ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 7, Issue 6

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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 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 penalty, nursing homes 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 or other penalties. In the absence of a penalty, nursing homes have little incentive to correct the underlying causes of resident abuse or neglect.

How to Use this Newsletter

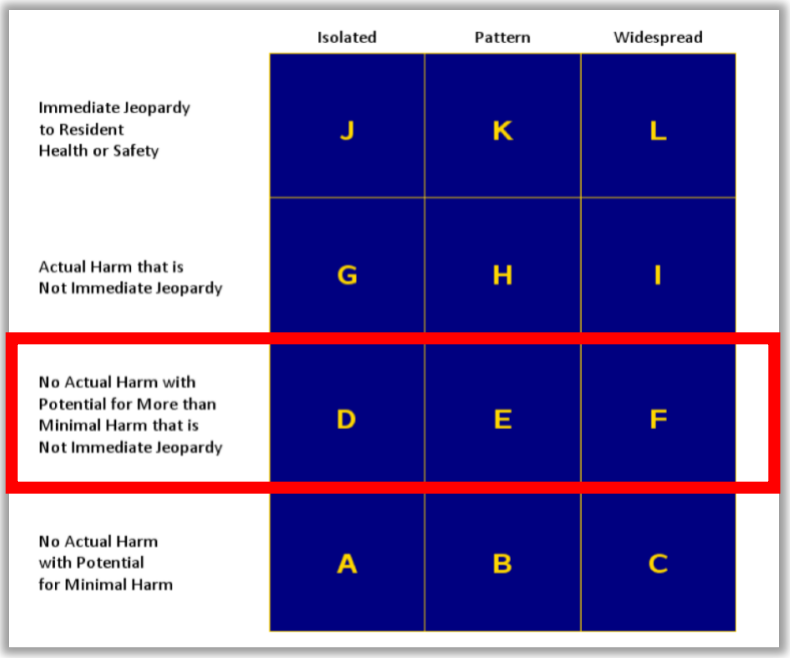
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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: Focus on Special Focus Facilities

Across the country, far too many nursing home residents live in facilities with long histories of serious noncompliance. To help address this problem, CMS created the Special Focus Facility Program. The Program was established to address facilities with "yo-yo compliance," i.e., a pattern of being cited for failure to comply with minimum standards, ostensibly correcting their deficiencies in order to continue to receive taxpayer funds, only to fall out of compliance again. The basic goal is that a facility either adopts meaningful corrections to its persistent problems or is terminated from federal funding. **This issue of the *Elder Justice Newsletter*** takes a close look at what SFF status really signals for residents and families, and why repeated deficiencies in these homes remain one of the clearest warning signs of risk to health, safety, and dignity.

An October 2025 HHS Office of Inspector General (OIG) analysis underscores the stakes. Reviewing SFF outcomes from 2013-2022, the OIG found that the program has not produced lasting improvement: nearly two-thirds of facilities that "graduated" from the SFF program later slipped back into the same kinds of quality failures that harmed residents and put the nursing homes on the list in the first place.

The current list of SFFs is available here. In addition, LTCCC's Provider Data Report includes information on whether a facility is a SFF, SFF Candidate, or Problem Facility.

⚠ **Note**: The nursing homes listed in this newsletter do not have a rating from CMS due to a history of serious quality issues. According to CMS, nursing homes in the SFF program are required to be subject to more frequent inspections, escalating penalties, and potential termination from Medicare and Medicaid.

Hearthstone Nursing & Rehabilitation Center (Oregon)

Repeated sexual touching and escalating threats: Facility failed to protect residents from abuse.

