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NEW YORK NURSING HOME CARE AND OVERSIGHT

STATEDWIDE FINDINGS FROM THE ACCOUNTABILITY GAP 2022-2024

LONG TERM CARE COMMUNITY COALITION
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Table of Contents

INTRODUCTION: WHY THIS MATTERS 3

SURVEY ACTIVITY AND IDENTIFICATION OF HARM 5

Survey coverage improved but remained below national levels 5

Identifying deficient care & its impact on residents was low 5

Harm findings were rare even when residents suffered pain or degradation 6

FEDERAL PENALTIES AND STATE TRANSPARENCY 8

Fine frequency & amount per fine among lowest in the country 8

OVERSIGHT MUST IDENTIFY VIOLATIONS AND THEIR CONSEQUENCES 9

STAFFING SHORTFALLS: A PERSISTENT AND PERNICIOUS PROBLEM 10

PRESSURE ULCERS: HIGH RATES, LOW ACCOUNTABILITY 11

High Rates 11

Low Enforcement 12

CONCLUSION & RECOMMENDATIONS 13

Governor Hochul and Department of Health: Make Resident Protection a Measurable State Priority 13

Assembly and Senate: Conduct Oversight Hearings and Require Follow-Through 14

State Comptroller: Build on Independent Scrutiny of Care and Public Spending 15

Attorney General: Expand Enforcement That Connects Resident Neglect with Financial Accountability 15

Individuals and Communities: Use the Evidence to Support Resident-Centered Advocacy 16

This report, searchable files with facility, county, legislative district and state performance indicators and other data, are available at www.nursinghome411.org/ny-accountability-2026/.

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

Introduction: Why This Matters

New York's nursing home quality and oversight warrant urgent corrective action. While our recent national study, The Accountability Gap, found that no state was doing a particularly good job ensuring that federal minimum standards of care and dignity were being implemented in the lives of vulnerable residents, there were many indicators of particularly serious quality problems in NY nursing homes and persistent failures in assuring that our nursing homes are operating in compliance with even the most basic minimum federal standards.[1]

These widespread and avoidable problems harm nursing home residents, the nursing staff we entrust with their care, New York families, and taxpayers.

- Far too many residents suffer every day when their calls for help go unanswered, when pain is not treated, and when they are treated inhumanely.
- Working in a nursing home is among the most dangerous jobs in the country.[2]
- Too many families of nursing home residents suffer from stress and distress.
- Unless corrected, the persistence of poor nursing home care will harm virtually every New York family at some point.
- When facilities provide inadequate staff, or cut back on food quality, activities, or therapy services, New York taxpayers are paying for broken promises of regulatory compliance, including, too often, blatant fraud.

Note on Nursing Home Requirements

Nursing homes participate in the Medicare and Medicaid programs voluntarily and because it is financially advantageous for them to do so.

By taking public funds, they are contractually obligated to provide sufficient staffing and services that meet federal minimum standards. When they submit cost reports to the government, they are attesting that those requirements have been met.

Thus, **every resident** who is put in a diaper when they can go to the bathroom with help, **every resident** with dementia who receives a drug to make them easier to care for, and **every resident** who develops pressure ulcers due to the facility failing to provide skin monitoring and care is another failure to fulfill promises to residents and contractual obligations to the public.

Our findings, based on federal data for 2022–2024, document widespread and significant staffing shortfalls, pressure-ulcer rates above national levels, and low citation and fine frequency relative to the resident population. Findings of actual harm or immediate jeopardy were limited, even when surveyors substantiated violations of basic care requirements that resulted in serious resident suffering.

[1] https://nursinghome411.org/ltccc-enforcement-study-2026/.

[2] See https://www.bls.gov/iif/nonfatal-injuries-and-illnesses-tables.htm#summary. Finding based on BLS file "highest-rates-for-total-cases-2024-national."

At the same time, there were some meaningful improvements in oversight by the state oversight agency, the New York Department of Health (DOH). Standard survey coverage increased, and staffing, pressure ulcer and resident rights citations became more frequent. New York's 2024 complaint-survey coverage and citation rate for inadequate staffing exceeded the corresponding national figures. Those gains should be acknowledged. However, they do not resolve the concerns identified by the care and enforcement data, the impacts of widespread understaffing, and other concerning indicators.

