**Nursing Homes: Unleashing Prosperity Through Deregulation of the Medicare Program (Executive Order 14192) – Request for Information**

**June 2025**

On January 31, 2025, President Trump issued Executive Order 14192 "Unleashing Prosperity Through Deregulation" that stated in part that for each new regulation introduced, federal agencies must identify at least 10 prior regulations to be eliminated. In response, the Centers for Medicare & Medicaid Services (CMS) issued a Request for Information on April 11 to assist in identifying regulations that could be considered for elimination from the Medicare Program.

LeadingAge submitted deregulation recommendations covering regulations for home health and hospice, Medicare Advantage, nursing homes, and Programs of All-Inclusive Care for the Elderly (PACE). What follows below are the LeadingAge recommendations for nursing home deregulation.

**Streamline Regulatory Requirements**

***Are there existing regulatory requirements (including those issued through regulations but also rules, memoranda, administrative orders, guidance documents, or policy statements), that could be waived, modified, or streamlined to reduce administrative burdens without compromising patient safety or the integrity of the Medicare program?***

**Minimum Staffing Standards.** The Minimum Staffing Standards for Long-Term Care Facilities final rule was published in the Federal Register on May 10, 2024. This rule requires nursing homes to have a registered nurse on-site 24 hours per day, seven days per week in every nursing home, regardless of the assessed needs of the unique resident population or the skills and competencies of the existing staff. The rule further requires all nursing homes to provide 3.48 hours per resident, per day of total nurse staffing, including 0.55 hours per resident, per day of registered nurse (RN) services and 2.45 hours per resident, per day of nurse aide services. This requirement exceeds the statutory requirement to provide 24-hour licensed nurse services sufficient to meet the needs of residents and to use the services of a registered nurse at least eight consecutive hours per day, seven days per week.

On April 7, Judge Matthew Kacsmaryk of the United States District Court for the Northern District of Texas, Amarillo Division, issued his decision in a lawsuit filed by the American Health Care Association and LeadingAge finding that the Centers for Medicare & Medicaid Services (CMS) had exceeded statutory authority in regulating these minimum staffing standards. The judge found that the staffing standard imposed by CMS went beyond the authority set forth by

Congress, who dictated in statute that nursing homes should have eight hours per day of RN services and sufficient staff to meet the needs of residents. The judge issued a decision to vacate the requirements on these grounds.

LeadingAge requests that the staffing standards be rescinded to allow nursing homes to staff to levels that best meet residents' needs based on requirements for sufficient and competent staff.

**Enhanced Facility Assessment.** The Minimum Staffing Standards for Long-Term Care Facilities final rule additionally contained provisions to require enhanced Facility Assessment requirements. In the 2016 Mega Rule "Requirements for Participation in Medicare and Medicaid Programs," CMS finalized provisions requiring nursing homes to conduct, document, and annually review a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. In the 2024 Minimum Staffing Standards for Long-Term Care Facilities final rule, CMS added requirements "to ensure that facilities are utilizing the assessment as intended by making thoughtful, person-centered staffing plans, and decisions focused on meeting resident needs, including staffing at levels above the finalized minimums as indicated by resident acuity."

These provisions include incorporating evidence-based methods when care planning for residents; including input of nursing home leadership, management, direct care staff, and residents, resident representatives, and family members; and developing a staffing plan to maximize recruitment and retention of staff. While the minimum staffing standards were not scheduled for implementation until 2026 and after, all nursing homes were required to implement enhanced Facility Assessment requirements beginning in August 2024. The implementation of these requirements has caused considerable administrative burden on nursing homes who must now allocate staff time and resources to update this document that is largely viewed as a check-the-box exercise by providers and regulators alike. Nursing homes will continue to provide staff with the competencies and skills sets required to assure resident safety and to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident per requirements at 42 CFR 483.25 without taking time away from resident care to complete this unnecessary paper compliance.

LeadingAge requests that the enhanced Facility Assessment requirements be rescinded to eliminate unnecessary administration burden.

**Enhanced Barrier Precautions.** In July 2022, the Centers for Disease Control & Prevention (CDC) released guidelines for implementing the use of personal protective equipment (PPE) in nursing homes to prevent spread of multidrug-resistant organisms (MDROs). Known as "enhanced barrier precautions" (EBP), these guidelines are meant to provide a less-restrictive way of protecting certain residents in the nursing home from spread of MDROs during high-contact care activities. This includes residents who are infected or colonized with an

MDRO or who have wounds or indwelling medical devices. EBP requires staff to don a gown and gloves when providing high-contact care to these residents such as toileting, bathing, dressing, assisting the resident with transfers such as moving from the bed into the wheelchair, or changing bed linens.

Recognizing CDC guidelines as an accepted national standard, CMS adopted these standards through a March 2024 policy memo, then later in the November 2024 updates to the Long-Term Care Surveyor Guidance, Appendix PP of the State Operations Manual. As such, these guidelines are now enforceable under Infection Control requirements at 42 CFR 483.80.

While CDC cites data from limited studies in nursing homes on the effectiveness of limiting transmission of MDROs through the use of EBP, they have failed to produce evidence that the use of EBP prevents serious negative outcomes, such as hospitalization or death, among nursing home residents. While an MDRO infection is not ideal, it is neither uncommon nor is it certain to result in a serious negative outcome. Likewise, a resident may be colonized with an MDRO for years without ever experiencing any serious negative impacts.

On the other hand, both nursing home residents and nursing home staff have identified negative impacts resulting from the use of EBP. Residents have expressed that staff use of PPE during high contact care activities is humiliating and demoralizing. Residents say implementation of EBP makes them feel as though they are "dirty" and makes these very intimate care activities feel impersonal. Staff report that the use of EBP is inconsistent with the "home-like environment" that nursing homes strive for. Additionally, EBP is a costly administrative burden, siphoning off much-needed money for the continued use of PPE and wasting precious time donning and doffing the PPE instead of providing personalized care.

LeadingAge requests that enhanced barrier precautions be removed from Appendix PP and that CMS be prevented from enforcing the implementation of these guidelines.

**Infection Control Guidance: SARS-CoV-2.** In response to the SARS-CoV-2 global pandemic, the CDC issued infection control guidelines for healthcare settings and management of healthcare personnel with SARS-CoV-2 infection or exposure that were updated numerous times as the virus and our understanding of the virus evolved. The most recent updates to this guidance, released in May 2023 and September 2022 respectively, recommend that individuals in healthcare settings including nursing homes that have been exposed to SARS-CoV-2 wear source control for a period of 10 days after last exposure and have a series of three viral tests spaced 48 hours apart. Individuals living or working in a healthcare setting where an outbreak has occurred must wear source control until 14 days have passed since the last new case was identified. Nursing home residents who test positive are placed on isolation and restricted to their rooms for at least 10 days and up to 20 days. Staff who test positive are restricted from work for at least 7-10 days and up to 20 days. Recognizing CDC guidelines as an accepted

national standard, CMS enforces these guidelines under Infection Control requirements at 42 CFR 483.80.

