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Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

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DATE: **June 1, 2020**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: ***Revised*** COVID-19 Survey Activities, CARES Act Funding, Enhanced Enforcement for Infection Control deficiencies, and Quality Improvement Activities in Nursing Homes

- ***CMS is committed*** *to taking critical steps to protect vulnerable Americans to ensure America's health care facilities are prepared to respond to the Coronavirus Disease 2019 (COVID-19) Public Health Emergency (PHE).*
- ***CMS has implemented*** *a new COVID-19 reporting requirement for nursing homes, and is partnering with CDC's robust federal disease surveillance system to quickly identify problem areas and inform future infection control actions.*
- ***Following the March 6, 2020 survey prioritization,*** *CMS has relied on State Survey Agencies to perform Focused Infection Control surveys of nursing homes across the country. We are now initiating a performance-based funding requirement tied to the Coronavirus Aid, Relief and Economic Security (CARES) Act supplemental grants for State Survey Agencies. Further, we are providing guidance for the limited resumption of routine survey activities.* ***CMS has revised the criteria requiring states to conduct focused infection control surveys due to the increased availability of resources for the testing of residents and staff and factors related to the quality of care.***
- ***CMS is providing Frequently Asked Questions related to health, emergency preparedness and life-safety code surveys***
- ***CMS is also enhancing the penalties for noncompliance*** *with infection control to provide greater accountability and consequence for failures to meet these basic requirements. This action follows the agency's prior focus on equipping facilities with the tools they needed to ensure compliance, including 12 nursing home guidance documents, technical assistance webinars, weekly calls with nursing homes, and many other outreach efforts. The enhanced enforcement actions are more significant for nursing homes with a history of past infection control deficiencies, or that cause actual harm to residents or Immediate Jeopardy.*
- ***Quality Improvement Organizations*** *have been strategically refocused to assist nursing homes in combating COVID-19 through such efforts as education and training, creating action plans based on infection control problem areas and recommending steps to establish a strong infection control and surveillance program.*

Background

The coronavirus presents a unique challenge for nursing homes. Therefore, CMS is using every tool at our disposal to protect our nation's most vulnerable citizens and aid the facilities that care for them. Since the pandemic began, CMS, in coordination with the Centers for Disease Control and Prevention (CDC), has provided ongoing technical guidance and assistance to all Medicare and Medicaid certified providers and suppliers, including nursing homes. Nursing homes have been ground zero for COVID-19. As the data from our required COVID-19 reporting from nursing homes indicates, additional immediate action is necessary to safeguard the health and safety of residents.

Further, to complement our technical assistance efforts, States and CMS have completed Focused Infection Control surveys in approximately 53% of the nation's nursing homes. We are calling on States to ensure that all Medicare and Medicaid certified nursing homes receive this onsite, targeted review and access to the new CARES Act funding will be tied to a state's progress on completing these surveys.

Guidance

Focused Infection Control Nursing Home Surveys and CARES Act Supplemental Funding

Currently, States receive over $397 million to perform oversight surveys and certification of Medicare and Medicaid certified providers and suppliers.

On March 4, 2020, CMS called for States to focus surveys on infection control and on March 23, 2020 provided a streamlined tool to facilitate these efforts. There is currently wide variation in the number of Focused Infection Control surveys of nursing homes performed by States, between 11%-100% (with a national average of approximately 54.1%). Based on the COVID-19 nursing home data being reported to the CDC, CMS believes further direction is needed to prioritize completion of focused infection control surveys in nursing homes.

Therefore, States that have not completed 100% of their focused infection control nursing home surveys by July 31, 2020 will be required to submit a corrective action plan to their CMS location outlining the strategy for completion of these surveys within 30 days. If, after the 30-day period, States have still not achieved surveys in 100% of their nursing homes, their CARES Act FY2021 allocation may be reduced by up to 10%. Subsequent 30-day extensions could result in an additional reduction of up to 5%. These funds would then be redistributed to those States that completed 100% of their focused infection control surveys by July 31.

Access to FY 2020 CARES Act allocations will be based on the following:

- All States may request FY 2020 CARES Act supplemental funding, up to their FY 2020 proportional allocation cap.
- States that have completed 100% of their nursing home focused infection control surveys will be able to request their entire FY 2020-FY2023 CARES ACT funding allocation (at their discretion) and can also apply for redistributed funding from States that failed to meet performance goals.

COVID-19 Survey Activities

In addition to completing the *COVID-19* Focused Infection Control *(FIC)* surveys of nursing homes, CMS is also requiring States to implement the following COVID-19 survey activities:

1. Perform on-site *FIC* surveys (*within 30 days of June 1, 2020)* of nursing homes with previous COVID-19 outbreaks, defined as:
   - Cumulative confirmed cases/bed capacity at 10% or greater; **or**
   - Cumulative confirmed cases/bed capacity at 20% or greater; **or**
   - Ten or more deaths reported due to COVID-19.

2. Perform on-site FIC surveys (start survey *within three to five days of identification*) of any nursing home with 3 or more new COVID-19 confirmed cases since the last National Healthcare Safety Network (NHSN) COVID-19 report, **or** 1 confirmed resident case in a facility that was previously COVID-free, ***and*** *other factors that may place residents' health and safety at risk. These factors include:*
   - *Multiple weeks with new COVID-19 cases;*
   - *Low staffing;*
   - *Selection as a Special Focus Facility per Section 1819(f)(8)(B) of the Social Security Act ;*
   - *Concerns related to conducting outbreak testing per CMS requirements; or*
   - *Allegations or complaints which pose a risk for harm or Immediate Jeopardy to the health or safety of residents which are related to certain areas, such a abuse or quality of care (e.g., pressure ulcers, weight loss, depression, decline in functioning).*

   *CMS will work with State Survey Agencies to identify facilities that meet the above criteria, and t*he FIC survey must start within 3-5 days of identification. State Survey Agencies are also encouraged to communicate with their State Healthcare Associated Infection coordinators prior to initiating these surveys.

   Facilities that meet the criteria above to trigger an FIC survey do not need to be re-surveyed if a FIC survey was conducted (as a stand-alone FIC survey or as part of a recertification survey) within the previous three weeks. For example, if a facility is surveyed with a FIC survey within 3-5 days after meeting the criteria, and the same facility meets the criteria for being surveyed within 3-5 days in any of the next three weeks, the survey team does not need to conduct another survey within those three weeks. However, if the facility meets the criteria for a survey in the fourth week after a FIC survey was conducted, an additional FIC survey must be conducted within 3-5 days.

