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THE ACCOUNTABILITY GAP

A National Examination of Nursing Home Oversight and Enforcement, 2022–2024

THE LONG TERM CARE COMMUNITY COALITION
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This report, searchable files with state performance indicators and other data, and other materials are available on our study page at https://nursinghome411.org/ltccc-enforcement-study-2026/.

We thank The New York Community Trust for its generous support of this project.

Executive Summary

The federal Nursing Home Reform Law establishes strong, resident-centered standards for care, safety, and dignity. Those standards, however, depend on effective monitoring and enforcement. This study examines how the federal Centers for Medicare & Medicaid Services (CMS) and the state survey agencies carried out that responsibility during calendar years 2022–2024, using data from CMS survey, deficiency, penalty, staffing, and Minimum Data Set reports.

Across the measures examined, the findings reveal a persistent accountability gap. **Survey activity recovered somewhat after the COVID-19 public health emergency, and the total number of cited health deficiencies increased. Yet resident-adjusted citation activity changed relatively little, financial penalties fell sharply, and surveyors overwhelmingly classified substantiated violations below the level of actual harm**. The same pattern appears across specific areas of care and resident protection, including infection control, sufficient staffing, pressure-ulcer care, psychotropic medication requirements, and resident rights.

The state differences are also substantial, but they should be understood within a broader national accountability problem. Nursing homes throughout the country are subject to the same federal requirements, yet the frequency with which state agencies identify violations, determine that residents were harmed, and impose financial consequences varies significantly. These differences do not establish that states with comparatively higher citation or harm identification rates are providing more effective oversight. Rather, the findings indicate different degrees of performance within a system that, nationally, is failing to ensure that residents consistently receive the care, services, safety, and dignity required under federal standards. **The relevant benchmark is not whether one state performs better than another, but whether states are effectively protecting residents and ensuring compliance with federal requirements. The evidence examined in this study, considered alongside decades of investigative reports, academic studies, and GAO and OIG findings, provides little basis for concluding that any state is meeting that benchmark.**

A particularly important finding is the regulatory treatment of resident harm. Under the federal scope-and-severity system, deficiencies classified below level G are treated as involving no actual harm, and facilities cited at those levels are highly unlikely to face any penalty whatsoever. Across the health deficiencies examined in this study, approximately 94% were classified as not causing any harm to any resident in the building. For several critical requirements, the share was even higher. Thus, **the issue is not simply whether surveyors are identifying noncompliance with minimum standards, but whether they are recognizing the impact of that noncompliance on residents**.

Taken together, the patterns revealed in state and federal data provide substantial evidence that nursing home standards are not being enforced with sufficient rigor and regularity to ensure that their protections are realized in residents' daily lives.

KEY FINDINGS

- **State survey activity.** Standard-survey coverage increased from 56.4% of providers in 2022 to 64.8% in 2024 but remained well below the federal expectation of roughly annual surveys. Complaint-survey activity changed little nationally, from 72.6% to 74.5%, while state performance varied widely. **See pp. 8-9.**
- **Deficiency citations and severity.** Survey agencies cited 128,675 health deficiencies in 2022 and 143,821 in 2024, an increase of about 12%. After adjusting for resident census, however, citation rates remained broadly similar across the years. Approximately 94% of cited health deficiencies were classified below actual harm each year, while state rates of identifying harm and immediate jeopardy differed substantially. **See pp. 10-12**.
- **Financial penalties.** The number of reported fines fell from 11,501 in 2022 to 5,210 in 2024, a decline of about 55%, while total fine dollars fell about 14%. Because resident census increased during the period, the resident-adjusted frequency of fines declined about 56.5%. Forty-nine of 52 jurisdictions reported fewer fines in 2024 than in 2022. **See pp. 13-15**.
- **Infection prevention and control.** F880 infection-control citations increased about 13% from 2022 to 2024, from 6,851 to 7,736. Over the same period, the number classified as actual harm or immediate jeopardy fell from 297 to 103, a decline of about 65%; by 2024, only 1.3% of F880 citations were classified G+. **See pp. 16-19**.
- **Nurse staffing.** Average nurse staffing rose modestly, but 2024 data showed substantial shortfalls relative to staffing levels expected to meet residents' basic clinical needs. About 90% of nursing homes with valid comparisons were below expected total staffing, and nearly two-thirds were at least 20% below expected. Yet surveyors issued only 1,012 F725 sufficient-staffing citations in 2024, and only 33 (3.3%) were classified as resulting in any harm or immediate jeopardy to one or more residents in the nursing home. **See pp. 20-24**.
- **Pressure ulcers.** Nursing homes reported roughly 94,000–95,000 residents with unhealed pressure ulcers in Q4 of each study year, close to 8% of the resident population. Survey agencies issued only about three F686 citations for every 100 residents reported with a pressure ulcer, and approximately three-quarters of substantiated F686 violations were classified below actual harm (despite the fact that, by definition, a pressure ulcer is an injury). State citation and harm-identification rates varied greatly. **See pp. 25–28**.
- **Antipsychotic drugs.** About one in five nursing home residents was reported as having received an antipsychotic in Q4 of each study year. Survey agencies issued 5,594 F758 citations over 2022–2024, but only 26 (0.46%) were classified at actual harm or immediate jeopardy; 99.5% were classified as "no harm." State drugging rates and regulatory responses varied substantially. **See pp. 29–32**.
- **Resident rights and dignity.** F550 resident-rights citations increased 45% from 2022 to 2024, yet state agencies still deemed 83% of nursing homes to have no violations of federal resident-rights requirements in 2024. Harm identification moved in the opposite direction: G+ findings declined from 69 in 2022 to 64 in 2024, and across the three years

approximately 97.6% of F550 violations were classified as causing no physical, clinical, or psychosocial harm to any resident. **See pp. 33-36**.

Taken together, the findings point to a regulatory system in which the identification of violations, recognition of resident harm, and imposition of meaningful consequences remain limited and highly variable. Federal nursing home protections are strong on paper. The accountability gap documented in this report is the distance between those protections and their enforcement in practice.

Introduction

U.S. nursing homes provide essential care, services, and home to over one million people every day and millions of people a year. In addition to those individuals, their families and loved ones have a significant stake in the quality and safety of nursing home care. And, because most nursing home care is paid for by the public (through Medicare and Medicaid), taxpayers have a vested interest in ensuring the integrity of the nursing home system.

For these reasons, the federal Nursing Home Reform Law, its implementing regulations, and sub-regulatory guidance establish a strong framework for quality of care and humane conditions in nursing homes. Nevertheless, serious problems, including substandard care, abuse, neglect, and demeaning conditions, are widespread and persistent problems.[1,2,3]

Fundamentally, there is a simple reason why problems persist: quality of care and dignity standards are not self-implementing. They require vigorous monitoring and meaningful enforcement.

There are many reasons for the persistence of poor care and conditions in U.S. nursing homes. However, fundamentally, there is a simple reason why problems persist: quality of care and dignity standards are not self-implementing. They require vigorous monitoring and meaningful enforcement.

Thus, the purpose of this study is to evaluate the extent to which the state and federal agencies charged with ensuring quality, safety, and dignity are carrying out their mission. The study period is the years 2022-2024. This work continues and builds on two previous studies: *Broken Promises*, published in 2021, and *Safeguarding NH Residents & Program Integrity: A National Review of State Survey Agency Performance*, published in 2015.[4,5]

METHODOLOGY

To gain information and insights into state and national performance, we utilized various CMS data resources, including MDS Frequency Reports, QCOR enforcement data, and Health Deficiencies reports. These data were used to review and evaluate the extent to which states are substantiating deficiencies, identifying when residents are harmed or put in immediate jeopardy, and penalizing nursing homes for substandard care. In addition to overall enforcement activity, several key quality indicators were selected for review to ensure that the study was responsive to variations in outcomes among the states.

QCOR data note: All citation and enforcement data in this study were obtained directly from CMS's Quality, Certification and Oversight Reports (QCOR) system. State figures are reported as

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[1] The Reform Law was enacted as part of Omnibus Budget Reconciliation Act of 1987.
[2] Federal regulations, known as the "Requirements for States and Long Term Care Facilities, 42 CFR Part 483," are available at https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483.
[3] Guidance for surveyors is in Appendix PP of the State Operations Manual, available at https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
[4] https://nursinghome411.org/wp-content/uploads/2021/10/Broken-Promises.NH-Oversight-Data-Assessment.pdf.
[5] https://nursinghome411.org/national-report-safeguarding-nursing-home-residents-program-integrity/.

presented in the applicable QCOR state reports and should not be aggregated to construct national results or recalculated using provider counts from a separate QCOR report. CMS cautions that QCOR data, including provider and supplier counts and percentages, are valid for the subset of providers or suppliers for which survey records are available in CASPER. LTCCC's analysis includes the 50 states, District of Columbia, and Puerto Rico.

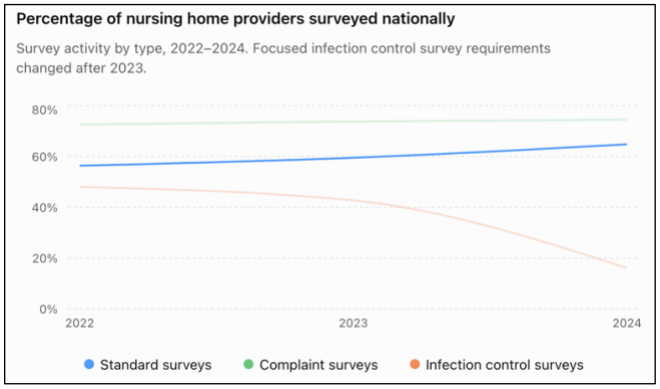
State Survey Activity, 2022–2024

Standard surveys, which are required to take place on a roughly annual basis, are the principal means by which state survey agencies assess whether nursing homes are complying with federal requirements for resident care, safety, and dignity. Complaint surveys are also crucial, since they are essentially the only mechanism for identifying and rectifying violations of minimum standards in between standard surveys. The third type of surveys tracked in federal data, focused infection control surveys, were implemented during the COVID pandemic. They are not discussed in depth here.

FINDINGS: STANDARD SURVEYS

Nationally, the percentage of nursing home providers receiving a standard survey increased over the three-year study period, from 56.4% in 2022 to 59.4% in 2023 and 64.8% in 2024. Thus, while standard survey coverage remained well below the federal requirement that states survey facilities once a year, on average, to ensure resident safety and compliance with minimum standards of care, the national trend moved in a positive direction over the course of the study period.

