The National CONSUMER VOICE for Quality Long-Term Care

SUMMARY

Summary of Chapters 5 & 7 Updates to the State Operations Manual

On January 30, 2026, the Centers for Medicare & Medicaid Services (CMS) issued QSO-26-03-NH, which updates Chapters 5 & 7 of the State Operations Manual (SOM). The SOM governs how state survey agencies (SAs) must enforce federal nursing home laws and regulations. Chapter 5 of the SOM addresses Complaint Procedures, while Chapter 7 covers the Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities. Much of the guidance incorporates existing guidance from Quality, Safety, & Oversight (QSO) memos into the SOM. The updates take effect on March 30, 2026.

Below is a summary of the most significant changes/updates to the SOM.

Chapter 5

Complaint Procedures

Changes to Chapter 5 include an updated example of Immediate Jeopardy involving discharge to an unsafe setting or in a manner that places the resident at risk of serious harm, when off-site investigations may be conducted, and a change of references from the "CMS regional office" to "CMS location."

5075.1 Immediate Jeopardy (for Nursing Homes, Deemed and Non-Deemed Non-Long Term Care Providers/Suppliers and EMTALA)

CMS has included updated examples regarding the identification by SAs of intakes that may be Immediate Jeopardy, which is defined as "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

CMS provides that intakes involving alleged abuse of a resident *that involve serious injury, harm, impairment, or death, or likelihood of such*, and uncertainty if the resident is adequately protected, are to be classified as Immediate Jeopardy.

Additionally, CMS added an example of unsafe discharges as a basis for Immediate Jeopardy. The language states:

For nursing homes, all intakes where a resident was discharged to an unsafe setting, or in a manner that places the resident at risk for serious harm (e.g., the resident still has medical needs but they cannot be supported in the setting they were discharged to).

This update will help address the endemic problem of unsafe discharges of nursing home residents. For years, advocates have argued that discharges to unsafe settings should be treated as immediate jeopardy. It is a credit to CMS that it included this update.

5075.5 Administrative Review/Offsite Investigation (for Nursing Homes and Deemed and Non-Deemed Non-Long Term Care Providers/Supplier

Added language clarifies that off-site investigations are not permitted unless approved in advance by CMS. CMS notes that these investigations are rare, but provides some examples of when off-site investigations might be warranted:

- Arbitration agreements
- Prohibition on third-party guarantees of payment
- Prohibition on charges for services covered under Medicaid.

CMS notes that it may approve off-site investigations of documents relevant to these types of complaints and that noncompliance can be cited and corrections required as necessary.

5330 – Reporting Abuse to Law Enforcement and the Medicaid Fraud Control Unit for Nursing Homes

CMS clarifies that when the State Agency (SA) or a CMS location confirms noncompliance related to abuse, they must report the cited finding to Law Enforcement and, if appropriate, to the Medicaid Fraud Control Unit.

5390 – CMS Location Oversight of Complaint-Related Processes

When conducting oversight of complaint-related processes by State Agencies, CMS locations must review State Agency workloads. CMS has added a requirement that this review include a review of complaints where noncompliance was not found and Medicaid-only complaint case volumes. This new requirement is in addition to existing requirements that CMS review other data sources showing State- or region-wide patterns, problem providers, State Agency processing times, workloads, and performance.

CHAPTER 7

Survey and Enforcement Process

Skilled Nursing Facilities/Nursing Facilities

The bulk of the updates included in the QSO occur in Chapter 7. While some information is new, much of it is existing guidance reincorporated into the SOM. Until 2017, Appendix P of the SOM provided guidance on standard and recertification surveys. In 2017, CMS launched the Long Term Care Survey Process, which replaced Appendix P. At that time, CMS also relocated significant amounts of information previously contained in Appendix P here, which resulted in an often-

confusing fragmentation of resources. In the updated guidance to SOM 7, CMS has reintroduced some of these resources into the SOM itself. However, this reintroduction is not exhaustive and will still require surveyors and others to refer to its webpage.

Below are highlights of the updated guidance in Chapter 7. The summary below covers brand-new guidance in Chapter 7.

7001 Definitions and Acronyms

CMS has updated the following definitions:

Abuse: CMS has now included the full definition of abuse as defined at 42 C.F.R. § 483.5

The willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse, including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

Immediate family: CMS has updated the definition of immediate family to match the definition in Appendix PP under Resident Rights. The definition of immediate family, as stated in regulation (42 CFR 488.301), means a husband or wife; natural or adoptive parent, child, or sibling; stepparents or stepsiblings; in-laws (father, mother, son, daughter, brother, sister); grandparent or grandchild.