3. Starting in FY 2021, perform annual Focused Infection Control surveys of 20 percent of nursing homes based on State discretion or additional data that identifies facility and community risks. *To count toward the required 20 percent, these FIC surveys must be stand-alone surveys not associated with a recertification survey. Additionally, FIC surveys conducted in FY 2021, triggered by meeting the criteria in #2 above, may count toward meeting the State's 20 percent requirement.*

States that fail to perform these survey activities timely and completely could forfeit up to 5% of their CARES Act Allocation, annually.

NOTE: *When conducting FIC surveys, long-term care (LTC) facility surveyors should be alert to, and investigate any concerns related to residents who have had a significant decline in their condition (e.g., weight loss, mobility) during the PHE.*

Additional COVID Activities

CARES Act funds may also be used for State-specific interventions (such as Strike Teams, enhanced surveillance, or monitoring of nursing homes). In addition, in August 2020, State Survey Agency priorities may also be informed by recommendations from the *Coronavirus Commission for Safety and Quality in Nursing Homes*.

Expanded Survey Activities

Finally, to transition States to more routine oversight and survey activities, once a state has entered Phase 3 of the Nursing Homes Re-opening guidance (https://www.cms.gov/files/document/nursing-home-reopening-recommendations-state-and-local-officials.pdf), or earlier, at the state's discretion, States are authorized to expand beyond the current survey prioritization (Immediate Jeopardy, Focused Infection Control, and Initial Certification surveys) to perform (**for all provider and supplier types**):

- Complaint investigations that are triaged as Non-Immediate Jeopardy-High
- Revisit surveys of any facility with removed Immediate Jeopardy (but still out of compliance),
- Special Focus Facility and Special Focus Facility Candidate recertification surveys, and
- Nursing home and Intermediate Care Facility for individuals with Intellectual Disability (ICF/IID) recertification surveys that are greater than 15 months.

When determining the order in which to schedule more routine surveys, States should prioritize providers based on those with a history of noncompliance, or allegations of noncompliance, with the below items:

- Abuse or neglect;
- Infection control;
- Violations of transfer or discharge requirements;
- Insufficient staffing or competency; or
- Other quality of care issues (e.g., falls, pressure ulcers, etc.).

Accrediting organizations may resume normal survey activities based on state reopening criteria. Any variations from the approved reaccreditation survey process must receive CMS-approval prior to implementation.

Frequently Asked Questions on Resumption of Survey Activities

CMS has received questions from stakeholders as well as Federal and State Surveyors related to the resumption of survey activities. We have attached FAQs addressing questions on LTC facility Health surveys, Emergency Preparedness surveys and Life Safety Code surveys (for all provider types), along with a Guide to Waived F-Tags and K-Tags for clarification.

Enhanced Enforcement for Infection Control Deficiencies

While CMS infection control deficiencies have been an ongoing compliance concern, the COVID-19 pandemic highlights the imperative that nursing home staff adhere to these fundamental health

and safety protocols. Due to the heightened threat to resident health and safety for even low-level, isolated infection control citations (such as proper hand-washing and use of personal protective equipment (PPE), CMS is expanding enforcement to improve accountability and sustained compliance with these crucial practices. In addition to enhanced enforcement, CMS is also providing Directed Plans of Correction, including use of Root Cause Analysis, to facilitate lasting systemic changes within facilities to drive sustained compliance.

Therefore, substantial non-compliance (D or above) with deficienc*ies* associated with Infection Control requirements *at F880* will lead to the following enforcement remedies:

- Non-compliance for an Infection Control deficiency when none have been cited in the last year (or on the last standard survey):
    - Nursing homes cited for current non-compliance that is not widespread (Level D & E) - *Directed Plan of Correction*
    - Nursing homes cited for current non-compliance with infection control requirements that is widespread (Level F) - *Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with **45**-days to demonstrate compliance with Infection Control deficiencies.*
- Non-compliance for Infection Control Deficiencies cited once in the last year (or last standard survey):
    - Nursing Homes cited for current non-compliance with infection control requirements that is not widespread (Level D & E) -*Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with **45**- days to demonstrate compliance with Infection Control deficiencies, Per Instance Civil Monetary Penalty (CMP) up to $5000 (at State/CMS discretion)*

      Nursing Homes cited for current non-compliance with infection control requirements that is widespread (Level F) -*Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with **45**-days to demonstrate compliance with Infection Control deficiencies, $10,000 Per Instance CMP*
- Non-compliance that has been cited for Infection Control Deficiencies twice or more in the last two years (or twice since second to last standard survey)
    - Nursing homes cited for current non-compliance with Infection Control requirements that is not widespread (Level D & E) -*Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, **30**-days to demonstrate compliance with Infection Control deficiencies, $15,000 Per Instance CMP (or per day CMP may be imposed, as long as the total amount exceeds $15,000)*
    - Nursing homes cited for current non-compliance with Infection Control requirements that is widespread (Level F) -*Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, **30**-days to demonstrate compliance with Infection Control deficiencies, $20,000 Per Instance CMP (or per day CMP may be imposed, as long as the total amount exceeds $20,000)*

- Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Harm Level (Level G, H, I), regardless of past history -*Directed Plan of Correction, Discretionary Denial of Payment for New Admissions with **30**-days to demonstrate compliance with Infection Control deficiencies.* Enforcement imposed by CMS Location per current policy, but CMP imposed at highest amount option within the appropriate (non-Immediate Jeopardy) range in the CMP analytic tool.

- Nursing Homes cited for current non-compliance with Infection Control Deficiencies at the Immediate Jeopardy Level (Level J, K, L) regardless of past history –In addition to the mandatory remedies of Temporary Manager or Termination, *imposition of Directed Plan of Correction, Discretionary Denial of Payment for New Admissions, **15**-days to demonstrate compliance with Infection Control deficiencies.* Enforcement imposed by CMS Location per current policy, but CMP imposed at highest amount option within the appropriate (IJ) range in the CMP analytic tool.

Quality Improvement Organization Support

While we have taken these important actions at a regulatory level, we have also strategically refocused the approach of the Quality Improvement Organizations (QIO) to assist in combating COVID-19 within these facilities.

