21 times from January 15 to January 23, according to the MAR. However, there was no documented evidence that the pain level was assessed those days.
- Though the resident's Comprehensive Care Plan (CCP) indicated ongoing assessment of the resident's pain, it did not include any interventions regarding pain management or details on medications or non-pharmacological interventions.
- **COVID-19 Facts:** Terence Cardinal reported 34 total COVID-19 related fatalities (confirmed and presumed) as of July 13, according to the New York Department of Health.¹²

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to detect resident harm. Anyone can report violations of the nursing home standards of care by contacting their state survey agency. To file a complaint against a nursing home, please use [this resource](#) available at CMS's Nursing Home Compare website. If you do not receive an adequate or appropriate response, [contact your CMS Regional Office](#).

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To learn more about nursing home and assisted living care, visit us online at
[MedicareAdvocacy.org](https://www.MedicareAdvocacy.org) & [NursingHome411.org](https://www.NursingHome411.org).

Note: The overall star rating of any facility identified in this newsletter is subject to change. The star ratings are current up to the date of newsletter's drafting.

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 "State Data and Policy Actions to Address Coronavirus," Kaiser Family Foundation (July 3, 2020), available at <https://www.kff.org/health-costs/issue-brief/state-data-and-policy-actions-to-address-coronavirus/>.

² See, for example, Li, Y. "COVID-19 infections and deaths among Connecticut nursing home residents: facility correlates," *Journal of the American Geriatrics Society* (June 18, 2020), available at <https://doi.org/10.1111/jgs.16689>.

³ Statement of Deficiencies for ShorePointe Nursing Center (May 15, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=235443&SURVEYDATE=05/15/2019&INSPTYPE=CMPL&profTab=1&Distn=7320.7&state=MI&lat=0&lng=0&name=SHOREPOINTE%20NURSING%20CENTER#>.

⁴ Facility Level COVID Data (CMS).

⁵ Statement of Deficiencies for Andover Subacute and Rehab II (Nov. 26, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=315248&SURVEYDATE=11/26/2019&INSPTYPE=CMPL&profTab=1&Distn=6781.6&state=NJ&lat=0&lng=0&name=ANDOVER%20SUBACUTE%20AND%20REHAB%20II>.

⁶ Tully, T. "After Anonymous Tip, 17 Bodies Found at Nursing Home Hit by Virus," *The New York Times* (April 17, 2020), available at [nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html](https://www.nytimes.com/2020/04/15/nyregion/coronavirus-nj-andover-nursing-home-deaths.html)

⁷ Facility Level COVID Data (CMS).

⁸ Caspi, Eilon, Death of Elders Due to Resident-to-Resident Incidents in Dementia in Long-Term Care Homes (quoting Lachs et al. 2016), available at https://coronertalk.com/wp-content/uploads/2018/04/Poster-Death-of-Elders-due-to-RRI-in-Dementia-ASA-2018-Final_v2.pdf.

⁹ Statement of Deficiencies for Catholic Eldercare on Main (August 16, 2019), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=245439&SURVEYDATE=08/16/2019&INSPTYPE=STD&profTab=1&Distn=7972.4&state=MN&lat=0&lng=0&name=CATHOLIC%20ELDERCARE%20ON%20MAIN>. Information obtained from two citations within deficiency report.

¹⁰ Facility Level COVID Data (CMS).

¹¹ Statement of Deficiencies for Terence Cardinal Cooke Health Care Center (January 31, 2020), available at <https://www.medicare.gov/nursinghomecompare/InspectionReportDetail.html?ID=335665&SURVEYDATE=01/31/2020&INSPTYPE=STD>.

¹² New York COVID-19 Fatality Data: Nursing Homes & Adult Care Facilities, Long Term Care Community Coalition (July 13, 2020). Available at <https://nursinghome411.org/ny-nursinghome-covid-data/>.