# ELDER JUSTICE


# What "No Harm" Really Means for Residents


Center for Medicare Advocacy & Long Term Care Community Coalition Volume 7, Issue 3


## 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 (approximately 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

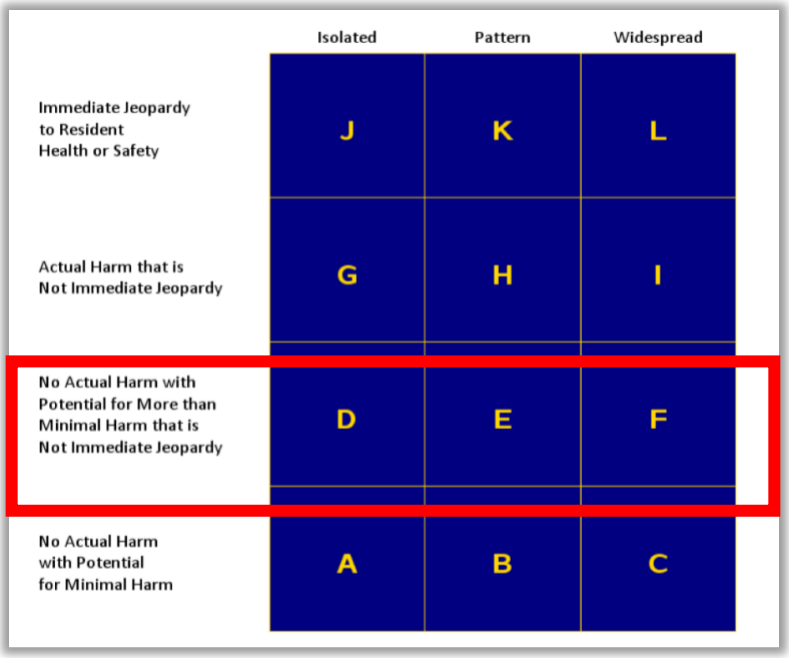
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

**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.



On April 22, 2024, the Centers for Medicare & Medicaid Services (CMS) issued a final rule mandating quantitative minimum nurse staffing standards for all nursing homes that accept Medicare and/or Medicaid funding. The rule requires facilities to provide a total of 3.48 hours per resident day (HPRD) of nursing staff time, including at least 0.55 HPRD from registered nurses (RNs) and 2.45 HPRD from certified nurse aides (CNAs).

Despite being a modest step forward, the rule has faced strong opposition. Industry lobbyists and their allies in Congress claim the requirements are too burdensome. In reality, the new minimum is well below what research—and federal law—indicates is necessary to ensure *safe* staffing. It falls short of the staffing levels residents need not only to live with dignity, but even to survive safely.

Adding to the controversy, two lawsuits have been filed seeking to overturn the rule. In one of these cases, a federal judge has already ruled in favor of the plaintiffs, casting uncertainty over the rule's future.

This issue of the *Elder Justice Newsletter* highlights facilities that continue to fall below the 3.48 HPRD threshold—underscoring how far the system still is from meeting even the new, insufficient standard.

## Highland Manor of Fallon Rehabilitation LLC (Nevada)

### Broken dentures, broken promises: Resident restricted to a limited diet.

**Facility overall rating**: ★☆☆☆☆

**Facility staffing rating:** ★★☆☆☆

The surveyor determined that the facility failed to ensure timely dental services for a resident with damaged dentures. The facility's policy and nursing home standards of care require providing routine and 24-hour emergency dental care (F790). The delay in replacing the resident's broken dentures led to the resident's placement on a limited "mechanical soft" diet, which, according to the resident, consisted only of soup and made them feel as though it was hastening their death. Despite this finding, the surveyor classified the violation as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- According to health records, facility staff informed a nurse that a resident's bottom dentures had been broken in half. A progress note from nearly three weeks later noted that resident's lower dentures were still broken.
- As a result, the resident was informed that their diet would be downgraded to a "mechanical soft" diet, which includes thin liquids and small portions. According to the citation, the resident said the facility informed them their diet was being changed. The resident was already receiving hospice care and felt that being unable to eat solid food was causing them to die faster than they would have otherwise.

- There was no documented evidence of the facility's attempting to repair the resident's dentures for a month from 07/18/2024 to 08/16/2024.
- A progress note documented that the resident refused to visit the dentist and requested that the facility buy denture glue to fix the dentures. However, the facility did not take action to repair the dentures or arrange a timely dental appointment for the resident.
- Facility staff confirmed that after the dentures were broken, the facility attempted to arrange a dental appointment, but there were delays in following through.
- During an interview, the administrator acknowledged that the previous resident advocate (RA) had not followed up, leaving the current RA to address the issue.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.38 hours per resident per day (HPRD) of total nurse staff time, including 0.40 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **Know Your Rights:** When left unaddressed for too long, dental problems can become serious issues. Nursing homes must assist residents in obtaining routine and 24-hour emergency dental care. Federal guidance defines "emergency dental services" to include "broken, or otherwise damaged teeth, or any other problem of the oral cavity that required immediate attention by a dentist." To learn more, check out LTCCC's fact sheet on dental services.