These guidelines are outdated and do not reflect the current realities of SARS-CoV-2 infection and its impact on nursing home residents. CDC data shows that as of May 18, 2025, SARS-CoV-2 accounts for only 125 cases per 100,000 nursing home residents and fewer than six hospitalizations per 100,000 residents, despite only 36% of nursing home residents being vaccinated against SARS-CoV-2. We know that repeated testing of asymptomatic individuals is costly, time-consuming, and physically uncomfortable, which could cause distress among nursing home residents, particularly those with cognitive impairments. Further, we know that social isolation, such as the social isolation that results from SARS-CoV-2-related restrictions, leads to negative outcomes among nursing home residents including loneliness, depression, suicidal ideation, and frailty. Studies on community-dwelling older adults found that social isolation contributes to physical and mental health issues including cognitive decline, immune dysregulation, stroke, and chronic conditions such as hypertension and obesity.

We also know that nursing homes struggle with workforce shortages, with the current national averages for total nurse staffing, RN staffing, and nurse aide staffing hovering at or falling below the CMS-recommended minimum standards of 3.8 hours per resident day, 0.55 hours per resident day, and 2.45 hours per resident day. Restricting staff from work based on these guidelines when they are otherwise well and fit to work only exacerbates these issues.

LeadingAge requests that CDC infection control guidelines for SARS-CoV-2 in health settings and guidelines for the management of healthcare personnel following SARS-CoV-2 infection or exposure be modified to allow for a more common-sense approach where individuals are only tested for SARS-CoV-2 infection if they show symptoms and residents are permitted to discontinue isolation and staff are permitted to return to work upon resolution of fever and improvement of symptoms.

***Which specific Medicare administrative processes or quality and data reporting requirements create the most significant burdens for providers?***

**Mandatory One-Star Penalties on Care Compare Five Star Quality Rating System.** The Nursing Home Care Compare Five Star Quality Rating System provides information on nursing home care by evaluating nursing homes in three areas: health inspections, staffing, and quality measures. Each category contains metrics on which nursing homes are scored and these scores are converted to star ratings of one through five stars, where one star indicates the lowest-performing nursing homes and five stars indicates the highest-performing nursing homes. Ratings are assigned for each individual category as well as an overall star rating that accounts for all three categories. Ratings are displayed publicly on the Care Compare website that is maintained by CMS, with minor updates occurring monthly as new health inspection

data becomes available, and more comprehensive updates occurring quarterly as staffing and quality measure data is updated.

While initially conceived as a way for consumers, their families, and caregivers to compare nursing homes and learn about nursing homes' quality, CMS has increasingly utilized the Five Star Quality Rating System as an enforcement mechanism to penalize nursing home providers for noncompliance with nursing home Requirements of Participation. CMS automatically assigns one-star ratings to nursing homes for certain types of noncompliance, such as a one-star rating for staffing if a nursing home fails to submit payroll-based journal data on time or a one-star rating for quality measures if a nursing home is found to have insufficient documentation in a resident's medical record to support a schizophrenia diagnosis. Not only is CMS's use of Care Compare as an enforcement mechanism not the intent of the program, but it actually conflicts with the intent in a harmful way by providing false information to consumers, their families, and caregivers. Assigning one-star ratings to nursing homes regardless of their actual staffing levels or performance on quality measures creates burden on nursing homes who must reconcile these false ratings to prospective residents, families, and referral sources such as hospitals or community social service agencies.

Notably, these arbitrary one-star penalties also constitute a double penalty for nursing homes, as the nursing home is penalized on Care Compare, then also penalized during the standard recertification survey. For example, as noted above, a nursing home that fails to submit payroll-based journal data on time for a quarter is automatically assigned a one-star rating for staffing. This nursing home is then cited at F851 for failure to submit staffing data, which is also displayed on Care Compare under the health inspections domain.

LeadingAge requests that arbitrary one-star penalties be removed and restricted from Care Compare and the Five Star Quality Rating System to allow for true reporting and display of nursing home data.

**Healthcare Personnel Vaccination Reporting Through NHSN.** Nursing homes are required as part of the SNF QRP to report rates of COVID and flu vaccination for healthcare personnel through the National Healthcare Safety Network (NHSN) system. COVID vaccination rates must be reported at least once per month, resulting in a quarterly average, and nursing homes must submit one report detailing the flu vaccination status of all healthcare personnel working at least one day during the respiratory virus season by May 15 each year. Both measures are displayed on Care Compare, calculated in the quality measures ratings domain, and utilized in the SNF Quality Reporting Program (QRP).

Originally, the stated intent of COVID-19 vaccination reporting was to help CMS assess whether nursing homes were taking appropriate steps to "limit the spread of COVID-19 among healthcare personnel, reduce the risk of transmission within nursing homes, and help sustain the abilities of nursing homes to serve their communities throughout the COVID-19 public

health emergency and beyond." Later, citing unsatisfactory flu vaccination rates among healthcare personnel in nursing homes, CMS stated that requiring reporting of flu vaccination rates had the potential to increase vaccination coverage. In other words, CMS felt requiring reporting of COVID and flu vaccination rates was an appropriate and necessary step to take to coerce the personal health choices of healthcare personnel working in nursing homes.

While we agree that nursing homes should be taking steps to prevent spread and transmission of COVID-19, flu, and other infectious diseases, reporting data on vaccination rates does not address this intent. Instead, this onerous reporting that requires hours of staff time to track, report, and ensure receipt is a measure of the personal health choices of healthcare personnel. As such, this information is not a reflection of the quality of care an individual may hope to receive in a given nursing home.

LeadingAge requests that requirements for reporting COVID-19 and influenza vaccination coverage among healthcare personnel be rescinded, that both measures be removed from the SNF QRP, and that both measures be removed from the Five Star Quality Rating System, as this data is not reflective of nursing home quality and the associated reporting is an unnecessary administrative burden on nursing home staff.

**Care Compare Long-Stay Antipsychotics Quality Measure.** Information on the use of antipsychotics in nursing homes is displayed on Nursing Home Care Compare through the quality measure Percentage of Long-Stay Residents Who Got an Antipsychotic Medication. This measure is based on the Minimum Data Set (MDS) assessment and measures the number of residents who reside in the nursing home for more than 100 days and who also received an antipsychotic medication. The measure excludes individuals who received an antipsychotic medication and also have a diagnosis of schizophrenia, Tourette's syndrome, or Huntington's disease. CMS maintains that measuring the use of antipsychotics in nursing homes is important because of the associated side effects and black box warnings on antipsychotic medications.

