

ISSUE BRIEF

Understanding CMS’s New Nursing Facility Guidance

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On June 29, 2022, the Centers for Medicare & Medicaid Services (CMS) released [revised Surveyor’s Guidelines](#) for nursing facilities, along with a [policy memorandum](#) describing the revised Guidelines and accompanying revisions. The Guidelines are used by government inspectors in determining whether and to what extent a nursing facility has violated federal requirements.

The revised Guidelines implement certain regulations promulgated in 2016, and also incorporate concepts from President Biden’s recently announced [initiative](#) to improve nursing facility care. Among other things, the revised Guidelines address staffing levels, visitation rights, infection prevention and control, and arbitration agreements. Notably, the Guidelines improve transfer/discharge standards and set forth important strategies to provide culturally competent care.

The revised Guidelines total 847 pages; within the Guidelines, new language is marked by red font. The revised Guidelines will not become effective until October 24, 2022, in order to give nursing facilities and government surveyors enough time to adapt. The current version of the Surveyor’s Guidelines—effective until October 24—is found at Appendix PP to the CMS State Operations Manual.

In general, the revised Guidelines represent a step forward, by implementing new regulatory provisions and strengthening guidance on others. This issue brief summarizes and explains the revisions that are of most interest to residents and their advocates. Note that each section of the revised Guidelines is identified two ways: by an “F-Tag” number, and also by the underlying regulation. The Guidelines are tied to the regulations because each guideline instructs government surveyors how they should interpret and enforce a particular section of the regulations. (“C.F.R.” refers to the Code of Federal Regulations.)

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STAFFING AND TRAINING

SUFFICIENT STAFFING

F-Tag F725, commenting on the staffing level regulation. (42 C.F.R. § 483.35(a))

The Guidance makes clear that compliance with state-law staffing minimums does not necessarily meet the federal requirement of sufficient staffing. Facilities are required to submit staffing levels through the Payroll-Based Journal system, and government surveyors can use this data to identify days that may require further investigation related to potential staffing insufficiency.

NURSE STAFFING

F-Tag F727, commenting on the nurse staffing regulation. (42 C.F.R. § 483.35(b))

The regulation requires that each facility have a registered nurse on duty at least eight hours daily, but resident needs may require additional registered nurse hours. As mentioned above, facilities are required to submit staffing levels through the Payroll-Based Journal system. Surveyors can use this data to identify dates on which the facility may have had insufficient nurse staffing.

TRAINING

F-Tags F940, F941, F942, F945, and F947, commenting on the training regulation. (42 C.F.R. § 483.95)

Training must be provided for staff, contract employees, and volunteers.

A facility assessment may indicate a need for additional training on such issues as “advance care planning, cultural competence, end-of-life care, geriatrics and gerontology (i.e., understanding of how human beings change as they grow older), substance abuse, working with young and middle-aged adults, grief and loss, interdisciplinary collaboration, person centered care, specialized rehabilitative therapy, trauma informed care, intellectual disability, mental disorder and quality of life and care.”

The Guidance lists 13 methods of effective communication, including sitting face to face, being aware of body language, and using visual aids.

Staff must be trained on infection prevention and control. This must include the facility’s surveillance system for identifying potential communicable diseases or infections in the facility, and how to use standard and transmission-based precautions.

Nurse aide in-service training can include webinars, but should not be webinars alone.

INFECTION PREVENTION AND CONTROL

INFECTION CONTROL

F-Tag F880, commenting on the infection control regulation. (42 C.F.R. § 483.80)

The Guidance notes “three categories of transmission-based precautions: contact precautions, droplet precautions, and airborne precautions.” Any of these should be used in conjunction with standard precautions. Contact precautions are used when the pathogens are spread by direct or indirect contact with the resident or environment. CMS provides guidance for each of these situations.