The Appendix PP language is much more expansive and inclusive:

> "For purposes of this regulation, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State's common law equivalent. It is important to understand that there are many types of families, each of which is equally viable as a supportive, caring unit. For example, it might also include a foster family where one or more adults serves as a temporary guardian for one or more children to whom they may or may not be biologically related. Residents have the right to define their family."

Instance or instances of noncompliance: means a factual and temporal occurrence(s) when a facility is not in substantial compliance with the requirements for participation. Each instance of noncompliance is sufficient to constitute a deficiency and a deficiency may be comprised of multiple instances of noncompliance. (42 CFR 488.401)

Nurse aide: Updated to be consistent with the regulatory language, it means any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in 42 CFR §488.301. (42 CFR 483.5)

Resident representative: Updated the definition of representative to match the regulatory definition at 42 C.F.R. § 483.5.

> Resident Representative or Representative - means any of the following:
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> (1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications;
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> (2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or
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> (3) Legal representative, as used in section 712 of the Older Americans Act; or
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> (4) The court-appointed guardian or conservator of a resident.
>
> (5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction. (42 CFR 483.5)

Substandard quality of care: Updated the definition of Substandard Quality of Care to match the regulatory definition at 42 C.F.R. § 488.301.

> *Substandard quality of care* means one or more deficiencies related to participation requirements under § 483.10 "Resident rights", paragraphs (a)(1) through (a)(2), (b)(1) through (b)(2), (e) (except for (e)(2), (e)(7), and (e)(8)), (f)(1) through (f)(3), (f)(5) through (f)(8), and (i) of this chapter; § 483.12 of this chapter "Freedom from abuse, neglect, and exploitation"; § 483.24 of this chapter "Quality of life"; § 483.25 of this chapter "Quality of care"; § 483.40 "Behavioral health services", paragraphs (b) and (d) of this chapter; § 483.45 "Pharmacy services", paragraphs (d), (e), and (f) of this chapter; § 483.70 "Administration", paragraph (p) of this chapter, and § 483.80 "Infection control", paragraph (d) of this chapter, which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.

7014.1 - Waiver of Nurse Staffing Requirements

CMS has updated the sections regarding granting of waivers of the requirements that nursing homes have licensed nurses 24 hours a day, an RN present 8 consecutive hours per day, 7 days per week, and the provision of RN services for more than 40 hours per week. These waivers are not new; they have been in law for years. CMS has updated survey guidance on how facilities may apply for a waiver, and the processes State Agencies should undertake to determine a facility's eligibility for a waiver.

Because these waivers are statutory, some apply only to skilled nursing facilities (Medicare providers) and others only to nursing facilities (Medicaid providers). Most nursing homes are dually certified as Medicare and Medicaid providers. If a facility is a dually certified provider, it may

only waive the Medicare-based requirements, leaving Medicaid-only waivers applicable in rare circumstances.

7014.1.1 – Skilled Nursing Facility (SNF)-Waiver of Requirement for a Registered Nurse (RN) More than 40 Hours a Week (Medicare-certified facilities only)

Medicare-certified nursing homes (SNFs) may apply for a waiver of the requirement that a facility provide the services of a registered nurse (RN) for more than 40 hours a week.

CMS may grant a waiver that a SNF provide the services of a registered nurse for more than 40 hours a week if:

- The facility is in a rural area;
- A full-time registered nurse is regularly on duty at the facility 40 hours a week; and
- Has only residents that do not require registered nurse or physician services for 48 hours (as indicated by a physician) or arrangements have been made for a registered nurse or physician to spend time at the facility when the regular full-time nurse is not on duty;
- CMS provides notice to the Office of the State Long-Term Care Ombudsman and the protection and advocacy system for individuals with developmental disabilities or mental disorders; and
- The facility notifies residents and their representatives of the waiver (if granted).

A waiver must be renewed annually and approved by CMS.

