

ELDER JUSTICE

What “No Harm” Really Means for Residents

Center for Medicare Advocacy & Long Term Care Community Coalition

Volume 8, Issue 3

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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.

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](#).

	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: The Psychosocial Cost of Care Failures

Federal regulations require nursing homes to provide care that allows residents to attain and maintain their highest practicable physical, mental, and psychosocial well-being. Despite these requirements, state survey agencies continue to identify facility failures that cause or contribute to mental and emotional distress—yet too often cite these deficiencies as causing "no harm" to residents. Residents' own accounts reveal the very real psychosocial consequences of living in deteriorating conditions, going without needed behavioral health services, experiencing violence, or waiting hours for help with basic needs. These failures are more than regulatory violations—they can undermine residents' dignity, autonomy, emotional security, and quality of life.

This issue of the *Elder Justice Newsletter* highlights six nursing homes cited for serious failures involving behavioral health care, staffing, environmental safety, and resident protection. Surveyors documented residents waiting hours for basic assistance, ordered psychiatric care that went unprovided for months, a pest-infested facility with sewage odors, and repeated resident-to-resident altercations without adequate behavioral interventions. Residents described feeling depressed, lonely, degraded, and desperate for help. Together, these cases demonstrate why psychosocial harm must be taken seriously when assessing nursing home deficiencies and underscore the need for meaningful oversight and accountability when facilities fail to protect residents' mental, emotional, and psychosocial well-being.

Avant Rehabilitation and Care Center (New Jersey)

"I am lonely, I want to kill myself.": Facility delays psychiatric care for suicidal resident for five months.

Facility overall rating: ★★★★★☆

The surveyor determined that the facility failed to provide necessary behavioral health care and services to a resident who expressed suicidal thoughts and feelings of loneliness ([F740](#)). Although crisis-screening staff recommended psychiatric follow-up and two physicians ordered a psychiatric consultation, the facility failed to ensure that the resident was ever seen by a psychiatrist. The resident's care plan also omitted the suicidal statements and significant behavioral health needs. Despite these findings, the surveyor cited the violation as no-harm.¹ The citation was based, in part, on the following findings from the [SoD](#):

- One resident repeatedly told staff, "I am lonely, I want to kill myself." The resident reported feeling lonely, bored, and isolated. Staff removed potentially harmful objects from the resident's room, instructed employees to monitor the resident closely, and arranged for a crisis evaluation.

- The psychiatric screening service evaluated the resident that day and recommended follow-up with a psychiatrist. Two separate physicians also issued orders for a psychiatric consultation on April 20 and April 21.
- Nevertheless, the facility failed to communicate the orders and recommendation to its psychiatric provider. More than five months later, the facility leadership confirmed that the resident had never been seen by a psychiatrist because the provider had not been told that an evaluation was needed.
- A psychiatric nurse practitioner who visited the facility weekly stated that he did not recall ever seeing the resident. The resident was finally scheduled for an appointment during the survey but was transferred out of the facility before the consultation occurred.
- Although the resident had diagnoses including bipolar disorder and severe cognitive impairment, the care plan omitted the resident's documented suicidal statements, aggression, bipolar disorder, and manic episode. Instead, the facility relied on a generic pandemic-related "loneliness and boredom" care plan, with interventions such as activities and video calls.
- **Know Your Rights:** Under federal law, nursing home residents must receive the behavioral health care required to maintain their mental well-being. When a resident expresses mental distress, facilities must ensure that physician-ordered psychiatric consultations are provided promptly, track behavioral changes, and update care plans with critical safety interventions. For more information on federal regulations around behavioral care and advocacy strategies, see [LTCCC's fact sheet on requirements for nursing home behavioral and social health services](#).

Nursing home residents must receive the behavioral health care required to maintain their mental well-being. When a resident expresses severe mental distress, facilities must ensure that physician-ordered psychiatric consultations are provided promptly, track behavioral changes, and update care plans with critical safety interventions.

Bria of River Oaks (Illinois)

“A sad, sad place to live.”: Lack of upkeep forces residents to live with mold, pests, and sewage.