While side effects are an important consideration, this quality measure causes undue burden on nursing homes by creating a false narrative that inappropriately influences both public opinion and clinical practice. By narrowly defining the exclusions of this measure, CMS fails to consider appropriate use of antipsychotic medications such as for individuals with cognitive impairments who may be suffering psychotic features such as auditory and visual hallucinations or delusions of persecution, all of which are common and can be extremely distressing and disruptive for individuals with cognitive impairment and those caring for them. CMS claims that they do not intend to completely eradicate antipsychotic usage in nursing homes; however, when providing notes on Care Compare to assist consumers in interpreting quality measures, CMS includes the statement "lower percentages are better" for the long-stay antipsychotics measure. Not only does this mislead the public into believing that a nursing home with rates higher than the state or national average must not be a quality nursing home,

but it also puts pressure on nursing home clinicians to pursue alternative treatments, even when an antipsychotic medication may be most appropriate. This poses unnecessary burdens for nursing homes who must defend clinical practices to CMS and the public while trying to manage unresolved and highly distressing symptoms among residents.

LeadingAge also notes that this quality measure is outdated, as are the black box warnings that led to concerns about antipsychotics in the nursing home population to begin with. The Food and Drug Administration (FDA), that is responsible for issuing black box warnings, is reportedly in the process of re-evaluating black box warnings and conducted a public workshop in 2024 to review data on risks and appropriateness of black box warnings for antipsychotics.

LeadingAge requests that this quality measure and associated reporting be modified to more accurately distinguish between appropriate and inappropriate use of antipsychotics in the nursing home.

***Are there specific Medicare administrative processes, quality, or data reporting requirements, that could be automated or simplified to reduce the administrative burden on facilities and providers?***

**Nursing Home Quality Measures.** Currently, nursing homes are evaluated on 40 quality measures. Thirty-three measures are reported publicly on Care Compare, including nine measures from the SNF QRP. An additional six measures are utilized in the SNF QRP but not reported on Care Compare, along with one measure from the SNF Value-Based Purchasing (VBP) program. By Fiscal Year (FY) 2028, eight additional measures will be added to SNF VBP. With so many measures spread across three different programs, it is challenging for consumers and the public to understand which measures are important, running the risk of rendering all measures meaningless. Further, there is little public understanding about the different programs that utilize these measures and why they are important. Even within the provider community, the programs represent little more than a policy lever for CMS to control Medicare funding.

LeadingAge recommends reviewing the three programs – the Five Star Quality Rating System, SNF QRP, and SNF VBP – and identifying ways to streamline measures and considering combining or at least better aligning the programs to reduce administrative burden.

**Minimum Data Set (MDS) Assessment – Streamlining Assessment Items.** Implemented in 2010, the MDS 3.0 assessment provides a standardized method of assessing residents' conditions and needs. The MDS is utilized for every resident that admits to the nursing home and is repeated at varying frequencies throughout the resident's stay. For short-stay residents admitted for skilled care, the assessment is conducted upon admission and discharge and may be completed additionally during the stay if any significant changes arise. For long-stay residents who are receiving long-term care, the assessment is conducted upon admission and discharge, and repeated on a quarterly basis and any time a significant change arises. In FY 2025, 10 different versions of this assessment are available, depending upon the type of

assessment being completed. The manual for understanding the requirements, intent, and timing of assessments is nearly 1,000 pages long.

These assessments, which can include upwards of 400 items across 21 sections, inform resident care planning; feed into quality ratings in the Five Star Quality Rating System on Care Compare, the SNF QRP, and the SNF VBP; and form the basis upon which Medicare payments are calculated and upon which many states calculate Medicaid reimbursement. They also require considerable amounts of staff time, with at least one registered nurse being designated to oversee the completion and timely submission of assessments, with contributions from multiple other staff on the interdisciplinary team.

While LeadingAge recognizes the importance of a standardized measurement of resident functioning and needs, the length of this assessment and complexity of the frequency and assessment types poses a significant administrative burden on nursing home providers. LeadingAge requests that the MDS assessment be reviewed to eliminate any unnecessary data items that do not directly impact payment or planning for the resident's care during the nursing home stay. LeadingAge also recommends re-evaluating the types and frequency of assessments to be completed to streamline timelines for long-stay residents to admission, discharge, and significant change.

**Risk-Based Survey.** In 2024, CMS began piloting a risk-based survey approach to improve the effectiveness and efficiency of the survey and certification process. The new survey model would allow consistently higher-quality nursing homes to receive a more focused survey that takes less time and resources than the traditional standard recertification survey while still ensuring compliance with health and safety standards. By prioritizing areas that pose increased risk to residents' health and safety, CMS aimed to more effectively allocate limited time and resources to nursing homes with lower quality whose residents are at a higher risk of harm.

CMS intended to identify "higher quality" nursing homes by indicators such as a history of fewer citations for noncompliance, higher staffing, fewer hospitalizations, and other characteristics such as no citations related to resident harm or abuse, no pending investigations for residents at immediate jeopardy for serious harm, and compliance with staffing and data submission requirements. The number of nursing homes selected for risk-based surveys based on these indicators would be limited, such as up to 10 nursing homes in a state, and if any concerns about resident safety were encountered during a risk-based survey, the survey would immediately be expanded. Selected nursing homes would receive a shorter survey during which a more focused review of required areas would be examined, allowing state agencies to then direct survey resources to more timely oversight of nursing homes where the risks to residents' health and safety were greater.

LeadingAge supports the concept of a risk-based survey approach and recommends that CMS move to implement this new survey model across all states. By streamlining the standard

recertification survey in this tested way, CMS will more efficiently direct survey resources where they are needed most and allow nursing homes to return more quickly to providing quality care to their residents.

**Opportunities to Reduce Administrative Burden of Reporting and Documentation**

***What changes can be made to simplify Medicare reporting and documentation requirements without affecting program integrity?***

**Payroll-Based Journal – Meal Breaks.** Payroll-based journal was implemented through the 2016 Mega Rule as a result of the Affordable Care Act as a way to track and report on the level of staffing in nursing homes. Under requirements at 42 CFR 483.70(p), nursing homes must electronically submit to CMS complete and accurate direct care staffing information through the payroll-based journal system. Currently, this data is used to identify potential issues during the survey and certification process and to publicly display information on total nurse staffing hours, RN hours, licensed practical nurse (LPN) hours, nurse aide hours, weekend staffing of nurses, physical therapist hours, nursing staff turnover, and nursing home administrator turnover.