INFECTION PREVENTIONIST

F-Tag F882, commenting on the infection preventionist regulation. (42 C.F.R. § 483.80(b))

The infection preventionist must be professionally-trained in nursing, medical technology, microbiology, epidemiology, or another related field, and should also have the background and ability to handle the job. Examples of certification are the Certification in Infection Prevention and Control which is conducted by the Certification Board of Infection Control and Epidemiology, Inc., and accredited by the National Commission for Certifying Agencies. The infection preventionist should have specialized training prior to beginning the job. Free training materials have been developed by CMS and the Centers for Disease Control & Prevention (CDC), and are available at https://www.train.org/cdctrain/training_plan/3814.

Hours per week for an infection preventionist can vary based on the facility and its residents. Based upon a facility-wide assessment, the facility should determine if the infection preventionist should work in that role on a full-time basis. The infection preventionist must work onsite and must have the time necessary to properly assess, develop, implement, monitor, and manage the infection and control plan, address training requirements, and participate in required committees. Specialized training may include care for residents with invasive medical devices, resident care equipment (e.g., ventilators), and treatment such as dialysis as well as high-acuity conditions. If a facility's resident population changes, the infection preventionist should evaluate whether additional training is needed.

RESIDENT RIGHTS

VISITORS

F-Tag F563, commenting on a resident's right under the regulations to accept visitors. (42 C.F.R. § 483.10(f)(4))

In the regulation, the right of a resident to accept a non-family-member visitor is subject to "reasonable clinical and safety restrictions." The new Guidance adds two new examples of a reasonable clinical and safety restriction:

1. Following guidance from the Centers for Disease Control and Prevention, or a local health department, when a potential visitor shows signs of a transmissible infection, and
2. Denying access, or supervising visitation, when a potential visitor has "a history of bringing illegal substances into the facility which places residents' health and safety at risk."

The Guidance also lists "considerations during a communicable disease outbreak." These considerations are certainly familiar from the COVID-19 pandemic and include outdoor and virtual visitation, indoor designated visiting areas, and infection prevention protocols. A resident on transmission-based precautions can still receive visitors, but the potential visitor must be made aware of the risk and the necessary precautions.

In general, although the Guidance mentions "virtual" visits, the emphasis is placed on allowing for in-person visitation.

SEXUAL ACTIVITY

F-Tag F600, commenting on a resident's right under the regulations to be free from abuse, neglect, and exploitation. (42 C.F.R. § 483.12)

The new Guidance elaborates on a resident's right to engage in consensual activity. New language states that if a facility "has reason to suspect that a resident may not have the capacity to consent to sexual activity, the facility must take steps to ensure that the resident is protected from abuse. These steps should include evaluating whether the resident has the capacity to consent to sexual activity."

INVOLUNTARY TRANSFER AND DISCHARGE

F-Tag F622, commenting on the transfer/discharge regulation. (42 C.F.R. § 483.15(c))

Residents frequently are forced out of facilities improperly when their Medicare coverage ends because the facility is discriminating against less-lucrative Medicaid coverage. New Guidance says that “[t]hese situations may require further investigation to ensure that discrimination based on payment source has not occurred.” This is true even if the resident has not requested a transfer/discharge appeal. Furthermore, the Guidance lists a helpful summary of the procedure that should be followed when a resident’s Medicare coverage ends:

In situations where a resident’s Medicare coverage may be ending, the facility must comply with the [notice] requirements [for Medicare/Medicaid coverage]. If the resident continues to need long-term care services, the facility ... should offer the resident the ability to remain, which may include:

- Offering the resident the option to remain in the facility by paying privately for a bed;
- Providing the Medicaid-eligible resident with necessary assistance to apply for Medicaid coverage ..., with an explanation that:
 - » if denied Medicaid coverage, the resident would be responsible for payment for all days after Medicare payment ended; and
 - » if found eligible, and no Medicaid bed became available in the facility or the facility participated only in Medicare, the resident would be discharged to another facility with available Medicaid beds if the resident wants to have the stay paid by Medicaid.