The improvement was widespread, though far from uniform. **Only thirty-four of the 52 states**[6] **had a higher percentage of providers receiving standard surveys in 2024 than in 2022**. Several states showed particularly large increases. Idaho rose from 16.7% of providers surveyed in 2022 to 72.2% in 2024; Delaware increased from 34.7% to 89.8%; and California increased from 38.1% to 71.6%. New Jersey, Mississippi, Washington, and Massachusetts also experienced increases of more than 20 percentage points over the period.



By 2024, several states reported standard survey coverage approaching or exceeding 85%. New Hampshire had the highest rate, at 93.6%, followed by **Nevada** (93.0%), **Delaware** (89.8%), **Louisiana** (87.8%), **Pennsylvania** (87.6%), and **Rhode Island** (85.9%). **At the other end of the spectrum**, **Alabama** reported standard surveys at only 12.1% of providers in 2024, followed by **Tennessee** (26.9%), **Virginia** (30.5%), **Maryland** (35.8%), **Ohio** (36.0%), and **Kentucky** (39.9%). **Alabama and Virginia declined in each year of the study period**. **Arizona experienced the largest overall decline**, falling from 80.4% in 2022 to 50.3% in 2024.[7]

[6] For the sake of simplicity, we refer to the jurisdictions included in the study – the 50 states, Washington, DC, and Puerto Rico – as "states" or "jurisdictions" in the report and data files.

[7] As noted above, federal requirements provide that state agencies are to conduct standard surveys at a statewide average interval of 12 months, with individual facility timeframes of 9-15 months. Consequently, the percentage of facilities surveyed within a calendar year is not equivalent to the percentage receiving timely or overdue surveys.

FINDINGS: COMPLAINT SURVEYS

As noted above, complaint surveys are a critical component of nursing home oversight and quality assurance. They are generally the only time that surveyors are assessing a facility's care in between standard surveys. Research has shown that, for mistreatment citations, complaint surveys were more likely to be substantiated as serious as compared to standard surveys.[8] This is likely due to surveyors investigating at or close to the time of the violation, making substantiation of the deficiency easier.

Complaint survey activity followed a markedly different pattern from standard survey activity. **The percentage of providers receiving complaint surveys remained essentially flat, increasing only modestly from 72.6% in 2022 to 73.8% in 2023 and 74.5% in 2024**. Some states consistently reported complaint survey activity at relatively high percentages of providers. In 2024, **Nevada reported complaint surveys involving 91.6% of providers, while South Carolina, Delaware, and California were each near 88%.** Other states experienced sizable increases over the study period, including South Dakota, Idaho, New Jersey, and North Dakota. Conversely, Alabama declined from 45.0% in 2022 to 18.3% in 2024, and Tennessee declined from 77.1% to 50.9%. At the other end of the spectrum, **the states with the lowest percentages of complaint surveys were Puerto Rico** (7.1%), **Alabama** (18.3%), **Maryland** (45.3%), **Kentucky** (46.8%), and **Massachusetts** (48.2%).

It is important to note that these data do not tell us whether complaints were appropriately investigated, substantiated, or resulted in deficiencies or findings of resident harm. An OIG report found that "many States are consistently failing to meet required timeframes for investigating the most serious nursing home complaints" and that their overall "analysis raises questions about some States' ability to address serious nursing home complaints and also about the effectiveness of CMS's oversight of States."[9]

Thus, a high complaint-survey percentage indicates greater complaint investigation activity, but not necessarily more effective enforcement of minimum standards of care and safety. Survey frequency, however, is only one component of oversight. The extent to which state survey agencies are effectively identifying violations, appropriately assessing their severity, and taking meaningful enforcement action is addressed in the analyses that follow.

Complete state survey activity data are available on the webpage for this report, https://nursinghome411.org/ltccc-enforcement-study-2026/.

[8] Liu, P.-J., Caspi, E., & Cheng, C.-W., "Complaints Matter: Seriousness of Elder Mistreatment Citations in Nursing Homes Nationwide," *Journal of Applied Gerontology*, (2022) 41(4), 908-917. https://journals.sagepub.com/doi/10.1177/07334648211043063

[9] US HHS OIG, States Continued To Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018, OEI-01-19-00421 (2020). https://oig.hhs.gov/reports/all/2020/states-continued-to-fall-short-in-meeting-required-timeframes-for-investigating-nursing-home-complaints-2016-2018/

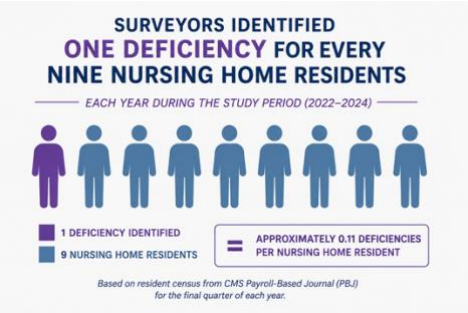
Deficiency Citations and Severity: Measuring Accountability

State survey agencies (SAs) hold fundamental responsibility for ensuring that nursing home residents receive care that meets or exceeds minimum standards, are free from abuse, and are able to live with dignity 24 hours per day, every day of the year. They are expected to accomplish this by identifying violations of federal nursing home requirements and accurately assessing their seriousness (i.e., the extent to which one or more residents in the facility experienced, or was put at risk of experiencing, harm to their clinical, emotional, or psychosocial well-being).

While facility-level deficiencies are most often used to gain insights into the quality of care in an individual home, state and national level deficiency data provide valuable insights into the extent to which a SA is fulfilling its responsibilities. And, because all Medicare- and Medicaid-certified nursing homes are subject to the same federal standards, citation patterns raise important questions about the extent to which residents in different states or regions are receiving comparable regulatory protections.

Deficiency Citation Rates

Nationally, state survey agencies cited 128,675 deficiencies in 2022, increasing to 142,830 in 2023 and essentially stable at 143,821 in 2024. Overall, survey agencies cited approximately 12 percent more deficiencies in 2024 than in 2022, suggesting increased survey activity following the significant disruptions to nursing home oversight during the COVID-19 public health emergency.



While national totals provide useful context, they do not account for the large differences in the size of state nursing home populations. To provide a more meaningful comparison, LTCCC calculated deficiency rates using the nursing home resident census reported through CMS's Payroll-Based Journal (PBJ) system for the final quarter of each year. This resident-adjusted measure helps place oversight activity in the context of the individuals the regulatory system is intended to protect.

Survey agencies identified approximately 109.4 deficiencies per 1,000 nursing home residents in 2022, 118.5 in 2023, and 117.3 in 2024. Put differently, surveyors identified approximately one deficiency for every nine residents in each year. It is worth noting that while overall deficiencies increased over the three-year period following the pandemic, deficiencies per nursing home resident remained substantially the same.

Resident-adjusted citation rates varied dramatically among states. Residents in some states experienced survey systems that identified deficiencies several times more frequently than residents in others. **States with the highest deficiency rates per resident were Oregon,**

Washington, Alaska, Montana, and New Mexico.[10] At the other end of the spectrum, **Alabama, New York, Kentucky, South Carolina, and Tennessee reported the lowest resident-adjusted citation rates during the three-year period**.

While overall deficiencies increased over the three year period following the pandemic, deficiencies per nursing home resident remained substantially the same.

These rates provide an important, but relatively high-level, picture of differences in oversight across states. The analyses that follow allow us to look more deeply by examining how frequently state survey agencies cite specific types of noncompliance associated with important measures of resident care and, critically, how often they identify those violations as causing actual harm or immediate jeopardy. Comparing state performance for the same categories of deficiencies provides a more meaningful basis for assessing the extent to which federal minimum standards are being enforced across the country.

State Variation in Identifying Harm and Immediate Jeopardy

Identifying deficiencies is only one component of effective oversight. Survey agencies must also determine the scope and severity of each violation. Under the federal classification system,[11] deficiencies assigned a scope and severity level of G, H, or I indicate that surveyors determined residents experienced actual harm. Deficiencies classified as J, K, or L indicate immediate jeopardy, meaning that noncompliance placed residents at risk of serious injury, serious harm, serious impairment, or death. These determinations are particularly important because, in the absence of an identification of harm or immediate jeopardy, a nursing home is unlikely to face any penalty whatsoever for the violation.

Among the health deficiencies included in QCOR's scope-and-severity database, the proportion classified at G or above remained relatively stable: 6.0% in 2022, 5.9% in 2023, and 6.0% in 2024. In other words, **approximately 94% of health deficiencies cited each year were classified as not causing any harm or risk of serious harm to any resident in the facility**. The proportion classified as immediate jeopardy (J+) was even smaller, though it increased modestly from 2.4% in 2022 to 2.6% in 2023 and 2.7% in 2024.

Behind these relatively stable national figures were substantial differences among states. Across the three years combined, **Kentucky had the highest proportion of G+ deficiencies, at approximately 17.1%, followed by Tennessee (15.3%), South Dakota (12.1%), Mississippi (11.6%), Utah (11.5%), and Illinois (11.2%)**. Kentucky and Tennessee were notable for consistently high rates of harm identification: Kentucky had the highest G+ percentage nationally in both 2022 and 2023, while Tennessee ranked second in those years and third in 2024. At the other end of the distribution, **Nevada had the lowest three-year G+ rate, at 1.5%,**

[10] Puerto Rico had by far the highest calculated rate in every year. However, its PBJ denominator contains only five providers in 2022, five in 2023, and six in 2024. Because the denominator is based on such a small number of providers, Puerto Rico's calculated resident-adjusted rates are unusually sensitive and are reported for completeness but excluded from state rankings and direct comparisons.

[11] https://nursinghome411.org/wp-content/uploads/2025/01/Scope_Severity-Grid.pdf.

followed by New Hampshire (2.0%), Maine (2.3%), Arkansas (2.5%), Arizona (2.5%), and West Virginia (2.8%).

