ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 7, Issue 5

IN THIS ISSUE: FOCUS ON VIOLATIONS OF REQUIREMENTS FOR A SAFE DISCHARGE

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

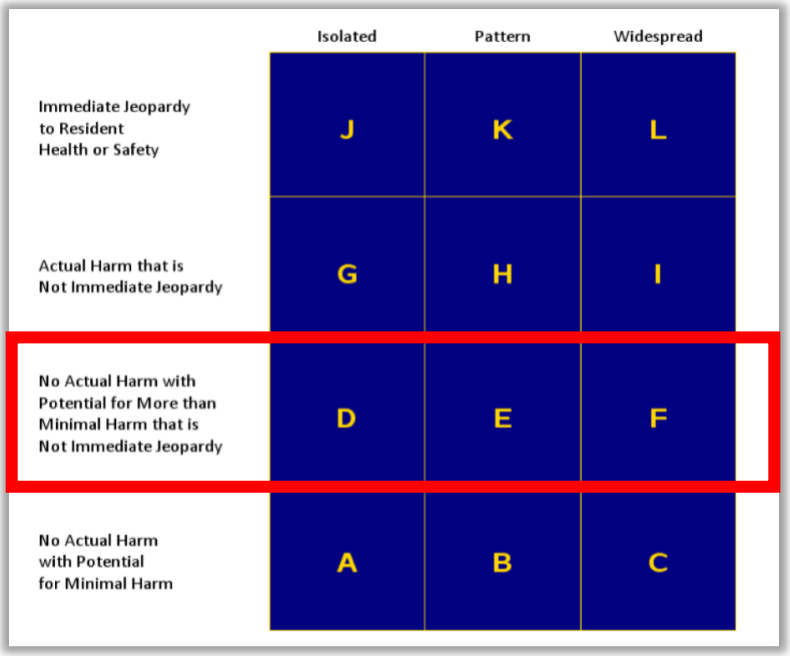
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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.



Unlawful or poorly managed transfers and discharges are among the most common and distressing violations experienced by nursing home residents. These actions can lead to trauma, hospitalization, and even homelessness.

In this issue, we highlight deficiencies where nursing homes failed to follow federal requirements, putting vulnerable residents at serious risk. Families, ombudsmen, and advocates must remain vigilant in ensuring residents' rights are protected during any discharge or relocation process.

For more information, see LTCCC's page on the Inappropriate Transfer or Discharge of Nursing Home Residents.

Auburn Rehabilitation & Nursing Center (New York)

Blue lips and unresponsive: Resident discharged without oxygen, arrives in medical crisis.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to ensure a safe discharge for a resident dependent on continuous oxygen therapy (F624). The resident was sent to an assisted living facility without oxygen tubing, traveled over 45 minutes without oxygen, and arrived cyanotic and unresponsive. Nevertheless, 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, the resident's care plan called for oxygen therapy at all times due to a diagnosis of chronic respiratory failure and congestive heart failure.
- The facility discharged the resident with no tubing connected to the oxygen tank. Staff noted that an oxygen tank was attached to the wheelchair but did not ensure that the resident had tubing or was receiving oxygen.
- Upon arrival at the assisted living facility, staff observed the resident with blue lips and slipping out of the wheelchair as the resident was in and out of consciousness. The facility's nurse performed a sternal rub to revive the resident while the family provided emergency oxygen and called 911.
- The resident transport service stated they were never told the resident required oxygen, and they do not provide or manage oxygen during transport.
- The resident recovered after being placed on oxygen by the assisted living staff, but only after an extended period without respiratory support.
- **Know Your Rights:** Every nursing home resident has the right to a safe discharge that supports their ongoing care needs. Facilities must coordinate medical services and equipment, including oxygen therapy, during and after discharge. Discharging a resident

Facilities must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge.

without critical supports places them at risk of serious harm or death. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Ignite Medical Resort Kansas City, LLC (Missouri)

Medication confusion: Five residents discharged without medications or follow-up care.

Facility overall rating: ★★☆☆☆

Abuse Icon: This nursing home has been cited for abuse. Learn more.