Selected measure	Period	New York	National
Facilities below expected nurse staffing	Q4 2024	95.6%	90.2%
Facilities at least 20% below expected staffing	Q4 2024	77.0%	64.3%
Reported residents with unhealed pressure ulcers	Q4 2024	9.60%	7.92%
Providers receiving a standard survey	2024	53.5%	64.8%
Health citations per 1,000 residents	2024	37.9	117.3
CMS fine records per 1,000 residents	2024	1.21	4.25

Staffing uses facilities with valid comparisons. Census-adjusted measures use Q4 average daily PBJ census.

Taken together, our findings raise serious questions about whether DOH identifies noncompliance and its consequences with sufficient rigor. They support an immediate review of surveillance, harm classification and enforcement, followed by measurable improvements in protecting residents from abuse and neglect and ensuring that taxpayer funds are used with integrity.

For our national study, with searchable data on every state's performance ensuring quality of care, compliance with federal standards for nursing home operations, and operational integrity, visit https://nursinghome411.org/ltccc-enforcement-study-2026/.

For this study's resources, including searchable information on key performance indicators by individual facility, county, and NYS legislative district, visit https://nursinghome411.org/ny-accountability-2026/.

To find and compare current nursing home staffing levels, expected staffing levels, inspection ratings and more, visit https://nursinghome411.org/data/.

Survey Activity and Identification of Harm

SURVEY COVERAGE IMPROVED BUT REMAINED BELOW NATIONAL LEVELS

The reported share of New York providers receiving a standard survey increased from 41.3% in 2022 to 44.5% in 2023 and 53.5% in 2024. National coverage increased from 56.4% to 59.4% and 64.8%. New York's mean annual coverage was 46.4%, ranking 44th out of 52 jurisdictions.

Complaint-survey coverage was comparatively stronger: 75.8% in New York in 2024 versus 74.5% nationally. Note: These figures describe investigation activity. They do not establish that complaints were investigated in a timely manner, substantiated appropriately, or resolved effectively.

IDENTIFYING DEFICIENT CARE & ITS IMPACT ON RESIDENTS WAS LOW

New York's health deficiency citation rate increased from 27.9 per 1,000 residents in 2022 to 37.9 in 2024. National rates were 109.4 and 117.3, respectively. New York had the second-lowest resident-adjusted rate among the 50 states and DC in each study year and across the three years combined.[3]

In addition to identifying the existence of substandard care, neglect, or abuse with a citation, it is critical that state surveyors accurately identify the extent to which one or more residents has suffered as a result. Far too often, surveyors fail to identify harm when basic care standards are violated. This is important because, in the absence of identification of resident harm or immediate jeopardy, it is highly unlikely that a facility will face any penalty. Fundamentally, "no harm" citations send a message to nursing homes that they can provide the level of substandard care identified with impunity.

See the special New York edition of *The Elder Justice Newsletter* for examples of so-called "no harm" citations.

The identification of harm is important because, when a violation is identified as "no harm," there is little chance that the facility will face any penalty. The newsletter invites readers to scrutinize the documented consequences for residents and judge for themselves whether violations classified as "no harm" caused physical, emotional, or psychosocial harm.

The State Citation Rates Scope & Severity Report accompanying our national study identified that, of the 8,350 health deficiencies cited in New York nursing homes from 2022–2024, DOH identified only 261 (3.1%) as causing harm or immediate jeopardy to one or more residents. The remaining 96.9% of citations were classified as "no harm" (below G in the CMS Scope &

[3] Puerto Rico is excluded from this comparison because of its small PBJ denominator.

Severity Grid[4]). This is approximately half of the national rate of harm identification, which is itself alarmingly low.

HARM FINDINGS WERE RARE EVEN WHEN RESIDENTS SUFFERED PAIN OR DEGRADATION

Nursing home industry lobbyists argue that New York's "lower rate of severe citations and financial penalties… reflects a system that identifies and corrects minor issues early, ensuring they are resolved before they result in resident harm."[5]

Unfortunately, countless complaints and cries for help from residents and families, years of horrific stories in newspapers across the state, the NY Attorney General's many lawsuits against nursing homes, and even self-reported nursing home staffing and quality data refute those arguments.

To address the question of whether low citation rates reflect (1) weak oversight or (2) high-quality of care (as industry lobbyists claim), our national study looked at the extent to which performance on important quality indicators matched state citation rates.

Following are key findings for New York:

Infection control. Poor infection control practices have been a widespread and serious problem in nursing homes since well before the COVID-19 pandemic.[6] Yet, from 2022-2024, New York issued a total of 351 infection control (F880) citations. Especially concerning is that only one of those citations in the entire three-year period was classified as causing harm or putting even a single resident in immediate jeopardy.