State differences were similarly pronounced for immediate jeopardy findings. Across 2022–2024, **Kentucky classified approximately 11.8% of deficiencies as J+**, followed by **Tennessee (11.7%), South Carolina (7.6%), Alabama (7.6%), and Texas (6.5%)**. By contrast, **Nevada classified only about 0.3% of its deficiencies as immediate jeopardy**, followed by **Arizona (0.4%), Hawaii (0.6%), Virginia (0.8%), Idaho (0.8%), and California (0.8%)**. Some individual-year changes were substantial — most notably Alabama, whose G+ rate rose from 5.3% in 2023 to 18.3% in 2024 — underscoring the importance of examining both multi-year patterns and annual results.

These disparities do not, by themselves, establish that one state survey agency is performing better than another, since states may differ in the nature and severity of the deficiencies they encounter. They do, however, demonstrate that survey agencies operating under the same federal scope-and-severity framework differ considerably in how often the deficiencies they substantiate are identified as causing actual harm or immediate jeopardy. The citation-specific analyses that follow provide a stronger basis for examining these differences by comparing state citation and harm-identification practices for specific indicators of quality and safety.

Complete state-by-state deficiency data, including resident-adjusted citation rates, are available on the webpage for this report, https://nursinghome411.org/ltccc-enforcement-study-2026/. See files State Deficiencies by Scope Severity 2022 2023 2024 and Resident-Adjusted State Citation Rates 2022-2024.

Fines: Financial Accountability for Substandard Care

Identifying a violation is only one step in holding a nursing home accountable. When facilities fail to comply with federal requirements, regulators have several enforcement remedies available, including civil monetary penalties (fines) and denials of payment. Fines are by far the more frequently imposed of these two penalties and provide a readily understandable measure of whether regulatory findings result in financial consequences for facilities.

For this analysis, LTCCC examined individual penalty records reported by CMS for calendar years 2022, 2023, and 2024. To obtain as complete calendar-year data as possible, we used the CMS penalty file released in November of the following year for each year studied: the November 2023 file for 2022 penalties, November 2024 for 2023, and November 2025 for 2024. Records were assigned to a calendar year based on the penalty date reported by CMS.

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.

This approach provides a consistent measure of penalties reported for each calendar year. It is important to note that, because final enforcement can be delayed by administrative dispute resolution, appeals, litigation, and other factors, these data should not be interpreted as necessarily being the time period in which the violation took place.[12]

Penalties Declined Substantially

CMS reported 12,742 nursing home penalty records in 2022, including 11,501 fines totaling $218.5 million. In 2023, the total number of penalties fell to 9,313, including 8,185 fines totaling $200.9 million. By 2024, CMS reported 6,288 penalties, including 5,210 fines totaling $188.2 million.

Thus, **from 2022 to 2024, the number of fines declined by approximately 55%**, while **total fine dollars declined by approximately 14%**. The decline in the number of fines was remarkably widespread: **49 of the 52 states and jurisdictions included in the study reported fewer fines in 2024 than in 2022**. Only Delaware, Mississippi, and South Dakota recorded more.

Fines constituted the large majority of the penalties reported in each year, accounting for approximately 90% of penalties in 2022, 88% in 2023, and 83% in 2024. The remaining reported penalties were denials of payment. Because fines represented the predominant form of reported penalty and allow for straightforward comparisons of both frequency and dollar amount, the remainder of this analysis focuses on fines.

[12] These data were derived from the Penalties files at data.cms.gov, which reports fines and payment denials but not the other, less common, types of penalties that may be imposed for a violation of minimum standards.

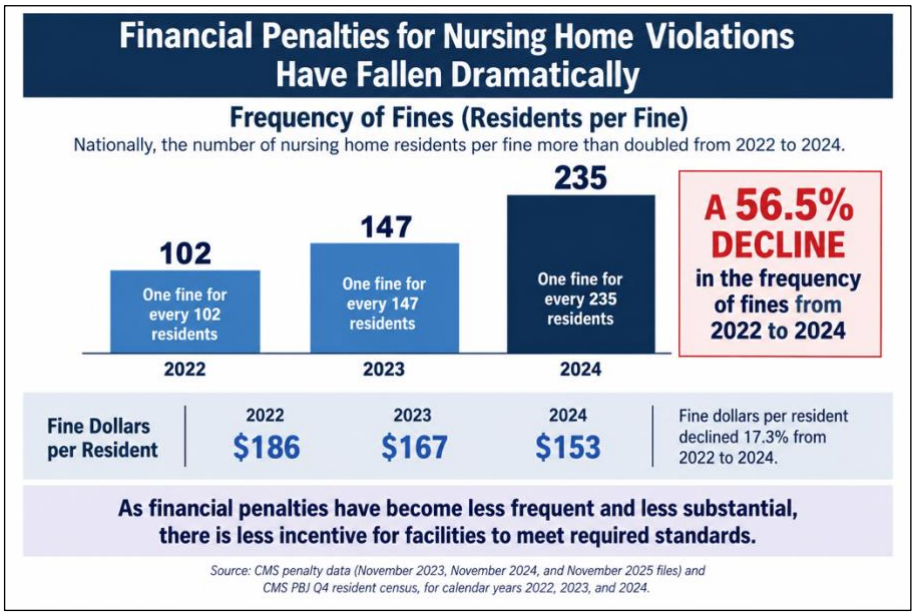
BRINGING ENFORCEMENT TO THE RESIDENT LEVEL

Given the wide variation in state nursing home populations, LTCCC also examined enforcement activity in relation to the number of residents each state's nursing homes serve. This resident-centered approach allows for more meaningful comparisons among states and helps illustrate the extent to which enforcement actions translate into consequences for facilities relative to the residents the regulatory system is intended to protect.

Nationally, **the frequency of fines declined substantially relative to the number of residents**. In 2022, CMS reported approximately one fine for every 102 nursing home residents. That fell to approximately one fine for every 147 residents in 2023 and one for every 235 residents in 2024.[13]

Fine dollars per resident also declined, although considerably less sharply. Nationally, fines totaled approximately $186 per nursing home resident in 2022, $167 in 2023, and $153 in 2024.

The two measures provide important, complementary perspectives on financial enforcement. The number of fines relative to residents reflects how frequently financial penalties are imposed in relation to the population the oversight system is charged with protecting, while fine dollars per resident provide a measure of the magnitude of those financial consequences. Both are important because penalties are intended not only to hold facilities accountable for noncompliance, but also to deter future violations. **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 results are especially striking because the **resident census increased about 4.2% from 2022 to 2024**, **while the number of fines fell about 54.7%**. Consequently, the resident adjusted frequency of fines fell about 56.5%. Fine dollars per resident declined about 17.3%.

[13] Methodological note: The resident denominator is the sum of facility-level average MDS census reported in PBJ for Q4 of the corresponding calendar year. It reflects the average daily resident census, not the number of unique residents who lived in nursing homes during the year.

Wide Differences Among States

The national figures also mask striking differences among states. Across the three study years, **Montana had the highest frequency of fines relative to its resident population** among the 50 states and District of Columbia, f**ollowed by Alaska, Wyoming, Kansas, Oklahoma, New Mexico, and Colorado**. Because the denominator is based on such a small number of providers, Puerto Rico's calculated resident-adjusted rates are unusually sensitive and are reported for completeness but excluded from state rankings and direct comparisons.[14]

At the other end of the distribution, **New York had the lowest resident-adjusted fine frequency**, **followed by Arizona, Alabama, Virginia, Arkansas, New Hampshire, Maine, and Maryland**. Across the three-year period, **Montana's rate of fines per resident was nearly ten times New York's**.

Fine amounts reveal a somewhat different pattern. Across the three years, **Illinois averaged approximately $465 in fines per resident per year**, followed by Montana ($446), the District of Columbia ($418), Washington ($386), and Rhode Island ($345). Puerto Rico again had a higher calculated rate, at approximately $568 per resident per year; as noted above, Puerto Rico's resident-adjusted results should be considered separately. By contrast, **Arizona averaged approximately $35 per resident per year, New York ($41), Maine ($47), Arkansas ($49), and Alabama ($50)**.

From Violations to Accountability

These findings take on additional significance when considered alongside the preceding analyses. Survey agencies classified approximately 94% of cited violations of minimum health care standards below the level of actual harm. Such classifications matter because facilities are unlikely to face a penalty when surveyors do not identify resident harm.

The enforcement data show what happens further along that accountability continuum. **Even as survey activity and overall deficiency citations recovered somewhat following the COVID-19 pandemic, the number of reported fines fell sharply between 2022 and 2024**.

Complete state-level penalty and fine data are available on the webpage for this report, https://nursinghome411.org/ltccc-enforcement-study-2026/. See the file National & State Fines 2022 2023 2024.xlsx.

[14] Puerto Rico should be considered separately from the states in interpreting resident-adjusted results. The PBJ data used for the resident denominator included only five Puerto Rico providers in 2022, five in 2023, and six in 2024. Because this unusually small denominator produces substantially higher calculated resident-adjusted rates, Puerto Rico is reported for completeness but is not included in state rankings or comparisons.

Infection Prevention and Control: Identifying Deficient Care and Resident Harm

A Longstanding Accountability Problem

Though the COVID-19 pandemic put a spotlight on infection prevention and control risks to nursing home residents, it has long been a pervasive and well-recognized problem in nursing homes. In 2020, the U.S. Government Accountability Office (GAO) reported that infection-control deficiencies were the most commonly cited type of nursing home deficiency. **GAO found that 82% of nursing homes surveyed from 2013–2017 had at least one infection-control deficiency**, and nearly half of those facilities had deficiencies cited in multiple consecutive years. About 40% of surveyed nursing homes continued to be cited annually in 2018 and 2019.[15]

GAO also found that **approximately 99% of infection-control deficiencies were classified by surveyors as not causing actual harm** in each year from 2013–2017. As noted elsewhere in this report, in the absence of an identification of harm or immediate jeopardy by surveyors, it is highly unlikely that a facility will face any penalty whatsoever. Thus, the essential message to the nursing home industry is that they will continue to get paid – and face no penalty – for substandard care and services, including poor infection control practices.

