ELDER JUSTICE

What "No Harm" Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition Volume 8, Issue 2

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What is a "No Harm" Deficiency?

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

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

Centers for Medicare & Medicaid Services (CMS) data indicate that most health violations (approximately 95%) are cited as causing "no harm" to residents. The failure to recognize resident pain, suffering, and humiliation when it occurs too often means nursing homes are not held accountable for violations through financial or other penalties. In the absence of a penalty, nursing homes have little incentive to correct the underlying causes of resident abuse or neglect.

How to Use this Newsletter

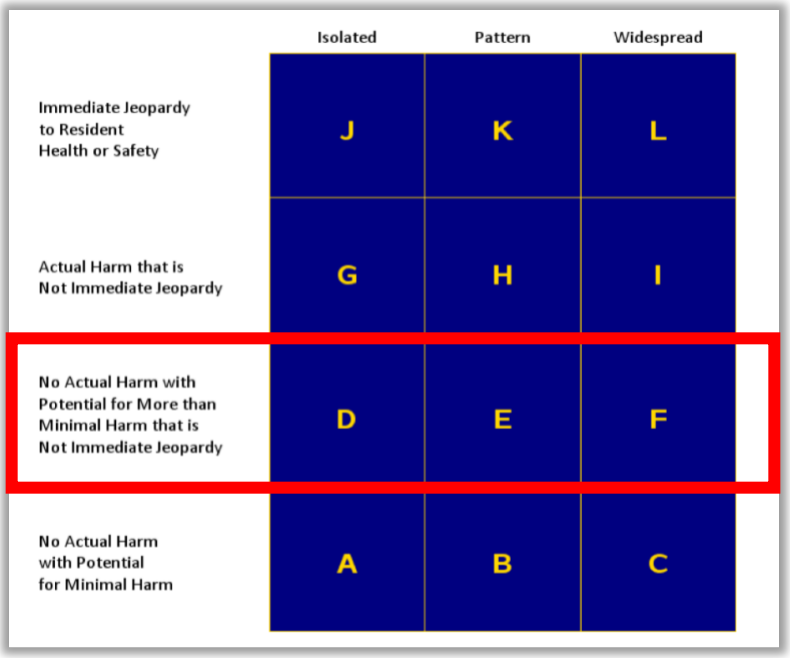
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

Our organizations encourage residents, families, ombudsmen, law enforcement, and others to use these cases to help identify potential instances of resident harm in their own communities. When state enforcement agencies and CMS fail to properly identify and penalize nursing homes for health violations, it is important for the public to be aware of nursing home safety concerns in their communities. Fundamentally, from our perspective, every suspected case of resident harm should be reported, investigated, and (if confirmed), appropriately sanctioned.

> *"Nursing home industry representatives often state that their industry is one of the most regulated in the country. But if those regulations are not enforced, what does that actually mean?"*
> – ***Broken Promises: An Assessment of Nursing Home Oversight***

All licensed nursing homes are rated on a scale of one to five, with one being the lowest possible rating and five being the highest. While studies have shown that having a high rating does not necessarily mean that a nursing home is safe, substandard care in lower rated facilities has become a matter of increasing public concern. Star ratings included in this newsletter are current up to the date of newsletter's drafting.

CMS and state survey agencies use the Scope and Severity Grid for rating the seriousness of nursing home deficiencies. For each deficiency identified, the surveyor is charged with indicating the level of harm to the resident(s) involved and the scope of the problem within the nursing home. The Elder Justice Newsletter covers "no harm" deficiencies cited from D-F on the grid. This chart is from the CMS Nursing Home Data Compendium 2015 Edition.



This Issue: Prescribing Silence Through Chemical Restraints

Although federal law has prohibited the use of chemical restraints in nursing homes for more than 30 years, inappropriate drugging remains a serious threat to resident safety and dignity. In March of this year, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released two reports confirming that nursing homes continue to misuse antipsychotic medications and, in some cases, even inappropriately diagnose residents with schizophrenia to justify their use. These medications are powerful drugs intended to treat specific psychiatric conditions, such as schizophrenia and bipolar disorder. They are not intended to simply sedate residents or manage behaviors associated with dementia or distress. When nursing homes rely on these drugs instead of identifying and addressing the underlying cause of a resident's symptoms, they not only fail to provide appropriate care but also compromise residents' dignity and autonomy while exposing them to serious risks, including falls, stroke, and increased mortality.

This issue of the *Elder Justice Newsletter* highlights six nursing homes cited for inappropriate drugging and other failures related to unnecessary psychotropic medications and chemical restraints. Surveyors documented residents receiving duplicate or excessive antipsychotic medications, sedatives administered without appropriate clinical justification or monitoring, medications continued despite family objections, and failures to implement required non-pharmacological interventions before resorting to drugs. These cases demonstrate that, despite longstanding federal protections, inappropriate drugging continues to place residents at unnecessary risk and underscores the need for strong oversight and enforcement to ensure residents receive safe, person-centered care.