## Chadwick Nursing and Rehabilitation Center LLC (Mississippi)

### Left in soiled conditions: Unanswered call lights lead to delays in care.

**Facility overall rating**: ★★☆☆☆

**Facility staffing rating:** ★★☆☆☆

The surveyor determined that the facility failed to ensure sufficient nursing staff to meet the needs of residents (F725). The delay in providing timely care, including failure to answer call lights and provide incontinence care, was found to have negatively impacted three residents. Despite these findings, the surveyor classified the violation as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a resident reported experiencing long delays in receiving incontinence care, resulting in soiled briefs and a strong odor.
- In an interview, facility staff stated there was only one CNA caring for 12 residents.
- Another resident reported frequent delays in call light responses, noting that staff would often pass off requests to the CNA, resulting in further delays.
- A third resident shared that during the night shift (11:00 PM to 7:00 AM), they received no assistance despite activating the call light.
- Staff confirmed chronic short-staffing, with only one CNA covering an entire hall without adequate support from nurses.
- During interviews, the director of nursing and the administrator both confirmed that timely care should be provided to all residents. However, staffing shortages and insufficient CNA support contributed to the failure to meet the residents' care needs.

- **Note**: The most recent staffing data indicate that this nursing home provides 3.45 hours per resident per day (HPRD) of total nurse staff time, including 0.50 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **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 right includes timely medical care, such as necessary tests and scans, as well as personal support in bathing, dressing, grooming, and oral hygiene, in accordance with the resident's preferences and customs. To learn more, see LTCCC's fact sheet on resident care and well-being.

## The Blossoms at Fort Smith Rehab & Nursing Center (Arkansas)

### Neglected catheter care: Increased risk of infection.

**Facility overall rating**: ★★☆☆☆

**Facility staffing rating:** ★★☆☆☆

The surveyor determined that the facility failed to provide proper care for two residents with indwelling catheters (F690), violating professional nursing standards and increasing the risk of infection for both residents. Despite this finding, the surveyor classified the violation as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- According to the surveyor, the facility neglected to notify the physician about a leaking catheter for one resident, failed to provide appropriate treatment for the resulting abrasions and leakage, and did not apply a dressing to the catheter site.
- The resident was observed sitting in a wheelchair with an indwelling catheter site that was red, swollen, and draining white/yellow mucous. No dressing was in place, indicating a lack of proper wound care and potential infection control failure.
- The surveyor also noted that another resident's catheter bag was found on the floor. Placing catheter bags on the floor violates infection control practices, and despite staff training, staff at this facility failed to consistently position the catheter bag correctly.
- The facility's policy clearly requires proper handling of catheter bags to prevent infection, which was not followed in these cases.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.42 hours per resident per day (HPRD) of total nurse staff time, including 0.22 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **Know Your Rights:** Proper catheter care is essential to prevent serious complications such as urinary tract infections, skin breakdown, and sepsis. Inappropriate or inconsistent care—such as failing to keep the site clean, protected, and monitored—places residents at significant risk for preventable infections, pain, and overall decline in health. Nursing home residents have the right to timely and appropriate catheter and wound care, and failure to provide this care increases the risk of preventable infections and violates basic standards of care. To learn more, see LTCCC's fact sheet on resident care and well-being.

## Bedrock Rehabilitation and Nursing Center at West (Florida)

### "Terrible care": Unanswered call lights and late medication deliveries.

**Facility overall rating**: ★★☆☆☆

**Facility staffing rating:** ★★☆☆☆

The surveyor determined that the facility failed to provide sufficient staffing to meet the needs of residents, resulting in delayed responses to call lights and untimely medication administration, as required by facility policy and professional standards of care (F725). Despite these findings, the surveyor classified the violation as no-harm.[4] The citation was based, in part, on the following findings from the SoD:

- In an interview, a resident described the care at the facility as 'terrible,' citing long waits for call light responses. The resident reported that staff would sometimes enter the room, turn off the call light, and never return. The resident also noted that weekends were especially difficult for receiving timely assistance.
- During both observation and interviews, it was revealed that another resident had a similar experience with delays in answering their call light. The call light went unanswered for over an hour, even though staff passed by it.
- During an interview, an employee confirmed that medications were being administered late, with four residents experiencing particularly long delays. The employee also acknowledged that, although facility protocol requires notifying the director of nursing when medications are administered late, they failed to do so.
- During an interview, another employee confirmed that medications were being administered late due to staffing issues.
- During interviews, both the director of nursing and the administrator confirmed that staffing was a challenge at the facility, often leading to delays in responding to call lights and administering medications. The director of nursing also mentioned working on the medication cart herself as part of a rotating schedule with other supervisors to help mitigate the issue.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.42 hours per resident per day (HPRD) of total nurse staff time, including 0.48 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **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.

