

# ELDER JUSTICE

## What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 8, Issue 1

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### What is a “No Harm” Deficiency?

Nursing homes that voluntarily participate in the Medicare and Medicaid programs must adhere to minimum standards of care established by the federal Nursing Home Reform Law and its implementing regulations. These standards ensure that every nursing home resident is provided services that help attain and maintain their “highest practicable physical, mental, and psychosocial well-being.” Under the Reform Law, nursing homes that fail to meet the federal requirements are subject to various penalties, based on the scope and severity of the violation(s).

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.

*In the absence of a penalty, nursing homes have little incentive to correct the underlying causes of substandard nursing home quality and safety.*

## 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](#).

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is Not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

### This Issue: 5-Star Quality Measure Rating ≠ Quality Care

This issue of the *Elder Justice Newsletter* examines a troubling disconnect in the federal nursing home rating system. Each facility in this issue (at the time of drafting) earned five stars for quality measures but only two stars overall, with poor health inspection and staffing ratings.

At first glance, a five-star quality measure rating suggests excellent care. Yet the statements of deficiencies highlighted in this issue tell a very different story. Residents were subjected to abuse, neglect, untreated medical conditions, medication errors, severe weight loss, unsafe living conditions, and other serious failures of care. These cases raise important questions about whether the Quality Measures component of CMS's Five-Star Rating System accurately reflects the experiences of nursing home residents.

As the [Center for Medicare Advocacy reported](#), the quality measures category relies heavily on facility-reported data that may be incomplete, inaccurate, or susceptible to manipulation. Because quality measure scores can significantly influence public ratings, facilities may appear to perform well on paper while continuing to accumulate serious deficiencies identified through state inspections and complaint investigations.

For consumers, advocates, and policymakers, the lesson is clear: a five-star quality measure rating does not mean five-star care. The cases in this issue demonstrate why staffing levels, inspection findings, resident complaints, and enforcement histories remain essential tools for evaluating nursing home quality. Most importantly, they remind us that the lived experiences of residents must remain at the center of any assessment of nursing home performance.

## Fernandina Beach Rehabilitation and Nursing Center (Florida)

**Severe weight loss ignored: Residents lost over 20% of body weight without timely intervention.**

**Facility overall rating:** ★★☆☆☆

**Health inspections:** ★☆☆☆☆

**Staffing:** ★★☆☆☆

**Quality measures:** ★★★★★

**Abuse Icon:** This nursing home has been cited for abuse. [Learn more.](#)

The surveyor determined that the facility failed to maintain acceptable nutritional status for two residents experiencing significant weight loss ([F692](#)). Despite clear evidence of declining intake and substantial weight loss, the facility failed to consistently provide ordered nutritional supplements and did not implement additional interventions in a timely manner. As a result, two residents lost more than 20 percent of their body weight within six months. Still, the

surveyor classified the violation as no-harm.<sup>1</sup> The citation was based, in part, on the following findings from the [SoD](#):

- One resident lost 21.57% of her body weight, declining from 108 pounds to 84.7 pounds in six months.
- The resident had dementia and severe cognitive impairment and required staff assistance with meals.
- A physician ordered Ensure nutritional supplements three times daily, yet observations repeatedly showed the resident’s meal trays did not include the supplement.
- Intake records showed the resident consumed 0% of her ordered Ensure supplements on 41 occasions during one month.
- Staff interviews revealed confusion over who was responsible for providing the supplements.
- A nurse reported she had not provided the supplement because the resident disliked a previous flavor, not realizing the order had already been changed months earlier.
- A second resident lost 26.24% of her body weight, dropping from 157 pounds to 115.8 pounds in six months.
- Meal records showed the resident consumed 50% or less of 34 meals in a 30-day period, yet documentation did not indicate additional nutritional interventions were implemented.
- Although staff were aware of the ongoing weight loss, care plans were not updated until the week of the survey.
- **Know Your Rights:** Nursing homes are required to monitor residents’ nutritional status and intervene promptly when weight loss occurs. Facilities must ensure residents receive physician-ordered supplements and must implement additional strategies – such as dietary adjustments, assistance with meals, or other interventions – to prevent further decline. Significant weight loss can lead to serious health complications and must be addressed quickly to protect residents’ health and well-being. To learn more, see [LTCCC’s fact sheet on food, nutrition, and dietary services](#).

