ELDER JUSTICE

What "No Harm" Looks Like in NY Nursing Homes

A Closer Look at Nursing Home Accountability in New York – *Special Issue*

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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 94%) 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

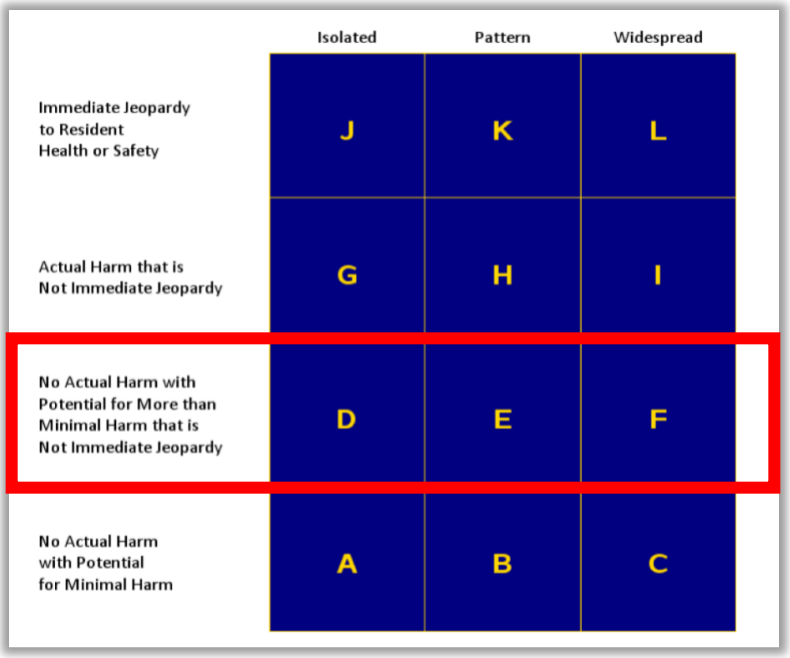
The *Elder Justice* newsletter provides examples of health violations in which surveyors (nursing home inspectors) identified neither harm nor immediate jeopardy to resident health, safety, or well-being. These examples were taken directly from Statement of Deficiencies (SoDs) on CMS's Care Compare website.

We 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.

For enforcement to serve as a meaningful deterrent, the financial consequences of failing to meet required standards must be sufficient to discourage noncompliance rather than allow it to become an acceptable cost of doing business – The Accountability Gap: A National Examination of Nursing Home Oversight and Enforcement

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.



The Accountability Gap in New York – Special Issue

Examining "No Harm" Citations and Their Consequences for Residents

State survey agencies, like the NY Department of Health, are responsible for assuring that nursing homes provide quality care and humane conditions. To the extent that nursing home problems are widespread and persistent is due to the failure of state agencies to properly identify violations and ensure that they are corrected.

LTCCC's national report, The Accountability Gap: A National Examination of Nursing Home Oversight and Enforcement, 2022-2024, examines the extent to which state survey agencies are identifying and addressing substandard nursing home care. Our companion report, New York Nursing Home Care and Oversight, provides key state findings. A central concern in this work is that the majority of violations are classified as causing "no actual harm" to any resident, even when the survey findings describe troubling failures in resident care resulting in avoidable pain and degrading conditions. This is particularly important because, in the absence of a finding of harm, there is little likelihood that the facility will face any penalty. The resulting message to operators is that they will be paid – and face no repercussions – for the substandard care identified.

This special New York issue of the *Elder Justice Newsletter* provides examples "no harm" citations from federal Statements of Deficiencies (SoDs). These cases raise a fundamental question: When surveyors document residents waiting hours for assistance, missing essential treatment, or facing serious threats to their safety and dignity, does a "no actual harm" classification adequately capture their experiences?

Van Duyn Center for Rehabilitation and Nursing (New York)

Infection Prevention and Control

Facility overall rating: ⚠ **Not available**

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

The surveyor determined that the facility failed to establish and maintain an infection prevention and control program (F880). Inspectors observed unvaccinated staff members failing to wear required facemasks, urinary catheter drainage bags and tubing resting directly on floors, and a broken soap dispenser in a resident's bathroom. At the time of the survey, six residents had been diagnosed with influenza. Despite these findings and the risks to residents, the surveyor cited the violation as no-harm.[1] The citation was based, in part, on the following findings from the SoD:

- Following a New York State declaration requiring unvaccinated healthcare workers to wear facemasks, inspectors observed unvaccinated nursing and dietary staff working in resident care areas without masks or wearing them improperly. Staff were observed administering

medications and serving residents in dining areas without properly covering their mouths and noses. At the time of the survey, six residents had been diagnosed with influenza.

- The director of nursing and another nurse in charge of infection control initially stated that a list of unvaccinated employees had been provided to supervisors to help monitor compliance with masking requirements. They later acknowledged that the list had not been distributed, despite their awareness that some unvaccinated staff were not wearing masks appropriately. As a result, supervisors did not have the information needed to effectively monitor compliance.
- Inspectors observed urinary catheter drainage bags and tubing lying directly on the floor for two residents. One resident's care plan required enhanced barrier precautions related to the catheter. A nurse aide acknowledged that the resident's drainage bag was touching the floor because the bed had been lowered too far. Nursing staff confirmed that catheter drainage bags should not be placed directly on the floor because of the risk of bacterial contamination and infection.
- Inspectors repeatedly observed that the bathroom soap dispenser in the room of a resident on enhanced barrier precautions was not functioning during the survey. Staff acknowledged the importance of handwashing before and after providing care to residents requiring these precautions but could not explain how long the dispenser had been broken or why maintenance had not repaired it.
- **Know Your Rights:** Nursing home residents have the right to reside in a safe, sanitary environment and to receive care that protects them from preventable infections. Facilities must implement effective infection prevention and control practices, including appropriate hand hygiene, use of protective equipment, and safe handling of medical devices. To learn more, see LTCCC's fact sheet on infection prevention and control.