Pressure ulcers. Pressure ulcers are serious wounds and an important indicator of nursing home quality.[7] Though DOH has had a decades-long effort to address this problem, New York nursing homes' reported rate of residents with unhealed pressure ulcers exceeded the national rate every year of the study.[8] In Q4 2024, the rates were 9.6% in New York versus 7.9% nationally.

83% of the time, DOH found no resident harm when it identified substandard pressure ulcer care.

Despite high pressure ulcer rates in the NY nursing home industry, DOH issued only 167 citations for failures to prevent or treat pressure ulcers over the three years. To put this in a national perspective, DOH ranked 49th lowest in the country in number of citations per resident with

[4] For more information on oversight requirements and the CMS Scope & Severity Grid, *see LTCCC's Guide to Nursing Home Oversight & Enforcement* at https://nursinghome411.org/reports-studies/guide-oversight/.
[5] Brodsky, R., "Nursing homes on LI, in state, poorly staffed, have lowest fines, report finds," *Newsday* (September 16, 2026), quoting Stephen Hanse, president and CEO of the New York State Health Facilities Association. https://www.newsday.com/news/health/nursing-homes-report-staffing-fines-wdkbt22w.
[6] For more information, *see* https://nursinghome411.org/wp-content/uploads/2026/09/LTCCC-Report-The-Accountability-Gap-2026-Infection-Prevention-and-Control.pdf.
[7] 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.
[8] Our study assessed rates for the fourth quarters of 2022, 2023, and 2024.

pressure ulcers.[9] Only 28 of those citations were identified as causing resident harm or immediate jeopardy.

A pressure ulcer is, by definition, a wound. Yet 83% of the time, DOH found no resident harm when it identified substandard pressure ulcer care. If a pressure ulcer isn't harm, what is?

Psychotropic medications. The inappropriate use of psychotropic medications, particularly antipsychotics, has long been a serious problem in nursing homes. Residents with dementia are especially vulnerable to receiving these powerful and dangerous drugs for staff convenience, in violation of federal care and resident rights standards. Rather than addressing the resident's underlying needs, these drugs can suppress their ability to express distress caused by pain, boredom, or fear.

New York nursing homes had an average antipsychotic (AP) drugging rate of 18.3% over the study period, modestly lower than the national rate of 20.7%. However, NY DOH's citations for inappropriate drugging were significantly lower than the national average. With 62 citations across the three years, NY had the fourth lowest citation rate in the nation (behind only Alabama, Tennessee, and Kentucky). DOH identified all of these citations as "no harm," meaning that providers are unlikely to face any penalty whatsoever.

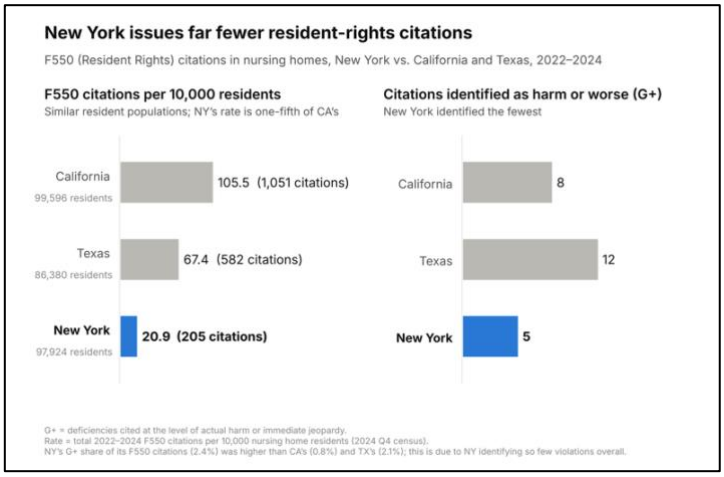
Resident rights. Resident rights and dignity standards are among the fundamental requirements that nursing homes are paid to provide. They were established almost 40 years ago, essentially to ensure that nursing homes aren't operated as storage facilities for vulnerable older adults.

Importantly, federal guidance explicitly recognizes that violations of these rights can harm residents even in the absence of physical injury. CMS specifically directs state oversight agencies (including DOH) 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, and emotional distress are therefore expected to be relevant factors in determining the seriousness of a violation.

