ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition — Volume 7, Issue 1

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

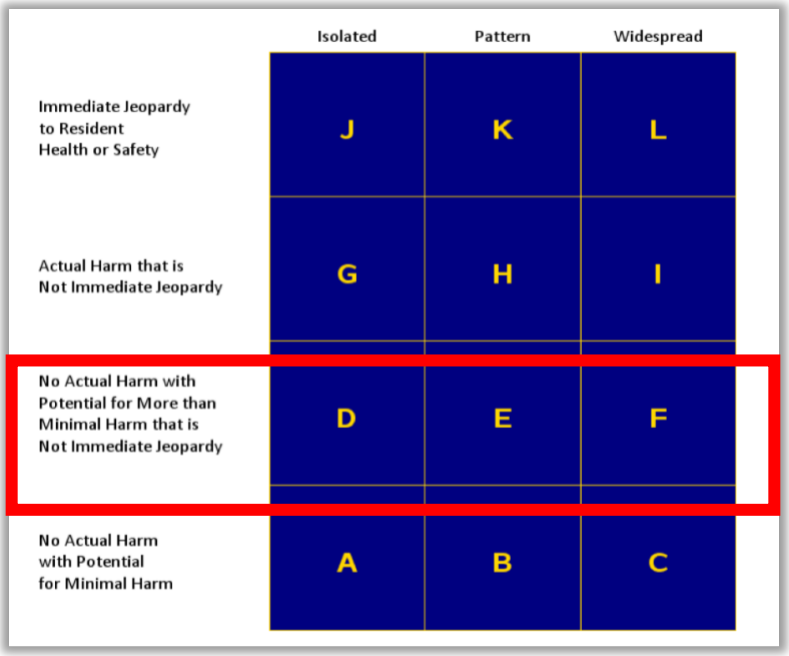
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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 five-star rating from the Centers for Medicare & Medicaid Services.

Nursing homes with five-star ratings are held up as models of high-quality care. However, even in these top-rated facilities, issues such as neglect, abuse, and inadequate care occur. Behind the stellar ratings, some facilities still struggle with issues that put residents at risk. This issue is a reminder that a higher CMS rating does not guarantee a safe environment, and ongoing vigilance and advocacy are essential to ensure residents receive the safe, respectful care they deserve.

Greenville Nursing and Rehabilitation (Kentucky)

Neglected smiles: Five-star facility fails to ensure timely dental care.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to ensure timely dental care for a resident, resulting in unmet oral health needs (F791). Although the deficient practice resulted in the resident feeling self-conscious about their teeth and appearance, the violation was cited as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- The surveyor noted that a resident was admitted to the facility with a care plan identifying decayed and missing teeth. The care plan directed staff to arrange necessary dental care and monitor the resident for any additional oral health concerns.
- According to the citation, the facility failed to schedule any dental appointments for the resident. Additionally, social services records showed no documentation of any dental referrals over several months.
- During an interview, the resident expressed a desire for top dentures as they had no teeth on top and severely decayed bottom teeth.
- Interviews with various staff members revealed awareness of the resident's dental concerns but records showed a lack of action. Although the resident had signed a consent form for dental services upon admission, they were not placed on the dentist's list.
- A family member of the resident stated that the resident had not seen a dentist since admission to the facility, despite health concerns and concerns about their appearance due to missing teeth.
- Interviews with the director of nursing services and executive director confirmed that residents should receive a dental assessment upon admission and, if they signed a consent form, they should be referred for routine dental care every three months. Both confirmed that the resident should have had at least one routine dental visit since admission and that staff were expected to follow proper referral and care procedures.
- **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.

Riverside Behavioral Healthcare Center (California)