In violation of the regulations, facilities sometimes conduct no-notice discharges when a resident supposedly is too dangerous; this often occurs while the resident is hospitalized. The Guidance limits this practice, allowing it only in “rare situations, such as when a serious crime (e.g., attempted murder or rape) has occurred.” Specifically related to hospitalizations, the Guidance says that a resident has the right to return unless the resident presents a documented danger to health or safety. (Similar guidance is also located at F626, commenting on a resident’s right to return after a hospitalization. (42 C.F.R. § 483.15(e))

If a resident leaves a facility against medical advice, the Guidance says that the situation should be investigated to make sure that the resident was not pressured to leave. Similar guidance is also located at F623, commenting on the notice requirements for transfer/discharge. (42 C.F.R. § 483.15(c)(3), (4)), and at F626, commenting on a resident’s right to return after a hospitalization. (42 C.F.R. § 483.15(e)).

MEDICARE NOTICES

F-Tag F582, commenting on a facility’s obligation under the regulations to notify residents of potential Medicare and Medicaid coverage of nursing facility care. (42 C.F.R. § 483.10(g)(17)-(18))

The Guidance explains the facility’s obligation to give appropriate notices related to Medicare coverage of nursing facility care: the Notice of Medicare Non-Coverage when a Medicare-reimbursed stay in the facility is ending, and the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage when the resident intends to continue services and the facility believes that the services will not be covered under Medicare. The content of the notices is set by Medicare laws and policy; among other things, they notify the resident of certain rights to appeal Medicare coverage determinations.

Importantly, the Guidance emphasizes that the Medicare notices are separate from the independent regulations requiring notice and appeal rights when a facility alleges that it has grounds to transfer or discharge the resident against the resident’s will.

NOTICE OF INVOLUNTARY TRANSFER AND DISCHARGE

F-Tag F623, commenting on the transfer/discharge notice regulation. (42 C.F.R. § 483.15(c)(3), (4))

The Guidance explains the steps that must be taken if a facility modifies a transfer/discharge notice. For significant changes, such as a change in reason for the transfer/discharge, or in the proposed destination of transfer, the facility must issue a new, modified notice, with a re-set of the 30-day notice period.

RETURNING TO FACILITY AFTER HOSPITALIZATION

F-Tag F626, commenting on a resident's right to return after a hospitalization. (42 C.F.R. § 483.15(e))

The Guidance explains that state-law bed holds apply regardless of a resident's payment source, while the federal return-from-hospitalization regulation applies only when a resident is returning to the facility from a hospital with Medicare or Medicaid coverage for nursing facility care.

A surveyor should investigate instances where the facility claims that it did not have an available room for a resident returning from the hospital, or could not meet the needs of such a resident. Investigation of the latter should include an examination of whether the facility meets similar care needs for other residents.

ARBITRATION AGREEMENTS

F-Tag F847, commenting on the arbitration regulation. (42 C.F.R. § 483.70(n)), and F-Tag F848, commenting on the arbitration provisions relating to the arbitrator and the location of any arbitration (42 C.F.R. § 483.70(n)(2))

An arbitration agreement requires all disputes between the resident and the facility to be resolved through private arbitration rather than court litigation. Resident advocates consider arbitration agreements harmful to residents — there is no good reason to sign away legal rights as part of an admission to a nursing facility.

The recently-promulgated arbitration regulation prohibits a facility from requiring arbitration, sets standards for explaining arbitration to residents and their representatives, and gives residents the right to rescind any signed arbitration agreement for 30 days.

The Guidance directs that “facilities should take every step to meet the resident's needs or special accommodations (e.g., literacy level, font size, format, language, etc.) when explaining [an] arbitration agreement.” Also, signing an agreement may not be enough to demonstrate that the resident (or representative) actually understood what was being signed, particularly when the arbitration is signed at the same time the resident is making an admission agreement. “[T]he facility should clearly distinguish the arbitration agreement from the admission agreement, so that residents or their representatives have a clear understanding of each agreement, and are able to enter into or decline the arbitration agreement.”

Regarding potential rescission, “[f]acilities should have a process, that is also explained to the resident or their representative, which ensures timely communication to the appropriate facility staff of a resident's or resident representative's desire to withdraw from, or terminate the arbitration agreement. Otherwise, miscommunications or delays could deny the resident or representative the right to withdraw from the agreement within the 30-day period.”