It is well-known that residents are particularly vulnerable to infection due to advanced age, frailty, chronic illness, frequent healthcare transitions, and other clinical factors. Research has associated nursing home infections with substantial morbidity and mortality, hospitalization, and healthcare costs.[16] Thus, to ensure that residents are safe and that risk is minimized, federal requirements mandate comprehensive systems to prevent, identify, investigate, and control infections and communicable diseases.[2] These requirements were enhanced in 2019 with implementation of the requirement that every nursing home have an infection preventionist.[17]

COVID-19 subsequently demonstrated the potentially devastating consequences of infection in nursing homes. In 2023, the HHS Office of Inspector General (OIG) reported that more than 1,300 nursing homes experienced COVID infection rates of 75% or higher during surge periods in 2020. Nevertheless, 54% of those facilities received no infection-control deficiency during the year, even though almost all underwent multiple surveys. OIG concluded that the results raised questions about the effectiveness of the survey process and recommended that CMS improve

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[15] GAO, *Infection Control Deficiencies Were Widespread and Persistent in Nursing Homes Prior to COVID-19 Pandemic*, GAO-20-576R (2020). https://www.gao.gov/products/gao-20-576r.

[16] Montoya, A., & Mody, L., "Common infections in nursing homes: A review of current issues and challenges, "*Aging Health, 7*(6), 889–899 (2011). https://doi.org/10.2217/AHE.11.80 (PubMed Central (PMC)).

[17] See, CMS, QSO 18-15-NH, Specialized Infection Prevention and Control Training for Nursing Home Staff in the Long-Term Care Setting (2018). https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-18-15-NH.pdf

both the identification of infection-control risks and guidance for assessing their scope and severity.[18]

Finding: Infection-Control Deficiencies Remain Widespread

State survey agencies issued **6,851 F880 infection-control citations in 2022, 6,271 in 2023, and 7,736 in 2024**. Thus, after declining approximately 8% in 2023, citations increased approximately **23% in 2024**, reaching a level about **13% higher than in 2022**.

The likelihood that facilities were cited varied considerably by state. In 2024, **Nebraska cited 67.0% of active providers, Washington 65.0%, Rhode Island 64.9%, Hawaii 62.8%, California 62.3%, Illinois 59.6%, and Arkansas 58.7%.** At the other end, **Alabama cited 6.7%**, followed by **Virginia (15.2%), Tennessee (18.9%), North Carolina (21.3%), South Carolina (22.3%), Arizona (23.2%), and New York (23.2%)**.

Citation rates reflect both the presence of deficient practices and the survey agency's identification of those practices. Thus, these differences cannot simply be interpreted as differences in nursing home quality. At the same time, given the longstanding documentation of widespread infection-control problems in nursing homes across the country, low citation activity cannot simply be assumed to demonstrate strong facility performance in any state. **In light of the persistence of this problem, the magnitude of the state citation variations raises serious questions about how effectively every state agency is identifying violations of the same federal standard.**

Finding: Surveyors Rarely Identify Actual Harm When They Find Infection-Control Violations

Our **findings regarding severity are particularly striking**. Of the 6,851 F880 citations issued in 2022, 297 — 4.3% — were classified at G or above, meaning that surveyors identified actual harm or immediate jeopardy. In 2023, only 163 of 6,271 citations — 2.6% — were G+. By 2024, just 103 of 7,736 citations — 1.3% — were classified at G or above.

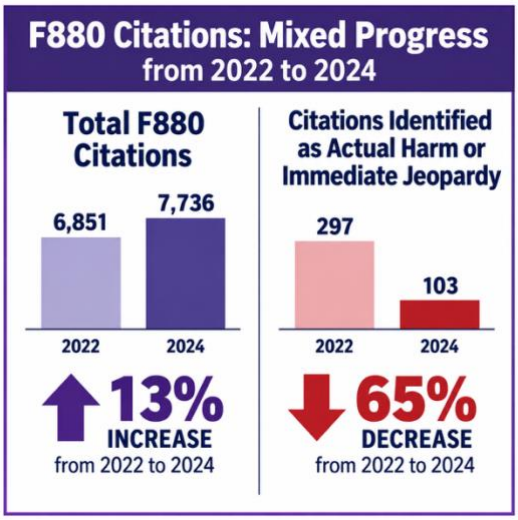
Year	F880 Citations	G+ Citations	G+ Rate
2022	6,851	297	**4.3%**
2023	6,271	163	**2.6%**
2024	7,736	103	**1.3%**

Put another way, surveyors classified **95.7% of infection-control violations as "no harm" in 2022, 97.4% in 2023, and 98.7% in 2024**. Between 2022 and 2024, the total number of F880

[18] U.S. Department of Health and Human Services, Office of Inspector General, More Than a Thousand Nursing Homes Reached Infection Rates of 75 Percent or More in the First Year of the COVID-19 Pandemic; Better Protections Are Needed for Future Emergencies, OEI-02-20-00491 (2023). https://oig.hhs.gov/reports/all/2023/more-than-a-thousand-nursing-homes-reached-infection-rates-of-75-percent-or-more-in-the-first-year-of-the-covid-19-pandemic-better-protections-are-needed-for-future-emergencies/

citations increased by approximately 13%, while the number identified as actual harm or immediate jeopardy fell by approximately 65%.

Not every infection-control violation necessarily results in a serious infection or other identifiable resident harm, and the data do not enable us to determine what severity level was warranted for every individual citation. Nevertheless, the trend warrants significant scrutiny.



It is also not a new concern. GAO found that approximately 99% of infection-control deficiencies were classified below actual harm during 2013–2017. A 2017 Kaiser Health News analysis similarly found infection-control citations to be extraordinarily widespread while high-level citations that could result in financial penalties were rare.[19] Most importantly, following the devastation of COVID-19, OIG specifically recommended that CMS improve how surveys identify infection-control risks and strengthen guidance for assessing their scope and severity.

Against that history, our finding that G+ identification fell from 4.3% to 1.3% between 2022 and 2024 is difficult to dismiss as simply another variation in survey results.

Finding: Where a Resident Lives Matters — Identifying Harm

Severity determinations also varied substantially among states. Across the three study years, among states with at least 20 F880 citations, **Tennessee had the highest proportion classified G+, approximately 11.3%**, followed **by New Hampshire (11.0%), Vermont (8.1%), Kentucky (7.8%), and Rhode Island (7.6%)**.

Interstate differences occur within a broader national pattern in which surveyors overwhelmingly characterize substantiated infection-control violations as causing no actual harm.

Conversely, **Alabama, Alaska, Washington, DC, Maryland, and Nevada recorded no G+ F880 citations during the entire three-year period**. **Nebraska classified only one of 396 F880 citations at G+; New York one of 351; Massachusetts two of 507; and Indiana three of 645**.

Some state percentages are based on relatively small numbers and should be interpreted accordingly. Nor do higher G+ rates necessarily mean that a state is providing strong oversight. Even Tennessee, the highest state among those with at least 20 citations, classified nearly nine out of ten F880 violations below actual harm.

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[19] Rau, J., "Infection Lapses Rampant In Nursing Homes But Punishment Is Rare," *Kaiser Health News/Los Angeles Times* (2017). https://kffhealthnews.org/aging/infection-lapses-rampant-in-nursing-homes-but-punishment-is-rare/.

The relevant benchmark is therefore not whether one state identifies harm more frequently than another, but whether the survey system is effectively identifying and responding to violations of standards designed to protect. The **interstate differences occur within a broader national pattern in which surveyors overwhelmingly characterize substantiated infection-control violations as causing no actual harm**.

The pattern is particularly significant in light of the report's broader findings. Financial penalties declined sharply between 2022 and 2024, even as F880 infection-control citations increased. At the same time, surveyors became substantially less likely to characterize those violations at a level of actual harm or immediate jeopardy. The data do not establish why these changes occurred, but they provide little basis for concluding that declining enforcement simply reflects the resolution of a longstanding infection-control problem.

For information on individual state performance, see the file "State Citations Infection Control 2022 2023 2024" at https://nursinghome411.org/ltccc-enforcement-study-2026/.

Nurse Staffing: Sufficiency x Regulatory Oversight

Sufficient nursing staff is fundamental to nursing home quality and resident safety. Dozens of studies, government reports, and investigations have found that nurse staffing levels, especially for RNs, are key indicators of a nursing home's ability to meet residents' needs and avoid adverse events such as pressure ulcers, falls, medication errors, etc….[20]

For these reasons, **federal standards require nursing homes to have sufficient qualified nursing staff to meet each resident's needs, based on individual resident assessments and care plans and considering the "number, acuity and diagnoses" of the facility's resident population**.[21,22]

Though the requirements are robust and resident-centered – in recognition of the fact that nursing homes are entrusted with the lives and care of a highly vulnerable population – insufficient staffing is a widespread and persistent problem. As noted elsewhere in this report, the federal nursing home standards are strong but they are not self-implementing. They can only be realized in the lives of residents through monitoring, oversight, and enforcement.

To assess the extent to which states are holding providers accountable when they fail to provide sufficient staff, we measured F725 (sufficient staffing) citations by state, both overall and in the context of average nurse staffing levels.

In addition, we conducted a focused assessment of the extent to which state performance on this measure was responsive to the extent to which facilities were providing the expected staffing to meet the needs of their residents. This assessment focuses on 2024, the year in which it became possible to determine a facility's expected staffing as a result of the development of the CASE (Casemix Adjusted Staffing Expectations) methodology. The CASE methodology is an evidence-based, peer-reviewed methodology for identifying the expected nurse staffing levels necessary to meet the clinical needs of a nursing home's residents, based on each nursing home's own assessments of its residents' needs.

For additional information on the Case methodology, the underlying study, and related resources, see LTCCC's Staffing Resource Center, https://nursinghome411.org/staffing-resource-center/.

[20] *See* list of studies at https://nursinghome411.org/nursing-home-staffing-studies-2026/.
[21] 42 CFR 483.35. https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483/subpart-B/section-483.35#p-483.35(a).
[22] State Operations Manual Appendix PP - Guidance to Surveyors for Long Term Care Facilities. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

Finding: Staffing Increased Modestly, But Remained Low

National nursing home staffing increased modestly during the study period. Average total nurse staffing increased from approximately **3.61 hours per resident day (HPRD) in Q4 2022 to 3.68 in Q4 2023 and 3.75 in Q4 2024**.

	Q4 2022	Q4 2023	Q4 2024
Total nurse staffing HPRD	**3.61**	**3.68**	**3.75**
F725 sufficient staffing citations	927	994	1,012
F725 G+ citations	68	51	33
F725 citations classified G+	7.3%	5.1%	3.3%

Finding: Citations Increased Modestly, While Identification of Resident Harm Fell By More Than Half

Survey agencies identified modestly increasing violations of the federal sufficient staffing requirement over the course of the study period. National QCOR reports show that F725 citations increased from 927 in 2022 to 1,012 in 2024, an increase of approximately 9%.

