LONG TERM CARE
COMMUNITY COALITION

*Advancing Quality, Dignity & Justice*

# Understanding & Responding to the Accountability Gap

## *A Guide for Residents, Families, Ombudsmen & Advocates*

**A companion to LTCCC's 2026 study, *The Accountability Gap***

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LTCCC's study webpage, https://nursinghome411.org/ltccc-enforcement-study-2026/, includes *The Accountability Gap* 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.

Visit www.nursinghome411.org for free data, fact sheets, guides, forms, webinars, dementia care tools, and other resources.

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## Why This Guide Matters

Federal nursing home standards establish comprehensive protections for resident care, safety, dignity, and quality of life. Nursing homes that accept Medicare and/or Medicaid agree – and are paid – to meet or exceed these standards for every single resident, no matter who pays for their care.

Unfortunately, far too often, nursing homes fail to meet federal standards, resulting in avoidable pain, suffering, degradation, and even death. The federal requirements are strong, but they are only meaningful if implemented in the lives of residents.

There are many reasons for the discrepancies between minimum requirements and the real-life experience of too many residents. However, fundamentally, the responsibility for ensuring that residents are protected falls to the federal Centers for Medicare & Medicaid Services (CMS) and the state agencies (usually the health department) that are required to effectively monitor care, inspect facilities, respond to complaints, and hold operators accountable when they break their promises to residents and their families.

LTCCC's national study, *The Accountability Gap*, examined nursing home oversight and enforcement from 2022–2024. It found significant weaknesses in the system intended to ensure that federal standards are realized in residents' daily lives. Residents face barriers to receiving decent care and living with dignity because weak oversight has led to an environment in which operators know that they can provide substandard care to maximize profits with impunity.

**This guide is designed to help residents, families, ombudsmen, and advocates put information into action – using federal standards, available data, LTCCC resources, and documentation of residents' experiences to advocate effectively for better care, dignity, and accountability.**

## What the Study Found

**Deficiencies and harm.** Approximately 94% of cited health deficiencies were classified below actual harm in each study year.

- Why is this important? Because unless surveyors identify the harmful impact to residents, a facility is unlikely to face any penalty whatsoever.
- Bottom line: Operators know that there is little chance of even a small penalty for deficient care and short staffing.

**Financial penalties.** Reported fines fell from 11,501 in 2022 to 5,210 in 2024. The resident-adjusted frequency of fines declined about 56.5%.

- Why is this important? Generally speaking, fines have never been a strong enough penalty to make it worthwhile for nursing homes to comply with minimum standards. Fines are infrequently imposed for a violation, and low fines can be seen as simply "the cost of doing business." The decrease in fines that we identified is, therefore, especially troubling because it sends a message to predatory operators that there are even more opportunities **to** profit from substandard care without facing meaningful financial consequences.

**Infection control.** By 2024, 98.7% of F880 infection-control violations were classified as "no harm."

- Why is this important? Infection control problems in nursing homes were identified as a serious and widespread problem well before the COVID-19 pandemic. The pandemic

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exposed the extent to which residents are extremely vulnerable. Our finding that surveyors rarely identify harm means that it is extremely unlikely that a facility will suffer any penalty – even a small one – for poor infection control practices.

- Bottom line: CMS and the state survey agencies are essentially sending the message that nursing homes can violate infection control protocols with impunity.

**Staffing.** About 90% of nursing homes with valid 2024 comparisons provided total staffing below expected levels. However, only 33 F725 (insufficient staffing) citations were classified at actual harm or immediate jeopardy.

- Why is this important? Staffing is widely considered the most important indicator of a nursing home's quality and safety. The failure to identify when residents are harmed as a result of insufficient staffing means that it is extremely unlikely that a facility will suffer any penalty for cutting staffing to maximize profits.
- Bottom line: When they don't have to worry about facing a penalty, too many providers will short staff – even to dangerous levels – to maximize profits. The result has been a normalization of extremely poor working conditions for staff and unmet needs and neglect for residents.

**Pressure ulcers.** Survey agencies issued only about three F686 citations for every 100 residents reported with a pressure ulcer; about three-quarters of substantiated F686 violations were classified below actual harm.