The Guidance provides significant detail on how to choose a specific arbitrator:

Facilities wishing to utilize binding arbitration agreements should make reasonable efforts to ensure that any arbitration agreement entered into with a resident or his or her representative provides for the selection of

an arbitrator who is impartial, unbiased, and without the appearance of a conflict of interest. This ensures the integrity of the arbitration process, and also ensures that residents who choose this alternative dispute resolution are treated with the same fairness they would have if they chose to litigate.

Facilities may put forward suggestions for the use of specific arbitrators for residents (or their representatives) to select. The resident or his or her representative is not obligated to use the arbitrator (either an arbitration services company or an individual arbitrator) suggested by the facility, and may suggest an alternative arbitrator of their choosing. Facilities are expected to make a reasonable attempt to come to agreement with the resident or resident's representative on the selection of a neutral arbitrator and provide a fair process for selecting an arbitrator or arbitration services company.

To ensure a neutral arbitrator is selected, the facility should avoid even the appearance of bias, partiality, or a conflict of interest, and should promptly disclose to the resident or his or her representative the extent of any relationship which exists with an arbitrator or arbitration services company, including how often the facility has contracted with the arbitrator or arbitration service, and when the arbitrator or arbitration service has ruled for or against the facility.

Likewise, the "binding arbitration agreement must allow for the selection of a [location] that is suitable in meeting the needs of both the resident or his or her representative, and the facility."

POSSIBLE USE OF ILLEGAL DRUGS

F-Tag F557, commenting on the regulation that requires that residents be treated with respect and dignity. (42 C.F.R. § 483.10(e)); and

F-Tag F563, commenting on a resident's right under the regulations to accept visitors. (42 C.F.R. § 483.10(f)(4))

Staff should be aware of the possible indicators of illegal drug use, such as unexplained drowsiness and slurred speech. The facility, however, "should not act as an arm of law enforcement," and should instead make referrals to local law enforcement as appropriate. Staff can confiscate illicit substances that are in plain sight, but should not search a resident without the consent of the resident or resident representative.

SMOKING

F-Tag F561, commenting on the resident's right of self-determination under the regulations. (42 C.F.R. § 483.10(f))

"If a facility changes its policy to prohibit smoking (including electronic cigarettes), it should allow current residents who smoke to continue smoking in an area that maintains the quality of life for these residents and takes into account non-smoking residents. The smoking area may be an outside area provided that residents remain safe. Residents admitted after the facility changes its policy must be informed of this policy at admission."

F-Tag F689, commenting on the regulation regarding accidents. (42 C.F.R. § 483.25(d))

The Guidance includes a long discussion of e-cigarettes and their risk, including respiratory risks and the risk of explosion/fire related to the battery. If a facility decides to allow e-cigarettes, it must develop policies for their safe use. Also, the facility should assess individual residents for their ability to safely use e-cigarettes.

ASSESSMENTS AND CARE PLANNING

CARE PLANS

F-Tag F656, commenting on the care planning regulation. (42 C.F.R. § 483.21(b))

The Guidance provides information on cultural competency and trauma-informed care. Each should be part of the care planning process, as appropriate.

TRAUMA-INFORMED CARE

F-Tag F699, commenting on the regulation on trauma-informed care. (42 C.F.R. § 483.25(m))

The Guidance includes multiple pages on the new regulation that requires facilities to provide appropriate care for residents who are “trauma survivors.” Facilities should use a “multi-pronged approach [in] identifying a resident’s history of trauma as well as his or her cultural preferences.” “Trauma survivors” may include “military veterans, survivors of large-scale natural and human-caused disasters, Holocaust survivors, survivors of physical, sexual, and/or mental abuse (past or current), or other violent crime, as well as residents with a history of imprisonment, homelessness, or who have suffered the traumatic loss of a loved one.” Common “triggers” include lack of privacy, loud noises, and bright lights, as well as various objects associated with past abuse. The Guidance lists specific interventions that may respond to certain triggers.