The updated guidance in this section includes:

> Rural is defined as an area not delineated as “urban” in the most recent census.
>
> A facility must provide evidence that it has an RN on duty 40 hours per week. Evidence includes timesheets or salary information showing an RN onsite 40 hours per week. A facility schedule is not acceptable.
>
> Facilities that received a waiver of this requirement in prior years must show they provided notice to residents, their guardians or representatives, and members of their immediate families a copy of the waiver. Facilities that do not have this evidence may still be granted a waiver but must provide evidence that notice was provided within 30 days.

7014.1.2 - Nursing Facility (NF)-Only Waivers of Nurse Staffing Requirements in Nursing Facilities (Medicaid facilities only)

This waiver allows Medicaid-only facilities to obtain a waiver from the 24-hour licensed nursing and RN 8 hours a day, 7 days a week requirement (one or both). CMS has included all of the waiver language from the regulation from 42 § C.F.R. § 483.5(e):

To the extent that a facility is unable to meet the licensed nurse and/or registered nurse requirements, a State may waive the requirements if—

- The facility demonstrates it has been unable, despite diligent efforts, to recruit appropriate personnel;

- The State determines that a waiver of the requirement will not endanger the health or safety of residents;
- The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;
    - The State agency provides notice of the waiver to the Office of the State Long-Term Care Ombudsman and the protection and advocacy system for individuals with a mental disorder; and
    - The nursing facility that is granted a waiver notifies residents and their resident representatives of the waiver.

A waiver is subject to review annually by the State. The State may require the facility to use other qualified, licensed personnel.

Updated guidance for this section includes:

- When documenting diligent efforts to hire, a facility must show
    - Ads and job postings
    - Compensation is comparable to that offered by other providers in the same general area.
- Before granting a waiver, an SA must conduct a standard survey to ascertain whether the absence of a licensed nurse or RN will endanger residents.
- The state, when determining the availability of an RN or physician to respond immediately to phone calls, can interview the RN or physician to confirm their availability.
- A facility granted a waiver in the prior year must provide evidence that it provided notice to residents, or their guardians or representatives, and members of the resident's immediate family. Facilities that lack this evidence may still obtain a waiver if they provide evidence that notice was given within 30 days.

7014.1.3 - Waivers of Nurse Staffing Requirements for Dually Participating Facilities (SNF/NFs)

As noted previously, most nursing homes are certified for Medicare and Medicaid. As a result, these facilities can only have the SNF requirements waived, meaning that a dually participating facility may not have the 24-hour per day licensed nursing requirement waived . Accordingly, dually certified facilities may obtain waivers only for the RN 40 hours per week. For this waiver, the guidance from 7014.1.1 must be followed.

7201.2 Team Composition

CMS has added the following guidance to the requirements for survey team composition:

- A surveyor who has not completed a Surveyor Minimum Qualifications Test (SMQT) may serve as a team member and complete survey tasks for which they have demonstrated understanding if they are supervised by a qualified SMQT surveyor.
- Initial and recertification survey teams must be multi-disciplinary, one of whom must be a registered nurse. Complaint investigations and on-site monitoring of compliance allow the use of a specialized investigative team that may include appropriate healthcare

professionals, as required, to investigate the allegation; however, a registered nurse is not required.

- The state must determine which members to make observations that include a resident's genital, rectal, or breast area. CMS states this would likely be limited to surveyors with professional licenses, such as RNs, licensed physical or occupational therapists, physician assistants, physicians, etc. Surveyors must attempt to obtain the resident's consent.

7203.2 Initial Certification Survey

With respect to the initial certification survey, CMS has added language directing surveyors to focus on both residents and the requirements related to qualification standards and resident rights notification, whether or not problems are identified during the information-gathering tasks. Additionally, they are instructed to review the rights notification statements in admissions contracts.

7203.3 Survey for Recertification

Newly added language in this section clarifies that the survey is outcome-oriented and uses a casemix-stratified sample of residents. Outcomes include both actual and potential negative outcomes, as well as a facility's failure to help each resident achieve and maintain their highest practicable level of well-being.

CMS includes a new section on resident privacy that surveyors must observe during all surveys.

> The survey team is instructed to conduct the survey in a manner that allows for the greatest degree of confidentiality for residents, particularly regarding the information gathered during the interviews.
>
> When observing residents, surveyors are directed to respect their right to privacy, including the privacy of their bodies. If the resident's genital, rectal area, or breast area must be observed in order to document and confirm suspicions of a care problem, a member of the nursing staff must be present at this observation, and the resident, or their legal representative, must give clear consent.
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> An observation of a resident's rectal, genital or breast area may be made without a resident's or legal representative's consent, if there is a strong possibility that the resident is receiving less than adequate care, which can only be confirmed by direct observation; the resident is unable to give clear consent; and a legal representative is not immediately accessible.