Despite strong federal standards, far too many nursing homes provide degrading and dehumanizing conditions. One reason for this is the paucity of state citations; nursing homes know that there is virtually no likelihood that they will face any penalty when residents are treated inhumanely or living conditions are poor.

[9] Only Kentucky and Alabama had lower pressure ulcer citation rates. https://nursinghome411.org/wp-content/uploads/2026/09/State-Pressure-Ulcer-Rates-Citations-2022-2023-2024.xlsx.

Nationwide, there were 7,981 resident rights citations over the three years studied. NY DOH cited facilities 205 times during that period. To put that in context, among the three states with the largest resident populations, California, New York, and Texas, New York cited by far the fewest resident rights violations. It also identified the fewest as causing resident harm.



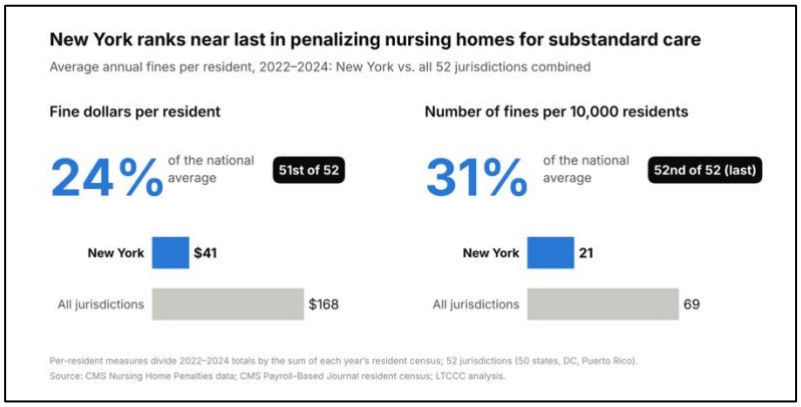
Explore nursing home staffing, care, and citation findings for individual facilities, counties, and legislative districts. Download the data files at https://nursinghome411.org/ny-accountability-2026/.

To read actual examples of "no-harm" citations, see our special New York edition of The Elder Justice Newsletter, *The Accountability Gap in New York: Examining "No Harm" Citations and Their Consequences for Residents*.

Federal Penalties and State Transparency

FINE FREQUENCY & AMOUNT PER FINE AMONG LOWEST IN THE COUNTRY

CMS reported 296 fine records for New York in 2022, 206 in 2023 and 118 in 2024, a decline of 60.1% from 2022 to 2024. Across the three years combined, New York had the lowest resident-adjusted fine frequency among the 50 states and DC.[10]



Although fewer fines were imposed, their total dollar amount increased substantially, suggesting a possible strengthening of DOH enforcement. Specifically, in order to change poor behavior, the cost of a penalty must outweigh the benefit of providing substandard care and services. The increase represents positive improvement on this measure, but New York's low frequency of fines and low fine amounts per resident still reflect a weak enforcement response to substandard care.

[10] Our study reviewed data on the imposition of federal fines in every state. We did not review the extent to which any state-imposed state penalties.

Oversight Must Identify Violations and Their Consequences

Regular and thorough inspections are a crucial safeguard for nursing home residents, who depend on their facility for care, safety, and humane treatment every day.

In respect to overall standard survey coverage, New York was well below the national average (64.8%) throughout the study period, though it improved substantively from 41.3% of providers in 2022 to 53.5% in 2024. Overall, NY DOH ranked 44th out of 52 in standard survey coverage. Complaint survey coverage in 2024 was slightly higher than the national average, 75.8% versus 74.5%. It is important to note that these measures describe recorded coverage, not whether inspections or complaint responses met required deadlines or effectively ensured compliance with minimum government standards.

Because state survey agencies exist to protect vulnerable residents, it is important to measure the extent to which DOH is holding providers accountable for substandard care, neglect, and abuse. Federal data indicated that DOH recorded 27.9 health deficiency citations per 1,000 residents in 2022 and 37.9 in 2024. While this indicates improvement over time, it falls far short of the national rate of 117.3 citations per 1,000 residents.[11] As our assessments of specific quality indicators – as well as decades of reports of substandard care, abuse, and neglect – show fewer nursing home citations do not establish better care.

In addition to the number of citations, the extent to which surveyors identify resident harm or immediate jeopardy is critical. In the absence of a finding of harm or IJ, it is highly unlikely that the facility will face any penalty for the substandard care.