However, per the Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual, meal breaks are not to be reported, regardless of whether they are paid or unpaid meal breaks. CMS instructs nursing homes to deduct a minimum of 30 minutes from staff time for all staff when reporting through payroll-based journal. As a result, nursing homes appear to be noncompliant with staffing requirements, such as current requirements to have an RN on site at least 8 hours per day, 7 days per week. This creates unnecessary burden for nursing homes who must then prove to CMS that staff were on-site and available as required but not counted in payroll-based journal due to short-sighted policies.

Being on a meal break does not preclude staff from working, even if it is simply answering a question or providing quick consultation on a resident issue, and would certainly not prevent any nurses from responding in an emergency. LeadingAge recommends that the payroll-based journal policy be modified to remove meal break exceptions and allow all shift hours to be counted in payroll-based journal data submissions.

**Discharge Notification – Ombudsman.** Requirements at 42 CFR 483.15(c)(3) require a nursing home to notify the resident and resident's representative prior to transfer or discharge. These requirements also state that a copy of this notice must be sent to a representative of the Office of the State Long-Term Care Ombudsman. Long-term care surveyor guidance in Appendix PP of the State Operations Manual states that the intent of the requirement to send copies of the notice to the ombudsman is "to provide added protection to residents from being inappropriately transferred or discharged . . .and to ensure that the Office of the State LTC Ombudsman is aware of facility practices and activities related to transfers and discharges."

Recognizing that nursing homes are required to provide within the notice of transfer or discharge an explanation of the right to appeal the transfer or discharge to the state; the name, address, email address, and telephone number of the state entity that receives appeal hearing requests; and the name, address, email address, and telephone number of the Long-Term Care Ombudsman, requiring the nursing home to send a copy of the notice to the ombudsman is an unnecessary administrative burden. Any issues or concerns about inappropriate discharge can be brought to the ombudsman by the resident / resident representative or the state, at which point the ombudsman may intervene as he sees fit. Otherwise, flooding the ombudsman office with notices of appropriate and uncontested transfers or discharges dilutes and distracts from any potential issues on which the ombudsman's time is better spent.

LeadingAge requests that requirements at 42 CFR 483.15(c)(3) be modified to remove requirements to send notice of transfer or discharge to the ombudsman office to conserve nursing home and ombudsman office resources for inappropriate discharges.

**Staff Training.** Finalized with the 2016 Mega Rule "Requirements for Participation in Medicare and Medicaid Programs", the staff training requirement at 42 CFR 483.95 outlines specific training topics, timelines, and minimum hours of in-servicing training that nursing home staff must complete each year.

This requirement fails to take into consideration other training requirements that are more appropriate to the role of the staff member, such as requirements at 42 CFR 483.35(d) that state the nursing home must ensure nurse aides are able to demonstrate competency in the skills and techniques necessary to care for residents' needs, requirements at 42 CFR 483.35(e)(7) that nursing homes review nurse aide performance at least annually and provide regular in-service education based on the outcomes of those reviews, requirements at 42 CFR 483.40(a) that staff possess appropriate competencies and skills sets to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, or any requirements specific to professional licensing for continuing education.

LeadingAge recommends that this regulation be modified to remove prescriptive training topics and timelines and allow nursing home leadership to determine the most appropriate training for staff based on evaluation of existing competencies and skills sets and the unique needs of the resident population and nursing home operations.

**Resident Matrix Form CMS-802.** Nursing homes must present to surveyors a completed form CMS-802 immediately upon arrival of the survey team for a standard recertification survey. The immediacy of this request means that nursing homes must constantly maintain an updated form that requires the listing of all residents that fall into each of 20 categories such as residents newly admitted in the past 30 days, residents with a dementia diagnosis of any type, residents who are on transmission-based precautions and so on. Much of this information is available in other documentation that surveyors will review throughout the course of the survey,

such as the Facility Assessment, and some information may only be relevant if concerns are identified otherwise throughout the course of the survey.

LeadingAge requests that CMS review form CMS-802 for opportunities to eliminate unnecessary items and streamline the form or extend the timeline in which nursing homes must supply this information to eliminate the administrative burden of constantly maintaining this onerous form.

***Are there opportunities to reduce the frequency or complexity of reporting for Medicare providers?***

**Minimum Data Set – Frequency of Assessments.** As noted above, the MDS 3.0 poses a significant administrative burden to nursing home providers. In addition to recommending streamlining of the items of this assessment, which can number upwards of 400 individual items across 21 sections, LeadingAge also recommends re-evaluation of the frequency of assessment completion. The Omnibus Reconciliation Act of 1987 (OBRA '87) requires Medicare- and Medicaid-certified nursing homes to conduct initial and periodic assessments for all residents. Nursing homes are also required to conduct assessments for Medicare Part A billing under the SNF Prospective Payment System (PPS) and the SNF QRP. OBRA requirements impose seven different types of assessment, including one that is updated quarterly for all residents. PPS requirements impose two assessments, with a third that is completed at the discretion of the nursing home anytime there is a change in the resident's condition or functioning that would impact payment. While SNF PPS and OBRA-required assessments can be combined, the tracking, scheduling, completion, and submission of these assessments is still onerous enough that nursing homes are required to designate a registered nurse to coordinate this process.

LeadingAge requests that the frequency of MDS assessment completion be reevaluated for long-stay residents to allow for less frequent assessment completion, permitting valuable RN time and time from other members of the interdisciplinary team to be returned to resident care.

**Reporting Allegations of Abuse.** Requirements at 42 CFR 483.12(c)(1) state that nursing homes must report all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property. Based on the Elder Justice Act, regulations require that these reports be made to outside officials including the State Survey Agency and adult protective services immediately, but not later than two hours after an allegation is made if the events that cause the allegation involve abuse or result in serious bodily injury.

While timely reporting of abuse and other incidents is extremely important, this timeline fails to consider the more important aspects of the process nursing homes engage in when an allegation has been made. Nursing homes must first assure the safety of the resident making the allegation and all other potentially impacted residents. This includes removing the resident

from an unsafe situation, conducting an assessment, and administering any needed medical attention or psychosocial support. The nursing home must also immediately begin a thorough investigation of the details and circumstances surrounding the allegation and take any necessary actions to assure resident safety. This process is urgent, may be complex, and often requires the attention and participation of several staff, including key management staff such as the Administrator, Director of Nursing, Director of Social Services, any clinical staff such as RNs and CNAs who are assigned to provide care to the resident, and any staff who may have information regarding the allegation. As such, a two-hour reporting window is unrealistic given that staff may not have had the opportunity to gather sufficient information and certainly should not be interrupting resident care and attention in order to make a report.

