ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition — Volume 7, Issue 4

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

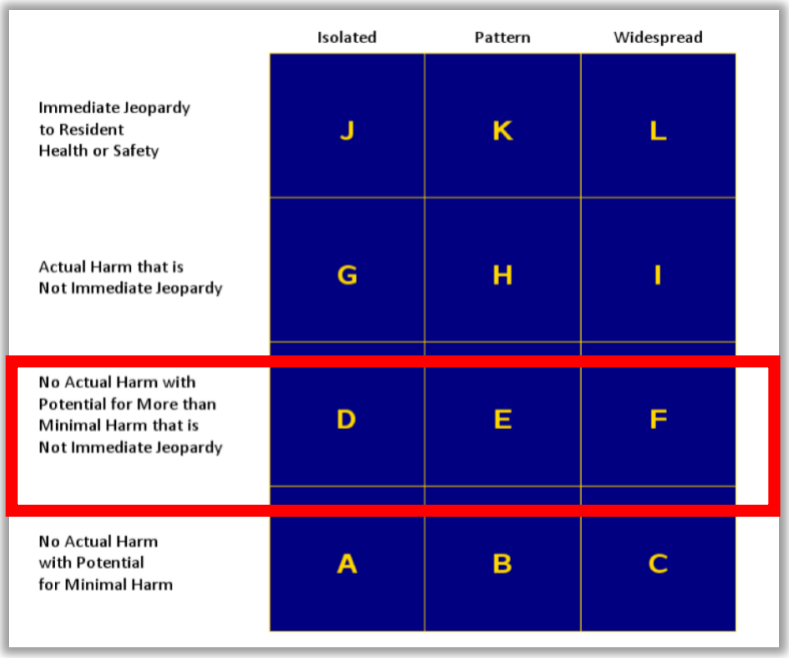
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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.



June marks *Elder Abuse Awareness Month*, a time to reaffirm our shared responsibility to protect older adults—especially those in nursing homes and other long-term care settings—from abuse, neglect, and exploitation. Abuse in these facilities remains widespread and underreported. Fear, cognitive impairments, and systemic failures often keep the truth hidden behind closed doors.

This month, we highlight nursing homes that were cited for violating one of the most fundamental resident rights under federal law—the right to be free from abuse, neglect, and exploitation. These violations involve disturbing failures—physical and emotional abuse, failure to prevent harm, and inadequate supervision of at-risk residents.

Abuse, neglect, and exploitation violations are not isolated incidents. They reflect systemic issues: chronic understaffing, poor training, and a culture that too often devalues older adults' lives. These failures are preventable—and unacceptable.

In this issue of the *Elder Justice Newsletter*, we examine the persistent lack of enforcement and oversight that allows harm to continue. As we recognize Elder Abuse Awareness Month, we call for stronger federal and state accountability, adequate staffing and meaningful staff training, and a renewed national commitment to dignity, safety, and justice for every nursing home resident. Every resident deserves to live free from harm.

Highpointe on Michigan Health Care Facility (New York)

Failure to protect: Facility ignores repeated abuse allegations.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to appropriately investigation serious allegations of abuse involving at least four residents. Despite federal requirements and facility policy mandating immediate and thorough investigations, including staff and resident interviews and protective actions, the facility failed to act in multiple instances (F610). Despite these findings, the surveyor classified the violation as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- **First incident**: Resident 226 was found in resident 208's room next to their bed with resident 208's breasts exposed. Resident 226, who is non-verbal and severely cognitively impaired, could not respond. Resident 226 denied touching resident 208 and left the room when questioned.
- Resident 81, the roommate of resident 208, confirmed someone entered the room but could not see or hear what occurred due to the privacy curtain. No additional witness interviews were conducted, and there was no assessment of whether other residents might have been affected.
- **Second incident:** Staff observed resident 226 standing in a common area with their genitals exposed in the presence of two residents, resident 33 and resident 50.
- Resident 226 denied the exposure when questioned.

- The incident was documented, but no immediate or comprehensive investigation followed.
- **Third incident**: Resident 226 was repeatedly found in resident 50's room, with at least three documented instances. These incidents occurred after the genital exposure event.
- Staff noted the issue but failed to escalate concerns or initiate appropriate safeguards.
- No formal investigations were conducted despite repeated room intrusions. According to interviews, nursing staff, supervisors, and nurse practitioners were either unaware or not properly notified.
- In all three incidents discussed above, the facility failed to follow its abuse policy requiring immediate investigation, staff and witness interviews, and appropriate administrative follow-up.
- During interviews, the director of nursing acknowledged that more should have been done to ensure the safety of all residents.

Nursing home residents have the right to be free from all forms of abuse, including physical and verbal aggression by other residents.