The surveyor determined that the facility failed to safely discharge five residents, resulting in confusion, medication errors, and serious lapses in care (F624). In one case, a resident received another person's medication and went days without any treatment. 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, residents were sent home without essential prescriptions, equipment, services, or provider follow-up.
- Resident 1 was discharged following a heart attack and active pneumonia. The resident was sent home without provider follow-ups or confirmed home health services.
    - The resident had 30 medications prescribed at the time of discharge and was given medications belonging to two other residents and took no medications post-discharge due to confusion and fear of harm.
- Resident 2 left the facility without any of the 16 medications prescribed to them, and the facility did not provide the resident with the name, phone number, and/or address for the pharmacy to which it sent the prescriptions.
    - In addition, the resident was discharged without medical equipment (despite needing a hospital bed and lift), and dialysis was not arranged, even though dialysis was required. The resident's family had to coordinate everything themselves after the discharge.
- Resident 3 left against medical advice but stated the facility had promised to send prescriptions to the pharmacy. None was received, and the resident went without medications altogether.
- Resident 4 was transferred to the hospital without provider authorization or documentation of discharge or transfer records.
- Resident 5 reported receiving no discharge instructions or therapy guidance and said staff were discussing diagnoses they had never heard before. There was no documentation of discharge education or care planning.
- **Know Your Rights**: Nursing home residents have the right to safe and well-planned discharges. Facilities are responsible for taking steps to coordinate medications, services, follow-up care, and essential equipment. Discharging a resident without completing these steps puts the resident's health, and sometimes their life, at risk. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

The Waters of Wakarusa Skilled Nursing Facility (Indiana)

Kicked out on Christmas: Resident discharged without proper notice.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to properly plan and coordinate the discharge of a resident recovering from complex gastrointestinal surgery and dependent on tube feeding (F624). Despite the resident's high medical needs and lack of a safe discharge plan, the facility pushed him out with no physician order, minimal documentation, and no community resources in place. Still, 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, a discharge plan dated 12/16/24 with a target date of 2/28/25 indicated the resident's goal was to discharge from the facility after a short-term stay.
- On 12/23/24, the facility informed the resident and his sister that he had to leave immediately because the facility "had nothing to skill him on" and insurance would not pay. There was no prior warning, planning documentation, or notice of Medicare non-coverage.
- During an interview, the facility administrator stated that on 12/24/24 the resident's sister left a message saying the resident was to be transported to the hospital because she refused to take him. However, when the administrator played the recording for the surveyor, the sister's message instead stated that neither she nor her sister could care for the resident, that he was homeless, and that she was very upset the facility was discharging him right before Christmas.
- In an interview, the facility's medical director indicated he had not been notified of, nor had any record of, ordering a discharge for the resident.
- A facility employee dropped the resident off at the hospital front door with no medical paperwork or transfer communication. The hospital later documented that he arrived homeless, dependent on tube feeding, and had expressed suicidal thoughts.
- Though the resident's discharge summary claimed he was discharged home and accompanied by family, interviews revealed he was alone and had no safe place to go.
- **Know Your Rights:** Every nursing home resident has the right to a safe and orderly discharge that protects their physical, mental, and psychosocial well-being. A resident cannot be discharged without appropriate notice and planning, and residents cannot be simply dropped off without support or documentation. To learn more, see LTCCC's fact sheet on notice requirements for transfer and discharge.

Main West Postacute Care (California)

"Never been homeless before": Resident discharged to a homeless shelter.

Facility overall rating: ★★★★☆

The surveyor determined that the nursing home failed to ensure a safe and appropriate discharge for a long-term resident with multiple serious medical and mental health conditions (F624). The resident was to be discharged to a homeless shelter, a decision that caused emotional distress and led to increased psychiatric medication. 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 the citation, a resident had multiple serious diagnoses and required oxygen, insulin, and regular breathing treatments.
- After being notified of an upcoming discharge, the resident became distraught and experienced near daily mood swings. Staff increased her antipsychotic medication twice in one month due to "angry outbursts."
- Despite being dependent on staff for bathing and walking only short distances in her room, the facility coded her MDS as being independent in walking 150 feet. Staff uniformly stated they had never seen her walk outside of her room.
- The facility planned to transition the resident from insulin injections to oral diabetes medication but had no physician order for this change.
- According to the citation, the resident stated, "I am not leaving," and her family confirmed she had never been homeless before. Staff acknowledged that she had lived in the facility for six years and would be forced to self-manage complex treatments alone.

Notice of transfer or discharge must be made by the facility at least 30 days before the resident is transferred or discharged.

- **Know Your Rights:** Nursing home residents have the right to remain in a facility unless a lawful discharge is necessary and properly planned. A nursing home cannot discharge a resident without ensuring their safety and that the receiving facility can meet the resident's needs. Discharge plans must involve the resident, their representative, physician, and the ombudsman, and must include appropriate services and supports. To learn more about the protections that limit when residents can be transferred or discharged, check out LTCCC's fact sheet on essential transfer and discharge protections.

Mission Point Health Campus of Jackson (Michigan)

"Walking with a Swiffer brand mop": Resident discharged twice without equipment, care, or housing.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to ensure a safe discharge for a vulnerable resident on two separate occasions, resulting in repeated hospitalizations, unsafe living conditions, and lack of critical services (F622). Despite serious failures in discharge planning, the surveyor classified the violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- According to the citation, in October 2023, the resident was discharged home without a walker, medical equipment, or home health services, despite therapy recommendations.
- By the following Tuesday, he had already fallen, was using a Swiffer mop as a walker, had no food or medication, and was found unresponsive during a welfare check.
- Following hospitalization and readmittance to the nursing home, the facility discharged the resident in November 2023 to a homeless shelter via a taxi.