LeadingAge requests that the timeline for making report of allegations of abuse be reevaluated to allow sufficient time to assure the safety of residents and engage in thorough investigation prior to making any reports.

***Are there documentation or reporting requirements within the Medicare program that are overly complex or redundant? If so, which ones? Please provide the specific Office of Management and Budget (OMB) Control Number or CMS form number.***

**Reporting of Additional Disclosable Parties Through Form CMS-855A.** In the November 2023 final rule Medicare and Medicaid Programs; Disclosures of Ownership and Additional Disclosable Parties Information for Skilled Nursing Facilities and Nursing Facilities; Medicare Providers' and Suppliers' Disclosure of Private Equity Companies and Real Estate Investment Trusts, CMS finalized provisions as required under the Affordable Care Act that require nursing homes to disclose ownership and additional disclosable parties through form CMS-855A upon initial enrollment in the Medicare and Medicaid programs, upon revalidation of enrollment, and anytime there are changes to the information.

To implement these requirements, CMS is requiring all nursing homes enrolled in Medicare to complete an off-cycle revalidation during which this information is submitted by August 1, 2025. CMS defines additional disclosable parties as any person or entity who: 1) exercises operational, financial, or managerial control over the facility or a part thereof, or provides policies or procedures for any of the operations of the facility, or provides financial or cash management services to the facility; 2) leases or subleases real property to the facility or owns a whole or part interest equal to or exceeding 5% of the total value of such real property, or 3) provides management or administrative services, management or clinical consulting services, or accounting or financial services to the facility. CMS adds that when in doubt, nursing homes should err on the side of disclosure.

The collection and reporting of this information presents significant administrative burden to nursing homes. Some of our members report disclosing more than 1,000 additional disclosable parties. Additionally, CMS requires extraordinary detail about the ownership and specific staff

of additional disclosable parties. Concerningly, it is widely believed that the collection of this detailed information will not address the issues on which CMS is focused and CMS's need for information could be satisfied through other available information such as the information derived from the Provider Enrollment, Chain, and Ownership System (PECOS), the Form 990 filed by not-for-profit entities, and Medicare cost reports.

LeadingAge requests that CMS reevaluate and waive aspects of these requirements related to additional disclosable parties to alleviate administrative burden and reallocate resources to initiatives that will better serve the objective of ownership transparency.

**Person-Centered Care Planning.** Under requirements at 42 CFR 483.21, nursing homes are required to develop and implement person-centered care plans that include instructions needed to provide effective and person-centered care and that meet professional standards of quality care. The baseline care plan must be developed and implemented within 48 hours of the resident's admission and must include the minimum healthcare information necessary to care for the resident, including initial goals, physician orders, dietary orders, therapy services, social services, and a Pre-admission Screening and Resident Review (PASARR) recommendation if applicable. The comprehensive care plan must be developed and implemented within seven days after completion of the comprehensive assessment, which must be completed within 14 days after admission. The comprehensive care plan must include the resident's goals, services required to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, and any specialized services or specialized rehabilitative services resulting from PASARR recommendations.

Our members tell us that the requirements for these two care plans are unduly burdensome and redundant. As stated explicitly in the requirement, the baseline care plan consists of orders for treatment and care that are already reflected elsewhere in the medical record. The compilation of this information into the baseline care plan is nothing more than paper compliance that neither influences nor changes resident care. Further, our members tell us that the baseline care plan is once again redundant as it often becomes the comprehensive care plan.

LeadingAge recommends eliminating the requirement for a baseline care plan to be completed within 48 hours of admission while maintaining requirements for a comprehensive care plan as written. In this way, nursing homes will be spared the administrative burden of paper compliance while continuing to provide necessary care according to orders on the resident's medical record until a comprehensive assessment can be completed.

**Identification of Duplicative Requirements**

***Which specific Medicare requirements or processes do you consider duplicative, either within the program itself, or with other healthcare programs (including Medicaid, private insurance, and state or local requirements)?***

**NHSN Reporting – Respiratory Illness Data.** Under infection control requirements at 42 CFR 483.80(g), nursing homes must report information on acute respiratory illnesses, including influenza, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2), and respiratory syncytial virus (RSV) through a standardized format and frequency specified by the Secretary.

At present, this format and frequency is weekly reporting through the NHSN system. The data currently reported includes facility census, resident vaccination status for the three identified respiratory illnesses, confirmed cases among nursing home residents for each illness, and hospitalizations of nursing home residents for each illness.

Weekly reporting of respiratory illness data was initiated during the COVID-19 public health emergency. At that time, a strong federal response was needed to monitor this catastrophic new virus and coordinate state and federal strategies for preventing and responding to outbreaks. The data was used to learn about this novel virus as well as inform the distribution of supplies and support from the federal government to state and local governments and entities. However, we have learned much in the five years since this virus emerged and the impact of the virus has significantly changed.

We are no longer in a national public health emergency and the federal government is no longer involved in large-scale efforts to provide resources and support coordinated response to long-term care. Allocations of PPE from HHS ended mid-way through the public health emergency, and strike teams are also a relic of the early days. Similarly, while nursing homes continue to receive support from public health, these responses are local activities, not federal response efforts, and are driven by local conditions within the state or region rather than conditions across the country.

Separate pre-existing requirements at both the federal level and state levels require information on infectious diseases, including respiratory illnesses, to be reported to public health authorities. Per these requirements, cases and clusters of cases among residents and staff are reported to public health to inform prevention, response, and recovery efforts at the local level.

LeadingAge requests that requirements for reporting respiratory illness data through NHSN be rescinded due to this duplication with other federal and state requirements. State and local public health entities will continue to have access to data on respiratory illness outbreaks, even without NHSN data, allowing for continued situational awareness, support, and outreach.

**NHSN Reporting – Resident Vaccination Status.** As noted above, in addition to reporting data on respiratory illness cases and hospitalizations, nursing homes are required to report vaccination status of residents for SARS-CoV-2, flu, and RSV. This reporting is submitted weekly along with other respiratory illness data through the NHSN system. However, due to the inclusion of a quality measure of resident vaccination status in the SNF QRP, this data is also reported on residents' MDS assessments that are completed upon admission for all residents

and at least quarterly thereafter for long-stay residents, making the NHSN reporting requirements duplicative.

Recognizing that the MDS assessment is the most logical and less burdensome way for nursing homes to report this information, LeadingAge requests that NHSN reporting of resident vaccination status be rescinded, allowing nursing homes to report this data only through the MDS assessment for all residents.