Every nursing home must provide each resident with a nourishing, palatable, well-balanced diet that meets their daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

## Rivertown Health and Rehabilitation Center (Alabama)

### Caregiver joins the argument: Staff escalates resident’s distress.

Facility overall rating: ★★☆☆☆

Health inspections: ★☆☆☆☆

Staffing: ★★☆☆☆

Quality measures: ★★★★★

The surveyor determined that the facility failed to provide behavioral health services in a manner that supported a resident’s mental and psychosocial well-being ([F740](#)). Rather than following the resident’s behavior care plan – which directed staff to remain calm, avoid power

struggles, and de-escalate conflict – a certified nursing assistant (CNA) engaged in a verbal confrontation with a cognitively impaired resident and responded with insulting remarks. Despite these findings, the violation was cited as no-harm.<sup>2</sup> The citation was based, in part, on the following findings from the [SoD](#):

- A resident had a history of traumatic brain injury, mood disorder, moderate cognitive impairment, agitation, argumentative behavior, and verbal outbursts.
- The resident’s care plan instructed staff to avoid power struggles, approach the resident calmly, maintain a calm environment, and use interventions designed to prevent escalation.
- During a lunch-time interaction, a CNA directed the resident to return to their room and eat. The interaction escalated into a verbal exchange.
- The resident reported that the interaction began when the CNA told them that their mother did not love them.
- Multiple staff witnesses reported hearing the CNA respond to the resident with insulting language after the resident became argumentative.
- One witness stated the CNA told the resident they were “lucky” she was on the clock or she would say what she really thought.
- The resident later reported that the CNA had upset them and that both parties exchanged insults during the confrontation.
- A nurse who witnessed the interaction stated that the CNA’s response constituted verbal abuse.
- The facility administrator confirmed that the resident’s behavior plan was in effect at the time and stated the incident could likely have been avoided if staff had followed the care plan and used appropriate de-escalation techniques.
- **Know Your Rights:** Residents have the right to receive behavioral health care in an environment that promotes dignity, emotional well-being, and respect. Staff must follow individualized behavior plans and use person-centered approaches when responded to challenging behaviors. Arguing with, insulting, or provoking residents can worsen distress. Nursing homes are responsible for training staff to respond calmly and appropriately, particularly when caring for residents with cognitive impairment or behavioral health needs. To learn more, see [LTCCC’s fact sheet on requirements for nursing home behavioral and social health services](#).

## The Rehabilitation Center of Albuquerque (New Mexico)

**Lost in the system: Urgent urology referral never scheduled.**

**Facility overall rating:** ★★☆☆☆

**Health inspections:** ★☆☆☆☆

**Staffing:** ★★☆☆☆

**Quality measures:** ★★★★★

The surveyor determined that the facility failed to provide appropriate urinary care and follow-up services for two residents ([F690](#)). One resident with documented urinary retention and a severely distended bladder never received an ordered urology appointment, while another

resident remained catheterized without documented reassessment, individualized care planning, or evidence that long-term catheter use remained clinically necessary. These failures placed residents at risk for infection, avoidable complications, and diminished quality of life. Despite these concerns, the surveyor classified the violations as no-harm.<sup>3</sup> The citation was based, in part, on the following findings from the [SoD](#):

- One resident reported ongoing bladder discomfort, inability to empty the bladder, and persistent urinary retention.
- A nurse practitioner ordered an immediate urology appointment on May 13, 2025, after imaging confirmed a markedly distended bladder.
- Surveyors found no documentation that the appointment was ever scheduled or completed.
- The resident later required an emergency room visit, where a catheter was inserted because of urinary retention.
- The resident told surveyors that he informed staff he was unable to urinate, but nothing was done.
- Facility leadership acknowledged that the referral order effectively disappeared from the system and that staff failed to arrange the appointment.
- A second resident had an indwelling urinary catheter in place but lacked documentation supporting the ongoing need for long-term catheterization.
- Surveyors found no documented attempt to remove the catheter, no reassessment of catheter necessity, no diagnosis supporting long-term catheter use, and no individualized goals or interventions addressing catheter care.
- **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 standards of care for resident well-being](#).

