ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition — Volume 7, Issue 2

IN THIS ISSUE:

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 their "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).

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.

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 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.

How to Use this Newsletter

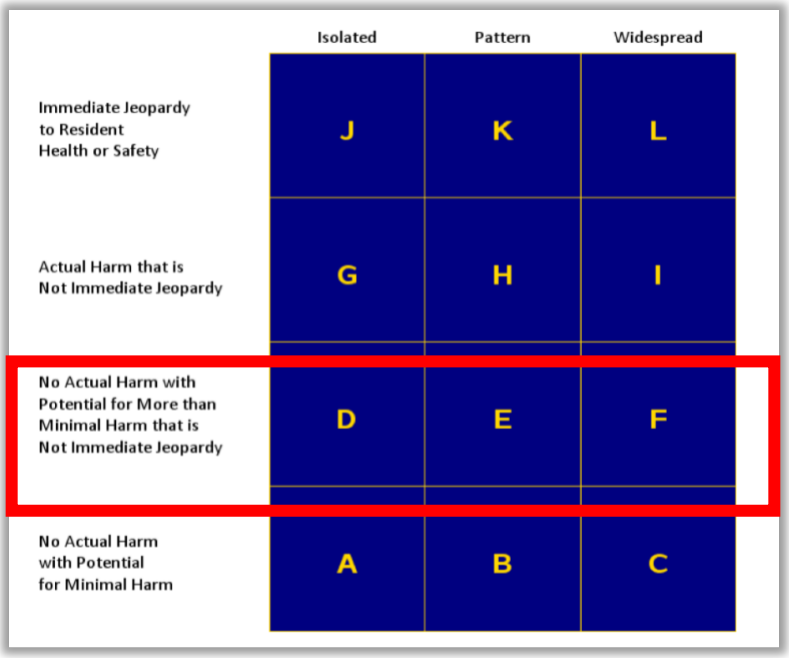
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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. 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 (if confirmed), appropriately sanctioned.

> *"Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?"*
> – ***Broken Promises: An Assessment of Nursing Home Oversight***

All licensed nursing homes are rated on a scale of one to five, with one being the lowest possible rating and five being the highest. While studies have shown that having a high rating does not necessarily mean that a nursing home is safe, substandard care in lower rated facilities has become a matter of increasing public concern. Star ratings included in this newsletter are current up to the date of newsletter's drafting.

CMS and state survey agencies use the Scope and Severity Grid for rating the seriousness of nursing home deficiencies. For each deficiency identified, the surveyor is charged with indicating the level of harm to the resident(s) involved and the scope of the problem within the nursing home. The Elder Justice Newsletter covers "no harm" deficiencies cited from D-F on the grid. This chart is from the CMS Nursing Home Data Compendium 2015 Edition.



This issue of the *Elder Justice Newsletter* highlights the expectations and failures associated with facilities that have received a three-star rating from the Centers for Medicare & Medicaid Services.

Nursing homes with a three-star rating represent what is considered an "average" facility, but too often this designation masks significant shortcomings in care and safety. While these facilities may meet some basic standards, too frequently they fail to provide the level of quality care necessary to ensure the well-being of residents.

This issue delves into the care problems that persist in what are considered "average" facilities and urges greater transparency and accountability to improve care outcomes for vulnerable populations. Ongoing vigilance and advocacy are essential to ensure residents receive the safe, respectful care they deserve.

Cobble Hill Health Center Inc (New York)

Broken bones: Failure to report and assess resident fall results in delayed medical care.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to ensure proper reporting and assessment of a resident fall, as required by facility policy and professional standards of care (F658). In this instance, the delay in reporting a resident's fall resulted in postponed treatment of a fracture. Despite this, the surveyor classified the violation as no harm.[1] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a resident was found on the floormat of their room. A registered nurse (RN) and a certified nursing assistant (CNA) transferred the resident back into bed but did not assess or report the unwitnessed fall.
- The following day, an x-ray revealed that the resident sustained an acute fracture in the upper part of the right thigh bone.
- The fall was not reported to the facility until two days after the resident was found on the floor, and only after the facility became aware of the injury through an interview with the RN.
- The facility's investigation revealed that the RN failed to report the fall despite acknowledging they had picked up the resident from the floor. In addition, the RN failed to document the fall, assess the resident's condition, record the assessment, or notify the physician, all of which are required by the facility's policies.
- During an interview, the CNA confirmed that they did not observe the RN assess the resident or report the fall.
- In an interview, the director of nursing stated that the RN admitted not reporting the incident to their supervisor "because they were tired and wanted to go home." The director of nursing noted that by failing to report the fall, there was evidence of neglect by the RN.

- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including neglect and failure to report injuries. Any injury, including one due to a fall, must be reported immediately to the facility administrator and relevant state agencies. The injury also needs to be assessed by the required nurses and physicians. The failure to report injuries not only violates state and federal regulations but also jeopardizes the safety and well-being of the resident. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Asbury Park Nursing & Rehabilitation Center (California)

Ignored pleas: Residents left in soiled conditions.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to respond in a timely manner to resident call lights for assistance with personal care, leading to discomfort, embarrassment, and emotional distress for multiple residents (F557). Still, the surveyor classified the citation as no harm.[2] The citation was based, in part, on the following findings from the SoD:

- A family member of a resident at the facility reported that the resident frequently had to wait over an hour for assistance with the bathroom, creating anxiety and frustration. Despite the resident's being able to communicate his needs, he would often wet or soil himself due to the delay in response.
- Similarly, another resident reported that he had to wait at least 30 minutes or longer for assistance with personal care, including emptying his urine bottle. He expressed concern that if this continued, the urine bottle would spill over into his bed.
- According to the surveyor, a third resident stated she waited for over an hour to be assisted to the toilet, during which her incontinence brief became soaked and visibly sagged. Despite the resident's calling for help and visibly showing distress, the facility staff did not respond in a timely manner.
- The surveyor observed a CNA walk past the resident's room ignoring the call light and the resident's verbal calls for help.
- The surveyor later observed the resident standing in the doorway in visible distress, wearing a wet incontinence brief and calling for help. She expressed difficulty in controlling her bowels and discomfort from having to wait too long for assistance.
- During an interview, another CNA acknowledged that the resident had been waiting for an extended period without help and that her incontinence brief had not been changed for a significant amount of time.
- A nurse entered the resident's room but did not provide direct assistance. Instead, the nurse instructed other staff to help and left the room, despite the resident's having already waited for over an hour.
- During interviews, the director of nursing confirmed that there had been repeated complaints from residents about delayed call light responses. Despite the director of nursing reminding staff to improve call light response time, issues persisted. The director of

nursing also acknowledged that staff were responsible for long delays in answering call lights, especially in the case of the third resident.

- **Know Your Rights:** Every resident has the right to receive the care and services they need to reach and maintain their highest possible level of functioning and well-being. This includes appropriate hygiene care of bathing, dressing, grooming, and personal needs, in accordance with the resident's preferences and customs. To learn more, see LTCCC's fact sheet on resident care and well-being.

Maple Springs Of Wasilla (Alaska)

Inappropriate drugging: Lack of informed consent for psychotropic medications.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to ensure that proper consent was obtained from the resident representative before making changes to a resident's psychotropic medication dosage, Risperidone (F758). Although this failure put the resident at risk for unnecessary medication consumption and potential adverse effects, the citation was classified as no harm.[3] The citation was based, in part, on the following findings from the SoD:

- The surveyor noted that the facility admitted a resident with Alzheimer's disease, dementia, and an anxiety disorder.
- According to the surveyor, the facility changed the resident's Risperidone (an antipsychotic drug used to treat schizophrenia) dosage multiple times between September 2022 and July 2023 without documenting or obtaining informed consent from the resident representative.
- Records revealed that the facility increased the dosage of Risperidone, but there was no documentation to indicate that the facility consulted the resident's representative or that the representative approved the change. Additionally, this medication adjustment was inconsistent with a previous plan to gradually wean the resident off the Risperidone.
- During interviews, staff revealed that while the facility had a medication consent form it was not consistently completed for each dosage change.
- In an interview, the director of nursing confirmed that consent should have been obtained for every dosage change, and the Psychiatric Advanced Nurse Practitioner (PANP) was instructed to complete the required consent form going forward.
- The director of nursing also stated that the facility would review its medication administration policies and ensure proper consent procedures are followed in the future.
- **Know Your Rights:** Every resident has the right to informed consent when it comes to their care and treatment. This means that they or their representative must be fully informed of their health status and any risks or benefits of the proposed treatment, as well as alternative treatments, before it is provided. Informed consent is critical with respect to dementia care and the use of antipsychotic medications, because these drugs are associated with serious risks, including heart attacks, strokes, Parkinsonism, falls, and even death. Antipsychotics are often not clinically appropriate for individuals with dementia, and their use should be carefully considered. Head to NursingHome411.org for a list of commonly prescribed antipsychotic (AP) drugs.