- Why is this important? Pressure ulcers are, by definition, a wound. How can surveyors identify that a facility is culpable for poor pressure-ulcer care yet not identify harm approximately 75% of the time? When is a pressure ulcer not harm?

**Antipsychotic drugs.** About one in five residents was reported as having received an antipsychotic in Q4 of each year. Of 5,594 F758 citations over 2022–2024, only 26 were classified at actual harm or immediate jeopardy.

- Why is this important? The overuse of antipsychotic drugs in nursing homes across the country has been recognized as a serious, avoidable problem for years. These drugs are not meant to treat "behaviors" associated with dementia and can expose residents to serious risks, including falls, strokes, and death.
- Bottom line: After nearly 15 years of federal attention to this issue, the persistence of widespread antipsychotic drugging and the extraordinarily small number of violations in which surveyors identified resident harm represent a serious failure of federal and state oversight. Residents should be able to count on regulators to identify inappropriate drugging, recognize its consequences, and hold facilities accountable when they violate federal requirements.

**Resident rights.** State agencies cited no F550 resident-rights violations at 83% of nursing homes in 2024; across the three years, about 97.6% of F550 violations were classified as causing no clinical, physical, or psychosocial harm to any resident.

- Bottom line: Federal law has guaranteed nursing home residents the right to dignity, respect, and a humane existence for more than 30 years. Yet the extraordinary rarity with which surveyors identify violations of these rights – or recognize harm when violations are found – effectively treats these fundamental protections as matters of little consequence.

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## Use the Study Data to Ask Better Questions

The searchable Excel files posted with the study can help you understand the broader oversight environment in your state. They are especially useful for comparing state activity, identifying patterns, and sharpening questions for a nursing home, state survey agency, or policymaker.

> **Important:** A low citation rate does not necessarily mean that a nursing home is providing better care. Citation data reflect what the state survey agency has identified. Use the citation data as context, not as a substitute for the resident's experience or other important data, like staffing levels.

| Dataset | What it can help you examine |
|---|---|
| **Resident-adjusted citation rates** | How often states identified health deficiencies relative to the nursing home resident population. |
| **Scope & severity** | The extent to which a violation is classified as causing harm (G+) or immediate jeopardy (J+) to one or more residents. |
| **Fines** | How often fines were reported and the amount of fines relative to resident census. |
| **Infection control** | F880 citation frequency and how often surveyors identified resident harm. |
| **Sufficient staffing** | F725 citation frequency, G+ findings, and the extent to which state oversight aligned with staffing shortfalls. |
| **Pressure ulcers** | Reported pressure-ulcer prevalence, F686 citations, and harm-identification patterns. |
| **Resident rights** | F550 citation frequency and how often surveyors identified physical or psychosocial harm. |
| **Nursing home staffing data** | Facility-level staffing data can be extremely useful in identifying the extent to which a facility has adequate staffing and is being held accountable for meeting residents' needs. |

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### How to Use the Data

- Compare your state with the national pattern and with other states, but do not assume that higher citation rates automatically mean better oversight.
- Pair state-level information with facility-level information whenever possible.
- Use the numbers to frame questions: “Why is our state identifying this issue less often?” or “How does the state survey agency make sure psychosocial harm is recognized?”

## Quick Access to Key Resources

| Resource | How it can help |
|---|---|
| **Study page** | Report, issue briefs, searchable state and national data files, and companion resources. https://nursinghome411.org/ltccc-enforcement-study-2026/ |
| **Learning Center** | Fact sheets, forms, guides, webinars, resident-rights resources, dementia care, abuse/neglect tools, and more. https://nursinghome411.org/learn/ |
| **Staffing Resource Center** | Quarterly staffing reports with expected staffing information, staffing guides, and other resources. https://nursinghome411.org/staffing-resource-center/ |
| **Guide for Residents & Families: Nursing Home Staffing** | Step-by-step instructions for using actual vs. expected staffing data to support advocacy. https://nursinghome411.org/residents-families-staffing-guide/ |
| **Provider Data Reports** | Ownership, ratings, fines, staffing, and other facility information. https://nursinghome411.org/data/ratings-info/ |
| **Abuse, Neglect & Crime Center** | Information and contacts for reporting abuse, neglect, and potential crimes. https://nursinghome411.org/learn/abuse-neglect-crime/ |
| **Handy Worksheets & Forms** | Tools and forms for documenting concerns and advocating for better care. https://nursinghome411.org/forms-advocacy/ |

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## Experience + Standard + Data + Documentation + Action

**Start with the resident's experience.** Ask whether the resident is receiving the care, services, dignity, and quality of life they need. Pay attention to what happens day to day — not just ratings or survey results.