**Schizophrenia Audits.** CMS began conducting schizophrenia audits in 2023 in an effort to identify erroneous coding of schizophrenia on the MDS assessment. As explained in CMS memo QSO-23-05-NH, CMS believes that providers may be erroneously diagnosing and coding nursing home residents as having schizophrenia in order to mask antipsychotic usage rates and artificially improve ratings on antipsychotic quality measures.

During audits, identified nursing homes are requested to provide documentation from the residents' medical records to justify schizophrenia diagnoses. Based on the documentation provided during the audit, CMS determines whether the diagnosis and MDS coding are accurate. For nursing homes that are found to have inaccurately coded schizophrenia on the MDS, ratings are downgraded and/or suppressed on Care Compare. CMS continues to monitor identified nursing homes' data after the audit to verify that identified issues have been corrected and to determine if ratings downgrades or suppressions should be lifted.

LeadingAge agrees that inappropriate diagnoses should be identified and corrected, and nursing homes that knowingly assign inaccurate diagnoses to avoid scrutiny on quality measures should be held accountable. However, the schizophrenia audits are now duplicative and the associated penalties constitute a double penalty. When CMS updated the long-term care surveyor guidance, Appendix PP of the State Operations Manual, in November 2024, the process for evaluating accuracy of diagnoses and coding was incorporated. Following the April 2025 implementation of this updated guidance, all nursing homes are now subject to these procedures during the standard recertification survey or any related complaint surveys. Diagnoses lacking appropriate documentation will be cited under F641 Accuracy of Assessment and subject to enforcement remedies including civil money penalties. Additionally, patterns of inaccurate coding will be referred to the Office of Inspector General and appropriate professional licensing boards.

As such, LeadingAge requests that schizophrenia audits and the associated penalties on Care Compare be terminated, allowing for any noncompliance to be identified and addressed through the survey and certification process.

**Payroll-Based Journal Audits.** Payroll-based journal was implemented through the 2016 Mega Rule as a result of the Affordable Care Act as a way to track and report on the level of staff in nursing homes. Currently, this data is used to identify potential issues during the survey and certification process and to publicly display information on total nurse staffing hours, RN

hours, LPN hours, nurse aide hours, weekend staffing of nurses, physical therapist hours, nursing staff turnover, and nursing home administrator turnover. The data is used to calculate nursing home ratings in the Five Star Quality Rating System and is utilized in the SNF QRP. Nursing homes that fail to submit data in a timely manner are penalized with an automatic one-star rating for staffing on Care Compare and are subsequently cited on survey under F851 Payroll Based Journal.

In 2018, CMS began conducting audits through CMS contractors to verify accuracy of staffing hours. These audits require nursing homes to upload staffing data to the auditor within a certain timeframe to verify compliance with PBJ requirements. Nursing homes that fail to respond to the audit within the allotted timeframe or for whom an audit identifies significant discrepancies between the hours reported and hours verified are penalized with an automatic one-star rating for staffing on Care Compare.

Verification of hours through audit and through the survey and certification process represents undue administrative burden and duplicative processes and penalty for nursing homes. LeadingAge requests that requirements be modified to audit PBJ data only when issues are identified and to remove mandatory one-star penalties associated with audits.

**Pre-admission Screening and Resident Review.** Requirements for pre-admission screening of residents was implemented as a result of OBRA '87 to prevent unnecessary placement of individuals with mental illness or intellectual disabilities in nursing homes. Under these requirements at 42 CFR 483.20(k), nursing homes must complete preadmission screening to determine that individuals with mental illness or intellectual disabilities require the level of services provided by the nursing home. These preadmission screenings require the state mental health or intellectual disabilities authority to make a determination based on an independent physical and mental evaluation performed prior to admission by a person or entity other than the state authority or nursing home. Both the evaluation and the determination by the state authority often require agency coordination that causes unnecessary delays in admission to the nursing home.

While inappropriate placement in nursing homes must be prevented, requirements for pre-admission screening and referral as operationalized through 42 CFR 483.20(k) are unnecessary due to subsequent requirements implemented through the 2016 Mega Rule that require resident assessment and care planning for all residents ensure that the needs of residents are identified and addressed, and that nursing homes do not admit residents whose needs they are unable to meet. Requirements at 42 CFR 483.30 require that physicians personally approve in writing recommendations for individuals to be admitted to the nursing home. Per requirements at 42 CFR 483.20(b) and 483.21(b), a comprehensive assessment must be completed within 14 days of admission and a comprehensive care plan developed within 7 days of the assessment, and both the assessment and care plan must be reevaluated upon a significant change in functioning or at least quarterly thereafter.

These requirements for assessment and care planning ensure that individuals with mental illness or intellectual disabilities are appropriately placed and that their needs are promptly identified and addressed. LeadingAge requests that PASARR requirements at 42 CFR 483.20(k) be eliminated to lessen administrative burden on both nursing home providers and state agencies while also preventing unnecessary delays in admission for individuals in need of nursing home care.

***How can cross-agency collaboration be enhanced to reduce duplicative efforts in auditing, reporting, or compliance monitoring?***

**Nursing Home Survey and Certification.** To certify participation in the Medicare and Medicaid programs, nursing homes must be in compliance with health and life safety code requirements. Compliance is verified through standard recertification surveys that take place at least every 15 months. Currently, health inspection surveys are conducted by state survey agencies or their designees (contractors). Life safety code inspections are carried out by the state agency or another entity such as the fire marshal, depending upon the state. Health inspections and life safety code inspections may take place concurrently, but more often our members tell us take place separately, meaning that the survey and certification process is delayed. Nursing homes that carry additional certifications, such as those with the Veteran's Administration, are subject to additional surveys by the certifying entity, despite being surveyed on the same requirements.

These multiple surveys impose an administrative burden on providers who must take time out of caring for residents to be available to on-site surveyors. This includes assisting with access to residents, coordinating access to families, providing access to different areas or systems within the building, providing access to or making copies of medical records or other pertinent documentation, responding to queries from surveyors or completing survey documentation, and so on. When the surveyor or inspector is new or unfamiliar with long-term care, the burden is even greater.

Other CMS-certified entities have the benefit of deemed status that allow for the survey and certification process to be carried out through an accrediting organization. This lessens the burden on state agencies who may be overwhelmed with standard certification and complaint surveys while ensuring more timely and efficient surveys for the provider. However, nursing homes have been denied this option.

LeadingAge requests that CMS re-evaluate the survey and certification requirements for opportunities to streamline the process. Ensure that health inspections and life safety code inspections occur concurrently. Collaborate with other certifying entities such as the Veterans Administration to consolidate certification processes. Consider deemed status for nursing homes to allow for certification of compliance by accrediting organizations.

