Care CEUs

Navigating Federal Regulations in Long-Term Care Facilities

1. A state introduces a new regulation requiring higher minimum RN hours per resident day than federal Conditions of Participation (CoPs) specify. Your facility participates in Medicare and Medicaid. From a federal compliance perspective, how should you set your staffing benchmark?

A. Align staffing to the federal CoPs and treat the higher state requirement as aspirational guidance that can be phased in if budgets allow.
B. Adopt the more stringent state RN staffing requirement as your operational benchmark, because administrators must always follow whichever regulation is more rigorous or specific than the federal baseline.
C. Average the federal and state expectations and staff to a midpoint, documenting budget constraints as justification for not meeting the higher standard.
D. Use the federal CoPs during weekdays and the state standard on weekends to demonstrate partial adherence to both regulatory frameworks.

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2. A new resident is admitted for long-term custodial care with minimal skilled needs and limited personal resources. From an operational and financial standpoint, why is it critical for your team to proactively secure and maintain Medicaid coverage for this resident?

A. Because Medicaid is the primary financing source for long-term services and supports, including nursing home care and personal care, funding the daily care of roughly 63 percent of nursing home residents nationwide.
B. Because Medicare Part A routinely covers extended custodial nursing home stays once a resident has used their 100 SNF benefit days, making Medicaid secondary in long-term care financing.
C. Because commercial Medicare Advantage plans usually assume full responsibility for room, board, and long-term assistance with activities of daily living, minimizing the need for Medicaid enrollment.
D. Because state survey agencies will waive most enforcement remedies for facilities that maintain a high proportion of privately paying residents without relying on Medicaid reimbursement.

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3. At 10:30 PM on a holiday, a state survey team arrives unannounced to begin a standard health survey. Your evening supervisor calls, asking if they can request that the surveyors return during regular business hours when leadership is present. Based on the survey framework under the CoPs, what is the most appropriate administrative response?

A. Tell the supervisor to allow entrance but limit access to resident care areas until the next day, as after-hours inspections are restricted to environmental and Life Safety Code observations.

B. Advise the supervisor to politely defer the survey until morning, since surveys are expected to occur only between 8:00 AM and 6:00 PM to avoid disrupting resident routines.
C. Instruct the supervisor to cooperate fully, because state surveyors are permitted to enter 24 hours a day, 7 days a week, including nights and holidays, and the facility must demonstrate continuous readiness across all shifts.
D. Suggest the supervisor request a written postponement from CMS, because leadership has the right to be on-site before a survey can evaluate clinical or operational systems.

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4. At 3:00 AM, a resident is found on the floor with a suspected hip fracture and bruising. A CNA reports that another staff member may have pushed the resident. The charge nurse documents the event but waits until the end of the 7:00 AM shift to notify you and the state agency. How does this response conflict with federal abuse reporting requirements?

A. Events that involve abuse or result in serious bodily injury must be reported immediately, but not later than 2 hours after the allegation is made, to the administrator and appropriate officials, so waiting until shift change violates the mandated reporting timeframe.
B. Abuse allegations can be held until the next business day as long as they are documented in the medical record and reported to the ombudsman within 5 working days.
C. Only confirmed abuse findings, not allegations or injuries of unknown source, must be reported to the State Survey Agency, so the nurse appropriately waited until more facts were available.
D. The facility is compliant as long as a written report is submitted to law enforcement within 30 days, since the 2-hour requirement applies solely to misappropriation of resident property.

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5. Your corporate owner decides to close a nursing facility that participates in Medicare and Medicaid. They instruct you to provide residents and families with a 30-day written notice because census has already dropped. Under federal CoPs, what is your regulatory responsibility as the licensed administrator regarding closure notification?

A. Provide verbal notice to residents and families 30 days before closure and send written notice only to the state Medicaid office within 10 days of the final discharge.
B. Submit written notice of the impending closure to the State Survey Agency, the State Long-Term Care Ombudsman, all residents, and their representatives at least 60 days before the scheduled closure date, unless a shorter timeline is specified by the Secretary after termination.
C. Post a general closure announcement in the lobby 45 days before the final day of operation, allowing families to request written confirmation if they choose.
D. Notify the ombudsman and survey agency 30 days before closure but defer written notice to residents until their actual discharge dates, to minimize anxiety and transfer trauma.