**Identify the applicable standard.** Use LTCCC's fact sheets and guides to identify what the nursing home is required to do. Frame the concern around the resident's needs and the facility's obligations.

**Use data where it helps.** Facility staffing data may provide direct context for missed or delayed care. State data can show whether a broader oversight pattern is unusual. Data strengthen a concern; they do not replace specific facts.

**Document what happened and the impact.** Record dates, times, what the resident needed, what was or was not done, who was notified, and what happened to the resident physically, clinically, functionally, emotionally, or psychosocially.

**Ask for a specific response.** Ask what will be done, who is responsible, and when it will be completed. For recurring problems, ask how the facility will address the underlying cause — not just the single incident.

**Escalate when necessary.** If the facility does not respond adequately, consider contacting the Long-Term Care Ombudsman Program and/or filing a complaint with the state survey agency. Serious or urgent safety concerns may require immediate action. See LTCCC's Abuse, Neglect, and Crime Reporting Center for contacts and helpful information.
https://nursinghome411.org/learn/abuse-neglect-crime/

**A useful way to frame the issue**

The resident needed _____.

The facility failed to provide _____.

The result was _____.

Federal standards require _____.

The facility's data also show _____.

We are asking the facility/agency to _____ by _____.

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## Document Harm, Not Just the Underlying Failure

One of the study's most important findings is how rarely surveyors identify resident harm. If a problem affects a resident, document the consequences when they are known. Harm is not limited to hospitalization or physical injury. It can include clinical decline, loss of function, pain, fear, humiliation, emotional distress, loss of dignity, loss of autonomy, or other psychosocial effects.

**Example**

Do not stop at: "The call bell was unanswered for 45 minutes." If known, document the impact: "The resident waited 45 minutes for toileting assistance, became incontinent, was embarrassed and crying, and said she was afraid to ask staff for help again."

## Sample Questions You Can Use

- "What does the resident's assessment and care plan require, and how is the facility ensuring that it is carried out consistently?"
- "Your staffing data show that reported staffing was below expected staffing. How are residents' assessed needs being met on this unit and across shifts?"
- "What did the facility determine was the cause of this problem, and what systemic corrective action is being taken so it does not recur?"
- "How did you evaluate the physical and psychosocial impact on the resident?"
- "If the state did not identify actual harm, what evidence did surveyors consider regarding pain, fear, humiliation, loss of function, or other consequences?"
- "What is the timeline for corrective action, and how will residents and families know whether it was effective?"

## When a Problem Is Not Fixed

- Raise the concern with the appropriate nurse, Director of Nursing, Administrator, or other responsible staff member. Ask for a specific corrective response.
- Put significant or recurring concerns in writing and keep a copy.
- Contact the Long-Term Care Ombudsman Program for assistance with resident rights, communication, and problem resolution.
- Consider filing a complaint with the state survey agency and/or the state Medicaid Fraud Control Unit. Include specific facts, dates, resident consequences, supporting records, and applicable standards when possible.
- If a previous complaint was unsubstantiated but the problem persists or residents continue to experience consequences, document the continuing problem and raise it again. If the state survey agency does not substantiate a problem, consider going to the state Medicaid Fraud Control Unit, CMS, your state or federal legislator, an attorney, or (if one exists) a local resident protection agency.

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## For Resident & Family Councils, Ombudsmen & Advocates

### Use the Findings to Ask Better Questions

The study data are particularly useful for identifying questions that deserve closer examination. They should not be used to assume that a state with more citations is necessarily doing a good job or that a state with fewer citations has better nursing homes.