Surveyors rank violations via a "scope and severity grid in which the violation is coded from A to L. G–I indicate the recognition of resident harm, while J–L indicate immediate jeopardy to one or more residents.[12] Across 2022–2024, New York classified 261 of 8,350 health deficiency citations (3.1%) at level G or above. This is about half the national rate of 6.0%, which itself is quite low.

Requirement cited in New York 2022–2024	All citations	G+ citations	G+ share
Sufficient nursing staff (F725)	165	1	0.6%
Pressure ulcer care (F686)	167	28	16.8%
Infection prevention and control (F880)	351	1	0.3%
Psychotropic medications (F758)	62	0	0.0%
Resident rights and dignity (F550)	205	5	2.4%

[11] It is important to note that, while our national study found variations in state performance, we did not identify any state that was consistently assuring quality, safety, or dignity in compliance with federal minimum standards.
[12] *See* LTCCC's Guide to Nursing Home Oversight for more information. https://nursinghome411.org/reports-studies/guide-oversight/.

Staffing Shortfalls: A Persistent and Pernicious Problem

Dozens of studies over the last 50 years have confirmed what residents, families, and nursing staff experience every day: staffing is the most important factor in ensuring safety of both residents and staff, as well as compliance with federal and state care requirements.[13] Nevertheless, in the fourth quarter of 2024, an astounding 95.6% of New York facilities with both reported and expected total staffing data (566 of 592) staffed below the levels expected to meet basic resident needs.[14] In other words – based on their own, self-reported data – nearly all New York nursing homes failed to meet the most important quality benchmark.[15] Of additional concern is that, among the 592 facilities with reported data, 456 (77.0%) were at least 20% below expected staffing levels.



Taken together, these figures – based on data that the nursing homes themselves report to the federal government – indicate serious and widespread failures to fulfill the promises made to vulnerable residents, families, and NY taxpayers (who pay for the majority of nursing home care).

While understaffing is a national problem, these data indicate that New York's nursing homes, on average, rank among the worst in the country for staffing shortfalls relative to residents' assessed clinical needs. NY ranked in the bottom four in the country in respect to facilities providing expected staffing. Only Texas, Indiana, and Georgia were worse.[16] As noted elsewhere in this report, and in dozens of studies and countless newspaper reports, the failure to provide sufficient staffing has devastating consequences for residents, families, and care staff.

New York's citation count for insufficient staffing (F725) increased from 27 in 2022 to 104 in 2024. Its reported F725 citation rate rose to 10.6% in 2024, above the national 6.0% average. Though small in relation to the levels of understaffing in NY nursing homes, these are promising trends in DOH's identification of the problem. However, only one of the 104 citations in 2024 was classified at G or above, meaning that it is extremely unlikely that the other 103 citations will result in any penalty whatsoever.[17] This weak response sends operators a troubling message: they can continue collecting public payments while facing little fear of meaningful consequences for insufficient staffing.

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[13] https://nursinghome411.org/wp-content/uploads/2026/08/Nursing-home-staffing-studies-2026.docx.

[14] Nursing homes report staffing to the federal government on a quarterly basis. The last quarter of 2024 was the first for which expected staffing (the level expected to meet residents' basic care and clinical needs) was available.

[15] Note: Expected staffing is an evidence-based benchmark developed using a peer-reviewed methodology. It estimates the nursing staff time needed to meet residents' basic clinical and care needs, using resident assessment data that facilities report to the federal government. See LTCCC's Nursing Home Staffing Resource Center for more information. https://nursinghome411.org/staffing-resource-center/.

[16] https://nursinghome411.org/wp-content/uploads/2026/09/State-Nursing-Home-Expected-Staffing-and-Oversight-2024.xlsx.

[17] It is important to note that a citation scoped at G or higher does not mean that an operator will definitely face a penalty for the substandard care, neglect, or abuse identified. Rather, a citation scoped at less than G in the federal scope and severity grid means that it is highly unlikely that any penalty whatsoever will result. See LTCCC's *Guide to Nursing Home Oversight & Enforcement* for more information.

Pressure Ulcers: High Rates, Low Accountability

High Rates

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."[18] 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."[19]

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. Unfortunately, NY nursing homes, on average, have historically had elevated rates of residents with pressure ulcers.

To address this persistent problem, in 2008 the NY Department of Health established the "Gold Stamp Program to Reduce Pressure Ulcers."[20] The Program invested public resources and embarked on collaborations with industry lobby associations to conduct what one DOH representative referred to in a meeting as the "war on the sore."