**Reporting Interfaces.** Nursing homes are subject to reporting requirements covering a range of data from resident assessments, illnesses, incidents, and discharges to staffing, census, and

state-level requirements. These multiple reporting requirements require nursing homes to engage with multiple digital interfaces, even when the data is all going to the same place (CMS) or serves the same broader purposes, regulatory compliance.

LeadingAge recommends evaluating reporting requirements and digital interfaces to streamline nursing home reporting into a single dashboard to which both CMS and the states have access. This will reduce administrative burden on nursing homes by allowing them to use a single sign-on and location for all reporting needs, rather than wasting weeks trying to solve enrollment and verification issues, as is often the case with NSHN and iQIES registrations. Having access to the same data in the same location will also reduce administrative burden for CMS and state agencies and potentially improve collaboration between the two entities that could work together to address the issues they are able to jointly identify.

***How can Medicare better align its requirements with best practices and industry standards without imposing additional regulatory requirements, particularly in areas such as telemedicine, transparency, digital health, and integrated care systems?***

**Physician Visits - Telehealth.** Physicians are required under 42 CFR 483.30(b)-(c) to review the resident's total program of care, including medications and treatments and visit residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Under F712 in the long-term care surveyor guidance, Appendix PP of the State Operations Manual, CMS specifies that these visits must be face-to-face and at the same physical location, not via a telehealth arrangement.

It is well known that there is a workforce shortage in healthcare and that long-term care is among the least sought-after jobs among healthcare professionals. Even in areas with comparatively less workforce issues, long-term care continues to struggle to recruit and retain staff, and recruitment and retention of physicians is no exception. Our members report difficulty recruiting attending physicians in long-term care and often times, an attending physician or medical director working in a nursing home is simultaneously contracted with multiple nursing homes, and/or working in private practice and hospitals. Recognizing these challenges, telehealth seems a logical solution, and one that has demonstrated results. During the COVID-19 public health emergency and after, waivers were in place that permitted physicians to conduct required visits via telehealth. Not only did residents receive the care they needed despite outbreaks or other barriers, but physicians were able to provide care to more residents, particularly in rural areas, because telehealth eliminated the inefficiencies of "windshield time" spent driving between nursing homes.

LeadingAge recommends that guidance on physician visits at tag F712 in Appendix PP of the State Operations Manual be revised to allow telehealth to be used to meet physician visit requirements.

**Physician Visits – Delegation of Tasks.** As noted above, physicians are required under 42 CFR 483.30(b)-(c) to visit residents at least once every 30 days for the first 90 days after admission and at least once every 60 days thereafter. Under F712 in the long-term care surveyor guidance, Appendix PP of the State Operations Manual, CMS clarifies the authority for non-physician practitioners to perform visits, sign orders, and sign Medicare Part A certifications and recertifications when permitted by the state. This "clarification" is a complex matrix distinguishing between skilled nursing facilities and nursing facilities, and between non-physician practitioners who are employed by the nursing home and those who are not. Non-physician practitioners (NPP) include physician assistants, nurse practitioners, and clinical nurse specialists.

According to CMS, a NPP may perform an initial comprehensive visit for a resident only in a nursing facility and only if the NPP is not employed by the facility. A NPP may not sign certification or recertification for patients in a SNF if the NPP is employed by the facility, but may do so if he is not employed by the facility. An NPP may not perform other required visits and sign orders for residents in a nursing facility if the NPP is employed by the nursing facility, but may perform visits and sign orders in the nursing facility if the NPP is not an employee, and may perform alternate visits and sign orders in a skilled nursing facility regardless of whether the NPP is an employee of the facility or not. These distinctions are unnecessarily complicated and unsympathetic to the realities of the workforce shortages long-term care providers are facing.

LeadingAge recommends that this guidance be rescinded and that non-physician practitioners be permitted to perform visits and sign orders, under the supervision of a physician, in both nursing facilities and skilled nursing facilities, regardless of their status as an employee of the facility.

**Civil Money Penalty Reinvestment Program.** Nursing homes that are found not to be in substantial compliance with requirements may be imposed a civil money penalty (CMP) for either the number of days or for each instance the nursing home is not in compliance. A portion of the CMPs collected are returned to the states in which CMPs are collected and state funds may be reinvested in activities that protect or improve the quality of care or quality of life of nursing home residents. This CMP Reinvestment Program is available to fund grants for nursing homes wishing to engage in these quality improvement activities.

In September 2023, CMS issued revisions to the program that imposed funding caps on projects and outlined an extensive list of non-allowable expenses. Most disappointing was a prohibition on the use of CMP funds for technology-related projects including telehealth equipment, electronic monitoring systems, or upgrades to electronic health records. As noted in a letter from LeadingAge state affiliates to HHS Secretary Kennedy and CMS Administrator Oz in May 2025, these policies create a critical barrier that is stifling innovation and impeding improvements in nursing home care.

LeadingAge requests that CMP Reinvestment Program funding authority be returned to states, allowing them the flexibility and discretion to approve programs and program funding that best address the quality challenges experienced by nursing homes within the state.

**Nurse Aide Training – Site Supervisors.** Requirements at 42 CFR 483.152 state that for a state to approve a nurse aide training and competency evaluation program (NATCEP), the program must meet certain requirements including specific requirements for instructors. Nurse aide training program instructors must be RNs who possess a minimum of two years' nursing experience with at least one year of experience in long-term care and must have completed a course in teaching adults or have experience teaching adults or supervising nurse aides.

It is well known that there is a nation-wide workforce shortage that includes a shortage of nurse educators and nurse aide instructors. Our members tell us that this lack of qualified educators and instructors complicates efforts to increase the number of available nurse aides.

LeadingAge requests that CMS reevaluate requirements for NATCEP instructor qualifications to allow more flexibility in the types of individuals who may serve as instructors, including experienced RNs who do not meet current requirements and experienced LPNs.

**SNF Three-Day Stay.** To qualify for a skilled nursing facility stay, Medicare beneficiaries must have an inpatient hospital stay of at least three consecutive days. This requirement excludes from care individuals who may need skilled care but were unable to access hospital services or who were held in outpatient observation status for some or all of their hospital stay. This requirement is permanently waived for beneficiaries enrolled in many Medicare Advantage and Special Needs Plans as well as Medicare Accountable Care Organizations, and was temporarily waived for Medicare fee-for-service beneficiaries during the COVID-19 public health emergency.

Permanently waiving this requirement would reduce administrative burden resulting from the need to determine a patient's hospital status prior to referral for or admission to skilled care. It would additionally reduce Medicare costs by eliminating the need for inpatient care and potentially preventing future hospitalizations if patients' needs can be addressed through skilled care and prevented from progressing. Congressional leaders are currently working to reintroduce legislation that would partially address this issue by allowing all time spent in an acute care hospital, regardless of inpatient or outpatient status, to qualify for skilled care.