In November 2019, CMS took a major step toward improving quality for Medicare beneficiaries in nursing homes as well as rural and underserved communities by awarding contracts to 12 experienced, community-based organizations to serve as QIOs and focus on areas of immediate need as well as urgent healthcare priorities. With varying degrees of intensity, QIOs provide education and training to every nursing home in the country. All nursing homes across the country can take advantage of weekly National Infection Control Training that focuses on all aspects of infection control, prevention and management to help nursing homes prevent the transmission of COVID-19 in facilities and keep residents safe. Additionally, as part of their ongoing work, the QIOs provide more direct assistance to around 6,000 small, rural nursing homes and those serving vulnerable populations in areas where access to care is limited with helping them understand and comply with CMS and CDC reporting requirements, sharing best practices related to infection control, testing and patient transfers.

Lastly, the QIOs are being deployed to provide technical assistance to nursing homes, which includes a targeted focus on approximately 3,000 low performing nursing homes who have a history of infection control challenges. Further, States may request QIO technical assistance specifically targeted to nursing homes that have experienced an outbreak. These requests should be sent to Anita Monteiro, Acting Director of the iQuality Improvement and Innovation Group at CMS: anita.monteiro@cms.hhs.gov. The QIOs help nursing homes identify what their greatest areas of infection control problems are, then create an action plan, and implement specific steps to establish a strong infection control and surveillance program in the nursing home. For instance, they train staff on proper use of personal protective equipment (PPE), cohorting residents appropriately and transferring residents safely. They monitor compliance with infection control standards and practices in the nursing home.

Nursing homes can locate the QIO responsible for their state here: http://www.qioprogram.org/locate-your-qio.

Contact

Questions about *LTC facility Survey activities* should be addressed to: *NHSurveyDevelopment@cms.hhs.gov.*
Questions about LTC facility enforcement should be addressed to: DNH_Enforcement@cms.hhs.gov.
Questions about Non-LTC facility survey activities and enforcement and Emergency Preparedness Surveys should be addressed to: QSOG_LifeSafetyCode@cms.hhs.gov.

Effective Date

Effective immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators immediately. This guidance will cease to be in effect when the Secretary determines there is no longer a Public Health Emergency due to COVID-19. At that time, CMS will send public notice that this guidance has ceased to be effective via its website.

/s/
David R.Wright

cc: Survey and Operations Group Management

Attachments:
FAQ on Resumption of Life Safety Code, Emergency Preparedness, and Long-Term Care Health Surveys
K-tag Waiver Guide
F-tag Waiver Guide

Resuming Long-Term Care (LTC) Standard Recertification Health Surveys;

and Emergency Preparedness and Life Safety Code Surveys for all Provider Types

Frequently Asked Questions (FAQs)

The purpose of this Frequently Asked Questions (FAQs) is to clarify existing guidance and provide additional guidance to State Survey Agencies (SAs) when conducting LTC standard recertification health surveys; and when conducting emergency preparedness (EP) and life safety code (LSC) surveys for all provider types.

LTC surveyors are expected to complete the COVID-19 Surveyor Training for Long Term Care facilities related to Staff and Resident Testing available on QSEP, prior to conducting a COVID-19 Focused Infection Control (FIC) Survey.

General

Q1. When conducting LTC recertification health surveys, if surveyors discover that the facility has one or more cases of COVID-19, must they combine the COVID-19 Focused Infection Control (FIC) survey with the standard recertification survey?

A. No. The Infection Control Facility Task performed as part of the standard recertification health survey is a comprehensive look at facility infection prevention and control practices, which would include a review of those practices necessary to prevent and control the spread of COVID-19.

For surveys beginning after November 30, 2020, the probes of the FIC survey tool have been combined with the Infection Control Facility Task Pathway, and incorporated into the LTC Survey Process (LTCSP) survey software. This revised pathway should be used for all LTC recertification surveys, infection control complaints, and FIC stand-alone surveys; therefore a separate FIC survey would not be necessary. Additionally, when creating the LTC recertification health survey shell in ASPEN Central Office, surveyors should not use the FIC code.

Q2. How should LTC standard recertification health surveys, and EP surveys and LSC surveys be conducted when there are active COVID-19 cases in the building?

A. Per QSO 20-35-All, States may resume performing LTC standard recertification health surveys, and EP and LSC surveys (for all provider types) at the State's discretion as soon as they have the resources (e.g., staff and/or PPE) to do so. Upon arrival, if the facility is cohorting COVID-19 positive residents, ensure only one surveyor is assigned to and stays exclusively in that area of the building. If a surveyor is restricted to a specific area of the building, the surveyor should meet virtually with the team throughout the survey. The team will have to retrieve that surveyor's data through email or some other secure means. The Long Term Care Survey Process (LTCSP) Procedure Guide (PG) provides three different data sharing methods: using file method, using secured wireless method, using secured wired method. Additionally, all surveyors should use appropriate infection control precautions when entering resident and/or patient rooms. See Interim Infection Prevention and Control Recommendations for Healthcare Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic. The surveyor's laptop computer is similar to bringing a note pad and pen into the resident's room. Residents, patients and facility staff should not touch the surveyor's laptop computer. The surveyor should not place the laptop computer on an unclean surface.

In situations where there is only one surveyor conducting the survey (e.g., complaint, LSC, or EP), to the extent possible, the surveyor should begin the survey activity in an area with negative residents and not return to that area once positive residents have been encountered.

Additionally, for surveyors conducting any type of survey, (e.g. LTC standard recertification, and complaint, EP, or LSC surveys for any provider type), survey agencies should supply surveyors with proper Personal Protective Equipment (PPE) and supplies including, but not limited to: N95 respirators, procedural/surgical masks, gloves, face shield/goggles/eye protection, hand sanitizer, and sanitizing wipes. Surveyors may use certain types of PPE and supplies provided by the facility, in an emergency. However, due to nationwide supply shortages, surveyors should not expect a facility to provide PPE and supplies.

Q3. Are certified providers and suppliers required to allow surveyors and Fire Marshals into their facilities?

A. Medicare and Medicaid certified providers and suppliers must grant access to Federal, State, and AO surveyors performing onsite inspections, including Fire Marshals performing LSC and emergency preparedness inspections. Per 42 CFR 489.53(a): "CMS may terminate the agreement with any provider if … (18) The provider or supplier fails to grant immediate access upon a reasonable request to a SA or other authorized entity for the purpose of determining, in accordance with § 488.3, whether the provider or supplier meets the applicable requirements, conditions of participation, conditions for coverage, or conditions for certification."