- Put a recurring “quality and oversight snapshot” on council agendas: staffing, recurring resident concerns, recent citations, and, if applicable, recent fines.
- Track whether problems cluster on particular units, shifts, weekends, or holidays.
- Ask facility leadership how its QAPI (quality improvement) process is responding to repeated complaints or deficiencies.
- Ask the state survey agency how it ensures that surveyors consider psychosocial as well as physical harm.
- Use state data to ask why a particular issue is identified much less frequently than in other states, while recognizing that the data alone cannot explain the difference.
- Follow up in writing after meetings and maintain a timeline of concerns, responses, and outcomes.

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## Simple Worksheet

| | |
|---|---|
| **Resident / Facility / Date(s)** | |
| **What happened?** | |
| **What did the resident need?** | |
| **What impact did the problem have on the resident?** | |
| **Applicable care standard / resident right** | |
| **Relevant data (staffing, citations, fines, etc.)** | |
| **Who was notified and what response was provided?** | |
| **Requested action and timeline** | |

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## Common Concerns & LTCCC Resources

| Concern | Start with |
|---|---|
| **Not enough staff / long waits for care** | Staffing Resource Center; Guide for Residents & Families: Nursing Home Staffing |
| **Pressure ulcers / wound care** | Care standards, assessment & care planning fact sheets; staffing resources |
| **Antipsychotic drugs / excessive sedation** | Antipsychotic drugging resources; Dementia Care Toolkits |
| **Infection prevention** | Infection Prevention & Control fact sheet and related resources |
| **Dignity, choice, privacy, autonomy** | Resident Rights to Dignity & Respect; Foundations of Resident Rights |
| **Poor response to complaints** | Fact sheet on the relevant issue; Resident grievances and complaints resources; Ombudsman resources |
| **Abuse or neglect** | Abuse, Neglect & Crime Reporting Center; Fact sheet on the relevant issue |
| **Unsafe or improper discharge** | Transfer & discharge fact sheets; Unsafe Discharge Complaint Form |
| **Pattern affecting several residents** | Resident & Family Council resources; Family Council Empowerment materials |

## Frequently Asked Questions

### Q: Does a low number of citations mean a nursing home is good?

A: **No**. It means the state survey agency cited relatively few violations. The study shows why citation frequency should be considered together with resident experience and other data.

### Q: Does a “no harm” citation mean no resident was harmed?

A: **No**. “No harm” is a regulatory classification. It does not establish that residents experienced no physical, clinical, functional, emotional, or psychosocial consequences.

### Q: Should I use state data to prove that my facility violated the law?

A: **No**. State data provide context. A facility-level concern should be built around the resident’s experience, applicable requirements, facility records and data, and documentation.

### Q: Where can I find facility-level staffing information?

A: LTCCC’s Staffing Resource Center and quarterly staffing reports provide actual and expected staffing for nursing homes nationwide.

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## Links to Useful Resources

- **LTCCC Learning Center:** https://nursinghome411.org/learn/ Fact sheets, forms, toolkits, webinars, and resident advocacy resources.
- **Nursing Home Data Center:** https://nursinghome411.org/data/ratings-info/ Facility ownership, ratings, fines, staffing, and related information.
- **Staffing Resource Center:** https://nursinghome411.org/staffing-resource-center/ Expected staffing methodology, quarterly data, practical guides, and research.
- **The Accountability Gap study page:** https://nursinghome411.org/ltccc-enforcement-study-2026/ Full report, issue briefs, searchable data files, and companion resources.

## Three Things to Remember

1. **A lack of citations does not prove that there is no problem.** The study found substantial gaps between resident-care concerns and regulatory findings.
2. **"No harm" does not mean that the resident experienced no harm.** It is a regulatory classification, and the resident's physical and psychosocial experience still matters.
3. **Use standards + data + resident experience together.** The strongest advocacy connects what happened to the resident, what federal standards require, what the available data show, and what corrective action is needed.

**You do not have to start from scratch**

LTCCC's website provides free fact sheets, data, forms, complaint tools, guides, dementia care resources, family council materials, and other resources designed to help residents, families, ombudsmen, and advocates promote better care and stronger accountability.

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