CMS includes a new section titled "Basic Principles of Using Photography During the Survey." State Agencies may decide to collect photographic evidence to support a finding of noncompliance. Agencies must develop guidance on the use of photography during the survey process and train staff in the proper use of cameras.

Other highlights include:

- Requiring written consent from the resident or his/her representative before taking a photograph and respecting a resident's refusal
- Avoid photographing the resident's face or other uniquely identifying information.
- Getting a complete set of photographs, overview, mid-ranges, and close-ups.
- How to properly document and handle photographs.

7203.1.1 Exit Conference

CMS has added additional guidance on how SAs should conduct exit conferences. The guidance reaffirms the requirement that an ombudsman, an officer of the resident group, or one or two residents be invited to the conference; if they are unable to attend, they should be given the option to attend virtually. Additionally, surveyors may provide an abbreviated exit conference to residents after completing the normal exit conference. The ombudsman must be invited to both.

During the exit conference, surveyors are only to discuss facts, citing problems that clearly violate regulatory requirements. They will not share scope and severity levels (unless immediate jeopardy is found), reveal the identity of an individual resident, or provide consultation about how a facility can become compliant. Surveyors should not make general statements such as, "Overall the facility is very good." Surveyors should also not assume intent for noncompliance or assign blame to the facility or individual staff. Also, surveyors should not provide consultation, such as explaining how the facility can be compliant; they should only discuss the facts and not rank requirements. Surveyors must cite problems that clearly violate regulatory requirements. The survey team must not discuss survey results in a manner that reveals the identity of an individual resident.

7203.3.2 - Determining Health Severity and Scope of Deficiencies

CMS incorporates guidance into the SOM around determining the scope and severity of a citation based on the impact on residents. It adds the matrix used to determine scope (isolated, pattern, widespread) and severity (1 – no actual harm with potential for minimal harm; 2 – no actual harm with potential for more than minimal harm that is not immediate jeopardy; 3 – actual harm that is not immediate jeopardy; 4 – immediate jeopardy to resident health or safety). CMS further incorporates language providing direction on steps SAs must take if immediate jeopardy (IJ) is identified, including notifying the facility and obtaining a written plan from the facility that describes the immediate actions to be taken to remove the IJ.

Surveyors are instructed to assess severity starting with the highest level of harm. If the outcome does not reach the highest level of severity, they are to review the other levels in consecutive order until a determination is made.

7205.6 Standard Survey Interval for Special Focus Facilities

CMS clarifies that facilities participating in the Special Focus Facility program, which focuses on facilities with a persistent record of non-compliance, must be surveyed at least once every six months.

7207.2 All Surveys Must Be Unannounced

The State must keep all surveys unannounced and their timing unpredictable. CMS clarifies that after entering a facility to conduct a standard health survey, surveyors must remain for at least five consecutive hours. In other words, surveyors may not enter to conduct an entrance conference and then leave to return the following day; nor should they enter a facility on a Friday and not return until Monday. Surveys must be conducted on consecutive days.

7207.2.2 Variance in Timing

CMS has issued updates on when surveys should be conducted, noting that survey times should vary to avoid predictability. CMS states, "The month in which a survey begins should not, if possible, coincide with the month in which the previous standard survey was conducted.

CMS requires that at least 10 percent of standard health surveys be conducted during off-hours. At least half of these off-hour surveys must be conducted on weekends. CMS clarifies that off-hour surveys begin either on the weekend or before 6:00 am.

When entering off-hours, the survey team should be alert to situations that might indicate concerns about issues such as staffing levels, infection control, medication errors, medication storage, abuse/neglect, pain management, behavioral health, restraints, accidents/hazards/smoking, and the environment.

7212.3 Informal Dispute Resolution

Facilities must be provided the opportunity for informal dispute resolution (IDR) whenever a civil monetary penalty is imposed. During this process, a facility may only challenge the facts underlying the deficiency and nothing else. IDR does not delay the imposition of remedies. During the IDR process, the state must notify the involved residents and the ombudsman and provide them with an opportunity to comment. If a state disagrees with an IDR finding, it is sent to CMS for a final decision.