Similar to other law enforcement, regulatory, and public health oversight, the Centers for Medicare & Medicaid Services (CMS) must continue to fulfill its statutory, regulatory and mission-focused priorities to ensure the health and safety of patients and residents. These vital oversight activities have taken on even greater importance during the public health emergency. CMS takes seriously the need to provide oversight of care delivery while not jeopardizing the health and safety of the patients, residents, and staff who may engage with surveyors during an inspection.

Q4. What protocols are in place for surveyors?

A. It is important to note that surveyors are in an observation, not direct care role when they enter a facility to conduct surveys. They are trained to both monitor and practice proper infection control protocols while performing their surveys. The safety of all involved, including the surveyors, is paramount.

All surveyors should wear appropriate PPE and adhere to the practices for COVID-19 infection prevention (e.g., social distancing, hand hygiene, etc.) while onsite, and adhere to any health-related screening protocols before entering a facility, including temperature checks and noting any potential signs or symptoms of infection.

Q5. Can a facility refuse entry to a surveyor based on results of screening protocols?

A. Facilities generally may not refuse entry to surveyors arriving to conduct a survey (see 42 C.F.R. §489.53(a)(18), quoted above). However, surveyors should not enter facilities if they are experiencing signs or symptoms of infection. Facility concerns related to a surveyor presenting with signs and symptoms of COVID-19 should be conveyed to the SA and, if necessary, the appropriate CMS location.

As noted in the Q4 response above, all surveyors should adhere to any health-related screening protocols before entering a facility for any potential signs or symptoms of infection (such as temperature or

fsymptoms, including coughing, sore throat, or other symptoms included in the CDC guidance here: https://www.cdc.gov/coronavirus/2019-ncov/symptoms-testing/symptoms.html).

Q6. Are surveyors required to be tested?

A. While CMS strongly encourages States to provide COVID-19 testing for surveyors (and many do), CMS does not have authority to mandate this as a requirement for state employees. Facilities can offer to test surveyors for COVID-19 prior to entry, and surveyors may agree to be tested, but facilities cannot require testing (or proof of testing) as a condition for surveyors entering the facility. Additionally, if a facility offers to test a surveyor, any associated fees should be disclosed prior to any test, and again, surveyors are not obligated to be tested.

Q7. Should the team try to minimize the number of surveyors who interact with known COVID-19 positive residents?

A. Yes, we recommend, where practical, one surveyor be assigned to COVID-19 positive residents only. Additionally, we recommend that a different surveyor be assigned to the COVID-19 suspected residents, or those residents under observation. CMS recommends that the surveyor that is assigned to the COVID-19 unit should stay on that unit for the entire survey while completing the investigation and tasks specific to that unit.

If a surveyor is restricted to a specific area of the building (e.g., because of cohorting), the surveyor should not physically meet with any other survey team member. The surveyor should meet virtually (on his/her own) with the team throughout the survey. In such case, the team will have to retrieve that surveyor's data securely (e.g., through email). The purpose of this is to ensure that surveyors who have been surveying on a COVID-19 positive or suspected positive unit do not also survey or make contact with persons on a non-COVID-19 unit.

Q8. Does the Personal Protective Equipment (PPE) requirement for surveyors change based on the COVID-19 status of the facility?

A. Yes, surveyors must comply with any mitigation strategies the facility has in place to prevent COVID-19 transmission. Surveyors should not move between COVID-19 positive, suspected positive, and non-COVID-19 areas within the facility. At a minimum, surveyors should wear face masks as appropriate, while in a facility during the Public Health Emergency (PHE). PPE may also be required, such as gowns, N95 respirators, and/or eye protection if confirmed COVID-19 residents are within the facility, as well as the type of transmission-based precaution a resident may be on (e.g., contact precautions), the type of resident procedure performed, and the potential for blood or body fluid exposures. Since the demand for PPE may vary based on the COVID-19 status of the building, surveyors should prepare adequate PPE for the entire survey.

Q9. For facilities with a COVID-19 unit, should that unit be included in the sample selection process?

A. Yes, the survey team should include COVID-19 suspected or confirmed residents in sample selection. Per QSO-20-38, when conducting FIC surveys, the survey team should select at least one sample resident who was confirmed COVID-19 positive or had signs or symptoms consistent with COVID-19, for purposes of determining compliance with infection control, including transmission-based precautions, and/or F886. The team would assign one surveyor to the COVID-19 unit who would be responsible to review the residents on that unit.

Entrance Conference

Q10. During LTC standard recertification health surveys, will survey teams be permitted to complete entrance activities by phone?

A. No. The LTC standard recertification health survey is unannounced. The entrance conference should be done safely onsite and in the presence of a facility representative using COVID-19 infection prevention practices. After identifying yourself to facility personnel and prior to conducting the entrance conference, the team coordinator/individual surveyor must ask the administrator if there are any confirmed/suspected cases of COVID-19 in the facility. At the entrance conference, the team coordinator and the facility representative should follow CDC guidance to maintain social distancing.

Initial Pool

Q11. During LTC standard recertification health surveys, if the initial pool of residents includes a COVID-19 positive resident, could that resident be replaced with someone who is negative?

A. No, a COVID -19 positive resident in the initial pool should not be replaced with a resident who is COVID-19 negative. The initial pool is intended to identify residents with high-risk care concerns to further investigate and determine the facility's compliance with the requirements of participation. With changes that have been put in place for the LTCSP starting November 30, 2020, the team is required to include at least one resident, if available, who is suspected or confirmed positive for COVID-19 in the initial pool, (Step 13 in the LTCSP procedure guide).

Investigations

Q12. During standard recertification surveys, will survey teams be permitted to complete phone interviews and record reviews offsite to minimize time onsite?

A. For the Initial Pool, surveyors should attempt to safely interview the resident in person, even if the resident is COVID-19 positive or suspected positive, using infection prevention practices (PPE, social distancing, etc.). As always, if an interview needs to be conducted with someone that is not present in the facility (e.g., resident representative), then a telephone interview should be attempted.

Surveyors should attempt to safely complete all of the initial pool activities onsite which includes resident observations, resident/family interviews (unless the family is not onsite), and record reviews during the first 8-10 hours of the survey.

CMS expects surveyors to clarify any discrepancies and corroborate any interview information onsite prior to sample finalization.

It is important to collect first-hand information and collect evidence through observations and interviews. During investigation, surveyors may still need to remain onsite to conduct additional observations or resident interviews; however, there may be opportunities to conduct additional phone interviews or record review offsite to determine whether the facility is in compliance with the requirement or not. There may be some opportunities to conduct a few additional survey activities offsite (e.g., team meetings, review of policy and procedures, exit conference).