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6. A resident with decision-making capacity refuses a family request for a lap belt, yet the family convinces the attending physician to write an order for the restraint to prevent wandering. From a Resident Rights perspective under 42 CFR Part 483, how should you respond as administrator?

A. Decline to implement the lap belt because residents have the right to be free from physical or chemical restraints used for discipline or staff or family convenience, and third-party requests do not override the resident's right to self-determination.

B. Honor the physician's order because a signed medical order supersedes the resident's expressed preferences when family members believe safety is at risk.
C. Apply the restraint only during night shifts when staffing is lower, documenting that the family requested limited use for fall prevention.
D. Implement a trial period of restraint until the next care plan meeting, since short-term use for observation is not considered a rights violation.

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7. To improve room utilization, your business office moves a stable resident to a different semi-private room without prior written notice, explaining the change the next day. No emergency or clinical need prompted the move. How would a surveyor likely view this under Resident Rights requirements?

A. As a violation, because residents have the right to receive advance written notice before any non-emergent change in room or roommate, and financial optimization does not justify bypassing that requirement.
B. As compliant, because the resident remained in the same facility and the change did not involve a transfer or discharge to a different provider.
C. As acceptable, as long as the resident did not verbally object when informed after the move and the family was notified by phone within 48 hours.
D. As compliant, provided the interdisciplinary team documents that the new room aligns with the facility's billing structure and improves payer mix stability.

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8. A long-term care ombudsman arrives at 7:30 PM on a Saturday to meet privately with a resident who recently filed a grievance. The evening charge nurse denies entry, citing posted visiting hours that end at 7:00 PM. In regulatory terms, what does this scenario most clearly demonstrate?

A. Appropriate enforcement of visitation rules, since resident privacy and sleep schedules allow facilities to restrict official visitors outside posted hours.
B. A failure to uphold the resident's Right of Access, because representatives of the State Survey Agency and Long-Term Care Ombudsman must have immediate, unrestricted access to residents regardless of facility visiting hours.
C. A breakdown in visitor screening procedures, because ombudsman visits must be scheduled at least 24 hours in advance to allow preparation of a private space.
D. A minor policy issue without rights implications, as the resident can simply reschedule the meeting for the next business day without impacting grievance resolution.

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9. During survey, a resident who entered your facility walking with a cane is now fully dependent for transfers. The record shows minimal restorative nursing documentation and vague notes that the decline was expected with aging. Under §483.24 and §483.25, how is a surveyor most likely to interpret this situation?

A. As compliant, as long as the resident or family verbally acknowledged that the decline might occur and no formal complaint was filed.
B. As compliant, because age-related functional decline is presumed unavoidable in long-term care and does not require specific restorative documentation.

C. As potential noncompliance with the no-decline standard for activities of daily living, because the facility has not provided a convincing, evidence-based documentation trail that the loss of mobility was clinically unavoidable despite appropriate interventions.
D. As acceptable, provided the attending physician wrote a short note stating that the resident's decreased mobility is likely due to disease progression.

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10. On an evening shift, a resident collapses and is pulseless. The nurse is unsure of the resident's current code status and spends several minutes searching the chart before initiating CPR. Under the Quality of Life and Quality of Care regulations, what is the primary compliance concern in this scenario?

A. Staff are not required to initiate CPR if the resident is elderly and has multiple comorbidities, since survival odds are presumed low in this population.
B. Nurses are allowed to delay CPR until the physician is contacted by phone, because verifying code status is more important than rapid intervention.
C. Personnel are required to provide basic life support, including CPR, to a resident requiring emergency care before EMS arrival unless there is a valid physician order or advance directive to the contrary, so delaying CPR to search the chart exposes the facility to citation.
D. The facility is compliant as long as EMS arrives within 10 minutes and assumes responsibility for any lifesaving efforts, regardless of staff actions before arrival.