CMS has updated the guidance to reflect that this process must be completed within 60 calendar days of the facility's request and that the final decision must be sent to the facility, containing the results for each challenged deficiency and a summary of the rationale for those results.

7301.1 Immediate Jeopardy Exists

CMS has updated guidance regarding the imposition of Civil Monetary Penalties (CMPs) when immediate jeopardy exists. The state may impose a per-day penalty, a per-instance penalty, or both when immediate jeopardy is found. As of 2024, the minimum and maximum penalties when immediate jeopardy is found:

Type of CMPS	Minimum	Maximum
Per Day	$8,351	$27,378
Per Instance	$2,739	$27,378

Additionally, CMS has clarified how per-instance CMPs may be imposed.

- In cases when multiple per-instance CMPs are imposed for any single day, the total amount of all CMPs for noncompliance may not exceed the maximum statutory and regulatory amount, nor less than the applicable minimum statutory and regulatory amount.
- When multiple per-instance CMPS are imposed for different days of noncompliance, the total amount of all CMPs imposed may exceed the statutory and regulatory maximum.

  The new guidance provides numerous examples.

7317 Acceptable Plan of Correction

CMS has added a requirement that a nursing home official, perferably the administrator, sign a plan of correction. However, other acceptable signers are the Director of Nursing or a corporate representative. The person signing the plan of correction must have management authority and responsibility.

7317.1 Verifying Facility Compliance

CMS has issued significant updates on how a facility must demonstrate it has returned to compliance. Specifically, a facility must provide credible written evidence that it returned to compliance on a specific date, that all deficiencies have been corrected, and that the facility is capable of remaining in substantial compliance. Revisits to determine compliance may occur at any time, but the burden is on the facility to demonstrate that it has corrected any errors.

7317.2 Revisits

On-site revisits to determine whether non-compliance has been removed are mandatory when a deficiency was categorized as substandard quality of care, harm, or immediate jeopardy. CMS has added updated guidance regarding when on-site visits are discretionary, noting that states may choose to use on-site visits to "assess the nature of the corrections and the extent to which they address and correct the deficiencies. When a state chooses to use an off-site revisit, CMS requires "credible evidence is used to conduct an offsite revisit," and provides detailed guidance on how such off-site revisits should be conducted.

CMS has added guidance on an instance in which new noncompliance is identified before or during a revisit. In these instances, if a facility has clearly demonstrated a return to compliance for the initial non-compliance and the new instance differs from the original, the initial survey is closed, and a new enforcement cycle begins for the newly identified non-compliance.

CMS has clarified procedures for off-site paper review revisits. These are only available for less serious violations without substandard quality of care. CMS outlines how off-site revisits must be conducted, including requiring the facility to provide supporting evidence that it has returned to compliance. CMS notes that a plan of correction is not itself evidence of compliance. CMS provides a detailed list of what it considers credible evidence, including training records, staff termination letters, new or revised policies, and other evidence.

7535-Use of Civil Money Penalty Funds

CMS has incorporated the updates it made to the Civil Monetary Penalty Reinvestment Program (CMPRP) in September 2025 into this section. The CMPRP allows individuals or groups to apply for grants to fund projects that use CMPs to benefit residents. States are required to accept applications for projects, and if a project is initially approved, it is sent to CMS for ultimate approval. Projects must include letters of support from participating nursing homes. The maximum amount is $6,000 per nursing home. Any one nursing home is eligible to participate in three different programs per year.

Allowable uses of CMP's include:

- Development and support of resident or family councils.
- Consumer information, such as informing residents of their rights.
- Training to improve quality of care.
- Activities to improve the quality of life for residents.

States are also allowed to use CMP funds for time-limited assistance to support and protect residents of facilities that close or are decertified. They cannot be used to meet regulatory requirements. Acceptable state costs include:

- Resident expenses such as food, supplies, medical equipment, or medications necessary during the transfer and relocation process;
- Expenses for seeking resident guardianship for the purpose of transfer, if required;
- State insurance expenditures, workmen's compensation, general liability insurance;
- Resident and family interactions to discuss transfer;
- Information for residents about facilities and working with facilities to discuss residents who may be transferring;
- Receivership costs (e.g., staff salaries, vendor payments).
- Medical records copying; and
- Transportation expenses, if needed, for the resident and family to visit other facilities.
- Other expenses approved by CMS.

The guidance lays out how facilities must process applications and submit them to CMS for approval. More information on the program may be found here.