Facility Tasks

Q13. Are there any facility tasks that need to be altered if there are COVID-19 cases in the building?

A. If the facility is experiencing an outbreak of COVID-19 at the time the survey team enters to conduct a recertification survey, the survey team should make adjustments in order to prevent further spread of COVID-19. Examples of facility tasks that may be modified include:

Resident Council Interview:

Group interviews must be done while social distancing. If this is not possible, the surveyor could ask to review the resident council minutes for any concerns voiced by the council and follow up on items identified with the Resident Council President or one of the active council members.

Additional guidance for conducting an in-person group interview includes:

- Limit the number of residents who are invited to the meeting to facilitate easier communication with facemasks on.
- Ensure the meeting is held in a room that allows for everyone to socially distance.
- Give a copy of the questions to the participating residents in advance of the interview.
- Speak loudly, clearly, and slowly so you can be heard through your facemask.

For residents who participate in the Resident Council interview and are not on transmission-based precautions (TBP), it is important for everyone including the assigned surveyor to wear a face covering/mask as appropriate, maintain social distancing and perform hand hygiene at all times.

Dining Task:

If the facility is allowing residents to gather in a dining area while maintaining social distancing, the surveyors should observe the first meal after entrance using the Dining Observation facility task pathway in the software. The team should cover ALL communal dining locations and room trays. If there are more dining areas than surveyors, prioritize the dining areas with the most dependent residents. The surveyor assigned to the COVID-19 unit would observe dining for the COVID-19 unit.

Per QSO-20-39, residents who are no longer on transmission-based precautions for either confirmed COVID-19, suspected COVID-19, or those on quarantine/observation for unknown COVID-19 status, may eat in the same dining room or area, while practicing social distancing (limited number of people at tables and at least 6 feet between each person).

However, if dining rooms are not being used, the survey team should investigate further and determine whether the requirements related to food and nutrition services are being met, and assess if assistance is being provided for residents who require assistance with dining. In addition, at a minimum, the survey team should observe the meal for their initial pool residents who have weight loss, food, or hydration concerns, wherever their meal is served.

Exit Conference

Q14. During standard recertification surveys, will survey teams be permitted to complete exit activities by phone?

A. The exit conference may be done by phone or through a virtual meeting if all invited parties agree, including the facility, ombudsman, and an officer of the organized resident group in order to limit the time the team spends in the facility.

During the LSC Exit Conference, discuss with the Administrator any significant deviation from standard procedures that the LSC team took due to COVID-19. Reaffirm that these deviations are in response to

the PHE and not indicative of permanent changes to LSC requirements or the LSC survey process. In most cases, the LSC team may have a separate exit conference with the administrator, unless conducted with the health survey team. They may also be done by phone or virtual meeting.

Waivers

Q15. To what extent are the COVID-19 Emergency Blanket Waivers modified due to the expansion of the survey activities authorized via CMS Memo QSO-20-35-ALL?

A. Specified COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers are in effect with a retroactive effective date of March 1, 2020, through the end of the emergency declaration. Please note, however, that some waivers have been modified or rescinded. The survey team should review the current waivers prior to determining compliance of those requirements.

Some requirements, including certain Physical Environment (PE) and Life Safety Code (LSC) provisions, have been temporarily waived or amended to give facilities maximum flexibility during the PHE. CMS, State Agencies (SA), and AO surveyors should review and confirm with the facility the waivers prior to determining compliance of those requirements. Refer to all of the waivers at the following link:

https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

Resuming Physical Environment (PE) and Life Safety Code (LSC) Surveys During/After the COVID-19 Public Health Emergency

Q16. What adjustments should Life Safety Code surveyors make during the survey process in response to COVID-19?

A. Due to the COVID-19 PHE, changes in facility operations may require surveyors to adjust standard PE and LSC survey procedures. Possible adjustments to PE and LSC survey procedures are listed below. These adjustments are intended only for the PE and LSC portion of a survey and not intended to alter or modify the health portion of a survey.

- Facility Tour
    - In certain circumstances, the PE and LSC survey team may choose not to enter rooms/wings which have been identified by the facility as containing confirmed/suspected COVID-19 cases. For instance, in nursing facilities, if the number of bedrooms inspected in the rest of the facility meets the representative sample of bedrooms listed in the State Operations Manual (SOM), Appendix I, Table 1, no special notations are required. If the number of bedrooms checked does not meet the representative sample of bedrooms listed in Table 1, the LSC team must note the reason for the reduced number of bedrooms checked and the number of bedrooms actually checked versus the total number of bedrooms (or the approximate percentage of bedrooms checked) in the K000 tag of the form CMS-2567.

SAMPLE SIZE OF RESIDENT/PATIENT ROOMS

The table below gives the sample size (number of patient/resident rooms to be checked) needed.

Number of Bedrooms in the Facility	Bedrooms to be Checked
20	19
40	36
60	52
80	66
100	80
200	132
300	169
400	196
500	217
600	234
800	260
1000	278
2000	322

SOM, Appendix I, Table 1

  - When inspecting smoke/fire barriers, the LSC team does not need to inspect the entire length of the barrier from outside wall to outside wall if the inspection would involve entering occupied resident rooms. As much of the barrier as possible should be inspected from the corridor, common areas, and storage/service rooms.

- Records Review
  - During the COVID-19 PHE, the following LSC inspection, testing and maintenance (ITM) items listed below were specifically NOT included as part of the 1135 blanket waivers (and therefore are not waived). The facility should have documentation available for review to demonstrate compliance.
    - Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump testing
    - Portable fire extinguisher monthly inspection
    - Elevators with firefighters' emergency operations monthly testing
    - Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing
    - Means of egress daily inspection in areas that have undergone construction, repair, alterations, or additions to ensure their ability to be used instantly in case of (emergency
    - Documented orientation training program related to the current fire plan in lieu of conducting fire drills
  - Other ITM timeframes and activities for facility, equipment, and LSC may have been adjusted at the discretion of the facility during the PHE in order to reduce disruption of patient care and potential exposure/transmission of COVID-19 (e.g., limit the number of outside vendor personnel entering the facility for annual fire alarm inspection, 5-year sprinkler pipe inspection, biennial smoke detector sensitivity test, etc.).