Unresolved altercation: Resident injured in physical abuse.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to protect residents from all types of abuse such as physical, mental, sexual abuse, and physical punishment (F600). Specifically, the facility failed to protect a resident from physical abuse during a reported altercation with a program counselor. Although the altercation resulted in injuries to the resident’s face, the incident was cited as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- According to the citation, an altercation occurred during which a resident and a program coordinator engaged in physical contact.
- Multiple staff members, including a CNA and an RN, observed and intervened during the incident. The altercation involved both parties swinging their arms and hitting each other.
- During interviews, staff confirmed that the program counselor failed to de-escalate the situation and instead attempted to retaliate against the resident.
- The resident sustained visible injuries, including scratches on the face and forehead redness, as well as reported dizziness after the altercation.
- The facility’s "Professional Assault Crisis Training" (Pro-Act) mandates de-escalation techniques to manage challenging resident behaviors. The director of nursing confirmed that the program coordinator did not follow this protocol.
- **Know Your Rights**: Nursing home residents have the right to be free from all forms of abuse, including physical and emotional abuse. Physical abuse may involve intentional acts such as hitting, pushing, or other physical aggression towards a resident, as well as the use of unnecessary force during care. Both state and federal laws mandate that any suspected or confirmed abuse must be reported immediately to the appropriate authorities. To learn more, see LTCCC’s fact sheet on requirements for nursing homes to protect residents.

Moravian Hall Square Health and Wellness Center (Pennsylvania)

Inconsistent care: Pressure ulcer risk increased.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to ensure appropriate pressure ulcer prevention and care for a resident (F686). Despite the resident having a pressure ulcer and discrepancies in the documentation and reporting, the violation was classified as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- A resident was diagnosed with generalized muscle weakness, arthritis of the right knee, and a pressure ulcer on the left heel.
- The care plan noted the resident's risk for skin breakdown due to immobility and required the use of boots with a cushioned bottom to prevent pressure on both feet.
- The surveyor observed the resident on two different occasions seated in a wheelchair with only a pressure-relieving boot on the left foot, while the right foot had only a sock and was in contact with the wheelchair footrest. A second pressure-relieving boot was later located in the resident's closet.
- During an interview, the resident stated that staff did not consistently apply the right boot despite availability and denied refusing its use.
- A nurse aide incorrectly reported that the resident had an order for a boot on the left foot only and claimed the resident owned only one boot. This contradicted observations of the second boot in the resident's closet.
- The failure to consistently apply prescribed pressure-relieving devices placed the resident at increased risk of further skin breakdown.
- **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.

> Pressure ulcers are serious medical conditions and one of the most important measures of the quality of clinical care in nursing homes.

Courage Kenny Rehabilitation Institutes Trp (Minnesota)

Verbal abuse ignored: Nursing home failed to report incident on time.

Facility overall rating: ★★★★★

The surveyor determined that the nursing home failed to protect residents from abuse (F609). Although an allegation of verbal abuse was made, the facility failed to report it to the state agency within the required two-hour timeframe. Still, the surveyor classified the citation as no-harm.[4] The citation was based, in part, on the following findings from the SoD:

- According to the citation, a nursing assistant allegedly verbally abused a resident by referring to the resident as a "piece of shit."
- The facility initiated an investigation into the incident and removed the nursing assistant from the schedule while the investigation was underway. However, the facility failed to report the allegation to the state agency within the required timeframe, waiting over 10 hours after the incident occurred.
- While the facility did report the incident, it failed to do so promptly. During the investigation, the nursing assistant denied the allegation, and the facility ultimately determined that the claim of abuse was unfounded.
- During an interview, the administrator acknowledged receiving the report via email but did not receive it immediately, as required by the facility's policy.

- The administrator stated that the abuse policy would be updated to ensure that staff are re-educated on the requirement to report allegations of abuse immediately
- **Know Your Rights:** Nursing home residents have the right to be free from abuse. Emotional abuse may include aggressive or hostile behavior/attitude towards a resident, staff speaking to residents with disrespect or contempt, and staff ignoring residents or leaving them socially isolated. Furthermore, there are both state and federal requirements for reporting abuse or neglect. Nevertheless, far too much resident abuse goes unreported. To learn more, see LTCCC's fact sheet on requirements for nursing homes to protect residents.

Belleair Health Care Center (Florida)