Adira at Riverside Rehabilitation and Nursing (New York)

Nurse Staffing

Facility overall rating: ★★☆☆☆

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.[2] 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.

Bishop Rehabilitation and Nursing Center (New York)

Pressure Ulcers

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to provide appropriate pressure ulcer care for five of seven residents reviewed (F686). Inspectors identified failures to ensure that residents' wound were properly assessed by qualified nursing staff and that prescribed wound treatments were completed. These failures involved residents with serious pressure ulcers, including Stage 4 wounds. Despite the findings, which surveyors characterized as substandard quality of care, the deficiency was cited as no-harm.[3] The citation was based, in part, on the following findings from the SoD:

- One resident had multiple pressure ulcers, including a Stage 4 ulcer on the lower back and several ulcers on the feet and legs. The Stage 4 ulcer involved extensive tissue damage, with exposed muscle and bone documented during a wound evaluation. Inspectors found inconsistencies in the resident's wound records, including ulcers that appeared in some assessments but were missing from others. There was no documented evidence that the wounds, including newly identified pressure injuries, were appropriately assessed by a qualified individual.
- A second resident had Stage 3 and Stage 4 pressure ulcers on the heel and ankle. The resident told inspectors that a nurse had not changed their dressing as ordered and, when asked to do so, said they were too busy. Inspectors observed that the dressing had not been changed as scheduled. The nurse acknowledged signing off on treatments at the beginning of the shift, before actually completing them, and stated that the resident's account of the missed dressing change was accurate.
- Another resident had Stage 4 pressure ulcers on the heel and lower leg. Inspectors found no documented evidence that the wounds had been assessed by a qualified individual for more than six weeks. A nurse acknowledged that a prescribed dressing change had not been completed, despite documenting that it had been done. The nurse also failed to document the reported refusal or notify a supervisor.
- A nurse reported that wound dressings were often not changed as ordered and acknowledged that missed treatments could interfere with healing. The nurse also stated that the facility had been without a wound care physician for approximately six weeks.
- Inspectors identified broader problems with wound care oversight. Licensed practical nurses documented whether wounds were healing or resolved without appropriate assessments by registered nurses (RNs) or qualified providers. An RN on the wound care team reported having no specific wound care training and being unsure which wound assessments licensed practical nurses were permitted to perform. The facility administrator also acknowledged not knowing how frequently the wound care team conducted rounds or the differences in nursing staff responsibilities.
- **Know Your Rights**: Residents have the right to receive care that prevents pressure ulcers (unless clinically unavoidable) and ensures timely treatment of wounds. Nursing homes are required to conduct regular skin assessments, quickly implement interventions when new pressure injuries appear, and notify appropriate clinicians. Under New York law, RNs, not LPNs, must perform the skin assessments. 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.

Newfane Rehab & Health Care Center (New York)

Antipsychotic Drugging

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.[4] 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-kept, 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.

Waterview Heights Rehabilitation and Nursing Center (New York)

Resident Rights and Dignity

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.[5] 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.

Auburn Rehabilitation & Nursing Center (New York)

Unsafe Transfer and Discharge

Facility overall rating: ⚠ **Not available**

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.[6] 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

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

equipment, including oxygen therapy, during and after discharge. Discharging a resident without critical supports places them at risk of serious harm or death. To learn more, see LTCCC's information on inappropriate transfer or discharge of residents.

Highpointe on Michigan Health Care Facility (New York)

Failure to Investigate Abuse

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to appropriately investigate serious allegations of potential abuse involving four residents (F610). Inspectors found that the facility failed to interview potential witnesses and other residents who may have been affected, and did not investigate an incident in which a resident exposed their genitals in a common area. Despite these findings, the surveyor classified the violation as no-harm.[7] 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 208, 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.
- The facility failed to appropriate investigate the repeated room intrusions. Interviews revealed that some nursing supervisors and medical providers had not been informed of the incidents.
- The facility failed to follow its abuse policy by conducting an incomplete investigation of the first incident and failing to appropriate investigate the subsequent incidents.
- During interviews, the director of nursing acknowledged that more should have been done to ensure the safety of all 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

Nursing home residents have the right to be free from all forms of abuse, including physical and verbal aggression by other residents.

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.

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 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 Van Duyn Center for Rehabilitation and Nursing (December 15, 2025). Available at https://nursinghome411.org/wp-content/uploads/2026/10/Van-Duyn-Center-for-Rehabilitation-and-Nursing-NY.pdf.
[2] 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
[3] Statement of Deficiencies for Bishop Rehabilitation and Nursing Center (May 5, 2026). Available at https://nursinghome411.org/wp-content/uploads/2026/10/Bishop-Rehabilitation-and-Nursing-Center-NY.pdf.
[4] 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.
[5] 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.
[6] 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.
[7] 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.