This section of the Guidance also includes extensive discussion of cultural competence. One issue is a resident’s language. “The care plan should identify the language spoken and what tools are available to communicate, whether it be with a communication board or other systems, or through translators. ... Staff must demonstrate proficiency in communicating with the resident to assure that critical information can be conveyed, such as a change in condition, the presence of pain, explanation of routine care, and the ability to refuse care and services.” The Guidance later notes that “[i]t may be necessary to engage the services of an interpreter to monitor or evaluate the effect of cultural interventions for non-English speaking residents.”

The Guidance lists several types of cultural preferences: “food preparation and choices; clothing preferences such as covering hair or exposed skin; physical contact or provision of care by a person of the opposite sex; or cultural etiquette, such as avoiding eye contact or not raising the voice.” A facility is instructed to consider that “[g]roup activities with both sexes may not be permitted or appropriate in some cultures, or that some “programming may be in conflict with ... cultural preferences.”

QUALITY OF CARE

ACTIVITIES

F-Tag F679, commenting on the facility’s obligation under the regulations to provide activities. (42 C.F.R. § 483.24(c))

The Guidance mentions the [Eden Alternative](#) philosophy of care as a good framework for supporting quality of life.

FOOT CARE

F-Tag F687, commenting on the foot care provision in the regulations. (42 C.F.R. § 483.25(b)(2))

The Guidance discusses infection prevention practices for foot care devices, including clippers and files.

BEHAVIORAL HEALTH SERVICES

F-Tag F740, commenting on the behavioral health services regulation. (42 C.F.R. § 483.40)

The Guidance states that residents with mental health diagnoses or substance use disorder may require different activities than other facility residents.

A facility may use a behavioral contract as part of the care planning process. Behavioral contracts could be used for issues such as leaving the facility without staff knowledge, attending counseling sessions or treatment programs, steps the facility can take if substance use is expected (including supervision, drug testing, and inspections), and referral to law enforcement for suspicion of a crime. If rewards and/or punishments are used, use of a contract sometimes could be considered abusive.

RESIDENT CALL SYSTEMS

F-Tag F919, commenting on the call system regulation. (42 C.F.R. § 483.90(g))

A call system must be available from each bedside, bathroom, or bathing facility. The system should be accessible to a resident lying on the floor, in case of falls.

ACCIDENTS

F-Tag F689, commenting on the regulation regarding accidents. (42 C.F.R. § 483.25(d))

Elopement

Elopement is defined in the Guidance as a resident leaving the premises without the facility's knowledge and (if necessary) supervision. "A situation in which a resident with decision-making capacity leaves the facility intentionally would generally not be considered an elopement unless the facility is unaware of the resident's departure and/or whereabouts."

Substance Use

The Guidance notes that residents with a history of a substance use disorder may be at particular risk of leaving the facility without notification or (of course) of substance use itself. Facilities should care plan to mitigate the risk, including "appropriate diversions."

When a resident has a history of a substance use disorder, the facility should assess the resident and understand the signs and symptoms of substance use. "Efforts to prevent substance use may include providing substance use treatment services, such as behavioral health services, medication-assisted treatment (MAT), alcoholic/narcotics anonymous meetings, working with the resident and the family, if appropriate, to address goals related to their stay in the nursing home, and increased monitoring and supervision." A facility should intervene if a resident shows signs of substance use.

Physical Restraints

The Guidance states that "[e]vidence shows that physical restraints cause more harm than good and seriously infringe upon a person's autonomy," and includes resources on bed rail safety from the Food and Drug Administration. The Guidance points out the many negatives of bed rail use, including entrapment and falls.

BED RAILS

F-Tag F700, commenting on the bed rail regulation. (42 C.F.R. § 483.25(n))

The Guidance states: "Facilities must attempt to use appropriate alternatives prior to installing or using bed rails.

The Food and Drug Administration has identified the following alternatives: roll guards, foam bumpers, lowering the bed and using concave mattresses.” These alternatives should be considered while also weighing resident-specific issues, e.g., a concave mattress may be inappropriate for a resident needing physical therapy in bed.

When a bed has a pre-installed rail, the facility must determine whether disabling the rail would pose a risk to the resident.