Facility overall rating: ⚠ **Not available**

The surveyor determined that the facility failed to protect residents from abuse when one resident repeatedly engaged in sexual touching and verbal aggression toward another resident, despite multiple warnings and escalating behavior (F600). Staff witnessed inappropriate sexual contact and verbal threats on several occasions, yet the facility failed to prevent additional incidents or implement adequate protective measures. Still, the surveyor classified the violation as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- On 4/3/25, multiple CNAs and a nurse witnessed Resident 208 touching the breast of Resident 32 in the dining room.
- Staff moved Resident 208 away, but the resident returned repeatedly, attempting to approach Resident 32 and becoming verbally aggressive when redirected.
- CNA statements documented Resident 208 saying sexualized and threatening remarks, including, "do you want some of this?" while pointing down toward his groin.

- Witnesses noted that Resident 32 was severely cognitively impaired and could not consent to any physical contact.
- On 4/11, Resident 208 become verbally aggressive toward staff and other residents, requiring police and EMS involvement for psychiatric evaluation; during this event, the resident threatened EMTs: "If I get you alone, I'll knock your f---ing teeth out."
- Despite these incidents, Resident 208 was returned to the facility the same day and continued to display aggression toward residents and staff.
- Multiple staff confirmed the sexual contact occurred, and yet the administrator stated he did not believe the behavior was willful and did not believe the facility could have prevented it.

Every nursing home resident has the right to live free from abuse, including sexual contact, harassment, and intimidation.

- **Know Your Rights:** Every nursing home resident has the right to live free from abuse, including sexual contact, harassment, and intimidation. Facilities must immediately intervene, report, investigate, and prevent recurrence of any suspected abuse. When a resident poses a risk to others, the nursing home must implement effective safety measures and reassess placement. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents from abuse, neglect, and exploitation.

Crystal Lake Healthcare and Rehabilitation (New Jersey)

Going viral: Facility staff filmed and shared abuse on social media.

Facility overall rating: ⚠ **Not available**

The surveyor determined that the facility failed to protect a resident's right to privacy and confidentiality when a nurse recorded the director of nursing (DON) striking a resident with a broom and then sent the video to a friend who posted it on social media (F583). The resident, who had severe cognitive impairment, was exposed publicly while staff not only failed to intervene in the abuse but facilitated its spread. Despite the gravity of the misconduct, the violation was cited as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- Local police were notified after a video surfaced online showing the DON hitting a cognitively impaired resident with a broom while multiple staff members stood by without intervening.
- A nurse admitted she recorded the incident on her cellphone and sent the video to a friend who then posted it publicly.
- The nurse told the surveyors she "did not know how resident privacy and confidentiality worked."
- Leadership – including the assistant DON and the facility administrator – confirmed that staff were not permitted to record residents and stated that all employees receive training on privacy and confidentiality.

- The facility's policy prohibits any use of cameras or recording devices without permission from the facility and the person being recorded, a condition clearly impossible to meet given the resident's severe cognitive impairment.
- **Know Your Rights**: Nursing home residents have the right to personal privacy, dignity, and freedom from abuse. Facilities must protect residents from unauthorized photography or video recordings, which are violations of federal and state law. Staff are required to report suspected abuse immediately and may not use personal cell phones to capture or share images of residents. To learn more, see LTCCC's webinar on the hidden dangers of social media in nursing homes.

Waterview Heights Rehabilitation and Nursing Center (New York)

Weeks without shower: Residents left without basic hygiene care.