- Deficiency Determination

- A facility should NOT be cited for missing an ITM timeframe or adjusted ITM activities during the PHE as specified in the 1135 blanket waivers, with the exception of the non-waived items listed above.
- A facility should NOT be cited for ABHR, fire drills, or walls and barriers deficiencies during the PHE that meet the 1135 blanket waiver conditions.
- Utilize the K-tag guide to assist with deficiency determination and identifying LSC requirements that are associated with 1135 waivers. K-tag waiver guide may be accessed within the Surveyor Resource folder located at the following website: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes
- All other PE and LSC deficiencies should be cited in accordance with regular survey procedures.

CMS recognizes that the approach to performing PE and LSC surveys during the PHE must initially be determined on a case-by case basis due to the various blanket waivers and flexibilities that were afforded to facilities during the PHE. Surveyors will need to use professional judgment, in consultation with SA and AO management and the CMS location the state is connected to, on a facility-by-facility basis, on how to survey and determine deficiencies.

Q17. Should a PE or LSC surveyor cite an Inspection, Testing, and Maintenance (ITM) deficiency that occurred prior to the PHE?

A. Yes. Should an ITM item be found as being deficient before the March 1, 2020 effective date of the 1135 blanket waivers (e.g. missed quarterly sprinkler inspection due by December 31, 2019) and the facility can verify that it was unable to correct the deficiency due to the PHE, cite the deficiency at the standard level and follow Plan of Correction (POC) guidance.

Q18. How should facilities deal with citations for ITM deficiency if they can't be corrected due to vendor access restrictions under the ongoing PHE?

A. In order to account for the unknown duration of the COVID-19 PHE and the time it will take facilities and vendors to return to full operations, cited deficiencies may require additional time beyond the standard enforcement timelines to come into substantial compliance (i.e. 90 days for denial of payment for new admissions and 180 days for termination in LTC facilities, and 60 days in non-LTC facilities). Facilities should request temporary LSC waivers, as applicable, as part of their POC if they can substantiate delays due to the PHE. The POC must still include details for corrective actions the facility will take in order to bring the facility back into substantial compliance once access restrictions are lifted. The temporary LSC waiver request should also include any mitigation necessary to reduce the risk to patient health and safety as a result of delayed correction of any deficient practice.

The SA and AO should review all temporary waiver requests and forward those recommended to the appropriate CMS Location for final approval or denial.

Q19. Have Emergency Preparedness requirements been adjusted under the PHE?

A. A limited number of blanket waivers were issued by CMS in relation to Emergency Preparedness for hospitals, Critical Access Hospitals (CAH), and End-Stage Renal Dialysis (ESRD) facilities. For all other provider types (including LTC facilities), Emergency Preparedness requirements remain unchanged. *Refer to emergency preparedness waivers at the following link:* https://www.cms.gov/about-cms/emergency-preparedness-response-operations/current-emergencies/coronavirus-waivers

K-tag Guide

This guide is intended to assist surveyors with matching 1135 blanket waivers and flexibilities with the corresponding K-tag(s). Surveyors will need to use professional judgment, in consultation with State Agency (SA) management and the CMS location, on how to survey and determine deficiencies on a case-by-case basis.

A. Limited per COVID-19 emergency declaration and/or COVID-19 survey protocol.
- Limited due to 1135 blanket waivers:
  - K111: Means of egress daily inspections in areas that have undergone construction, repair, alterations, or additions to ensure its ability to be used instantly in case of emergency were NOT part of the 1135 blanket waivers for the PHE.
  - K163: Requirements that would otherwise not permit temporary walls and barriers between patients were waived as part of the 1135 blanket waivers for the PHE.
  - K325: Prescriptive requirements for the placement of alcohol-based hand rub (ABHR) dispensers were waived as part of the 1135 blanket waivers for the PHE. Due to the increased fire risk, bulk containers (over five gallons) will still need to be stored in a protected hazardous materials area.
  - K353: Sprinkler system monthly electric motor-driven and weekly diesel engine-driven fire pump tests have been deemed critical and were not part of the 1135 blanket waivers for the PHE. These tests must be evaluated during the recertification survey. The schedules for inspection, testing and maintenance for the rest of the sprinkler system are permitted to be adjusted by the 1135 blanket waiver and do not need to be evaluated during the recertification survey.
  - K355: Portable fire extinguisher monthly inspections were not part of the 1135 blanket waivers for the PHE. These tests must be evaluated during the recertification survey. The schedules for inspection, testing and maintenance of other aspects of portable fire extinguishers are permitted to be adjusted by the 1135 blanket waiver and do not need to be evaluated during the recertification survey.
  - K531: Elevators with firefighters' emergency operations monthly testing has been deemed critical and NOT part of the 1135 blanket waivers for the PHE. Tests must be evaluated during the recertification survey. The schedules for inspection, testing and maintenance for the rest of the elevator system is permitted to be adjusted by the 1135 blanket waiver and do not need to be evaluated during the recertification survey.
  - K712: In lieu of a physical fire drill, a documented orientation training program related to the current fire plan, which considers current facility conditions, is acceptable. The training will instruct employees, including existing, new or temporary employees, on their current duties, life safety procedures and the fire protection devices in their assigned area.
  - K918: Emergency generator 30 continuous minute monthly testing and associated transfer switch monthly testing have been deemed critical and were not part of the 1135 blanket waivers for the PHE. These tests must be evaluated during the recertification survey. The schedules for inspection, testing and maintenance for the rest of the emergency generator system is permitted to be adjusted by the 1135 blanket waiver and do not need to be evaluated during the recertification survey.

- Limited due to COVID-19 survey protocol
    - K131: Rated barriers do not require close up inspection if required to enter occupied resident room.
    - K372: Rated barriers do not require close up inspection if required to enter occupied resident room.