MEDICATIONS

NON-PHARMACOLOGICAL INTERVENTIONS

F-Tag F741, commenting on the regulation regarding non-pharmacological interventions. (42 C.F.R. § 483.40(a)(2))

The Guidance lists some new examples of non-pharmacological interventions:

- Assisting the resident outdoors in the sunshine and fresh air;
- Providing access to pets or animals;
- Assisting the resident to participate in activities that support spiritual needs;
- Assisting with the opportunity for meditation and associated physical activity (e.g., chair yoga);
- Utilizing techniques such as music, art, electronics/computer technology systems, massage, essential oils, and reminiscing;
- Assisting residents with substance use disorders to access individual or group counseling services;
- Assisting residents with access to therapies, such as psychotherapy, behavior modification, cognitive behavioral therapy, and problem-solving therapy; and
- Providing support with skills related to verbal de-escalation, coping skills, and stress management.

PAIN MANAGEMENT

F-Tag F697, commenting on the pain management regulation. (42 C.F.R. § 483.25(k))

The Guidance provides significant guidance on use of opioids for pain management. Caution is urged, given the risk of addiction and overdoses. Combining opioids and benzodiazepines should be avoided, due to the risk of respiratory depression. Opioids may be used in end-of-life care. Naloxone has been approved by the Food and Drug Administration to reverse the effects of opioids.

PSYCHOTROPIC MEDICATIONS

F-Tag F758, commenting on the psychotropic medication regulation. (42 C.F.R. § 483.10(c)(3), (e))

The Guidance states that reduction of antipsychotics should not lead to an increase in other psychotropic medications, unless supported by clinical information. In other words, the “other” psychotropics should not be used when their documented use appears to be a substitution for another psychotropic medication rather than for the original or approved indication. The Guidance notes that “CMS is aware of situations where practitioners have potentially misdiagnosed residents with a condition for which antipsychotics are an approved use (e.g., new diagnosis of schizophrenia) [in order to] exclude the resident from the long-stay antipsychotic quality measure.”

The Guidance gives recommendations for gradual dose reductions.

If a resident cannot communicate the impact of medication side effects, surveyors are instructed to consider how a “reasonable person” would experience the side effects.

IMPROPER DIAGNOSIS OF PSYCHIATRIC CONDITION

F-Tag F641, commenting on the requirement that resident assessments be accurate. (42 C.F.R. § 483.10(g))

Consistent with the discussion immediately above, the Guidance notes that some residents have been misdiagnosed with psychiatric disorders in order to justify use of antipsychotic medications. In these situations, surveyors can make referrals to state medical boards or boards of nursing. Similar guidance is also located at F658, commenting on services provided under a care plan. (42 C.F.R. § 483.21(b)(3))

ABUSE, NEGLECT, AND CRIMES

RESIDENT-TO-RESIDENT ABUSE

F-Tag F600, commenting on a resident’s right under the regulations to be free from abuse, neglect and exploitation. (42 C.F.R. § 483.12)

Preexisting guidance discussed how a resident-to-resident altercation could be an instance of abuse. The new Guidance adds language stating that a “surveyor should not assume that every resident-to-resident altercation results in abuse,” since arguments or disagreements are not necessarily abuse.

DETERMINING LEVEL OF PSYCHOSOCIAL HARM WHEN ASSESSING SEVERITY OF ABUSE VIOLATION

F-Tag F600, commenting on a resident’s right under the regulations to be free from abuse, neglect, and exploitation. (42 C.F.R. § 483.12)

According to the new Guidance, psychosocial harm should be assessed based on a “reasonable person” standard, by asking how much harm a “reasonable person” would have suffered as a result of the abuse in question. As a result, severity of abuse is not reduced by the fact that a resident with dementia may not express any outward emotion about an incident. Specifically, a finding of “immediate jeopardy” or “actual harm” can be supported even without immediate evidence of an effect on a resident.

Also, surveyors should keep in mind that 1) residents often are frail and vulnerable, 2) residents rely on staff for assistance, and 3) a resident may consider the facility to be “home,” with an expectation of safety and privacy.