LeadingAge requests that CMS waive requirements for three-day inpatient hospital stays while maintaining other eligibility requirements for SNF stays to ensure access to care for those who need it.

**Additional Recommendations**

***We welcome any other suggestions or recommendations for deregulating or reducing the administrative burden on healthcare providers and suppliers that participate in the Medicare program.***

**CNA Training Lock-out.** Many nursing homes participate in Nurse Aide Training and Competency Evaluation Programs (NATCEPs) that provide on-site training for individuals to become certified nurse aides. These programs provide a valuable pipeline for the long-term care workforce in addition to enabling nursing homes to ensure that nurse aides are instilled the skills, competencies, and professional values the nursing home finds most essential in caring for residents. These valuable training programs can be suspended, however, if the nursing home is subject to specific enforcement including survey findings of substandard quality of care or being enforced certain remedies for noncompliance such as a CMP over a certain threshold or a Denial of Payment for New Admissions, regardless of whether the noncompliance that led to these findings and enforcement remedies was related to the training program or resident care.

Congressional leaders are working to reintroduce bills that would fix the legislation on which these regulations are based. Bills introduced last Congress would allow nursing homes whose NATCEP suspension was not based on findings of substandard quality of care to resume their training programs as soon as they have been certified to have come back into substantial compliance.

LeadingAge requests that CMS adopt a similar regulatory waiver that would allow nursing homes whose NATCEPs have been suspended to resume the program as soon as they have come back into substantial compliance, provided the program was not suspended due to findings of substandard quality of care.

**Civil Money Penalties.** Nursing homes are cited for noncompliance with Requirements of Participation through the survey and certification process. As a result of findings of noncompliance, CMS or the state may impose financial penalties on the nursing home in an effort to ensure a return to and maintenance of compliance. New requirements at 42 CFR 488.430 finalized in the FY 2025 SNF PPS rule give CMS or the state survey agency the authority to enforce multiple financial penalties for a single type of noncompliance, such as per day and per instance CMPs, regardless of whether the deficient practice constituted immediate jeopardy.

Allowing CMS or the state to impose multiple penalties on the nursing home for noncompliance creates barriers to quality improvement. When nursing homes are assessed large fines for noncompliance that was promptly corrected, they have less money available for the care and services residents depend on. This means less money is available to recruit and retain staff, implement quality improvement initiatives, or make improvements to the physical environment

such as renovating outdated physical structures to improve indoor air quality and accommodate private rooms. Nursing homes facing extreme financial hardship may even be forced to make changes to operations including the need to reduce resident programs, reduce staff, reduce admissions, or close entirely, creating access issues for older adults seeking nursing home care.

LeadingAge recommends rescinding this rule to lessen the punitive overreach of CMS and state agencies and allow providers more financial flexibility to address areas of noncompliance and needed quality improvement.

**Emergency Plan Testing.** Under Emergency Preparedness requirements at 42 CFR 483.73(d), nursing homes must develop an emergency preparedness plan that is tested at least twice per year. One test must be a community-based or individual facility-based full-scale exercise. An example of a full-scale exercise would include multiple agencies, including the nursing home and other healthcare settings, emergency management partners, and community members simulating a natural or man-made emergency such as earthquake or cyber-attack. This would include acting out coordination, communication, evacuation, and resource allocation according to emergency plans to test response capabilities.

To meet requirements for a second test each year, nursing homes have the option to conduct an additional full-scale community- or individual facility-based exercise or to perform a mock disaster drill, a tabletop exercise, or workshop. For example, the nursing home may convene a meeting of personnel in a conference room for an afternoon where they identify a hypothetical natural or man-made emergency and engage in group discussion to review step-by-step how this emergency would be handled according to the emergency plan, including problem-statements, directed messages, or prepared statements designed to challenge the emergency plan.

While some CMS-certified providers, such as nursing homes, are required to complete two tests per year, other CMS-certified providers such as Home Health Agencies are required to complete only one test per year. Not only is the requirement for two tests per year unduly burdensome, taking staff away from their responsibilities of caring for residents, but our members tell us that very little is gained from performing a second exercise each year, particularly those such as tabletop exercises and workshops.

LeadingAge recommends modifying the requirement to eliminate the second annual exercise and requiring only one full scale community- or individual facility-based exercise each year to ensure a more meaningful experience for the remaining testing exercise while taking less time from residents for administrative exercises.

**Facility Reported Incidents.** Nursing homes are required to report incidents that occur under various sections of the Requirements of Participation. Under 42 CFR 483.12(c)(1), nursing homes must report alleged violations involving abuse, neglect, exploitation, or mistreatment,

including injuries of unknown source and misappropriation of resident property, to the state survey agency and adult protective services in accordance with state law. Nursing homes must conduct thorough investigations of alleged violations and report the results to officials including the state agency in accordance with state law within five working days of the incident.

Often times, reporting of these incidents leads to an on-site investigation by the state agency, documented as a "complaint survey" and if it is determined that abuse occurred, a finding of noncompliance at F600 Free from Abuse and Neglect, which states that the facility failed to protect the resident from abuse. Nursing homes are cited at F600 for all incidents of abuse that occur, regardless of whether the perpetrator of the abuse of a staff member or another resident or visitor, regardless of whether the nursing home failed to heed any signs that abuse may occur, and regardless of any actions taken by the nursing home to ensure abuse did not reoccur.

This lack of distinction unfairly sends the message that all incidents are the same and that nursing homes are complicit in abuse. There is a significant difference between a nursing home that identifies and immediately reports resident-to-resident abuse according to requirements and a nursing home that fails to identify the abuse or identifies it but chooses not to report, hoping to avoid citation. There is a significant difference between a nursing home who allows a resident who has demonstrated aggressive behavior to continue to interact with other residents without supervision and a nursing home who immediately puts interventions in place such as enhanced supervision, behavioral support, and staff training to prevent further incident.

This failure to make the distinction of nursing homes that are committed to protecting residents from abuse creates significant burden on these nursing homes who must then work to make this distinction from a position of defense in a system stacked against them.

LeadingAge recommends modifying administrative processes to clearly distinguish on form CMS-2567 Statement of Deficiencies when a finding of abuse is based upon a Facility-Reported Incident, indicating that the nursing home promptly identified and reported the abuse in compliance with requirements, and when these citations are findings of past noncompliance, meaning that the nursing home took immediate action to correct noncompliance and prevent future noncompliance. LeadingAge further requests that the same distinctions are made on Care Compare, and that CMS directs state agencies to distinguish and separately track surveys based on Facility-Reported Incidents from other complaint surveys.