[It is important to note that nursing homes are already paid and contractually obligated to prevent and treat pressure ulcers appropriately. Basic care is not an optional service deserving a bonus. Offering additional payments to meet existing obligations, without meaningful consequences for failing residents, risks rewarding neglect and making public subsidies a substitute for accountability. Residents' rights must be enforced, not made contingent on another round of incentives.]

Unfortunately, 14 years after the Gold Stamp Program, New York facilities reported unhealed pressure ulcers among 9.95% of residents in Q4 2022, 9.72% in Q4 2023 and 9.60% in Q4 2024. The corresponding national rates were 8.18%, 8.09% and 7.92%. New York's rate declined modestly but remained above the national rate in every year.

Residents reported with unhealed pressure ulcers	New York	National
Q4 2022	9.95%	8.18%
Q4 2023	9.72%	8.09%
Q4 2024	9.60%	7.92%

[18] 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.

[19] 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.

[20] See https://www.leadingageny.org/?LinkServID=75063D46-0AEE-3E20-4A7A5B296914D972.

Low Enforcement

By definition, a pressure ulcer is a wound. Thus, when a survey team substantiates that a facility has provided substandard or negligent care to prevent or treat pressure ulcers, a reasonable person would likely conclude that, at a minimum, the resident was harmed.

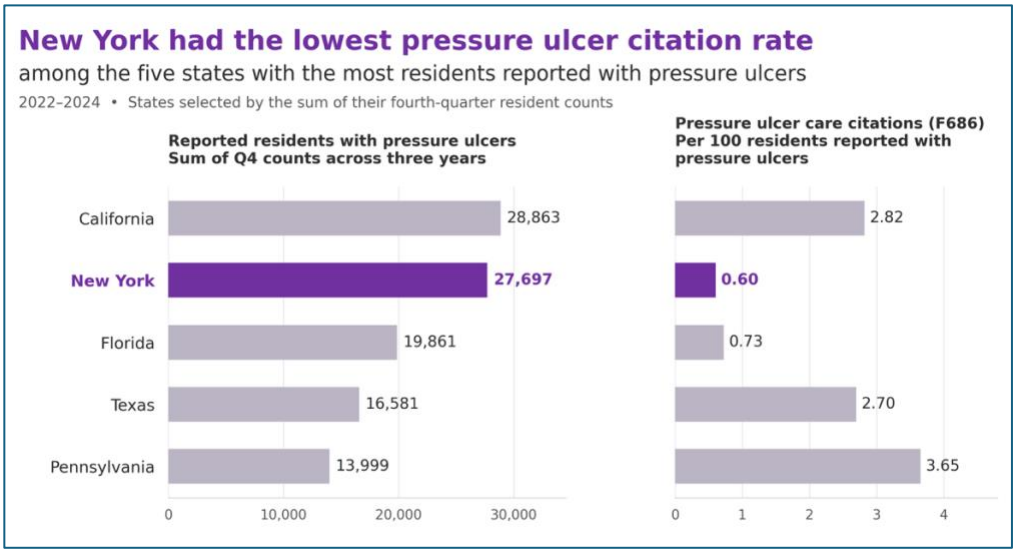
However, too often, that is not what happens in our nursing home oversight system. One of the most striking findings of our national study was that, in fact, even when surveyors substantiate substandard pressure ulcer care, they only identify it as causing resident harm about 25% of the time. If a pressure ulcer is not a harm, what is?

The New York Department of Health's (DOH) rate of harm identification in pressure ulcer care violations is even lower than the low national average: 16.8%. In other words, even when NY surveyors identify substandard pressure ulcer care – which DOH has recognized as a serious problem for decades – they fail to identify any harm to a single resident 83.2% of the time. The message to NY nursing home operators is clear: you can provide this level of substandard care and not have to worry about any repercussions.

Pressure-ulcer care citations (F686) increased from 43 in 2022 to 76 in 2024. While low, it is a positive trend. In 2024 Q4, NY nursing homes reported 9,185 residents with unhealed pressure ulcers. State surveyors issued 76 citations during that year. Sixty-six (86.8%) of those were identified as not causing any harm to a single resident.

These findings undercut the nursing home industry's claim that low citation rates demonstrate good care or successful prevention of problems.

These findings undercut the nursing home industry's claim that low citation rates demonstrate good care or successful prevention. New York's pressure ulcer rates remained above the national average, while surveyors classified most documented pressure ulcer care violations as "no harm." Presenting low citation rates as proof of success turns a warning sign about oversight into an excuse for complacency. Failure to recognize harm is not evidence that harm was prevented.