The Guidance lists examples of incidents that might cause psychosocial harm, including the posting of demeaning photos or videos.

NEGLECT

F-Tag F600, commenting on a resident’s right under the regulations to be free from abuse, neglect, and exploitation. (42 C.F.R. § 483.12)

The Guidance explains that “neglect” is not an automatic finding when a surveyor finds a violation of the regulations relating to residents’ rights, quality of care, or quality of life. “[A] citation for neglect would require additional evidence that identifies that the facility knew, or should have known, to provide the staff, supplies, services, policies, training, or staff supervision and oversight to meet the resident’s needs, but continued to fail to take action necessary to avoid the potential for harm, or actual harm to the resident.”

REPORTING SUSPECTED CRIMES IN THE FACILITY

F-Tags F607 & F609, commenting on the regulation that requires policies to ensure reporting of any crime committed in the facility. (42 C.F.R. § 483.12(b)(5))

The Guidance states that employees should report any suspected crimes committed in the facility, and the facility must not retaliate against the employee for such reports. Also, the facility must post a notice of the right to report suspected crimes.

Facility staff should exercise caution when handling materials that may be evidence in a subsequent criminal investigation.

“For alleged violations of abuse or if there is resulting serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made.” For other suspected crimes, facility must report the allegation within 24 hours. Then, within 5 working days of the incident, the facility must provide in its report sufficient information to describe the investigation results and any corrective actions taken (if the allegation was verified).

The Guidance includes a lengthy discussion of the types of incidents that must be reported. Not surprisingly, all staff-to-resident abuse must be reported to the nursing facility administrator and state officials. Resident-to-resident altercations must be reported if a “willful action ... results in physical injury, mental anguish, or pain.” An “injury of unknown source” must be reported if the injury is “suspicious” due to the injury’s extent or location, or because of the number of injuries, either at one time or over a period of time. Reportable instances of “misappropriation of resident property” include theft of personal property or prescription medication.

The Guidance lists factual examples of the type of “neglect” that must be reported. These include financial/procurement issues: failure to make payroll or pay bills, insufficient staff, lack of essential supplies, or shortage of food. They also include care deficiencies such as “repeatedly ignoring” residents’ needs for assistance, failure to provide needed pain management, and failure to provide care to the extent that a resident develops a Stage 3 or 4 pressure ulcer.

The Guidance notes that a violation relating to resident’s rights, quality of care, or quality of life does not automatically constitute abuse, neglect or a crime.

FACILITY OPERATIONS

QUALITY ASSURANCE

F-Tag F865, commenting on the regulation requiring a quality assurance and performance improvement program. (42 C.F.R. § 483.75(a))

Under the regulation and Guidance, “[e]ach facility must develop, implement, and maintain an effective, comprehensive, data-driven QAPI [quality assurance and performance improvement] program that focuses on indicators of the outcomes of care and quality of life.” A facility must disclose quality assurance committee records to surveyors to determine whether the facility has complied with quality assurance requirements — for example, if “the facility’s infection control data indicates that staff may not have responded in a timely and effective manner to address an outbreak of a communicable disease.”

USING DATA

F-Tag F867, commenting on the program feedback regulation. (42 C.F.R. § 483.75(c))

The Guidance provides an extensive discussion of the regulatory requirement that a facility “establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring.” Ways of collecting feedback from staff and residents include surveys, questionnaires, meetings, and suggestion boxes. Systems should also include ways that the facility provides feedback to staff, residents, and resident representatives.

“[E]ach facility must conduct at least one improvement project annually that focuses on high-risk or problem-prone areas, identified by the facility through data collection and analysis.”

CONCLUSION

Overall, the revised Guidelines are good news for residents. As always, however, the true test is whether laws and guidelines actually are put into practice in nursing facilities. Once the Guidelines become effective on October 24, 2022, residents, family members, and advocates should not be shy in demanding that nursing facilities honor the regulations and guidance in full. The Justice in Aging guide, [25 Common Nursing Home Problems —and How to Resolve Them](#), can be an important resource in this advocacy.