- Despite having Medicaid coverage and expressing interest in long-term care, the facility told the resident the only way to stay was to pay $374 per day. The facility could not explain why the resident was required to pay private rates.
- Discharge records again showed no home health referrals, equipment, or pharmacy information provided.
- Therapy documented that the resident needed assistance for walking, daily activities, and swallowing, but none of these was addressed in the resident's discharge plan.
- **Know Your Rights**: When nursing homes fail to coordinate safe discharges, residents face a high risk of hospitalization, injury, and even death. Furthermore, residents have the right to remain in a facility unless specific legal criteria are met. The facility must find that the receiving facility is capable of meeting the resident's needs. If a resident is eligible for Medicaid, they must be given access to certified beds without being forced into private pay. To learn more, see LTCCC's fact sheet on nursing home transfer and discharge rights.

Town and Country Nursing and Rehabilitation Center (Texas)

"No one knew what to do": Residents discharged without home health, equipment, or wound care.

Facility overall rating: ★☆☆☆☆

The surveyor found that the facility discharged two vulnerable residents with significant medical needs without confirming home health services, arranging durable medical equipment (DME), or coordinating post-discharge care (F624). The lack of coordination was attributed, in part, to the absence of a social worker. Despite these failures and the known risks, 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, the facility discharged Resident 1 after hip surgery, and the resident required extensive assistance and use of a wheelchair.
- The physician ordered home health care at discharge, and the rehab director had notified leadership in advance that Resident 1 would need a wheelchair. However, according to the citation, no home health services were arranged, no DME (durable medical equipment) was delivered, and the family was left to secure care through a local nonprofit after discharge.
- According to the surveyor, Resident 1's discharge summary was incomplete, missing signatures, dates, and confirmation of follow-up care.
- Facility staff, including nurses, rehab, and MDS coordinators, acknowledged that discharge needs had been raised repeatedly in morning meetings but that no action was taken. One nurse told surveyors that the family was told they would have to "handle it on her own" because there was no social worker at the facility.

> A nursing home's failure to confirm care coordination following a transfer or discharge is not just poor communication, it is a breakdown of the entire care system.

- Home health ultimately did not begin until five days after discharge, and the agency confirmed it was a nurse practitioner from an outside nonprofit, not the facility, who made the referral.
- Resident 2, a younger resident with a healing surgical wound, was discharged with physician orders for home health and wound care. However, staff failed to confirm that any services were actually in place.
- Resident 2 received a few days' worth of wound supplies and was expected to perform his own dressing changes. One nurse said she gave the resident "his things" 15-20 minutes before transport arrived and let him leave without clearing the discharge with social services.
- Interviews revealed that the social worker was unlicensed, newly hired, and had no long-term care experience or training. She stated she was "trying to train herself" and had only worked on one or two discharges.
- Other staff acknowledged they were unfamiliar with the facility's own discharge policy and admitted they had not confirmed any follow-up services before releasing the residents. When asked about the process, several staff said they simply assumed someone else had taken care of it.
- **Know Your Rights**: Nursing homes are legally required to coordinate post-discharge care, including arranging medical services and equipment. Facilities must not discharge residents without proper preparation simply because of internal staffing shortages. For more information on resident rights pertaining to transfer and discharge, see LTCCC's fact sheet.

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
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LONG TERM CARE COMMUNITY COALITION
Advancing Quality, Dignity & Justice

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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 Auburn Rehabilitation & Nursing Center (April 21, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/07/Auburn-Rehabilitation-Nursing-Center-NY.pdf.
[2] Statement of Deficiencies for Ignite Medical Resort Kansas City, LLC (October 3, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/07/Ignite-Medical-Resort-Kansas-City-LLC-MO.pdf.
[3] Statement of Deficiencies for The Waters of Wakarusa Skilled Nursing Facility (January 1, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/07/The-Waters-of-Wakarusa-Skilled-Nursing-Facility-IN.pdf.
[4] Statement of Deficiencies for Main West Postacute Care (August 23, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/08/Main-West-Postacute-Care-CA.pdf.
[5] Statement of Deficiencies for Mission Point Health Campus of Jackson (December 20, 2023). Available at https://nursinghome411.org/wp-content/uploads/2025/08/Mission-Point-Health-Campus-of-Jackson-MI.pdf.
[6] Statement of Deficiencies for Town and Country Nursing and Rehabilitation Center (February 22, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/08/Town-and-Country-Nursing-and-Rehabilitation-Center-TX.pdf.