## Early Memorial Nursing Facility (Georgia)

### Inadequate pressure ulcer care: Gaps in documentation and treatment.

**Facility overall rating**: ★☆☆☆☆

**Facility staffing rating**: ★☆☆☆☆

The surveyor determined that the facility failed to ensure appropriate pressure ulcer care, including weekly skin assessments, documentation of wound care, and timely wound care, as required by facility policy and professional standards (F686). The lack of consistent, documented wound care led to missed opportunities to assess and manage pressure ulcers, potentially worsening residents' conditions. Despite these findings, the surveyor classified the violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- The surveyor observed that a resident was admitted to the facility with multiple diagnoses, including a right hip stage four pressure ulcer, right ankle and heel pressure ulcers, and other medical conditions.
- Wound care observations indicated that while a wound care RN followed the physician's orders for cleansing and dressing application during observed visits, there were significant gaps in documentation. Weekly skin assessments were not documented for April through July 2023, and physician orders for wound care were not consistently followed by facility staff during that time.
- A second resident was admitted with a stage four sacral pressure ulcer and other medical conditions. Wound care observations revealed a lack of consistent documentation and weekly skin assessments for this resident.
- Similarly, a third resident, admitted to the facility with a stage four sacral pressure ulcer, colostomy, and hypertension, had incomplete and inconsistent documentation of wound care and skin assessments.
- Interviews with staff revealed confusion regarding responsibilities for weekly skin assessments and wound care, with inconsistencies in care between the wound care nurse and other nurses assigned to residents, especially during weekends.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.40 hours per resident per day (HPRD) of total nurse staff time, including 0.38 RN HPRD. These staffing levels are far below safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **Know Your Rights:** A resident with pressure ulcers has the right to receive care that is consistent with professional standards of practice to promote healing, prevent infection, and prevent new ulcers from developing. To learn more, check out LTCCC's fact sheet on pressure ulcers.

## Highland Care Center (New York)

### Missing the mark: The importance of informed consent in resident care.

**Facility overall rating**: ★★☆☆☆

**Facility staffing rating:** ★★☆☆☆

The surveyor found that the facility failed to obtain informed consent before a change to the resident's medication. This violates the resident's right to be notified of changes regarding their care and treatment (F580). Although the facility violated the resident's right, the surveyor classified this violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- The surveyor noted that a resident was prescribed Buspirone, an anti-anxiety medication, but neither the resident nor their representative was informed until 5 days later.
- Facility policy requires notification of any treatment change within 24 hours. Despite documentation in both a physician's order and nursing notes confirming the medication was prescribed to address anxiety, this notification was not made within the required timeframe.
- In an interview, a nurse stated that the nursing supervisor was responsible for notifying the resident's representative.
- The resident's attending physician confirmed that a telephone order was issued due to the resident's agitation and emphasized that the representative should have been contacted, prior to administering the new medication, to discuss risks and benefits.
- **Note:** The most recent staffing data indicate that this nursing home provides 3.18 hours per resident per day (HPRD) of total nurse staff time, including 0.43 RN HPRD. These staffing levels are far below minimum safety thresholds identified in a landmark 2001 federal study (4.10 Total Nurse Staff HPRD).
- **Know Your Rights:** Every resident has the right to informed consent about their care and treatment. This right 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 the treatment is provided. Informed consent is critical in respect to dementia care and the use of antipsychotic medications because these medications are dangerous and generally not clinically appropriate for people with dementia. To learn more, see LTCCC's fact sheet on informed consent.

## 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).

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**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 Highland Manor of Fallon Rehabilitation LLC (Aug 22, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/04/Highland-Manor-of-Fallon-Rehabilitation-LLC-F790.pdf.
[2] Statement of Deficiencies for Chadwick Nursing and Rehabilitation Center LLC (June 5, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/04/Chadwick-Nursing-and-Rehabilitation-Center-LLC-F725.pdf.
[3] Statement of Deficiencies for The Blossoms at Fort Smith Rehab & Nursing Center (March,1 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/04/The-Blossoms-at-Fort-Smith-Rehab-Nursing-Center-F690.pdf.
[4] Statement of Deficiencies for Bedrock Rehabilitation and Nursing Center at West (Feb 23, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/04/Bedrock-Rehabilitation-and-Nursing-Center-at-West-F725.pdf.
[5] Statement of Deficiencies for Early Memorial Nursing Facility (Aug 22, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/04/Early-Memorial-Nursing-Facility-F686.pdf.
[6] Statement of Deficiencies for Highland Care Center (February 6, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/04/Highland-Care-Center-F580.pdf.