Note: References to "PRN" or "as-needed" in the following citations relate to prescriptions in which the prescriber has allowed for nursing staff to determine when to administer a medication rather than a set dosage (such as twice a day for ten days). PRN prescriptions are of special concern because they provide opportunities for abuse, in particular the administration of a drug for the convenience of staff rather than for the resident's benefit.

Valley View Manor Hcc (Minnesota)

Chemical restraints by convenience: Resident given duplicate antipsychotics without required safeguards.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to ensure residents were free from chemical restraints (F605). A resident with dementia received duplicative antipsychotic medications without individualized target behaviors, appropriate non-pharmacological interventions, or documentation supporting when one medication should be used instead of the other. Surveyors also found staff administered antipsychotic medications to gain the resident's

cooperation rather than first attempting required non-drug approaches. Despite these serious concerns, the violation was cited as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- One resident with Alzheimer's disease and severe vascular dementia received scheduled and as-needed Seroquel and later as-needed Haldol, resulting in duplicate antipsychotic therapy. Surveyors found no individualized target behaviors identifying when one medication should be used instead of the other.
- Between October 30 and November 13, 2025, the resident experienced five falls while receiving both medications. The consulting pharmacist stated that duplicate therapy increased the risk of sedation, dizziness, low blood pressure, and falls, and said she would have recommended discontinuing one of the medications had she known both were being administered.
- One of the falls resulted in staples to the back of the resident's head.
- Both Haldol and Seroquel contain warnings in their packaging for increased mortality in elderly patients with dementia-related psychosis. They increase the risk of falls in the elderly due to their sedative and blood pressure effects.
- No rationale was provided for the use of both antipsychotics. There was no documentation of non-pharmacological intervention.
- The nurse and interim assistant director of nursing stated that they were unaware that attempting non-pharmacological intervention was even necessary before administering PRN (as-needed) doses of antipsychotics.
- The interim assistant director of nursing also admitted that he was unaware that the medications were part of the same drug class and of their side effects. The nursing director said both should not have been in the same drug order since they are part of the same drug class.
- **Know Your Rights:** Prior to the administration of any PRN psychotropic, nursing homes must attempt and document non-pharmacological interventions. Medications should not be used as chemical restraints to enforce resident cooperation. For more information on non-pharmacologic approaches to dementia care, see LTCCC's webinar on reducing reliance on antipsychotics for people living with dementia.

> Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose, for excessive duration, without adequate monitoring, without adequate indications for its use, or in the presence of adverse consequences which indicate the dose should be reduced or discontinued.

Forest Hills Rehabilitation & Healthcare Center (Pennsylvania)

No parameters, no non-drug care: Resident repeatedly given sedating gel.

Facility overall rating: ★★☆☆☆

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

The surveyor determined that the facility failed to ensure a resident was free from chemical restraints that were not necessary to treat the resident's medical symptoms, lacked justification, and did not demonstrate individualized nonpharmacological approaches to care (F605). Despite repeated administrations of a sedating psychotropic medication without documented non-drug interventions or clear criteria for use, the surveyor cited the violation as no-harm.[2] The citation was based, in part, on the following findings from the SoD:

- One resident, who had cerebral palsy, intellectual disabilities, and severe cognitive impairment, had a care plan for inappropriate verbal and physical behaviors, including grabbing staff, combative behavior during care, spitting, screaming, inappropriate exposure, and striking out.
- The care plan included continuous supervision by one staff member, distraction techniques, soft music, allowing the resident to calm in his room, and visual stimuli, such as observing birds.
- The resident had an order for Lorazepam gel, a psychotropic medication and central nervous system depressant, to be applied to the back of the neck every eight hours as needed for anxiety, agitation, or aggression.
- Surveyors noted that applying the medication as a topical gel to the back of the neck allowed it to be administered rapidly without the resident's awareness or ability to refuse, particularly given the resident's severe cognitive impairment.
- Records showed the resident received Lorazepam gel 18 times between January 10 and February 24, 2026. The resident's record did not define the resident's anxiety, agitation, or aggression in measurable and observable terms to guide staff on when the drug was clinically indicated.
- The director of nursing could not provide documentation that nonpharmacological interventions were used before the 18 administrations.
- **Know Your Rights**: Residents have the right to be free from unnecessary psychotropic drugs and chemical restraints. Facilities must use individualized, non-drug approaches before PRN psychotropic medications unless clinically inappropriate, and residents should be able to participate in decisions about their care and treatment. For more information, see LTCCC's fact sheet on dementia care and psychotropic drugs.