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11. You are hiring a new Activities Director. The candidate has enthusiasm and general management experience but no therapeutic recreation credentials, no occupational therapy background, and less than one year of supervised work in a therapeutic activities program. From a Quality of Life standpoint under §483.24, what is your best regulatory option?

A. Proceed with the hire because the regulations focus on resident satisfaction with activities rather than the director's formal education or experience.
B. Either require the candidate to meet one of the federal qualification pathways, such as completing a state-approved training course or obtaining the requisite experience or certification, or hire a different individual who already meets those criteria before assigning them to direct the activities program.
C. Appoint the candidate as Activities Director immediately but list an RN as the official director on paper to satisfy qualification requirements.
D. Hire the candidate and delegate all clinical responsibilities to social services, since the activities role is limited to entertainment planning and does not fall under federal quality regulations.

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12. A resident who was continent on admission develops urinary incontinence and is placed on an indwelling catheter for staff convenience during busy night shifts. The care plan documents no attempt at toileting programs or catheter removal. Under §483.25, how should this be evaluated?

A. As noncompliant, because residents who are continent on admission must receive services to maintain continence, and catheterization is prohibited unless clinically necessary and followed by prompt assessment for removal and restorative interventions.

B. As compliant, since urinary incontinence is common in long-term care and catheters are an acceptable default method for managing nighttime care workload.
C. As compliant if the family verbally agreed to catheter use, even without documented attempts to restore continence or assess for removal.
D. As acceptable practice provided the resident does not develop a symptomatic urinary tract infection, regardless of whether restorative services are attempted.

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13. Your facility begins admitting more residents with PTSD and complex behavioral symptoms, but the Facility Assessment and staffing education plan still reflect a primarily low-acuity physical rehab population. From a behavioral health perspective, what is the most significant regulatory vulnerability?

A. Primarily a physician issue, because behavioral health competencies are considered part of the medical director's responsibilities and not addressed in the Facility Assessment.
B. A minor documentation gap, since behavioral health services are optional in skilled nursing facilities as long as basic nursing care is provided.
C. Nonalignment between the Facility Assessment and actual resident population, which undermines compliance with §483.40 and §483.71 because staff competencies and training in trauma-informed, non-pharmacological interventions are not demonstrably matched to current behavioral health needs.
D. An infection control concern only if the behavioral health population has higher rates of communicable disease, since psychological diagnoses do not affect competency expectations.

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14. During a review of psychotropic medications, the consultant pharmacist recommends gradual dose reductions for several residents and flags one antipsychotic as lacking a clear clinical indication. Three months later, the same residents remain on unchanged doses, and the charts contain no physician rationale addressing the pharmacist's concerns. Under §483.45, what is the core compliance issue?

A. There is no violation as long as the residents have not experienced obvious adverse drug events, since stable dosing implies clinical effectiveness.
B. The facility has failed to ensure that identified medication irregularities are acted upon, because the attending physicians must either adjust the regimen or document clinically sound rationales in the record to maintain a drug regimen free from unnecessary drugs.
C. Responsibility lies solely with the external pharmacy, because the facility is not required to track or follow up on consultant pharmacist recommendations.
D. The facility is compliant if the medical director verbally agreed that no changes were needed, even if that decision was never documented in the medical record.

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15. A resident has a PRN prescription for an antipsychotic ordered for agitation, which has been renewed monthly for six months without a face-to-face evaluation. Nursing documentation shows occasional mild restlessness but no severe behaviors. How does this pattern conflict with federal pharmacy standards?

A. The practice is compliant if the pharmacist notes the PRN order in the monthly review, even without recommending dose reduction or discontinuation.

B. PRN antipsychotic orders have no federal duration limits as long as the nurse believes they may be helpful and the family has not raised objections.
C. Renewing a PRN antipsychotic indefinitely is acceptable provided the dose remains low and the resident does not refuse the medication.
D. PRN antipsychotic orders are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for appropriateness of the medication, so repeated renewals without evaluation and clear indications violate §483.45(e).