Facility overall rating: ★★☆☆☆

The surveyor determined that the facility failed to maintain a safe, clean, comfortable, and homelike environment ([F921](#)). This directly impacted 28 residents and had the potential to impact all 232 residents in the facility. Several residents directly described the emotional toll of living in these conditions, including feeling depressed, sad, and wanting to leave the facility. Despite severe and widespread environmental degradation—and residents' own reports of its emotional impact—the violation was cited as no-harm.² The citation was based, in part, on the following findings from the [SoD](#):

- Surveyors found widespread water damage throughout the facility, including ceiling tiles in the conference room, dining rooms, bathrooms, and resident rooms that were stained with dark discoloration resembling mold or mildew. Tiles were missing entirely in some rooms, exposing pipes and cloth covered in black stains.
- Flying insects were observed throughout the facility, including resident rooms, bathrooms, dining areas, and common spaces. Pest control reports from seven months ago revealed unresolved issues including large holes in walls that allowed rodent entry, standing water in the dishwashing room, and uncleaned food debris on floors.
- Resident rooms were in significant disrepair, with missing dresser drawers, detached closet doors, broken soap and paper towel dispensers, rusted resident bed frames and closet shelves, peeling paint, crumbling drywall, and damaged walls and flooring.
- Multiple resident rooms lacked functioning call light cords, leaving residents unable to alert nurses in an emergency.
- Handrails along one hallway were completely detached from the drywall. High-traffic hallways and resident rooms had extremely sticky floors layered with dirt, dust, wax, and grease.
- The housekeeping supervisor admitted that the facility's disinfectant had not worked effectively in warm weather for over a month and admitted that one shower room had such a strong sewage odor that he would not shower there himself.
- Basic maintenance problems remained unresolved throughout the facility. Surveyors found bathrooms with loose faucets that produced only a trickle of water, a resident bathroom where the hot water reached only 79°F, far below the 99°F the maintenance director deemed fair.
- While facility policy requires daily preventative maintenance inspections, the maintenance director had "no idea" the bathrooms were in such disrepair. The facility could not prove that they were performing these mandatory checks.
- One resident stated that these deficiencies made her feel "depressed" and that social services had failed to find her a room elsewhere.
- Another resident described her room as "depressing" and the facility as a "sad, sad place to live in." She said she would rather live in any other facility.
- **Know Your Rights:** Residents have the right to live in a safe, clean, comfortable, and homelike environment that supports their dignity and well-being. Nursing homes must address sanitation problems, pests, water damage, broken fixtures, and other environmental conditions that can make residents feel unsafe, ashamed, depressed, or unwelcome in their own home. For more information, see [LTCCC's fact sheet on safe environments](#).

Optalis Health and Rehabilitation of Troy (Michigan)

Cries for help ignored: Facility failed to provide needed behavioral health services.

Facility overall rating: ★★☆☆☆

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

The surveyor determined that the facility failed to ensure residents received necessary behavioral health care and services ([F740](#)). Three residents experienced delayed or unmet psychiatric and psychological care because the facility failed to coordinate behavioral health services, implement individualized behavioral interventions, or monitor whether treatment was effective. Nevertheless, the deficiency was cited as no-harm.³ The citation was based, in part, on the following findings from the [SoD](#):

- The facility's social services director, who helped coordinate behavioral and psychiatric services, left the facility, leaving only one other social worker. The director was not replaced for weeks despite the facility's high admission and discharge census. One resident's family agreed to a psychiatric consultation after expressing concerns about worsening confusion and questioning the resident's antipsychotic medication. Although the family expected to participate in the consultation, the psychiatric evaluation never occurred, and no one informed them why.
- The resident had no individualized behavioral care plan, no identified target behaviors, and no non-pharmacological interventions, despite receiving psychotropic medication and exhibiting anxiety related to therapy and fear of falling.
- A second resident was admitted following repeated hospitalizations for confusion, agitation, and suicidal statements. Hospital records documented psychiatric treatment, yet after admission, the nursing home never completed three separate physician-ordered psychiatric consultations, failed to implement a behavioral care plan, and provided no behavioral health oversight despite the resident later threatening suicide and requiring hospitalization.
- A third resident, who reported depression following a serious motor vehicle accident, consented to psychiatric and psychological services shortly after admission. Although the referral was documented and incorporated into the care plan, the resident never received the requested behavioral health services, and staff could not locate any documentation showing the consultation had occurred.
- A social worker confirmed that psychiatric appointments are supposed to be scheduled within a few days. Medical staff reported that they were unaware that some of these residents had not had their evaluations.
- **Know Your Rights:** Residents are entitled to individualized behavioral health services, including non-pharmacological interventions. When psychiatric or psychological services are ordered or requested, nursing homes must ensure those services are provided in a timely manner, develop individualized care plans that include appropriate non-drug interventions, monitor residents' symptoms and treatment, and coordinate care among physicians, social workers, and behavioral health providers. Delayed or absent behavioral health care can leave residents' emotional distress, depression, anxiety, or suicidal thoughts unaddressed. For help providing appropriate care, see [LTCCC's fact sheet on resident assessment and care-planning](#).