Sea Cliff Healthcare Center (California)

More Risperdal than intended: Duplicate orders and missing behavioral interventions.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to ensure residents reviewed for unnecessary medications were free from unnecessary psychotropic drugs (F605). Despite one resident receiving more Risperdal than intended and the facility failing to separately track non-drug interventions for multiple psychotropic medications, the surveyor cited the violation as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- One resident was prescribed Risperdal, an antipsychotic, at 1mg twice daily, but the facility continued administering an older 0.5mg twice-daily order at the same time. As a result, the

resident received 1.5mg twice daily, 50% more than the prescriber intended, for more than two months. The physician assistant stated the increased dose was not intended, and the consultant pharmacist had previously asked the facility to clarify the duplicate orders.

- Surveyors observed the resident lying in bed asleep on three occasions. Staff stated the resident previously had frequent angry outbursts but was now sleeping and resting more often in bed.
- The same resident also received citalopram and Remeron, both antidepressants. Records grouped together the resident's non-drug interventions for antipsychotic and antidepressant use and did not identify which interventions were attempted for each medication. Nursing staff acknowledged they could not determine which interventions worked for each medication.
- A second resident received quetiapine and risperidone, both antipsychotics, for different behaviors. Staff verified that the facility did not separately document which non-drug interventions were attempted for each medication.
- A third resident received divalproex sodium, a mood stabilizer, for mood swings. The resident's record did not show documented evidence that non-drug interventions were attempted before administering the medication.
- A fourth resident received alprazolam, an antianxiety medication; mirtazapine, an antidepressant; and Seroquel, an antipsychotic. Staff stated they would not know the effectiveness of the non-drug interventions because they were documented together, not separately.
- **Know Your Rights:** Residents have the right to be free from unnecessary psychotropic drugs and chemical restraints. Facilities must document individualized non-drug approaches and monitor whether psychotropic medications are necessary and effective. To learn more about how to respond appropriately to symptoms of dementia, see this fact sheet on dementia- information, see LTCCC's fact sheet on dementia-related behaviors.

The Haven on the River (Illinois)

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

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to appropriately manage a resident's psychotropic medication (F605). Surveyors found that the facility failed to respond to a pharmacy review for an as-needed (PRN) psychotropic medication, failed to document clear indications for use, and repeatedly administered the drug against explicit family instructions. Despite these violations, the deficiency was cited as no-harm.[4] The citation was based, in part, on the following findings from the SOD:

- One resident was prescribed Ativan (lorazepam) on three separate occasions using different and inappropriate indications, including "nausea related to depression" and "comfort

related to Alzheimer's disease." The facility's nurse practitioner later acknowledged that neither indication was an appropriate reason to prescribe Ativan.

- The resident's power of attorney had repeatedly asked that the facility stop administering Ativan because it caused adverse reactions, making the resident more aggressive and violent. Family members reported that they had already stopped giving the medication at home for the same reason.
- Nurses confirmed that the medication transformed the resident into "a whole different person" who exhibited much more aggressive and violent behaviors.
- Although the medication was discontinued, it was restarted twice without the family's knowledge, and the power of attorney stated she was never notified when the medication was reordered.
- Surveyors found that nine of the 11 times Ativan was administered, the facility failed to document the resident's symptoms or behaviors that justified giving the medication. The director of nursing stated she believed the diagnosis attached to the order was sufficient documentation, while surveyors found that staff should have documented the resident's condition each time the medication was administered.
- The nurse who first reordered Ativan for the resident could not explain why or recall the resident's symptoms.
- A consultant pharmacist requested that the prescriber either discontinue the medication or document the reason it should continue beyond the 14-day federal limit for as-needed psychotropic medications, but the request was never addressed.
- **Know Your Rights:** Nursing homes must limit as-needed psychotropic medications to 14 days unless a prescriber documents a clinical rationale to extend the duration. Staff must document specific behavioral indications before administering the medication. For more information, see LTCCC's fact sheet on informed consent to dementia care and services.

Nursing home facilities must limit as-needed psychotropic medications to 14 days unless a prescriber documents a clinical rationale to extend the duration. Staff must document specific behavioral indications before administering the medication.