Conclusion & Recommendations

Substandard nursing home care threatens residents' health, comfort, and dignity, burdens families and caregivers, and wastes taxpayer dollars. New York needs a coordinated response with clear responsibilities, deadlines, and public reporting. That response must begin with a fundamental change in priorities: protecting residents, supporting families, and ensuring that care staff have the resources to do their jobs.

State leaders must stop treating the perpetuation of nursing home businesses as a substitute for protecting the people who depend on them. They must stop giving operators a pass for substandard care on the strength of industry claims that sufficient staffing is unaffordable. Research, financial disclosures, and New York's enforcement cases have exposed how owners and their related companies can extract substantial sums while residents go without necessary care. A nursing home's reported margin does not capture all the money flowing to those who profit from its operation. Accepting claims of poverty while overlooking those payments shields operators from accountability and leaves vulnerable residents to bear the consequences. Sufficient staffing is a contractual and moral obligation, not an optional expense to be funded only after owners' financial demands are satisfied.

Importantly, access to a nursing home bed is not meaningful access to care when there are too few staff to meet basic needs. What protection does that bed offer a resident left in soiled bedding, given sedating drugs instead of appropriate care, or left with painful wounds that worsen without treatment? What security does it provide someone who lives with the fear of humiliation, physical violence, or sexual abuse?

These are not abstract concerns. For years, residents, families, attorneys, and ombudsmen have described such experiences, while inspection findings and news investigations have documented profound, often heart-rending, failures. The data examined in this report reinforce the urgency of those warnings. Residents should not have to endure pain, fear, or degrading conditions while operators continue receiving public payments and state leaders accommodate industry demands at the expense of residents' care and rights.

Public funding must purchase necessary care, and oversight must protect the people receiving it. The recommendations that follow call for measurable action to make those obligations a reality.

Governor Hochul and Department of Health: Make Resident Protection a Measurable State Priority

- **Integrate nursing home accountability into implementation of the Master Plan for Aging.** Establish specific goals for sufficient staffing, prevention of avoidable harm, resident rights, and quality of life. Assign responsible officials, publish deadlines, and

include residents, families, and independent advocates in evaluating progress. Nursing home residents must be central to the state's commitment to aging with dignity.[21]

- **Improve the timeliness and effectiveness of inspections.** Address overdue surveys and complaint delays while strengthening surveyor recruitment, training, and supervision. Require meaningful observations of care and private resident, family, and staff interviews. Use reported and expected staffing data, along with key quality measures, to identify potential concerns and support survey investigations. Develop and implement mechanisms for the independent review of samples of citations classified below G to assess whether surveyors adequately investigated physical and psychosocial consequences and assigned appropriate severity levels.
- **Protect survey independence.** Screen employees and contractors for conflicts, document surveyor qualifications, and independently evaluate survey quality. Protect assignments and enforcement decisions from provider and trade association influence. A September 2026 HHS OIG audit identified inadequate federal oversight of states' use of contract surveyors, underscoring the importance of these safeguards.[22]
- **Require operators to correct violations and sustain compliance.** In a 2017 audit, OIG estimated that NY DOH had not obtained evidence of correction for 72% of deficiencies cited in 2014.[23] Without verification and sustained follow-through, citations risk becoming paperwork that leaves residents exposed to continuing neglect and signals to operators that empty promises can substitute for meaningful correction. DOH must require evidence that violations are corrected and that improvements last, with meaningful consequences when operators fail to comply.

Assembly and Senate: Conduct Oversight Hearings and Require Follow-Through

- **Hold public hearings on nursing home care and DOH performance.** Examine staffing, complaint response, harm classification, repeat violations, and enforcement. Include residents, families, ombudsmen, independent experts, and frontline workers so that hearings address the consequences of oversight failures in residents' daily lives. Rather than rely on highly paid industry lobbyists, solicit input from nursing home administrators and operators who are actually providing quality care and services.

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[21] New York State, *Master Plan for Aging: Final report* (2025). The report presents proposals for further consideration and implementation; the recommendation above calls for explicit resident protection goals. https://planforaging.ny.gov/master-plan-aging-final-report.

[22] U.S. Department of Health and Human Services, Office of Inspector General (2026). *CMS could improve oversight of states' use of contract surveyors for nursing home surveys* (A-04-24-08105). https://oig.hhs.gov/documents/audit/11873/A-04-24-08105.pdf *See*, also, surveyor qualification and conflict requirements, 42 C.F.R. § 488.314.