Facility overall rating: ⚠ **Not available**

The surveyor determined that the facility failed to provide essential activities of daily living (ADL) care, including bathing, grooming, and timely incontinence care, for multiple residents (F677). Residents dependent on staff for hygiene went weeks without showers, were observed with soiled clothing, long untrimmed nails, and unwashed hair, and in several cases, visitors – not staff – alerted personnel that residents were sitting in urine or feces. Still, the surveyor classified the violations as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- A resident with dementia was found repeatedly soaked in urine, with soiled linens and a heavily saturated incontinence brief. Staff stated there were only two aides for a 38-resident unit and could not recall when the resident last received care.
- A cognitively intact resident reported not receiving a shower for three weeks; task records showed no documented bathing for 30 days.
- A resident dependent on staff for all ADLs was found with stool on their hands, nails, linens, and body; their visitor reported they had not received a shower or hair wash for three to four weeks.
- Another resident had long, sharp nails, dry scaly skin, and stated they had not been shaved or bathed "in a long time." Records reflected no shower for the previous 30 days, and staff could not identify when care was last provided.
- Staff acknowledged that significant hygiene care was not completed due to staffing shortages, and facility leadership could not confirm when residents last received showers or nail care.
- **Know Your Rights:** Every nursing home resident has the right to receive adequate assistance with bathing, grooming, and incontinence care. Facilities must ensure that all residents receive regular hygiene care that protects their comfort, dignity, and health. Failure to provide these services places residents at serious risk of skin breakdown, infection, and emotional harm. To learn more, see LTCCC's fact sheet on standards of care for resident well-being.

Juniper Village – The Spearly Center (Colorado)

Unaddressed wounds: Resident's pressure injuries worsen without timely assessment or treatment.

Facility overall rating: ⚠ **Not available**

The surveyor determined that the nursing home failed to provide timely and adequate pressure ulcer care for a resident at high risk for skin breakdown (F686). Despite clear evidence of new wounds – including a coccyx ulcer that progressed from Stage 2 to Stage 3 – the facility did not notify the wound specialist, update care plans, or implement essential interventions for more than two weeks. Nevertheless, the surveyor classified the violation as no-harm.[4] The citation was based, in part, on the following findings from the SOD:

- A resident fully dependent on staff for mobility and incontinence care developed a new coccyx pressure ulcer, identified as Stage 2 on 3/22/25. The wound care provider was not notified until 3/27/25, by which time the ulcer had deteriorated to Stage 3.
- The resident also developed a deep tissue injury (DTI) to the left heel, identified on 3/20/25. However, the facility failed to obtain any treatment orders for 20 days, until the surveyor discovered the lapse.
- Although the resident's care plan documented a high risk for skin breakdown, the facility did not update the care plan with appropriate interventions until 4/8/25 – 18-20 days after onset of the wound.
- CNA repositioning records showed the resident rarely refused care, contradicting staff claims that refusals caused delays. Documentation revealed that the resident spent several consecutive hours positioned on their back despite requirements for turning, as required by the resident's care plan.

> Nursing homes are required to conduct regular skin assessments, quickly implement interventions when new pressure injuries appear, and notify appropriate clinicians.

- The facility ordered an air mattress and additional interventions only during the survey, long after the wounds had worsened.
- Nursing notes lacked evidence that hospice, the wound specialist, or the physician were notified when wounds worsened, despite staff assertions that notifications had occurred.
- The wound care provider confirmed that both the coccyx ulcer and heel DTI were caused by pressure and should have been addressed promptly.
- **Know Your Rights:** Residents have the right to receive care that prevents avoidable pressure ulcers and ensures timely treatment of any wounds. Nursing homes are required to conduct regular skin assessments, quickly implement interventions when new pressure injuries appear, and notify appropriate clinicians. Delays in treatment increase the risk of pain, infection, and irreversible skin breakdown. To learn more, check out LTCCC's fact sheet on pressure ulcers.

Rockwell Park Rehabilitation and Healthcare Center (North Carolina)

Left without support: Resident repeatedly observed without prescribed range of motion device.