## Adira at Riverside Rehabilitation and Nursing (New York)

**Short-staffed for weeks: Residents left waiting hours for help and stuck in bed.**

**Facility overall rating:** ★★☆☆☆

**Health inspections:** ★☆☆☆☆

**Staffing:** ★★☆☆☆

**Quality measures:** ★★★★★

The surveyor determined that the facility failed to provide sufficient nursing staff to meet residents' needs on multiple shifts over a one-month period ([F725](#)). Residents reported long waits for assistance, missed therapy sessions, and being forced to remain in bed due to inadequate staffing levels. Staffing records confirmed that the facility fell below the minimum staffing levels outlined in its own Facility Assessment on numerous occasions. Nevertheless, the surveyor classified the violation as no-harm.<sup>4</sup> The citation was based, in part, on the following findings from the [SOD](#):

- During a resident council meeting, several residents reported the facility was short-staffed on multiple shifts and weekends, resulting in delayed responses to call bells and residents remaining in bed longer than they wished.
- One resident reported waiting two hours to be taken to the bathroom, stating staff sometimes came to assist only when providing routine care rather than when the call bell was activated.
- Another resident stated they remained in bed all day on a Sunday because there were not enough staff to assist them out of bed.
- Review of staffing schedules showed the facility was below minimum staffing levels on 19 out of 31 days.
  - The staffing coordinator reported the facility relied on four staffing agencies to cover vacancies and frequently asked staff to work double shifts.
  - Certified nursing assistants stated they worked double shifts multiple times per week.
  - Staff reported that when the facility was short-staffed, it was impossible to get all residents out of bed, sometimes leaving dozens of residents waiting.
- Facility leadership stated the facility had adequate staffing and noted that additional helpers were available to answer call bells or assist with non-care tasks, though these helpers did not provide direct resident care.
- **Know Your Rights:** Nursing homes are required to provide sufficient nursing staff on every shift to meet residents' needs. Chronic understaffing can result in delayed responses to call bells, missed therapy sessions, inadequate assistance with mobility, and unmet basic care needs. Residents have the right to receive timely assistance and to live in an environment where staffing levels are adequate to ensure their health, safety, and dignity. To learn more, check out [LTCCC's fact sheet on nursing home staffing standards](#).

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.

## Bella Terra St. George (Utah)

**A facility in disrepair: Residents endured cold rooms, leaks, odors, and lost belongings.**

**Facility overall rating:** ★★☆☆☆

**Health inspections:** ★☆☆☆☆

**Staffing:** ★☆☆☆☆

**Quality measures:** ★★★★★

The surveyor determined that the facility failed to provide a safe, clean, comfortable, and homelike environment for numerous residents (F584). Residents reported persistent maintenance problems, unclean living conditions, missing personal belongings, and unresolved temperature complaints. Surveyors observed leaking plumbing, damaged rooms, strong urine odors, stained furnishings, and evidence that resident grievances regarding personal property

and environmental concerns were not adequately addressed. Despite affecting multiple residents throughout the facility, the violation was cited as no-harm.<sup>5</sup> The citation was based, in part, on the following findings from the [SoD](#):

- Surveyors identified environmental concerns affecting 13 residents, including cold rooms, leaking toilets and sinks, flooding showers, damaged doors, unclean rooms, strong urine odors, and missing personal belongings.
- Residents reported that rooms remained uncomfortably cold for weeks or months, with some residents wrapping themselves in multiple blankets or creating makeshift coverings to stay warm.
- Surveyors observed:
  - A leaking toilet with towels wrapped around the base to absorb water.
  - A loose toilet seat covered with brown stains.
  - A sink leaking into a basin placed underneath it.
  - A shower that flooded into a resident's room during use.
  - Damaged doors, missing window screens, stained walls, and dirty furnishings.
- Multiple residents reported that housekeeping failed to adequately clean their rooms, remove trash, or address persistent odors.
- Strong urine odors were documented in several areas of the facility, including memory care unit and resident hallways.
- Several residents reported missing clothing, blankets, dentures, and other personal belongings, with no evidence that grievances had been documented or investigated.
- Staff acknowledged that procedures for inventorying and labeling resident belongings had not been consistently followed for years, contributing to lost property.
- Maintenance staff confirmed ongoing complaints regarding room temperatures and stated that some thermostats had been improperly configured, causing heating issues.
- Surveyors also observed stained privacy curtains, soiled bedding, dirty dining areas, and furniture and walls marked with unidentified brown substances.
- **Know Your Rights:** Residents have the right to live in a safe, clean, comfortable, and homelike environment. Nursing homes must maintain resident rooms and common areas, address maintenance concerns promptly, safeguard personal belongings, and respond appropriately to grievances. Facilities are also responsible for ensuring residents are protected from environmental hazards, unsanitary conditions, and avoidable loss of personal property. To learn more, see [LTCCC's fact sheet on residents' right to a safe environment](#).