Because the nursing home resident census also increased over this period, the increase was smaller when considered relative to the resident population. F725 citations increased from approximately 0.79 per 1,000 residents in 2022 to 0.83 per 1,000 residents in 2024, an increase of about 5%.

However, the identification of resident harm – historically low – moved sharply in the opposite direction.

Nationwide, surveyors classified 68 F725 deficiencies at G or above in 2022, 51 in 2023, and 33 in 2024. Thus, while the total number of citations increased, the number classified at G or above fell by half. Put another way, by 2024, surveyors classified 96.7% of the insufficient staffing violations they identified as causing no harm whatsoever to residents.

These findings are particularly concerning given the essential role nursing staff play in virtually every aspect of resident care. Insufficient staffing affects whether residents receive timely assistance with eating, toileting, repositioning, medications, wound care, monitoring for changes in condition, and implementation of their care plans. CMS guidance explicitly recognizes that insufficient staffing can cause both physical and psychosocial harm.

The Findings Echo Our Previous Study of 2018-2020 Enforcement

These findings are consistent with a central finding of LTCCC's earlier *Broken Promises* study (covering 2018-2020): though dangerous nursing home understaffing has been a widespread problem for decades, state surveyors cite insufficient staffing relatively infrequently and, even when they do, are highly unlikely to identify that residents have been harmed or put in immediate jeopardy as a result.

Finding: Nursing Homes Provided Substantially Less Staffing Than Expected to Meet Resident Needs

As discussed above, the CASE methodology provides an evidence-based benchmark for determining the extent to which nursing homes are providing the staff necessary to meet the clinical needs of their residents. LTCCC began utilizing this methodology to provide the public with expected staffing information in our quarterly nursing home staffing reports in 2024.[23] The following analyses are based on our staffing report for 2024 Q4.

Staffing Type	Reported HPRD	Expected HPRD	Difference
RN	0.67	0.98	**32% below expected**
CNA	2.29	3.25	**30% below expected**
Total Nursing	3.84	4.92	**22% below expected**

Note: Reported staffing in this table reflects nursing homes with valid CASE expected-staffing comparisons and therefore differs from the national Q4 staffing average reported above.

On average, **nursing homes provided approximately 1.08 fewer total nursing hours per resident per day than expected based on the needs of their residents**. For a nursing home with 100 residents, that represents approximately 108 fewer nursing hours every day.

The RN shortfall was particularly substantial. Reported RN staffing was nearly one-third below expected staffing nationally. This is significant because RNs perform critical clinical functions, including resident assessment and care planning, clinical surveillance, identification and management of changes in condition, infection control, and supervision and coordination of nursing care.

Finding: State Surveyors Rarely Identified Insufficient Staffing — And Almost Never Identified Harm

The 2024 expected-staffing findings provide important independent context for evaluating regulatory oversight.

On average, **day in and day out, U.S. nursing homes provided 22% less total nursing staffing, 30% less CNA staffing, and 32% less RN staffing than expected based on resident needs** in 2024 Q4. Yet state survey agencies issued only 1,012 F725 sufficient staffing citations during the entire year.

Even when insufficient staffing was identified, surveyors rarely identified resident harm. Only 33 of those 1,012 citations — 3.3% — were classified at G or above.

[23] https://nursinghome411.org/data/staffing/.

Expected staffing and F725 are not interchangeable measures. A facility staffing below its CASE expected level does not automatically violate F725. However, it is strong evidence that a facility is not providing the levels of staffing expected to meet the basic clinical needs of its residents. Conversely, staffing above expected levels may not be sufficient, especially if a facility is not ensuring that nursing staff have the competencies necessary to meet resident needs.

Independent, data-driven analysis identified widespread and significant staffing shortfalls, while state agencies identified comparatively few instances of insufficient staffing.

Nevertheless, the comparison is directly relevant to oversight. **Both measures concern whether staffing is sufficient in relation to resident needs.** Federal requirements direct facilities to provide staffing based on resident assessments and care plans and the number, acuity, and diagnoses of their resident populations. CMS also requires surveyors to review PBJ staffing information during recertification surveys and investigate staffing concerns identified through those data.

Thus, these findings present sharply conflicting pictures. Independent, data-driven analysis identified widespread and significant staffing shortfalls, while surveyors and state agencies identified comparatively few instances of insufficient staffing.

Despite widespread understaffing,

Only 0.2%

of nursing homes were cited at G+ for insufficient staffing in 2024.

G+ means that the surveyors identified physical harm, psychosocial harm, or immediate jeopardy of harm to one or more residents. In the absence of identification of harm, a nursing home is unlikely to face any penalty for insufficient staffing.

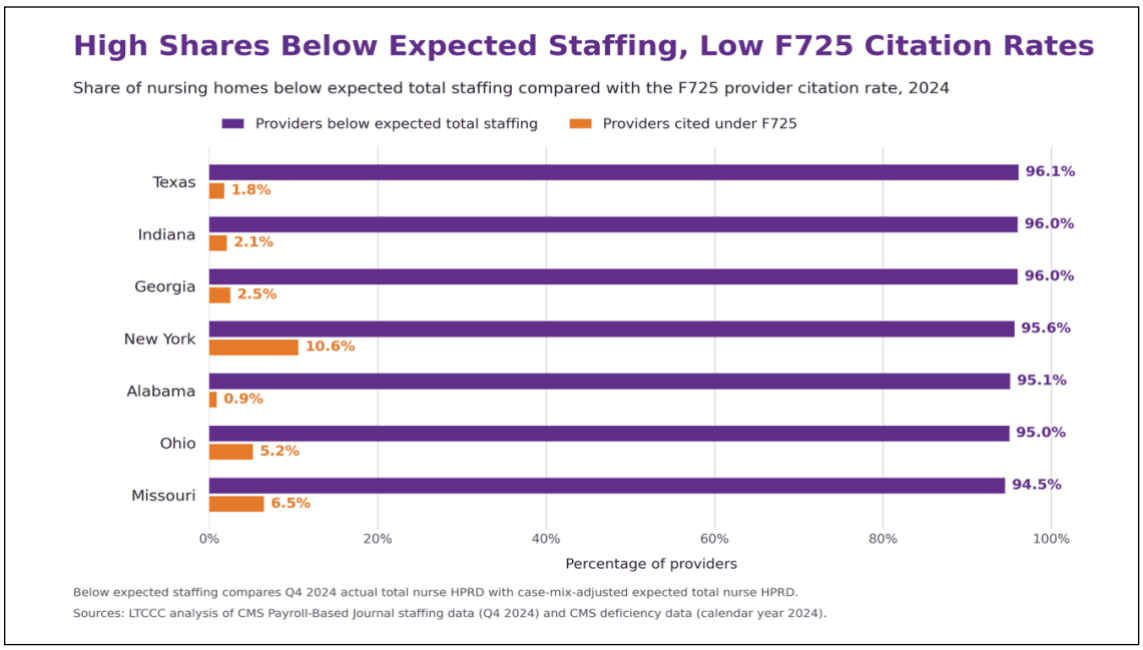
FINDING: STAFFING SHORTFALLS WERE WIDESPREAD, BUT STATE RESPONSES VARIED SUBSTANTIALLY

The facility-level 2024 Q4 data indicate that below-expected staffing was widespread across the country. Approximately **90% of nursing homes with valid expected staffing data provided total nursing staffing below their expected levels**, and **nearly two-thirds were at least 20% below expected**.

Several states had particularly high concentrations of facilities below expected staffing. For example, approximately **96% of facilities in Texas, Indiana, Georgia, and New York** were below expected total staffing; in **Alabama**, **Ohio**, and **Missouri the percentages were about 95%**.

Yet only a small share of providers in these states were cited for insufficient staffing:[24]

[24] Methodological note: National totals and provider citation rates are taken directly from QCOR's national reports. State figures are taken directly from QCOR's state reports. Because the state-report citation counts do not sum to the national totals, state outputs were not aggregated to calculate national figures.



The magnitude of the staffing shortfall was also substantial. In 2024 Q4, 9,276 of 14,433 — close to two out of three — U.S. nursing homes with valid actual-to-expected staffing comparisons provided total nurse staffing at least 20% below the level expected based on the needs of their residents, as reflected in the facilities' own MDS assessments.[25] The **ten worst performing states** in this regard were **Texas**, **Indiana**, **Georgia**, **Illinois**, **Ohio**, **Virginia**, **Missouri**, **New York**, **Maryland**, and **New Mexico**.

FINDING: STATE IDENTIFICATION OF RESIDENT HARM WAS EVEN MORE LIMITED

As noted elsewhere in this report, in the absence of identification of resident harm or immediate jeopardy by surveyors (i.e., a citation of "G" or higher on the Scope and Severity Matrix),[26] it is highly unlikely that a facility will face any penalty whatsoever. Thus, it is crucial that surveyors identify resident harm when it exists.

In 2024, **California issued 97 F725 citations without identifying actual harm or immediate jeopardy in a single case**. **Michigan issued 77 citations with no G+ findings, New Jersey 58, and Oregon 47**. Overall, 32 states (including DC and PR) did not identify a single instance of resident harm due to understaffing in all of 2024.

Across the full 2022–2024 period, Oklahoma issued 99 F725 citations without identifying a single case of actual harm or immediate jeopardy. **West Virginia issued 42** without a G+ finding; **Maine 30; Arizona 24; Vermont 24; New Hampshire 23; Arkansas 22; Hawaii 22; and Maryland 22**.

For information on individual state performance, see the file "State Nursing Home Expected Staffing and Oversight 2024" at https://nursinghome411.org/ltccc-enforcement-study-2026/.

[25] As reflected in their case-mix indexes.
[26] https://nursinghome411.org/wp-content/uploads/2025/01/Scope_Severity-Grid.pdf.