B. For all other tags not listed, follow standard survey process to the greatest extent possible.

Blanket 1135 Waived Tags (effective since 3/1/20)

(Red = Substandard QOC * = partial requirements waived)

483.10	**Resident Rights**	**483.35**	**Nursing Services**
*F552	Right to be Informed/Make Treatment Decisions	*F728	Facility Hiring and Use of Nurse
*F559	Choose/Be Notified of Room/Roommate Change	F729	Nurse Aide Registry Verification, Retraining
F560	Right to Refuse Certain Transfers	F730	Nurse Aide Perform Review – 12Hr/Year In-Service
F565	Resident/Family Group and Response	**483.60**	**Food and Nutrition Services**
*F573	Right to Access/Purchase Copies of Records	*F811	Feeding Asst – Training/Supervision/Resident
483.15	**Admission, Transfer, and Discharge**	**483.75**	**Quality Assurance and Performance Improvement**
*F621	Equal Practices Regardless of Payment Source	*F865	QAPI Program/Plan, Disclosure/Good Faith Attempt
*F623	Notice Requirements Before Transfer/Discharge	*F866	{Phase 3} QAPI/QAA Data Collection and Monitoring
F625	Notice of Bed Hold Policy Before/Upon Transfer	*F867	QAPI/QAA Improvement Activities
483.20	**Resident Assessments**	**483.90**	**Physical Environment**
F636	Comprehensive Assessments & Timing	F911	Bedroom Numbers of Residents
F637	Comprehensive Assmt After Significant Change	F912	Bedrooms Measure at Least 80 Square Ft/Resident
F638	Quarterly Assessment At Least Every 3 Months	F913	Bedrooms Have Direct Access to Exit Corridor
F640	Encoding/Transmitting Resident Assessment	F914	Bedrooms Assure Full Visual Privacy
*F645	PASARR Screening for MD & ID	F915	Resident Room Window
483.21	**Comprehensive Resident Centered Care Plan**	F916	Resident Room Floor Above Ground
*F655	Baseline Care Plan	*F917	Resident Room Bed/Furniture/Closet
F656	Develop/Implement Comprehensive Care Plan	F918	Resident Equipped/Near Lavatory/Toilet
F657	Care Plan Timing and Revision	F920	Requirements for Dining and Activity Rooms
*F660	Discharge Planning Process	**483.95**	**Training Requirement**
483.30	**Physician Services**	*F947	Required In-Service Training for Nurse Aides
*F712	Physician Visits-Frequency/Timeliness/Alternate NPPs		
*F714	Physician Delegation of Tasks to NPP		

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The table below displays the waived language for the tags that are partially waived.

Table 1: Partially waived regulatory language

Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
Resident Rights	*F552	§483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.	CMS is waiving requirements in 42 CFR 483.10(c) (5) with some exceptions to allow a long term care facility to transfer or discharge resident to another LTC facility solely for cohorting purposes. Exceptions: In § 483.10, we are only waiving the requirement, under § 483.10(c)(5), that a facility provide advance notification of options relating to the transfer or discharge to another facility. Otherwise, all requirements related to § 483.10 are not waived.
Resident Rights	*F559	§483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.	CMS is waiving the requirements in 42 CFR 483.10(e) (5), (6), and (7) solely for the purposes of grouping or cohorting residents with respiratory illness symptoms and/or residents with a confirmed diagnosis of COVID-19, and separating them from residents who are asymptomatic or tested negative for COVID-19. This action waives a facility's requirements, under 42 CFR 483.10, to provide for a resident to share a room with his or her roommate of choice in certain circumstances, to provide notice and rationale for changing a resident's room, and to provide for a resident's refusal a transfer to another room in the facility. This aligns with CDC guidance to preferably place residents in locations designed to care for COVID-19 residents, to prevent the transmission of COVID-19 to other residents.
Resident Rights	*F573	§483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself.	Pursuant to section 1135(b)(5) of the Act, CMS is modifying the requirement at 42 CFR §483.10(g)(2)(ii) which requires long-term care (LTC) facilities to provide a resident a copy of their records within two working

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		(ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed.	days (when requested by the resident). Specifically, CMS is modifying the timeframe requirements to allow LTC facilities ten working days to provide a resident's record rather than two working days.
Admission, transfer and discharge	*F621	§483.15(c)(9) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part (as defined in § 483.5) are subject to the requirements of § 483.10(e)(7) and must be limited to moves within the particular building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part's locations.	CMS is waiving requirements in 42 CFR 483.15 (c)(9) (with some exceptions) to allow a long term care (LTC) facility to transfer or discharge residents to another LTC facility solely for cohorting purposes.
Admission, Transfer and Discharge	*F623	§483.15 (c) (3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must— (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	CMS is waiving the requirements in §483.15(c) (3), (c)(4)(ii), (c)(5)(i) and (iv) (with some exceptions) to allow a long term care (LTC) facility to transfer to discharge residents to another LTC facility solely for cohorting purpose. Exceptions: in § 483.15, we are only waiving the requirement, under § 483.15(c)(3), (c)(4)(ii), (c)(5)(i) and (iv), for the written notice of transfer or discharge to be provided before the transfer or discharge. This notice must be provided as soon as practicable.

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15 (c) (4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; §483.15 (c) (5) *Contents of the notice.* The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge & (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such	

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;	
Resident Assessment	*F645	(k) Preadmission screening for individuals with a mental disorder and individuals with intellectual disability. (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with— (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—	Per blanket 1135 waiver, CMS is waiving 42 CFR 483.20(k), allowing nursing homes to admit new residents who have not received Level 1 or Level 2 Preadmission Screening. Level 1 assessments may be performed post-admission. On or before the 30th day of admission, new patients admitted to nursing homes with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to State PASARR program for Level 2 Resident Review.
Comprehensive Resident Centered Care Plan	*F655	§483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must— (i) Be developed within 48 hours of a resident's admission.	CMS is waiving 483.21(a)(1)(i), (a)(2)(i). In § 483.21, we are only waiving the timeframes for certain care planning requirements for residents who are transferred or discharged for the purposes for cohorting purpose. Receiving facilities should complete the required care plans as soon as practicable, and we expect receiving facilities to review and use the care plans for residents from the transferring facility, and adjust as necessary to protect the health and safety of the residents the apply to.

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		§483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan— (i) Is developed within 48 hours of the resident's admission. §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary.§483.21 Comprehensive Person-Centered Care Planning	
Comprehensive Resident Centered Care Plan	*F660	§483.21(c)(1) Discharge Planning Process The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and— (viii) For residents who are transferred to another SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on	CMS is waiving the discharge planning requirement in §483.21(c)(1)(viii), which requires LTC facilities to assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use. This temporary waiver is to provide facilities the ability to expedite discharge and movement of residents among care settings. CMS is maintaining all other discharge planning requirements, such as but not limited to, ensuring that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident; involving the interdisciplinary team, as defined at 42 CFR §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan address the resident's goals of care and treatment preferences.