Lincolnwood Rehabilitation and Healthcare Center (Rhode Island)

Crying for help, but no one followed up: Residents went without needed behavioral health care.

Facility overall rating: ★☆☆☆☆

The surveyor determined that the facility failed to provide necessary behavioral health monitoring and interventions for residents experiencing acute psychological distress (F740). Staff failed to ensure physician-ordered psychiatric consultations, the provision of behavioral health follow-ups to vulnerable residents, and adequate tracking of another resident's escalating aggressive behaviors. 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 called the Rhode Island Department of Health crying after reporting that the facility had discontinued the antidepressant medication that the resident had taken for years. The resident described feeling “very depressed” and said that “nobody is helping.” The resident had diagnoses including anxiety, depression, and adjustment disorder, and an assessment indicating moderately severe depression.
- The resident’s care plan flagged a high risk for self-harm related to a history of suicidal ideation. Although psychiatric and psychological providers documented that the resident would benefit from continued behavioral health services, the facility failed to ensure the resident received any psychological follow-ups. During this period, the resident threatened to kill a nursing assistant and was later documented screaming at staff.
- A second resident, who had post-traumatic stress disorder, severe cognitive impairment, and dementia, had a physician's order for a psychiatric consultation shortly after admission. The consultation never occurred, despite the resident’s care plan calling for psychiatric and psychological services.
- The same resident was later physically assaulted by another resident with a history of behavioral issues.
- The aggressor’s care plan, dated more than six months prior, stated that the resident had “the potential to demonstrate physical behaviors” and provided instructions to document behavior and attempted interventions.
- The aggressor’s progress notes revealed that the resident had previously punched staff on multiple occasions and urinated on another resident’s floor.
- A nurse admitted that she expected to see at least daily documentation of this resident’s behavior. Yet, a behavior log was never established.

Residents have the right to receive timely behavioral health services that address depression, trauma, suicidal thoughts, aggression, and other mental health needs. Facilities should implement physician-ordered psychiatric consultations promptly; actively manage residents with high-risk mental health diagnoses, such as PTSD and severe depression; and accurately track behavior to ensure a safe environment for all.

- **Know Your Rights:** Residents have the right to receive timely, individualized behavioral health services that address depression, trauma, suicidal thoughts, aggression, and other mental health needs. When psychiatric or psychological services are ordered, nursing homes must ensure those services are actually provided. Facilities must also monitor behavioral symptoms, identify triggers, document attempted interventions, and evaluate whether those interventions are effective. To determine the extent of harm resulting from facility noncompliance, surveyors can refer to [LTCCC's guide on psychosocial outcome severity](#).

Hillside Health Care Center (Missouri)

Unmonitored and unsafe: Facility failed to protect residents from repeated altercations.

Facility overall rating: Not provided due to Special Focus Facility status.

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

The surveyor determined that the facility failed to monitor, document, and respond to residents' behaviors ([F740](#)). As a result, residents with known histories of aggression were involved in repeated, preventable physical altercations without meaningful interventions to reduce the risk of future violence. Despite this, the violation was cited as no-harm.⁵ The citation was based, in part, on the following findings from the [SoD](#):