Pressure Ulcers: Identifying Poor Care and Resident Harm

Pressure ulcers — also known as pressure injuries or bedsores — are serious wounds and an important indicator of nursing home quality. While not every pressure ulcer is preventable, research indicates that, "[i]n the vast majority of cases, appropriate identification and mitigation of risk factors can prevent or minimize pressure ulcer formation."[27] According to the Centers for Disease Control and Prevention, "[p]ressure ulcers… are serious medical conditions and **one of the important measures of the quality of clinical care in nursing homes**."[28]

For these reasons, **federal requirements place substantial responsibilities on nursing homes to identify residents at risk, implement appropriate preventive interventions, and provide treatment to heal existing pressure ulcers and prevent infection and additional wounds**. Failure to provide care that comports with these minimum standards is coded as a violation under F686. Importantly, CMS states that a resident need not actually develop a pressure ulcer for noncompliance to exist when a facility fails to implement necessary preventive interventions.

Pressure ulcers therefore provide an especially useful lens through which to assess nursing home oversight. We can compare an independently reported measure of the problem — the number of residents reported through the Minimum Data Set (MDS) as having an unhealed pressure ulcer — with the frequency with which state survey agencies identify violations of the federal pressure-ulcer standard and, when they do, whether they identify the extent to which residents suffered harm.

Important Note: Both quantitative research and direct reports from families over the years indicate that, too often, facilities fail to identify – much less treat – pressure ulcers. Thus, the **public data on pressure ulcer rates understate the true breadth of the problem**. According to a national study using hospital data, nursing homes only reported 67.7% of stage 3 or 4 pressure ulcers.[29]

FINDING: PRESSURE ULCERS ARE A SERIOUS AND PERSISTENT PROBLEM

Even with under-reporting, pressure ulcers were a remarkably significant and persistent problem throughout the period studied. In the fourth quarter of 2022, nursing homes reported **93,770 residents with an unhealed pressure ulcer, or 8.18% of residents**. The number increased to **95,240 residents (8.09%) in 2023** and stood at **94,724 residents (7.92%) in 2024**.

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[27] Edsberg, L., Langemo, D., Baharestani, M., Posthauer, M., & Goldberg, M., "Unavoidable Pressure Injury: State of the Science and Consensus Outcomes," *Journal of Wound, Ostomy & Continence Nursing*, 2014; 41(4), 313–334. https://doi.org/10.1097/WON.0000000000000050.

[28] Park-Lee, E. and Caffrey, C., *Pressure Ulcers Among Nursing Home Residents: United States*, *2004*. Available at www.cdc.gov/nchs/data/databriefs/db14.pdf.

[29] Sanghavi P, Chen Z., "Underreporting of Quality Measures and Associated Facility Characteristics and Racial Disparities in US Nursing Home Ratings," *JAMA Netw Open.* 2023; 6(5):e2314822. https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2805170.

Finding: Citations for Inadequate Pressure-Ulcer Care are Rare

Given the fact that pressure ulcers are widely acknowledged as a serious concern in nursing homes and are unambiguously (clinically speaking) a harmful event, citation data provide a valuable context for evaluating the effectiveness of state oversight of nursing home quality.

State survey agencies issued **3,052 F686 citations in 2022, 2,895 in 2023, and 2,916 in 2024**. Relative to the number of residents reported with unhealed pressure ulcers, this equated nationally to approximately **3.25 citations for every 100 residents with a reported pressure ulcer in 2022, 3.04 in 2023, and 3.08 in 2024**.

The national results are similar to those found in our previous report on nursing home oversight, *Broken Promises*, which covered 2018-2020. That study found that survey agencies issued the equivalent of fewer than three F686 citations per 100 residents with reported pressure ulcers during those three years.

Finding: Where a Resident Lives Matters — Identifying Inadequate Care

The national rate obscures enormous differences among states. Across the three study years, **Wisconsin issued approximately 10.5 F686 citations for every 100 residents reported with pressure ulcers**, followed by **Rhode Island (9.4), Illinois (8.9), Kansas (8.5), and Michigan (7.4)**.

At the other end of the distribution, **Alabama issued approximately 0.3 citations per 100 residents reported with pressure ulcers**, followed by **Kentucky (0.34), New York (0.60), Florida (0.73), and Tennessee (0.79)**. Wisconsin's resident-adjusted citation rate was therefore approximately **35 times Alabama's** and more than **17 times New York's** over the study period.

A state's low citation activity cannot simply be assumed to reflect an absence of the underlying resident-care problem.

These findings provide important insight into the extent to which state survey agencies are identifying and responding to inadequate pressure ulcer care. Pressure ulcers are wounds, and clinical evidence indicates that they are generally preventable and, when they occur, responsive to appropriate treatment. The substantial differences between the prevalence of reported pressure ulcers and the frequency with which states cite inadequate pressure ulcer care therefore raise meaningful questions about the effectiveness and consistency of state oversight. The data do not establish that every resident with a pressure ulcer experienced deficient care. However, the persistence of pressure ulcers, comparatively low rates of F686 citations, and substantial variation among states provide important evidence for assessing how effectively survey agencies are identifying failures to meet this critical federal care standard.

Finding: Surveyors Usually Do Not Identify Harm Even When They Find Substandard Pressure Ulcer Care

The extent to which surveyors identify harm when citing substandard care is critical because, unless harm or immediate jeopardy are cited, it is very unlikely that the facility will face any penalty for the violation. Thus, **our findings in respect to surveyors' categorization of the**

severity of pressure ulcer violations raise a separate and significant accountability concern. Of the 3,052 F686 citations issued nationally in 2022, 851 — 27.9% — were classified at G or above, meaning that surveyors identified actual harm or immediate jeopardy.[30] The proportion declined to 25.8% in 2023 and 24.6% in 2024.

In other words, **surveyors persistently classified approximately three-quarters of substantiated violations of pressure ulcer prevention and treatment standards as not resulting in any resident harm**.

This finding warrants particular attention given the nature of pressure ulcers and the requirements of F686. Pressure ulcers are, by definition, injuries involving damage to the skin and underlying tissue, and clinical evidence indicates that they are generally preventable and/or responsive to appropriate treatment. CMS guidance provides explicit examples in which deficient pressure ulcer care constitutes actual harm or immediate jeopardy.

The fact that surveyors classified approximately three-quarters of all pressure ulcer care violations as "no-harm" raises serious questions about whether surveyors are accurately identifying the impact of substandard care and neglect on residents.

A facility could feasibly be cited when it fails to implement necessary preventive interventions even when a pressure ulcer has not developed. But that limited exception should not obscure the significance of the overall finding. Where a facility's failure contributes to the development or worsening of a pressure ulcer, or results in inadequate treatment of an existing wound, a finding below the level of actual harm warrants serious scrutiny**.** Against that backdrop, the fact that surveyors classified approximately three-quarters of all pressure ulcer care violations as "no-harm" raises serious questions about whether surveyors are accurately identifying the impact of substandard care and neglect on residents. **If a pressure ulcer is not a sufficient basis for identifying that a resident has suffered harm, what is?**

The persistence of this finding is also notable. Our previous study, *Broken Promises*, found that surveyors identified harm or immediate jeopardy in approximately **23% of pressure-ulcer citations** during 2018–2020. In the current period, the national G+ rate was slightly higher, but still only about one-quarter of citations.

FINDING: WHERE A RESIDENT LIVES MATTERS — IDENTIFYING RESIDENT HARM

Here again, state differences were substantial. Across the three years, **surveyors classified more than half of F686 citations at G+ in several states, including Idaho, South Dakota, Montana, Colorado, Utah, Kentucky, and Vermont**.[31] By contrast, **Alabama, Alaska, and New Hampshire recorded no G+ F686 citations during the three-year period**. Nevada identified

[30] For more on how surveyors identify and rank violations of minimum care standards, see our *Guide to Nursing Home Oversight & Enforcement*, available at https://nursinghome411.org/reports-studies/guide-oversight/.
[31] Several of these percentages are based on relatively small numbers of citations and should be interpreted accordingly.

harm or immediate jeopardy in only approximately 3% of its F686 citations, Maryland in about 6%, Arkansas in about 7%, and Louisiana in about 8%.

Importantly, these differences should not be interpreted as evidence that states with comparatively high G+ rates are providing strong or effective oversight. Even in states that identified harm more frequently, substantial numbers of violations of the federal pressure-ulcer minimum standard were still classified as no harm. More fundamentally, the federal requirements are resident-centered: facilities are required to provide the care and services necessary to prevent avoidable pressure ulcers and promote healing for every resident they admit and retain, based on that resident's needs. **The relevant benchmark is therefore not whether one state identifies harm more frequently than another, but whether state oversight is effectively ensuring that these protections are realized in the lives of residents 24/7,** as required by federal law and regulation.

The differences among states matter, but they occur within a broader context of very limited identification of deficient care and resident harm.

This distinction is particularly important when considering the longstanding argument made by industry lobbyists that variations in state performance are unfair to nursing homes. **The results provide evidence of a regulatory system that, across every state, identifies deficient pressure ulcer care and resulting resident harm at levels that are difficult to reconcile with the prevalence and seriousness of the underlying problem**. The differences among states matter, but they occur within a broader context of very limited identification of deficient care and resident harm. Industry lobbyists may argue that variation in state agency performance is unfair to providers; the more consequential concern raised by these findings is that residents receive markedly different, and often very limited, regulatory protection depending on where they live.

These findings are also important in the context of the broader enforcement trends identified in this report. Financial penalties declined sharply from 2022 through 2024, while the prevalence of reported pressure ulcers changed little. Thus, the decline in penalties was not accompanied by a comparable improvement in this important measure of resident care, reinforcing concerns about whether deficient care and resulting resident harm are being consistently identified and addressed.

For information on individual state performance, see the file "State Citations Pressure Ulcers 2022 2023 2024" at https://nursinghome411.org/ltccc-enforcement-study-2026/.