Altercare of Hartville Ctr for Rehab & Nursing (Ohio)

Staffing shortages: Inadequate care leads to resident discomfort and distress.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to provide timely incontinence care and adequate staffing during the night shift, leading to discomfort, embarrassment, and emotional distress for some residents (F677). Despite residents being left in soiled briefs and bedding for extended periods, the surveyor cited the violation as no harm.[4] The citation was based, in part, on the following findings from the SoD:

- The surveyor observed that the facility was understaffed during the night shift, with only two nurses and seven State Tested Nursing Assistants (STNAs) assigned to care for 39 residents across two halls. One STNA left early, causing a gap in coverage and leaving one hall without adequate staff for the remainder of the night.
- As a result of the staffing shortage, four residents did not receive the necessary incontinence care. These residents went unmonitored and were not assisted with incontinence needs throughout the night. Two of the residents were found in the morning with soiled briefs and bedding.
- During an interview, one of these residents confirmed that they were not receiving timely care, and that their room had a strong smell of urine.
- In interviews with staff, the facility acknowledged the staffing issues and confirmed they are actively working on improving staffing levels to ensure adequate coverage for all shifts, especially during the overnight hours.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.43 hours per resident per day (HRPD) of total nurse staff time. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD). This nursing home received a three-star overall rating and a one-star staffing rating from CMS.
- **Know Your Rights:** Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Every facility must have sufficient and competent nursing staff to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. To see the latest staffing levels in your nursing home, check out LTCCC's nursing home staffing data.

Crossroads Care Center of Mayville (Wisconsin)

Prolonged catheter use: Lack of verified medical necessity.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to ensure that an indwelling catheter for a resident was medically necessary, as required by facility policy (F690). Still, the surveyor cited the violation as no harm.[5] The citation was based, in part, on the following findings from the SoD:

- According to the citation, the facility sent the resident to the hospital on 06/01/24 for acute respiratory failure and sepsis. The facility readmitted the resident on 06/03/24.
- During the resident's hospital stay, the hospital inserted an indwelling catheter. The catheter then remained in place for two months in the nursing home, but there was no documented medical reason for its continued use.
- The surveyor noted that a physician's order for the catheter did not include a medical diagnosis or specific justification for its continued use.
- The facility's policy mandates that catheter use must be supported by a physician's order and medical justification. Additionally, proper infection control techniques must be implemented to ensure the resident's safety.
- During an interview, the director of nursing explained that the catheter was kept in place for "comfort" as the resident was under hospice care, but no formal medical justification was provided for its use during the two-month period.
- **Know Your Rights:** Nursing home residents have the right to receive appropriate and timely care for wounds, medication lines, and catheters. Without the proper medical justification for any treatment provided, residents may be at risk of unnecessary harm or infection. To learn more, see LTCCC's fact sheet on resident care and well-being.

Carmel Home (Kentucky)

Care gaps: RN coverage shortfalls.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to provide sufficient nursing services of a registered nurse (RN) for at least eight consecutive hours per day, seven days a week, in many instances from July to September 2023, as required by facility policy and federal regulations (F727). Despite this failure affecting resident care and safety, the deficiency was cited as no harm.[6] The citation was based, in part, on the following findings from the SoD:

- The surveyor reviewed the facility's staffing sheets and noted there was no RN coverage for eight consecutive hours on many days from July to September of 2023.
- In an interview, the Director of Nursing confirmed that no dedicated RN was available on weekends but stated that resident safety was maintained because the administrator, who is an RN, resided onsite.
- Additionally, during interviews, the business office manager stated they were unaware of the lack of RN coverage. They believed that the administrator's RN hours were being counted as part of the required direct care hours.
- The administrator confirmed she was both the administrator and an RN. She acknowledged that the facility experienced days without RN coverage but stated she was unaware that her hours as an RN did not count toward meeting the required RN coverage.
- **Note:** Having appropriate staffing levels is necessary for ensuring the safety and well-being of residents in nursing home facilities, as it allows for timely care, reduces the risk of neglect, and supports a higher standard of personalized attention.

- **Know Your Rights:** Sufficient staffing is one of the most important indicators of a nursing home's quality and safety. Every facility must have sufficient and competent nursing staff to ensure residents attain or maintain their highest practicable physical, mental, and psychosocial well-being. To see the latest staffing levels in your nursing home, check out LTCCC's nursing home staffing data.

Can I Report Resident Harm?

YES! Residents and families should not wait for annual health inspections to report resident harm or neglect. 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 Care Compare website. If you do not receive an adequate or appropriate response, contact your CMS Location (formerly known as Regional Office).

Center for Medicare Advocacy
MedicareAdvocacy.org

LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

Elder Justice
Volume 7, Issue 2

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

[1] Statement of Deficiencies for Cobble Hill Health Center Inc (February 16, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Cobble-Hill-Health-Center-Inc-F658.pdf.
[2] Statement of Deficiencies for Asbury Park Nursing Rehabilitation Center (August 6, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Asbury-Park-Nursing-Rehabilitation-Center-F557.pdf.
[3] Statement of Deficiencies for Maple Springs of Wasilla (July 6, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Maple-Springs-of-Wasilla-F758.pdf.
[4] Statement of Deficiencies for Altercare of Hartville Ctr For (December 20, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Altercare-Of-Hartville-Ctr-For-F677.pdf.
[5] Statement of Deficiencies for Crossroads Care Center of Mayville (August 15, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Crossroads-Care-Center-of-Mayville-F690.pdf.
[6] Statement of Deficiencies for Carmel Home (February 15, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/03/Carmel-Home-F727.pdf.