Residents have the right to live in a safe, clean, comfortable, and homelike environment. Nursing homes must maintain resident rooms and common areas, address maintenance concerns promptly, safeguard personal belongings, and respond appropriately to grievances.

## Meridian Meadows Transitional Care (Idaho)

**Medication oversight failures: Duplicate orders and missing safety monitoring.**

**Facility overall rating:** ★★☆☆☆

**Health inspections:** ★☆☆☆☆

**Staffing:** ★☆☆☆☆

**Quality measures:** ★★★★★

**Abuse Icon:** This nursing home has been cited for abuse. [Learn more.](#)

The surveyor found that the facility failed to ensure residents were free from unnecessary medications and failed to implement appropriate monitoring for medication side effects ([F757](#)). One resident had duplicate medication orders that increased the risk of medication errors, while another was prescribed a high-risk medication without documented monitoring for potentially serious adverse effects. Despite these deficiencies, the surveyor classified the violation as no-harm.<sup>6</sup> The citation was based, in part, on the following findings from the [SoD](#):

- One resident was prescribed Ativan (lorazepam) for anxiety and terminal agitation. Federal drug safety information identifies several potential adverse effects of lorazepam, including sedation, respiratory depression, cognitive impairment, agitation, dependence, and withdrawal symptoms.
- Surveyors found no documented monitoring parameters in the resident’s care plan or physician orders to assess for these potential side effects.
- The director of nursing confirmed that the resident’s record lacked monitoring interventions for lorazepam use.
- A second resident had two active physician orders for suppositories as needed for constipation, creating a duplicate medication order.
- Duplicate medication orders increase the risk of overmedication, confusion regarding administration, and medication errors.
- During an interview, a nurse acknowledged that the duplicate orders were an error.
- **Know Your Rights:** Residents have the right to be free from unnecessary medications and to receive medications safely. Nursing homes must routinely review medication regimens, eliminate duplicate or unnecessary drug orders, and monitor residents for side effects associated with high-risk medications. For more information, see [LTCCC’s fact sheet on medication errors](#).

## 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 Newsletter*

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To learn more about nursing home and assisted living care, visit us online at  
[MedicareAdvocacy.org](https://MedicareAdvocacy.org) & [NursingHome411.org](https://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.

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<sup>1</sup> Statement of Deficiencies for Fernandina Beach Rehabilitation and Nursing Center (June 27, 2024). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/Fernandina-Beach-Rehabilitation-and-Nursing-Center-FL.pdf>.

<sup>2</sup> Statement of Deficiencies for Rivertown Health and Rehabilitation Center (July 24, 2025). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/Rivertown-Health-and-Rehabilitation-Center-AL.pdf>.

<sup>3</sup> Statement of Deficiencies for The Rehabilitation Center of Albuquerque (June 27, 2025). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/The-Rehabilitation-Center-of-Albuquerque-NM.pdf>.

<sup>4</sup> Statement of Deficiencies for Adira at Riverside Rehabilitation and Nursing (August 30, 2024). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/Adira-at-Riverside-Rehabilitation-and-Nursing-NY.pdf>

<sup>5</sup> Statement of Deficiencies for Bella Terra St George (November 13, 2024). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/Bella-Terra-St-George-UT.pdf>.

<sup>6</sup> Statement of Deficiencies for Meridian Meadows Transitional Care (April 3, 2026). Available at <https://nursinghome411.org/wp-content/uploads/2026/06/Meridian-Meadows-Transitional-Care-ID.pdf>.