Antipsychotic Drugging: Resident Exposure and Regulatory Oversight

The inappropriate use of antipsychotic (AP) drugs in nursing homes is a longstanding and widespread problem. Too often, residents are administered powerful AP drugs for the convenience of staff. In addition to resulting in the chemical restraint of residents, AP drugs are associated with serious adverse effects, particularly for older people with dementia.[32]

Since implementation of the 1987 Nursing Home Reform Law, federal nursing home regulations and guidance have provided significant resident protections governing psychotropic drug use.[33] In 2012, following HHS Office of Inspector General (OIG) reporting on the widespread off-label use of AP drugs, CMS launched the National Partnership to Improve Dementia Care in Nursing Homes to improve dementia care and reduce unnecessary antipsychotic drugging.[34,35]

As we approach 15 years since the launch of CMS's national effort to address this issue, the inappropriate antipsychotic drugging of nursing home residents continues to be a widespread, persistent, and harmful problem. In 2026, the HHS Office of Inspector General (OIG) reported that its review of nursing home inspections found instances in which facilities gave antipsychotics to residents with dementia to manage their behavior for the benefit of staff, failed to implement required safeguards, and lacked adequate medical director and pharmacist oversight.[36]

For this study, LTCCC analyzed CMS Minimum Data Set (MDS) frequency data for item N0450A, which identifies whether residents received an antipsychotic since admission, reentry, or the prior OBRA assessment, whichever was most recent. It is important to note that this measure differs from CMS's publicly reported long-stay antipsychotic quality measure, which, during the study period, used different specifications and excluded residents with certain diagnoses, including schizophrenia. That distinction is important. In a companion 2026 report, OIG found instances in which nursing homes inappropriately diagnosed residents with schizophrenia to mask misuse of antipsychotic drugs and artificially inflate their star ratings.[37]

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[32] *See*, for example, the U.S. Food and Drug Administration's "black box warning" for Zyprexa (2008). https://www.accessdata.fda.gov/drugsatfda_docs/nda/2008/020592Orig1s049.pdf.

[33] Centers for Medicare & Medicaid Services. *State Operations Manual, Appendix PP — Guidance to Surveyors for Long Term Care Facilities*. https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

[34] HHS Office of Inspector General (OIG), Medicare Atypical Antipsychotic Drug Claims for Elderly Nursing Home Residents, OEI-07-08-00150 (2011). https://oig.hhs.gov/reports/all/2011/medicare-atypical-antipsychotic-drug-claims-for-elderly-nursing-home-residents/.

[35] CMS, *CMS Announces Partnership to Improve Dementia Care in Nursing Homes* (2012). https://www.cms.gov/newsroom/press-releases/cms-announces-partnership-improve-dementia-care-nursing-homes.

[36] OIG, *Nursing Homes' Inappropriate Use of Antipsychotic Drugs Poses a Risk to Residents*, OEI-02-23-00200 (2026). https://oig.hhs.gov/reports/all/2026/nursing-homes-inappropriate-use-of-antipsychotic-drugs-poses-a-risk-to-residents/.

[37] OIG, *Nursing Homes Inappropriately Diagnosed Residents with Schizophrenia to Mask the Misuse of Antipsychotic Drugs*, OEI-02-23-00201 (2026). https://oig.hhs.gov/reports/all/2026/nursing-homes-inappropriately-diagnosed-residents-with-schizophrenia-to-mask-the-misuse-of-antipsychotic-drugs/.

Finding: One in Five Residents Administered Antipsychotic Drugs

Nationally, reported antipsychotic use changed relatively little during the study period. Approximately 21.1% of residents were reported as having received an antipsychotic in Q4 2022, 20.7% in Q4 2023, and 20.4% in Q4 2024.

	2022	2023	2024
Residents reported as receiving an antipsychotic*	**21.1%**	**20.7%**	**20.4%**
F758 citations	**1,781**	**1,781**	**2,032**
G+ citations	**10**	**4**	**12**
F758 citations classified G+	**0.6%**	**0.2%**	**0.6%**

**MDS rate reflects Q4 of each year; citation data reflect the calendar year.*

Finding: Where a Resident Lives Matters — Drugging Rates Vary Substantially

In Q4 2024, **Missouri had the highest reported antipsychotic use rate, at 29.8%, followed by Illinois at 28.9%, Louisiana at 27.4%, South Dakota at 26.3%, Mississippi at 26.1%, and Alabama at 26.0%**.

At the other end of the spectrum, among the 50 states, **Hawaii had the lowest rate, at 13.4%, followed by Florida at 13.6%, Delaware at 14.3%, Texas at 14.7%, and Washington at 16.4%**.

Finding: Citations Were Rare Relative to the Scale of Antipsychotic Use

State survey agencies issued **1,781 F758 citations in 2022, 1,781 in 2023, and 2,032 in 2024**.

Given the persistently high nursing home AP drugging rates, these numbers are striking. A systematic review and meta-analysis found a median lifetime prevalence of psychotic disorders of less than 1% (7.49 per 1,000 people),[38] yet about 20% of nursing home residents – more than 240,000 individuals a day – were reported as receiving antipsychotic drugs. The resulting bottom line is that, **despite over a decade of "black box warnings," "partnerships," and enhanced enforcement guidance, state agencies only cited nursing homes at a rate less than one percent of the number of residents administered these powerful drugs**.

Important note: Though these measures are not equivalent (receiving an antipsychotic does not by itself establish an F758 violation), **the disconnect between persistently high drugging rates and persistently minimal deficiency citations is remarkable and troubling**. In this regard, it is worth noting that F758 oversight encompasses substantially more than whether a drug was inappropriately administered. CMS directs surveyors to examine whether there is an adequate clinical indication; whether underlying causes of resident distress have been investigated;

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[38] Moreno-Küstner B, Martín C, Pastor L, "Prevalence of psychotic disorders and its association with methodological issues. A systematic review and meta-analyses," PLoS ONE 13(4): e0195687 (2018). https://doi.org/10.1371/journal.pone.0195687.

whether non-pharmacological approaches have been attempted; whether residents are monitored for adverse consequences; and whether gradual dose reduction requirements have been implemented.[33]

FINDING: SURVEYORS ALMOST NEVER IDENTIFIED RESIDENT HARM

Our **findings regarding the severity of F758 violations raise even more significant concerns**.

Of the 1,781 F758 citations issued nationally in 2022, only 10 (0.6%) were classified at G or above, meaning that surveyors identified resident harm or immediate jeopardy. In 2023, just four of 1,781 citations (0.2%) were G+. In 2024, 12 of 2,032 citations (0.6%) were classified at G+.

Across the entire three-year study period, surveyors substantiated 5,594 violations of federal psychotropic-medication protections. Only 26 (0.46%) were classified at actual harm or immediate jeopardy. Put another way, 99.5% of all F758 violations identified during the three-year period were classified as "no harm."

This finding is particularly important given the nature of the regulatory requirement and CMS's own guidance concerning severity. CMS defines harm to include impairment or decline in a resident's mental, physical, functional, or psychosocial status.[2] CMS's survey guidance also provides examples of medication deficiencies constituting actual harm, including a failure to evaluate a resident for gradual dose reduction after delirium had resolved when the resident consequently remained drowsy and inactive.

In other words, CMS guidance does not require hospitalization, permanent physical injury, or death before deficient medication management constitutes actual harm. **Yet the findings indicate a marked reluctance on the part of state survey agencies to identify resident harm when citing these violations**.

These findings also have significant implications in respect to accountability for violations of minimum care standards. As discussed earlier in this report, when a deficiency is cited as "no harm" it is highly unlikely that the operator will face any penalty whatsoever. This means that, despite CMS's national campaign to reduce antipsychotic drugging, **the essential lesson for operators is that they can flout dementia care and psychotropic drugging standards with impunity.**

FINDING: WHERE A RESIDENT LIVES MATTERS — IDENTIFYING INAPPROPRIATE DRUGGING AND HARM

State enforcement of F758 varied significantly. Across the three years, the average state percentage of active providers cited under F758 was **highest in Wyoming (34.2%), Washington (29.4%), New Mexico (24.6%), Kansas (23.2%), and Montana (22.0%)**. At the other end of the

spectrum, **average provider citation rates were below 4% in Kentucky, Tennessee, Alabama, New York, South Dakota, and New Jersey**.

Differences in identifying harm were even more pronounced. Across the entire three-year period, Kansas issued 302 F758 citations without identifying a single case of actual harm or immediate jeopardy. The same was true in Ohio (275 citations), Indiana (235), Wisconsin (217), Missouri (168), Iowa (140), Georgia (128), Nebraska (118), North Carolina (109), and Florida (90).

Even among states that identified harm, G+ findings were exceptionally rare. California classified only 9 of 689 citations (1.3%) at G+; Texas 4 of 307 (1.3%); Illinois 4 of 433 (0.9%); Washington 2 of 187 (1.1%); and Pennsylvania only 1 of 313 (0.3%). Rhode Island had the highest G+ share among states with at least 20 F758 citations, but even there it was only one of 25 citations (4.0%).

VARIATIONS IN OVERSIGHT: A PROBLEM FOR RESIDENTS, NOT PROVIDERS

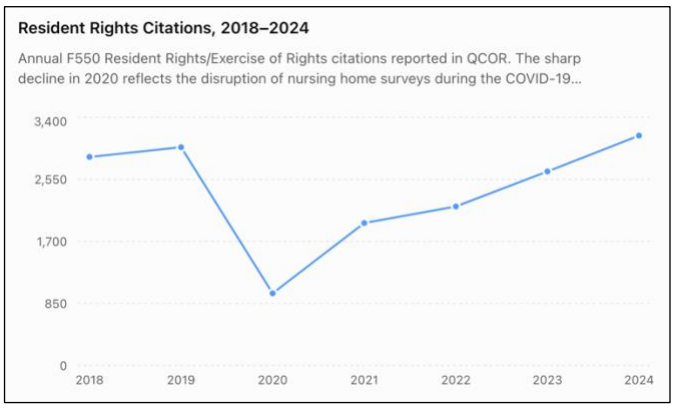
The interstate differences therefore occur within a much broader national pattern: survey agencies almost never identified harm when they substantiated violations of federal protections governing unnecessary psychotropic medications. These findings also provide important context for longstanding industry complaints that variation among state survey agencies subjects providers to inconsistent regulatory treatment. The more consequential problem revealed by these data is not that some providers face more rigorous oversight than others, but that **residents receive markedly different levels of regulatory protection depending on where they live**. Moreover, those differences occur within a national system in which identification of harm was extraordinarily rare. Rather than demonstrating that some states impose excessive regulatory burdens, the variation documented here is more consistent with **different degrees of failure to identify and respond to violations that put vulnerable residents at risk**.

For information on individual state antipsychotic drugging rates and F758 citation performance, see the accompanying datasets at https://nursinghome411.org/ltccc-enforcement-study-2026/.

Resident Rights and Dignity: Identifying Violations and Resident Harm

Federal nursing home standards require facilities to protect and promote the rights of every resident and to provide care and services in an environment that maintains or enhances each resident's dignity, autonomy, and quality of life. These are not aspirational goals. **Resident rights and dignity standards are among the fundamental requirements that nursing homes are paid to provide**.