- **Know Your Rights:** Nursing home residents have the right to be free from all forms of abuse, including physical and verbal aggression by other residents. Abuse can take the form of hitting, threatening, name-calling, or any behavior that causes fear or harm. Facilities are required under both state and federal law to protect residents from such mistreatment and to report all allegations or incidents of abuse promptly. When facilities fail to act, residents' safety and dignity are put at serious risk—and far too often, these incidents go unreported. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

The Waters of Springfield LLC (Tennessee)

No report, no accountability: Sexual abuse allegation ignored.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to report an allegation of sexual abuse to the state survey agency involving a resident (F609). Despite a documented complaint and internal investigation, facility leadership did not notify the state or the appropriate agencies of the incident, citing the resident's later recanting. 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 was admitted to the facility with dependence on staff for multiple daily care needs.
- A facility investigation document indicated that a family member reported a man had been entering the resident's room and attempting to touch and kiss the resident.

- According to the citation, a resident reported an incident of alleged sexual abuse by an unidentified man who entered their room and touched them inappropriately. The resident described being touched and complimented in a sexual manner and stated that the individual left their room after being told to stop.
- A family member of the resident relayed the allegation to staff, who then informed the facility's administrator and director of nursing.
- The resident later recanted the allegation, and the facility did not report the incident to the state survey agency as required.
- During interviews, both the administrator and the director of nursing acknowledged that the incident had not been reported to the state. They claimed this was because the resident had recanted the allegation within two hours.
- According to the citation, the facility's abuse prevention program policy requires immediate reporting of any suspected or alleged abuse to state licensing and certification agencies, including the Tennessee Department of Health (TDH/SSA).
- Both the administrator and director of nursing later admitted that they understood that all abuse allegations, regardless of perceived credibility or retraction, must be reported to the appropriate authorities per federal law and facility policy.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including sexual abuse and unwanted physical contact. When a resident or family member reports inappropriate behavior, the facility is legally obligated to take immediate action. This includes reporting the allegation to the facility administrator and appropriate state agencies, conducting a thorough investigation, and ensuring the resident's safety. Failing to report or respond to such abuse not only violates state and federal regulations but also places residents at continued risk of harm. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Nursing home residents have the right to be free from all forms of abuse, including sexual abuse and unwanted physical contact. This includes reporting the allegation to the facility administrator and appropriate state agencies.

Birchwood Terrace Rehab & Healthcare (Vermont)

Known risk, no protection: Abuse policy not followed.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to protect a resident from physical abuse during an altercation with another resident (F600). Despite documented behavioral concerns and prior incidents involving both residents, the facility did not take effective steps to prevent further aggression or ensure resident safety. Despite this, 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 citation, staff observed a resident throw a clipboard at a second resident, striking them on the elbow. The second resident threw the clipboard back, after which the first resident threw it again—this time missing.
- The second resident sustained a skin tear as a result of the clipboard being thrown at them.
- The second resident had previously exhibited verbal and physical aggression toward the first resident, including making verbally aggressive comments.
- A physician's note documented that the second resident had repeatedly shown verbal and physical aggression toward several other residents, including involvement in a confirmed physical altercation. Although their behavior improved somewhat after an increased dose of a Selective Serotonin Reuptake Inhibitor (SSRI), a type of medication commonly used to treat depression, anxiety, and other mood disorders, the physician determined the resident still posed a safety risk to themselves and others.

Nursing home residents have the right to be free from all forms of abuse, including physical and verbal aggression by other residents.

- The facility's "Abuse, Neglect, and Exploitation" policy defines abuse to include the "willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting with resulting physical harm, pain, or mental anguish, which can include staff to resident abuse and certain resident to resident altercations." The policy stated the facility would implement written procedures to prohibit and prevent such incidents.
- **Know Your Rights:** Nursing home residents have the right to be free from all forms of abuse, including physical and verbal aggression by other residents. Abuse can take the form of hitting, threatening, name-calling, or any behavior that causes fear or harm. Facilities are required under both state and federal law to protect residents from such mistreatment and to report all allegations or incidents of abuse promptly. When facilities fail to act, residents' safety and dignity are put at serious risk—and far too often, these incidents go unreported. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Madonna Manor Nursing Home (Massachusetts)

Restrained without review: Failure to evaluate use of jumpsuit on resident.

Facility overall rating: ★★★☆☆☆

The surveyor determined that the facility failed to evaluate the use of a one-piece jumpsuit as a restraint for a resident to ensure it was the least restrictive device and necessary (F604). 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:

- According to observations, a resident at the facility appeared well-groomed, pleasant, and dressed in a one-piece jumpsuit with a rear zipper.

- A physician prescribed a one-piece jumpsuit to be worn at all times except during personal hygiene. According to the citation, the jumpsuit was initiated due to the resident smearing feces.
- There was no documented restraint assessment to determine if the jumpsuit was a restraint and the least restrictive option.
- The facility's physical restraint policy requires that restraints be used only for medical symptoms, be the least restrictive method, and be regularly assessed by an interdisciplinary team.
- The resident's care plan included the use of a jumpsuit to address fecal smearing and help preserve the resident's dignity, stating that scheduled toileting had not been effective in resolving the behavior.
- During interviews, a nurse acknowledged that the jumpsuit was a restraint and said it had been used for five or six months. The nurse was not aware of other attempted interventions or care plan assessments.
- The director of nursing also confirmed during interviews that the one-piece jumpsuit was a restraint and admitted that no documentation showed that alternative interventions were attempted or that a restraint assessment had been completed either when the restraint was initiated or at the July re-evaluation.
- **Know Your Rights:** Nursing home residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. According to CMS's interpretive guidance, a physical restraint is any manual method, physical or mechanical device, equipment, or material that meets all the following criteria: 1) is attached or adjacent to the resident's body; 2) cannot be removed easily by the resident; and 3) restricts the resident's freedom of movement or normal access to their body. To learn more, check out LTCCC's fact sheet on physical restraints.