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		quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.	
Physician Services	*F712	§483.30(c) Frequency of physician visits §483.30(c)(3) Except as provided in paragraphs (c)(4) and (f) of this section, all required physician visits must be made by the physician personally. §483.30(c)(4) At the option of the physician, required visits in SNFs, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner or clinical nurse specialist in accordance with paragraph (e) of this section. (4) At the option of the physician, required visits in SNFs after the initial visit may alternate between personal visits by the physician and visits by a physician assistant, nurse practitioner, or clinical nurse specialist in accordance with paragraph (e) of this section**.**	Physician Visits in Skilled Nursing Facilities/Nursing Facilities. CMS is waiving the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in- person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options. Physician Visits. 42 CFR 483.30(c)(3). CMS is waiving the requirement at § 483.30(c)(3) that all required physician visits (not already exempted in § 483.30(c)(4) and (f)) must be made by the physician personally. We are modifying this provision to permit physicians to delegate any required physician visit to a nurse practitioner (NPs), physician assistant, or clinical nurse specialist who is not an employee of the facility, who is working in collaboration with a physician, and who is licensed by the State and performing within the state's scope of practice laws. CMS is not waiving the requirements for the frequency of required physician visits at § 483.30(c) (1).
Physician Services	*F714	§483.30(e)(4) A physician may not delegate a task when the regulations specify that the physician must perform it personally	Physician Delegation of Tasks in SNFs. 42 CFR 483.30(e)(4). CMS is waiving the requirement in § 483.30(e)(4) that prevents a physician from delegating a task when the regulations specify that the physician must perform it personally. This waiver gives physicians the ability to delegate any tasks to a physician assistant, nurse practitioner, or clinical nurse specialist who meets the applicable definition in 42 CFR 491.2 or, in the case of a

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			clinical nurse specialist, is licensed as such by the State and is acting within the scope of practice laws as defined by State law. We are temporarily modifying this regulation to specify that any task delegated under this waiver must continue to be under the supervision of the physician. This waiver does not include the provision of § 483.30(e)(4) that prohibits a physician from delegating a task when the delegation is prohibited under State law or by the facility's own policy.
Nursing Services	*F728	§483.35(d) Requirements for facility hiring and use of nursing aides— (ii)(A) That individual has completed a training and competency evaluation program, or a competency evaluation program approved by the State as meeting the requirements of §§483.151 through 483.154; or (B) That individual has been deemed or determined competent as provided in §483.150(a) and (b). (2) Non-permanent employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee any individual who does not meet the requirements in paragraphs (d)(1)(i) and (ii) of this section. (3) Minimum competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual— (i) Is a full-time employee in a State-approved training and competency evaluation program;	CMS is waiving the requirements at 42 CFR 483.35(d) (with the exception of 42 CFR 483.35(d)(1)(i)), which require that a SNF and NF may not employ anyone for longer than four months unless they met the training and certification requirements under § 483.35(d). CMS is waiving these requirements to assist in potential staffing shortages seen with theCOVID-19 pandemic. To ensure the health and safety of nursing home residents, CMS is not waiving 42 CFR § 483.35(d)(1)(i), which requires facilities to not use any individual working as a nurse aide for more than four months, on a full-time basis, unless that individual is competent to provide nursing and nursing related services. We further note that we are not waiving § 483.35(c), which requires facilities to ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		(ii) Has demonstrated competence through satisfactory participation in a State-approved nurse aide training and competency evaluation program or competency evaluation program; or (iii) Has been deemed or determined competent as provided in §483.150(a) and (b).	
Food and Nutrition Services	*F811	§483.60(h) Paid feeding assistants- §483.60(h)(1) State approved training course. A facility may use a paid feeding assistant, as defined in § 488.301 of this chapter, if— (i) The feeding assistant has successfully completed a State-approved training course that meets the requirements of §483.160 before feeding residents;	CMS is modifying the requirements at 42 CFR §§ 483.60(h)(1)(i) and 483.160(a) regarding required training of paid feeding assistants. Specifically, CMS is **modifying** the minimum timeframe requirements in these sections, which require this training to be a minimum of 8 hours. CMS is modifying to allow that the training can be a minimum of 1 hour in length. CMS is not waiving any other requirements under 42 CFR §483.60(h) related to paid feeding assistants or the required training content at 42 CFR §483.160(a)(1)-(8), which contains infection control training and other elements. Additionally, CMS is also not waiving or modifying the requirements at 42CFR §483.60(h)(2)(i), which requires that a feeding assistant must work under the supervision of a registered nurse (RN) or licensed practical nurse (LPN).
Quality Assurance and Performance Improvement	*F865	§483.75(b) Program design and scope. A facility must design its QAPI program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility	CMS is modifying certain requirements in 42 CFR §483.75, which requires long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.	
Quality Assurance and Performance Improvement	*F866 (phase 3)	§483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the	CMS is modifying certain requirements in 42 CFR §483.75, which requires long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.

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Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		facility will use the data to develop activities to prevent adverse events.	
Quality Assurance and Performance Improvement	*F867	§483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained . §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on	CMS is modifying certain requirements in 42 CFR §483.75, which requires long-term care facilities to develop, implement, evaluate, and maintain an effective, comprehensive, data-driven QAPI program. Specifically, CMS is modifying §483.75(b)–(d) and (e)(3) to the extent necessary to narrow the scope of the QAPI program to focus on adverse events and infection control. This will help ensure facilities focus on aspects of care delivery most closely associated with COVID-19 during the PHE.

Blanket 1135 Waived Tags (effective since 3/1/20)

(Red = Substandard QOC * = partial requirements waived)

Regulatory Grouping	F Tag	Partially Waived Regulatory Language	Blanket 1135 Waiver language
		high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.	
Physical Environment	*F917	§483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv) §483.90(e)(2) -The facility must provide each resident with-- (iv) Functional furniture appropriate to the resident's needs, and individual closet space in the resident's bedroom with clothes racks and shelves accessible to the resident.	CMS is waiving requirements under 42 CFR 483.90 to temporarily allow for rooms in a long-term care facility not normally used as a resident's room, to be used to accommodate beds and residents for resident care in emergencies and situations needed to help with surge capacity. Rooms that may be used for this purpose include activity rooms, meeting/conference rooms, dining rooms, or other rooms, as long as residents can be kept safe, comfortable, and other applicable requirements for participation are met. This can be done so long as it is not inconsistent with a state's emergency preparedness or pandemic plan, or as directed by the local or state health department.
Training	*F947	§483.95(g) Required in-service training for nurse aides. In-service training must— §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.	CMS is modifying the nurse aide training requirements at §483.95(g)(1) for SNFs and NFs, which requires the nursing assistant to receive at least 12 hours of in-service training annually. In accordance with section 1135(b)(5) of the Act, we are postponing the deadline for completing this requirement throughout the COVID-19 PHE until the end of the first full quarter after the declaration of the PHE concludes.