Facility overall rating: ⚠ **Not available**

The surveyor determined that the facility failed to implement a prescribed right-hand splint for a resident with hemiplegia and limited range of motion – despite clear physician orders and therapy recommendations (F688). Staff repeatedly charted that the splint was in place, even when the resident was visibly without it. The resident, who could not apply the splint independently, attempted to alert the staff through gestures. The violation was nevertheless cited as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- The resident had a physician order dating back to November 2023 requiring a right resting hand splint after morning care and removal after evening care.
- Occupational therapy documented the resident needed the splint up to eight hours daily, and that nursing staff had been educated and were responsible for the splinting program following discharge from therapy.
- Despite this, surveyors observed the resident multiple times over three days – in bed, in a wheelchair, and in common areas – without the splint, even though staff had charted that it was on.
- During observations, the resident, unable to speak, pointed to his flaccid right hand and used thumbs-down gestures to indicate that staff were not applying the splint.
- Staff interviews revealed widespread misunderstanding:
    - A nurse aide reported she "hadn't seen the splint for weeks" and had never been told she was responsible for applying it.
    - A nurse stated she assumed therapy still applied the splint, even though the resident had been discharged from therapy two months earlier.
    - The therapy director confirmed nursing was responsible and that proper education had been provided; she also indicated that the resident had not worsened only because he could occasionally remove the splint after application – something that never occurred because it was never applied.
- The director of nursing acknowledged that the splint should have been applied as ordered and that nursing staff failed to follow the care plan and medical orders.
- **Know Your Rights**: Residents have the right to receive care that maintains or improves their functional abilities. When a resident requires a supportive device to prevent contractures or preserve mobility, the facility must ensure it is used exactly as ordered. Failure to do so can lead to loss of function, pain, and long-term disability. To learn more, see LTCCC's fact sheet on resident assessment and care planning.

Beckley Healthcare Center (West Virginia)

Months without glasses: Resident left waiting for essential vision care due to repeated delays.

Facility overall rating: ⚠ **Not available**

The surveyor found that the facility failed to ensure timely access to necessary vision services and assistive devices for a resident who required new prescription glasses (F685). Despite having seen an eye doctor in January, the resident waited months, with no explanation, as payment approvals and paperwork stalled. The surveyor classified the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- Resident 139 reported she had been waiting "a long time" for glasses and could not understand the delay.
- The eye doctor examined the resident on 1/28/25, but the consultation report was not documented as received by the facility until 3/25/25, nearly two months later.
- The social worker told surveyors that the eye doctor was "old school" and mailed consults, contributing to delays.
- The staff responsible for processing payment requests told surveyors she had submitted two requests to corporate to expedite payment—however, only one email could be produced, sent on 4/8/25, and written in response to the resident's complaint to the surveyor.
- The Business Office Manager ("BOM") stated she only gave the invoice to the employee on 4/8, contradicting the employee's claim of two prior requests; the BOM said the employee had confused this case with another resident.
- These internal inconsistencies resulted in the resident waiting months for glasses needed for basic daily functioning.
- **Know Your Rights**: Every resident has the right to receive timely vision and hearing services, including corrective devices such as glasses and hearing aids. When delays occur, residents may experience avoidable declines in independence, safety, and quality of life. Facilities are responsible for coordinating care, processing payments, and ensuring assistive devices are provided promptly. For more information, see LTCCC's fact sheet on standards of care for resident well-being.

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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

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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 Hearthstone Nursing & Rehabilitation Center (May 23, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Hearthstone-Nursing-Rehabilitation-Center-OR.pdf.
[2] Statement of Deficiencies for Crystal Lake Healthcare and Rehabilitation (December 30, 2024). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Crystal-Lake-Healthcare-and-Rehabilitation-NJ.pdf.
[3] Statement of Deficiencies for Waterview Heights Rehabilitation and Nursing Center (May 9, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Waterview-Heights-NY.pdf.
[4] Statement of Deficiencies for Juniper Village – the Spearly Center (April 25, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Juniper-Village-the-Spearly-Center-CO.pdf.
[5] Statement of Deficiencies for Rockwell Park Rehabilitation and Healthcare Center (May 23, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Rockwell-Park-Rehabilitation-and-Healthcare-Center-NC.pdf.
[6] Statement of Deficiencies for Beckley Healthcare Center (April 10, 2025). Available at https://nursinghome411.org/wp-content/uploads/2025/12/Beckley-Healthcare-Center-WV.pdf.