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16. Your Infection Preventionist (IP) is an LPN who has no formal infection prevention training, works in the building only intermittently, and does not attend Quality Assessment and Assurance (QAA) meetings. In light of §483.80, what is the principal regulatory concern?

A. The IP role does not meet federal requirements because the IP must be qualified by education, training, experience or certification in a relevant field, work at least part-time at the facility, and serve as an active member of the QAA committee reporting on the Infection Prevention and Control Program.
B. There is minimal risk as long as the facility's hand hygiene posters are up and staff self-report any infection trends they notice.
C. The arrangement is acceptable if the IP title is shared with the Director of Nursing, regardless of whether infection control duties are being performed.
D. The facility is compliant as long as annual influenza vaccination rates are high, since vaccination outcomes substitute for formal IP qualifications.

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17. Audit data show frequent use of broad-spectrum antibiotics for respiratory symptoms without documented cultures, clear stop dates, or review of alternatives once lab results return. Under §483.80, what is the most effective quality improvement step to align practice with federal expectations?

A. Ask nurses to call physicians less often about respiratory symptoms to reduce the overall number of antibiotic orders in the chart.
B. Have the Infection Preventionist, Director of Nursing, and Medical Director implement an antibiotic stewardship protocol that requires documented indications, culture orders when appropriate, time-limited orders, and routine monitoring of antibiotic use patterns informed by facility assessment data.
C. Rely on the consultant pharmacist's annual report to retrospectively identify any problematic antibiotic regimens without changing daily prescribing practices.
D. Focus exclusively on resident education about hand hygiene, since reducing transmission obviates the need for a formal stewardship program.

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18. Your Facility Assessment still describes a primarily short-stay orthopedic rehab population, but your current census includes more residents with advanced dementia and complex behaviors. Staffing patterns and competencies have not been adjusted. According to §483.71 and §483.35, what should you do first to mitigate regulatory risk?

A. Focus exclusively on revising policies, since the Facility Assessment is an administrative formality that does not drive staffing decisions.

B. Increase the use of agency staff on night shift without revising the Facility Assessment, since temporary staffing is exempt from data-driven planning requirements.
C. Ask charge nurses to document that current staffing is sufficient based on their subjective impression, and use these notes in place of revising the formal assessment.
D. Update the Facility Assessment using evidence-based, data-driven methods to reflect the current resident population's diagnoses, acuity, and behavioral health needs, and then use that assessment to inform unit- and shift-specific staffing levels and competency-based training.

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19. Your 120-bed facility averages 90 occupied beds. The Director of Nursing (DON), a registered nurse, frequently covers the unit as charge nurse on evening shifts due to RN shortages. From the perspective of §483.35, what is the regulatory implication of this staffing pattern?

A. It is acceptable provided that licensed practical nurses cover day shifts, since the RN coverage requirement applies only to daytime hours.
B. It is compliant as long as the DON is physically present in the building, regardless of the number of residents or concurrent administrative duties.
C. It is permissible if the DON documents that the facility has difficulty recruiting RNs, since workforce shortages automatically justify dual roles.
D. It is noncompliant, because the DON may serve as a charge nurse only when the facility's average daily occupancy is 60 or fewer residents, and your higher census requires separate RN coverage for charge responsibilities.

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20. A recent survey uncovered an Immediate Jeopardy (IJ) situation related to unsafe transfers. The IJ was cleared, but the facility has not yet achieved substantial compliance 3 months after the original survey. Under the enforcement framework in the State Operations Manual, what federal remedy now becomes mandatory?

A. Imposition of a Denial of Payment for New Admissions (DPNA), because failure to achieve substantial compliance within 3 months requires CMS to cut off federal reimbursement for new residents.
B. Automatic termination of the provider agreement at 3 months, since any IJ citation must result in decertification if not fully resolved within that timeframe.
C. No additional remedies until 6 months have passed, because the initial clearance of the IJ resets all enforcement timelines.
D. Conversion of all Civil Monetary Penalties (CMPs) from per-day to per-instance fines, as CMP structure automatically changes at the 3-month mark regardless of compliance status.

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