Residents at risk: Failure to implement proper wound care protocols.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to provide proper treatment and care for two residents in accordance with physician orders and professional standards of care (F684). Despite the presence of skin injuries and outdated dressings on both residents, the surveyor cited the violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- One resident had a central catheter line inserted in his right upper arm. On May 1, the surveyor observed the dressing dated April 21. Facility staff failed to change the dressing weekly as required by a physician's orders.
- A skin tear was noted on the resident's left arm. The resident stated that the wound happened about a week and a half prior when a nurse attempted to lift the resident and improperly removed a skin dressing. This exposed a raw, wet area, and there was no documentation of the required dressing change.
- Additionally, the facility failed to follow physician orders for medication and dressing changes, did not maintain sterile dressing protocols, and missed required dressing changes.
- A second resident had a skin tear on the left elbow, but the facility did not document any dressing changes during the month of May. The surveyor found the dressing outdated, with a raw area underneath. Physician orders were in place for skin tear care but were not implemented according to the prescribed schedule.
- Additionally, through observation and interviews, it was noted that a nurse removed dressings from both residents with bare hands, increasing the risk of infection.
- In an interview, the director of nursing stated that dressings were removed improperly by staff members without gloves, indicating that the facility failed to maintain proper sterile dressing protocols as per established standards.
- **Know Your Rights:** Nursing home residents have the right to proper and timely care for wounds and medication lines. Failure to change the dressing every week and to wash hands before handling the line can lead to harm and infection. To learn more, see LTCCC's fact sheet on resident care and well-being.

New York Center For Rehabilitation & Nursing (New York)

Silent fall: Facility fails to report critical injury.

Facility overall rating: ★★★★★

The surveyor determined that the facility failed to report an injury of unknown source to the New York State Department of Health (NYSDOH) within the required two-hour timeframe (F609). Although the resident was found lying on the floor with a bump on their forehead and a fractured neck, the surveyor cited the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- A resident with a diagnosis of dementia and reduced mobility was admitted to the facility and later found on the floor with swelling on the forehead. The resident was diagnosed with a cervical spine fracture following the fall, which was unwitnessed, and the resident was unable to communicate how the fall occurred.
- Federal regulations require nursing homes to report any "injuries of unknown source" to the facility administrator and relevant state agencies. According to the citation, the facility failed to report the unwitnessed fall to NYSDOH within two hours of their awareness as required because of the injury sustained.
- Additionally, there was no documented evidence in the resident's medical chart that the facility reported the injury.
- During interviews, both the director of nursing and assistant director of nursing acknowledged that this injury should have been reported.
- **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, especially one of unknown source, must be reported immediately to the facility administrator and relevant state agencies within 2 hours of the incident. 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).

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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 Greenville Nursing and Rehabilitation (June 20, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Greenville-Nursing-and-Rehabilitation-F791.pdf.
[2] Statement of Deficiencies for Riverside Behavioral Healthcare Center (July 11, 2024). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Riverside-Behavioral-Healthcare-Center-F600.pdf.
[3] Statement of Deficiencies for Moravian Hall Square Health and Wellness Center (April 20, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Moravian-Hall-Square-Health-and-Wellness-Center-F686.pdf.
[4] Statement of Deficiencies for Courage Kenny Rehabilitation Institutes Trp (January 11, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Courage-Kenny-Rehabilitation-Institutes-Trp-F609.pdf.
[5] Statement of Deficiencies for Belleair Health Care Center (May 1, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/Belleair-Health-Care-Center-F684.pdf.
[6] Statement of Deficiencies for New York Center for Rehabilitation & Nursing (April 24, 2023). Available at https://nursinghome411.org/wp-content/uploads/2024/12/New-York-Center-for-Rehabilitation-Nursing-F609.pdf.

ELDER JUSTICE

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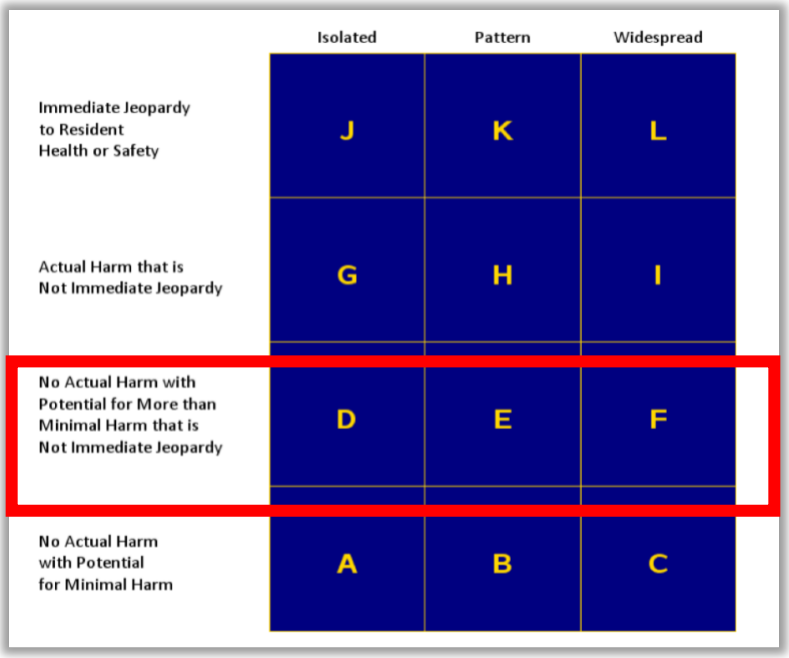