Nursing home residents have the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms.

Riveridge Rehabilitation and Healthcare Center (Missouri)

Silenced in the shower: CNA abuse.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to protect a resident from abuse by a certified nursing assistant (CNA) during a shower (F600). The facility also failed to respond adequately to prior concerns about this specific CNA raised by staff. 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:

- A review of a facility reported incident report revealed that CNA 1 was showering a resident with the assistance of CNA 2. When the resident began yelling, CNA 1 allegedly covered her mouth with his hand and sprayed water in her face to prevent her from being heard.

- CNA 2 immediately told CNA 1 to stop the action, which he did.
- In an interview, CNA 2 reported that "it was typical for [CNA 1] to be inconsiderate and disrespectful to residents; [CNA 1] spoke rudely to residents, and during care would intentionally cause residents to feel uncomfortable."
- An interview revealed that CNA 3 heard the yelling from the incident and witnessed CNA 1 with his hand over the resident's mouth. CNA 3 reported the incident to the charge nurse.
- CNA 3 also stated in an interview that CNA 1 had abused several residents and had allegedly blackmailed coworkers into silence.
- During an interview, CNA 1 admitted to putting his gloved hand over the resident's mouth, stating it was to prevent other residents from hearing her yelling. He said he did not consider the act to be abusive because he did not physically harm the resident.
- The CNA was terminated following the incident. After the termination, the nursing home administrator received additional reports alleging prior abuse by the same staff member.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including physical, verbal, and emotional harm. Verbal abuse can include yelling, threats, or any language meant to intimidate or demean a resident. Covering a resident's mouth, even without causing physical injury, is a clear violation of their dignity and autonomy and may be considered both physical and emotional abuse. Federal and state regulations require all suspected or observed abuse to be reported immediately to the facility administrator and appropriate authorities. Failure to report or investigate such incidents puts residents at serious risk and undermines their legal rights to safe, respectful care. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Medical Suites at Oak Creek (the) (Wisconsin)

Fall, fracture, and failure: Neglect leads to broken ankle.

Facility overall rating: ★☆☆☆☆

The surveyor found that the facility failed to protect a resident from harm when staff failed to follow a resident's care plan and subsequently failed to follow required procedures, dropping the resident during a transfer (F600). Despite the neglect resulting in a fall and a fracture, the surveyor classified the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a resident who required a two-person mechanical lift was improperly transferred by two CNAs using only a gait belt, contrary to the care plan.
- During the transfer, the resident fell and sustained a closed displaced bimalleolar fracture of her right ankle.
- One CNA reported told the resident, "I'm not your bitch," and another reportedly said, "I am not your slave."

Nursing home residents have the right to be free from all forms of abuse, including physical, verbal, and emotional harm.

- The incident and injury were not reported to a nurse until approximately three hours later, despite facility policy requiring immediate notification and investigation.
- The CNAs involved were not suspended until the following day, and facility leadership failed to initiate a timely investigation.
- The resident was found visibly upset, tearful, and continued to experience pain, anxiety, and mood changes after the incident. Swelling and bruising developed, and the resident ultimately required ER care, casting, and regular administration of pain medication (oxycodone). The resident's care plan clearly required two people for all transfers. Facility staff failed to follow this protocol, directly resulting in the fall. Despite this, the CNAs completed their shifts and were not suspended until the following day.
- The facility's abuse and neglect policy requires immediate investigation when abuse or neglect is suspected. No documentation explained why the care plan was disregarded or why the verbal abuse was not reported.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including neglect, abuse (verbal and physical) 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.

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).

Elder Justice
Volume 7, Issue 4

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 Highpointe on Michigan Health Care Facility (September 16, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/Highpointe-on-Michigan-Health-Care-Facility-F610.pdf.
[2] Statement of Deficiencies for The Waters of Springfield LLC (July 25, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/The-Waters-of-Springfield-LLC-F609.pdf.
[3] Statement of Deficiencies for Birchwood Terrace Rehab Healthcare (December 31, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/Birchwood-Terrace-Rehab-Healthcare-F600.pdf.
[4] Statement of Deficiencies for Madonna Manor Nursing Home (August 21, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/Madonna-Manor-Nursing-Home-F604.pdf.
[5] Statement of Deficiencies for Riveridge Rehabilitation and Healthcare Center (September 13, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/Riveridge-Rehabilitation-and-Healthcare-Center-F600.pdf.
[6] Statement of Deficiencies for Medical Suites at Oak Creek (the) (July 15, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/06/Medical-Suites-at-Oak-Creek-the-F600.pdf.