- According to documents, a resident attacked another resident, throwing the resident to the ground. Staff found the victim with blood on their neck and blood, bruising, and a laceration on their ear.
- Although there was an order to monitor aggression and document the aggressor's behaviors, staff repeatedly failed to document required behavior observations, leaving numerous shifts blank and failing to complete the required monthly behavioral summary.
- Despite the violent incident, staff did not update the resident's care plan with new interventions to prevent such future altercations.
- Less than two weeks later, another resident with a documented history of physical aggression hit their roommate in the mouth after the roommate accidentally fell into a privacy curtain.
- Although the resident's care plan already identified a history of aggressive behavior, the facility again failed to update the care plan, implement additional interventions, or initiate behavioral monitoring after the assault.
- The medication administration record contained no order to monitor this resident's behavior, despite a social services assessment indicating behavior tracking was in place.
- Neither the resident's care plan nor the mental status exam was updated after the incident. An LPN acknowledged that staff relied on care plans to identify residents' behavioral triggers and interventions yet admitted they were unaware of the resident's history of prior altercations.
- Surveyors identified the same pattern across multiple residents, including one resident involved in multiple altercations within a one-month span whose record lacked behavioral

monitoring, monthly behavioral summaries, and meaningful care-plan revisions to address escalating aggression.

- **Know Your Rights:** Residents have the right to receive individualized behavioral health care and to be protected from foreseeable harm involving other residents. When a resident exhibits aggression or other distressing behaviors, nursing homes must assess the behavior, identify possible triggers, implement appropriate person-centered interventions, monitor whether those interventions work, and revise the care plan when necessary to reduce the risk of future incidents. To read more about some of the causes of conflicts between residents, check out [LTCCC's presentation on harmful resident-to-resident incidents](#).

Troy Victorian Rehabilitation & Nursing Care Center (New York)

Short-staffed and short-changed: Basic care deficiencies strip resident dignity.

Facility overall rating: ★☆☆☆☆

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

The surveyor determined that the facility failed to maintain sufficient staffing to meet residents' needs ([F725](#)). These staffing shortages left vulnerable residents neglected for extended periods, compromising their well-being. Despite these serious concerns, the violation was cited as no-harm.⁶ The citation was based, in part, on the following findings from the [SoD](#):

- During a resident group interview, multiple residents reported waiting extended periods for assistance, being left unattended after requesting help, and experiencing rude or disrespectful treatment from staff. Residents stated that staff often promised to return but never did.
- Staffing records spanning nearly two months showed that the facility repeatedly fell below the staffing levels identified as necessary in its own Facility Assessment.
- Staff could not consistently provide incontinence care, showers, or bed baths, and residents routinely waited one to three hours for assistance.
- One resident stated that after activating the call light, CNAs would enter the room, say "I'm not your aide," turn off the call light, and leave without providing assistance. The resident reported waiting one to three hours for help using the bathroom and described lying in bed soaked in urine after staff failed to respond. The resident said they felt degraded when staff refused to help and witnessed nursing assistants arguing over assignments in front of residents.
- **Know Your Rights:** Nursing homes must provide sufficient nursing staff to meet each resident's needs and provide the care necessary to maintain residents' physical, mental, and

Psychosocial harm is real harm. When residents are left waiting for basic care, denied needed mental health services, exposed to violence, or forced to live in degrading conditions, the consequences can include fear, anxiety, humiliation, depression, loss of dignity, and social withdrawal—even when surveyors label the deficiency "no harm."

psychosocial well-being. Chronic understaffing is not merely an administrative problem—it can leave residents waiting for toileting, hygiene, bathing, meals, and other essential care, undermining their health, dignity, and quality of life. To learn more about nursing home staffing, see [LTCCC's Nursing Home Staffing Resource Center](#).

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 state or local representative](#) or 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 Avant Rehabilitation and Care Center (October 12, 2022). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Avant-Rehabilitation-and-Care-Center-NJ.pdf>.

² Statement of Deficiencies for Bria of River Oaks (August 3, 2023). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Bria-of-River-Oaks-IL.pdf>.

³ Statement of Deficiencies for Optalis Health and Rehabilitation of Troy (October 26, 2023). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Optalis-Health-and-Rehabilitation-of-Troy-MI.pdf>.

⁴ Statement of Deficiencies for Lincolnwood Rehabilitation and Healthcare Center (June 12, 2023). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Lincolnwood-Rehabilitation-and-Healthcare-Center-RI.pdf>.

⁵ Statement of Deficiencies for Hillside Health Care Center (July 14, 2023). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Hillside-Health-Care-Center-MO.pdf>.

⁶ Statement of Deficiencies for Troy Victorian Rehabilitation & Nursing Care Center (May 9, 2025). Available at <https://nursinghome411.org/wp-content/uploads/2026/08/Troy-Victorian-Rehabilitation-Nursing-Care-Center-NY.pdf>.