This issue of the *Elder Justice Newsletter* highlights the expectations and failures associated with facilities that have received a three-star rating from the Centers for Medicare & Medicaid Services.

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.

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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.

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

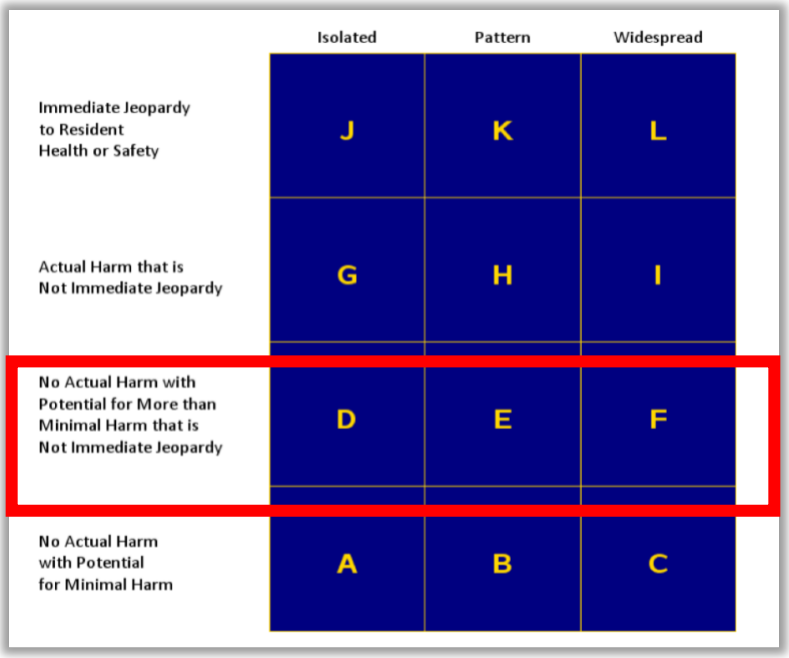
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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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[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.

ELDER JUSTICE

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

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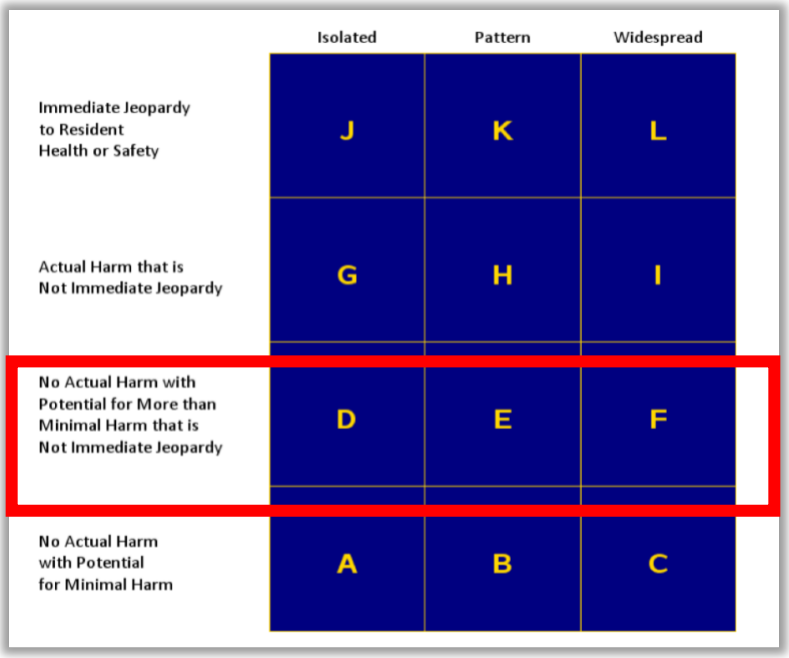