To ensure that these requirements are implemented in the lives of residents, the federal standards are intentionally resident-centered. CMS guidance directs facilities to treat residents with respect and dignity, honor their choices and preferences, respect their privacy, respond to requests for assistance in a timely manner, and support residents in exercising their rights without interference, coercion, discrimination, or reprisal.[39] In 2009, to address the continued persistence of degrading care and conditions, CMS announced a "sharpened focus" in nursing home surveys on dignity, individual choice, accommodation of needs and preferences, and quality of life.[40]



Source: CMS QCOR data; LTCCC analysis. Guam excluded consistent with study methodology.

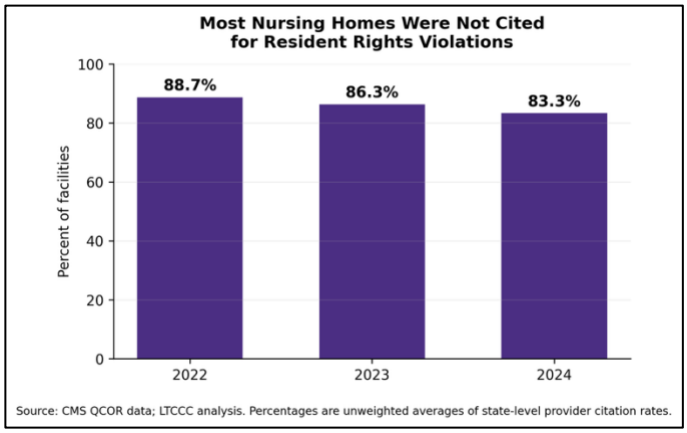
Importantly, **federal guidance explicitly recognizes that violations of these rights can harm residents even in the absence of physical injury**. CMS specifically directs surveyors that "the survey team must consider the potential for both physical and psychosocial harm when determining the scope and severity of deficiencies related to dignity." Humiliation, fear, emotional distress, loss of self-worth, and loss of autonomy are therefore expected to be relevant factors in determining the seriousness of a violation.

Finding: Resident Rights Citations Increased to Pre-Pandemic Levels But Remain Low

State survey agencies issued 2,177 F550 Resident Rights/Exercise of Rights citations in 2022, 2,657 in 2023, and 3,147 in 2024. This represents a 45% increase over the study period, to a level slightly higher than pre-pandemic levels. Nevertheless, even at the 2024 level, **citations for violations of resident rights remained relatively uncommon.** Despite resident rights being a

[39] Centers for Medicare & Medicaid Services, *State Operations Manual, Appendix PP — Guidance to surveyors for long term care facilities*, F550, Resident Rights/Exercise of Rights, 42 C.F.R. § 483.10(a)–(b). https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.
[40] Centers for Medicare & Medicaid Services, *New Medicare nursing home guidance to include quality of life and environment requirements* (2009). https://www.cms.gov/newsroom/press-releases/new-medicare-nursing-home-guidance-include-quality-life-environment-requirements.

persistent and widespread concern for residents and families,[41] surveyors issued only about 2.6 F550 citations per 1,000 nursing home residents in 2024.[42] This is particularly notable in light of CMS's 2009 announcement that it was directing state agencies to sharpen their focus on ensuring resident dignity, choice, and quality of life.



Provider-level data also provide an important perspective on the extent to which states are – or are not – identifying resident rights deficiencies. In 2022, close to 90% of nursing homes were deemed by state survey agencies to have no violations of federal resident rights requirements. Identification rates increased in each of the following two years. However, even with that increase, state survey agencies deemed 83% of nursing homes to have no violations of federal resident rights requirements in 2024 — a striking finding given the breadth of those protections and longstanding concerns about residents being subjected to demeaning or inhumane treatment.

Finding: Where A Resident Lives Matters — Identifying Rights Violations

Citation rates varied enormously among states. Across the three study years, **Iowa issued approximately 7.0 F550 citations per 1,000 nursing home residents**, followed by Michigan (5.0), Oregon (4.2), Illinois (3.6), and California (3.6). At the other end of the spectrum, **Alabama issued approximately 0.35 citations per 1,000 residents**, followed by Kentucky (0.55), New York (0.71), New Jersey (0.85), and Florida (0.88).

The provider data reveal similarly striking differences. In 2024, surveyors identified F550 violations in **32.4% of active nursing homes in Vermont, 29.8% in California, 29.1% in Illinois, and 28.5% in Iowa**. On the other end of the spectrum, Alabama surveyors cited approximately **1.3% of active nursing homes**.

Finding: Surveyors Almost Never Identify Actual Harm When They Find Resident Rights Violations

The severity findings raise even more significant concerns.

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[41] *See*, for example, Troyer, J. and Sause, W., "Association between Traditional Nursing Home Quality Measures and Two Sources of Nursing Home Complaints," Trust HSR: Health Services Research 48:4 (2013), https://pmc.ncbi.nlm.nih.gov/articles/PMC3725524/pdf/hesr0048-1256.pdf, which found that resident rights were the third most common complaints made to the North Carolina LTC Ombudsmen Program.

[42] Based on 2024 Q4 resident census data.

Of the **2,177 F550 citations issued nationwide in 2022, only 69 — 3.2% — were classified at G or above**. This means that 97% of the time that surveyors substantiated a resident rights violation in 2022 they found that not a single resident suffered any physical or psychosocial harm (or immediate jeopardy) as a result. In 2023, surveyors identified harm or immediate jeopardy in **61 of 2,657 citations — 2.3%**. In 2024, only **64 of 3,147 citations — 2.0% — were classified at G or above**.

Thus, while the number of resident-rights violations identified by surveyors increased 45% between 2022 and 2024, the number in which surveyors identified actual harm or immediate jeopardy actually declined slightly, from 69 to 64.

These findings are particularly important because the federal survey guidance expressly rejects the notion that harm must be physical. CMS directs surveyors assessing dignity violations to consider both physical and psychosocial harm. This recognizes the reality that being humiliated, ignored, deprived of meaningful choice, or treated without respect, can have consequential effects on a resident even when those effects do not manifest as a physical wound or injury.

	2022	2023	2024
F550 citations	2,177	2,657	3,147
Citations per 1,000 residents	1.85	2.20	2.57
G+ citations	69	61	64
G+ rate	3.2%	2.3%	2.0%
Cited below actual harm	96.8%	97.7%	98.0%

Not every F550 violation necessarily results in actual harm. But against CMS's explicit instruction to consider psychosocial consequences, **the classification of approximately 98% of substantiated resident-rights violations as below actual harm warrants serious scrutiny**. The finding raises questions about whether the survey system is adequately recognizing the impact that violations of dignity, autonomy, and other fundamental rights have on residents' quality of life and well-being.

The severity determination also has important practical consequences. As discussed elsewhere in this report, deficiencies cited below actual harm are highly unlikely to result in a penalty. Fundamentally, the result is a clear message to the nursing home industry: they will be paid – and face little fear of penalty – for care, treatment, and services that violate resident rights protections.

Finding: Where A Resident Lives Matters — Identifying Harm

State differences in the identification of harm were extraordinary. Across the three study years, **North Carolina classified 66 of 301 F550 citations — 21.9% — at G or above**, while Colorado classified **19 of 89 — 21.3% — at G+**. The next-highest state among those with substantial numbers of citations was Missouri, at approximately 5.2%.

At the other end of the spectrum, numerous states identified **no F550 violations at actual harm or immediate jeopardy during the entire three-year period**. These included **Pennsylvania, despite 395 F550 citations; Massachusetts, despite 203; Florida, despite 190; Minnesota, despite 173; Connecticut, despite 127; Louisiana, despite 112; Georgia, despite 108; and West Virginia, despite 107. In 2024, 32 states and Washington, DC** identified every F550 violation they substantiated as not causing any resident harm or immediate jeopardy.

A clear message to the nursing home industry: they will be paid – and face little fear of penalty – for care, treatment, and services that violate resident rights protections.

These differences should not be taken to mean that North Carolina or Colorado necessarily provide strong oversight. Even in those states, approximately four out of five F550 violations were classified as no harm. Rather, the findings illustrate both substantial interstate variation and a broader national pattern of limited to no identification of harm.

For information on individual state performance, see the State Citation Frequency Resident Rights 2022 2023 2024.xlsx dataset at https://nursinghome411.org/ltccc-enforcement-study-2026/.

Conclusion

The federal Nursing Home Reform Law establishes meaningful, resident-centered standards for care, safety, dignity, and quality of life. But those protections are of little value if violations are not identified, resident harm is not recognized, and meaningful consequences do not follow when minimum standards are not met.

The findings in this report point to a persistent accountability gap. Across the measures examined, survey and enforcement activity often bore little relationship to the extent and seriousness of known problems in nursing homes. Financial penalties declined substantially. Surveyors overwhelmingly classified substantiated violations of minimum health requirements as, essentially, harmless. In critical areas including infection control, sufficient staffing, pressure ulcer care, psychotropic medication requirements, and resident rights, the data reveal a broad national pattern of limited identification of deficient care and resident harm.

There are substantive differences in state performance and those differences matter. At the same time, the findings provide little basis for concluding that states with comparatively higher citation or harm-identification rates are consistently meeting the federal benchmark. The appropriate standard is not whether one state performs better than another. It is whether every resident is receiving the care and protections required by law.

Ultimately, effective nursing home oversight must be measured by its impact on residents. Survey activity, citations, severity classifications, and penalties are not ends in themselves. Their purpose is to ensure that residents receive sufficient staffing, appropriate clinical care, protection from abuse and neglect, freedom from unnecessary drugging, and respect for their dignity, autonomy, and rights every day.

The findings in this study underscore the need for stronger, more consistent, and more resident-centered oversight and enforcement. They also reinforce the importance of transparency. Residents, families, ombudsmen, advocates, policymakers, researchers, and the public should be able to examine how well nursing homes are meeting federal standards and how effectively government agencies are carrying out their responsibility to protect residents.

LTCCC's study webpage, https://nursinghome411.org/ltccc-enforcement-study-2026/, includes the report, issue briefs, searchable state and national data files, and other resources to help stakeholders and policymakers explore the findings and use them to support better care and stronger accountability for the safety, health, and dignity of nursing home residents.