[23] U.S. Department of Health and Human Services, Office of Inspector General, *New York Did Not Always Verify Correction of Deficiencies Identified During Surveys of Nursing Homes Participating in Medicare and Medicaid* (A-02-15-01024) (2017). https://oig.hhs.gov/reports/all/2017/new-york-did-not-always-verify-correction-of-deficiencies-identified-during-surveys-of-nursing-homes-participating-in-medicare-and-medicaid/.

- **Require DOH to demonstrate improvement and address staffing needs.** Establish deadlines and public reporting on overdue inspections, delayed complaint investigations, enforcement actions, and whether facilities correct violations and remain in compliance. Examine whether DOH has enough qualified state inspectors and provide funding tied to a clear staffing and performance plan. Legislators should use the local data tools to identify and assess whether care in their communities complies with minimum standards.
- **Examine DOH's use of private companies to inspect nursing homes.** Require DOH to report which companies it hires, what they are paid, how their inspectors are trained, and how DOH checks the thoroughness and integrity of their work. Examine whether these companies have actual or potential conflicts. Outsourcing inspections must not weaken their independence or thoroughness, or DOH's responsibility for protecting residents.

STATE COMPTROLLER: BUILD ON INDEPENDENT SCRUTINY OF CARE AND PUBLIC SPENDING

The Comptroller's audits over the years have provided important independent scrutiny of DOH's oversight and protection of vulnerable residents. Building on that work, a comprehensive examination of current nursing home surveillance, enforcement, and spending oversight would help determine the extent to which DOH is assuring quality care and accountability.

- **Assess whether DOH uses its enforcement authority effectively.** Examine timeliness, harm classification, repeat deficiencies, and verification of correction. Determine whether promises of corrective action are being accepted in place of substantive and lasting action to assure resident safety and dignity.
- **Audit DOH's controls over nursing home spending.** Examine the reliability of cost reports, scrutiny of payments to related companies, and enforcement of applicable direct care spending requirements. Determine whether DOH identifies questionable expenditures, recovers amounts owed, and refers suspected misconduct for investigation.
- **Examine DOH's administration of civil money penalty reinvestment funds.** Review balances, awards, recipients, project selection, and documented results. Determine whether expenditures comply with program requirements, especially the prohibition against giving funds to nursing homes to help them attain the quality of care and services that they are already being paid to provide.

ATTORNEY GENERAL: EXPAND ENFORCEMENT THAT CONNECTS RESIDENT NEGLECT WITH FINANCIAL ACCOUNTABILITY

Build on the Attorney General's recent nursing home cases to pursue remedies that protect residents and send a message to operators that they will be held accountable for substandard care and fraud.

- **Continue to investigate patterns of neglect and diversion of care resources.** Combine actual and expected staffing data with evidence from complaints, clinical records,

ownership information, and financial transactions. Examine the conduct of owners, operators, landlords, and related companies where warranted.

- **Make sufficient staffing and sustained care improvements enforceable conditions of relief.** Seek court orders and settlements requiring staffing to meet or exceed expected staffing thresholds, adequate coverage across shifts, and clinical and financial monitoring. Require verification, public progress reporting, and consequences for noncompliance. The Centers settlement, for example, already provides a model through required staffing improvements, dedicated care funding, and independent monitors.[24]

Individuals and Communities: Use the Evidence to Support Resident-Centered Advocacy

Families, ombudsmen, advocates, and community leaders can use LTCCC's tools to examine individual facilities, counties, and legislative districts and identify high and low performing facilities. Pair findings from LTCCC's study of 2022-2024 performance with current information and residents' experiences. Our Staffing Resource Center and guides explain the measures and provide practical steps for seeking better care and stronger accountability.

- **NY report & resources: https://nursinghome411.org/ny-accountability-2026/**.
- **National report and state-level data: https://nursinghome411.org/ltccc-enforcement-study-2026/.**
- **Current (latest) nursing home staffing and provider performance data: https://nursinghome411.org/data/**.
- **The Nursing Home Staffing Resource Center: https://nursinghome411.org/staffing-resource-center/**.

[24] New York Attorney General, *Attorney General James secures $45 million and delivers major reforms to four nursing homes following significant financial fraud and resident neglect*. https://ag.ny.gov/press-release/2024/attorney-general-james-secures-45-million-and-delivers-major-reforms.