Glasgow Hills of Journey (West Virginia)

Trying to get up: PRN Ativan given without documented behaviors or non-drug care.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to ensure a resident was free from chemical restraints (F605). A resident received repeated doses of the sedative Ativan (lorazepam) without required time limits, adequate documentation of behaviors warranting its use, or evidence that non-pharmacological interventions had been attempted first. Surveyors also found the medication was administered to address behaviors such as attempting to get out of bed or transfer independently, raising concerns that it was being used for staff convenience rather than to treat a medical symptom. Despite these findings, the surveyor cited the violation as no-harm.[5] The citation was based, in part, on the following findings from the SoD:

- A resident was prescribed Ativan every 12 hours PRN (as needed). The order, dated May 18, 2024, had no time limit.
- A monthly pharmacy review recommended discontinuing the PRN Ativan or reordering it for a specific number of days. The physician signed the review on June 12, 2024, but the order was not changed until July 6, 2024; when changed, it was reordered for 60 days.
- Records identified unacceptable reasons for two doses: the resident refused to stay in bed, repeatedly attempted to get up without assistance, and attempted to transfer or ambulate unassisted.
- Records showed the resident received 29 doses of PRN Ativan from late May through July 6, with no specific behaviors or non-pharmacological interventions listed. Documentation listed only "increased agitation" from the physician's order.

Residents have the right to be free from psychotropic drugs used as chemical restraints. When medication is medically necessary, facilities must use the least restrictive alternative for the least amount of time, re-evaluate ongoing need, and not use medication for staff convenience.

- The director of nursing said it was "wrong" not to list the behaviors or interventions and that the facility later changed how it documents use of PRN Ativan.
- **Know Your Rights**: Residents have the right to be free from psychotropic drugs used as chemical restraints. When medication is medically necessary, facilities must use the least restrictive alternative for the least amount of time, re-evaluate ongoing need, and not use medication for staff convenience. PRN psychotropic drugs require clear limits and documentation of attempted non-drug approaches. For more information, see LTCCC's fact sheet on dementia care and psychotropic drugs.

Newfane Rehab & Health Care Center (New York)

Medication oversight failures: Duplicate orders and missing safety monitoring.

Facility overall rating: ★★★☆☆

The surveyor determined that the facility failed to ensure residents receiving psychotropic drugs received gradual dose reductions or had documented clinical reasons why dose reductions were inappropriate (F605). Despite psychotropic medications continuing with missing or inadequate dose-reduction efforts and no medical provider documentation of contraindications, the surveyor cited the violation as no-harm.[6] The citation was based, in part, on the following findings from the SoD:

- One resident was cognitively intact, had no indicators of psychosis, and received Aripiprazole, an antipsychotic, for depression from August 2024 through June 2025 without an attempted gradual dose reduction or physician documentation showing that a reduction was clinically contraindicated.

- The facility's psychotropic medication review forms left blank whether a gradual dose reduction had occurred, was attempted, or was contraindicated. Weekly behavior documentation did not support that the resident posed a danger to self or others.
- Surveyors observed the resident as well-kempt, pleasant, cooperative, and displaying no behaviors. A physician stated the resident was stable, should have had Aripiprazole reduced no later than February 2025, and that the drug was considered a chemical restraint.
- A second resident, diagnosed with Alzheimer's disease and depression, received both an antidepressant and antipsychotic. Records repeatedly documented no gradual dose reduction for the antidepressant and no physician documentation showing that reductions were contraindicated. The resident's assessments documented no behaviors, yet the antipsychotic dosage was later increased.
- Facility staff described confusion over responsibility for recommendations, physician follow-up, and documentation of gradual dose reductions.
- **Know Your Rights**: Residents have the right to be free from unnecessary psychotropic drugs and chemical restraints. Nursing homes must attempt gradual dose reductions and behavioral interventions unless clinically contraindicated, and must document the rationale when reductions are not attempted. For more information, see LTCCC's fact sheet on dementia care and psychotropic drugs.

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 Valley View Manor Hcc (November 19, 2025). Available at https://nursinghome411.org/wp-content/uploads/2026/07/Valley-View-Manor-Hcc-MN.pdf.
[2] Statement of Deficiencies for Forest Hills Rehabilitation & Healthcare Center (March 13, 2026). Available at https://nursinghome411.org/wp-content/uploads/2026/07/Forest-Hills-Rehabilitation-Healthcare-Center-PA.pdf.
[3] Statement of Deficiencies for Sea Cliff Healthcare Center (January 14, 2026). Available at https://nursinghome411.org/wp-content/uploads/2026/07/Sea-Cliff-Healthcare-Center-CA.pdf.
[4] Statement of Deficiencies for The Haven on the River (March 25, 2026). Available at https://nursinghome411.org/wp-content/uploads/2026/07/The-Haven-on-the-River-IL.pdf
[5] Statement of Deficiencies for Glasgow Hills of Journey (May 22, 2025). Available at https://nursinghome411.org/wp-content/uploads/2026/07/Glasgow-Hills-of-Journey-WV.pdf.
[6] Statement of Deficiencies for Newfane Rehab & Health Care Center (June 5, 2025). Available at https://nursinghome411.org/wp-content/uploads/2026/07/Newfane-Rehab-Health-Care-Center-NY.pdf.