June marks *Elder Abuse Awareness Month*, a time to reaffirm our shared responsibility to protect older adults—especially those in nursing homes and other long-term care settings—from abuse, neglect, and exploitation. Abuse in these facilities remains widespread and underreported. Fear, cognitive impairments,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

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

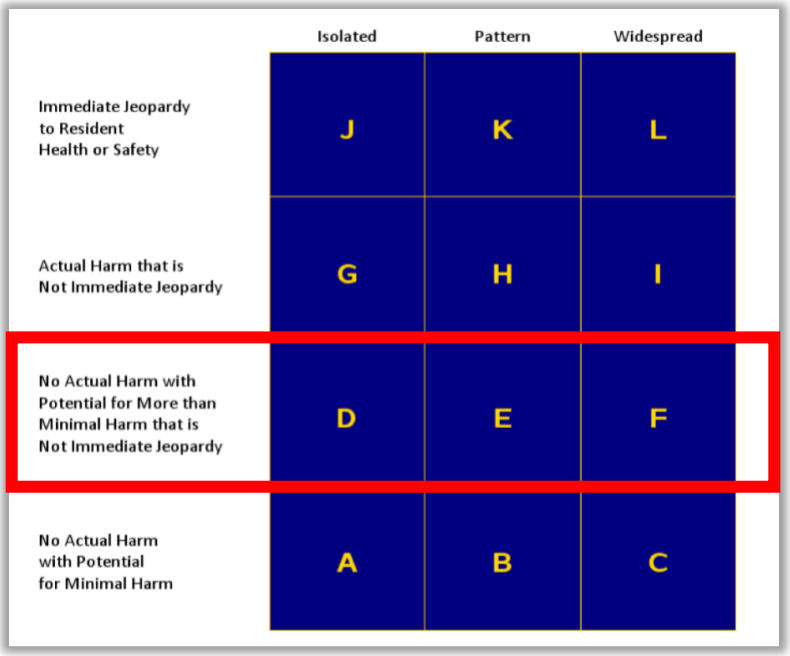
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

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.

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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 5

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[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.

ELDER JUSTICE

What "No Harm" Really Means for Residents

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

IN THIS ISSUE: SPECIAL FOCUS FACILITIES

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.

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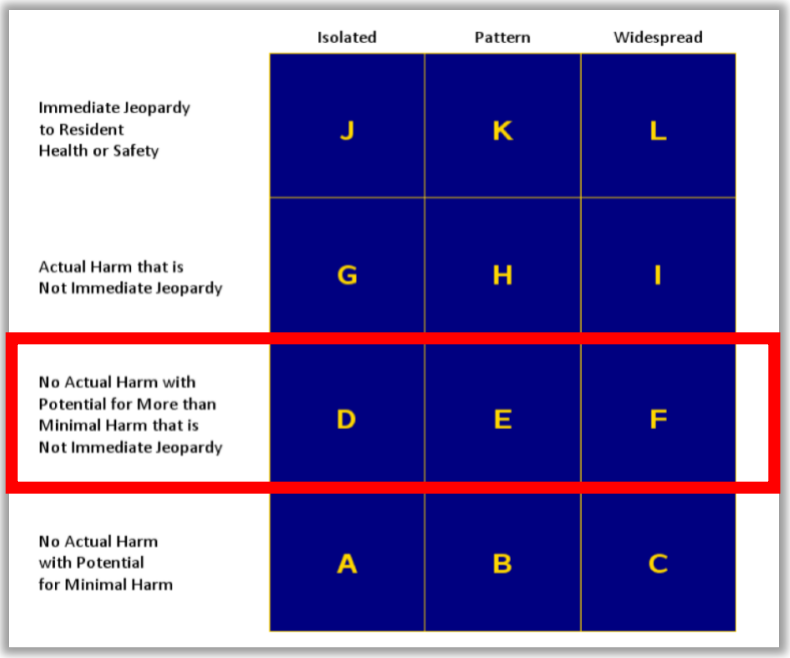
All licensed nursing homes are rated on a scale of one to five, with one being the lowest possible rating and five being the highest. While studies have shown that having a high rating does not necessarily mean that a nursing home is safe, substandard care in lower rated facilities has become a matter 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.

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- **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.

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- 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.