
— NURSING HOME LITIGATION

Nursing Home Oversight in 2026

What Changed, and How to Read the Record Now

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Nursing home cases have always been built from two things: the resident's chart and the facility's regulatory history. This year the ground under both shifted. CMS rewrote parts of the survey process, the federal minimum staffing standards were repealed, arbitration fights continue, and complaints now routinely name the management company, the owner, and the outside wound care or dietary contractor along with the operator. Here's what changed and what it means for reading a record.

THE SURVEY PROCESS GOT TOUGHER IN SOME SPECIFIC WAYS

CMS revised the State Operations Manual chapters on complaints and enforcement through memo QSO-26-03-NH, first issued January 30, 2026 and revised April 3. A few changes stand out for litigation.

At least 10 percent of standard surveys now have to start outside business hours, split between weekends and weekday early mornings or evenings, and surveyors have to stay on site for a meaningful stretch. The idea is simple: a facility should run the same at 2 a.m. on a Sunday as it does at 10 a.m. on a Tuesday. For attorneys, off-hours survey findings may finally give you independent evidence of what happens on nights and weekends, which has always been the hardest part of a nursing home case to prove.

Unsafe discharge is now on CMS's list of immediate jeopardy examples, the most serious deficiency level.

State agencies have been told to reject generic plans of correction that don't show how the facility will actually fix the problem. A rejected or rewritten plan can tell you what the facility knew and what it promised.

And per-instance civil money penalties now show up on Nursing Home Care Compare, so you can see a facility's enforcement history before you ever serve discovery.

THE STAFFING RULE IS GONE. THE DUTY ISN'T.

The 2024 minimum staffing rule would have required a registered nurse on site around the clock and set floors of 3.48 total nurse staffing hours per resident day, including 0.55 RN hours and 2.45 nurse aide hours. It was challenged in court, Congress delayed enforcement, and CMS repealed it by an interim final rule published December 3, 2025, effective February 2, 2026.

What's left is the older and more flexible requirement: enough nursing staff with the right skills to meet each resident's needs (42 C.F.R. § 483.35). There's still an RN on site at least 8 straight hours a day, 7 days a week, a full-time RN director of nursing, and a licensed charge nurse every shift, with limited waivers. Facilities still have to do a facility assessment (§ 483.71) that sizes up their residents and the staff and skills needed to care for them. They still report payroll-based staffing data to CMS, and turnover and weekend staffing still appear on Care Compare.

Without a federal number to point to, staffing cases turn on the residents' actual acuity and on the facility's own assessment of what it needed. The facility assessment, the Payroll-Based Journal data, the MDS acuity picture, and the daily assignment sheets become the core evidence.

ARBITRATION

CMS's 2019 arbitration rule (42 C.F.R. § 483.70) says a facility can't make signing a pre-dispute arbitration agreement a condition of admission or continued care, and the agreement has to say so. It has to be explained in a way the resident or representative understands, with an acknowledgment. The resident gets 30 calendar days to back out. The agreement has to provide a neutral arbitrator and a convenient location, and it can't discourage anyone from talking to surveyors, officials, or the ombudsman. Facilities have to keep signed agreements and arbitration decisions for five years.

Whether a given agreement holds up is a legal question under the Federal Arbitration Act and state contract law. But the chart often has a lot to say about it. What was her BIMS score on the admission MDS? Did a physician document whether she could make decisions? Who signed, and did that person have authority as health care proxy, POA, or guardian? What did the admitting nurse write about her orientation that day? What medications was she on?

EVERYBODY GETS NAMED NOW

Industry coverage this year describes plaintiffs naming everyone who touched the resident's care: the operator, the management company, the parent, the private equity owner, the medical director, and the contracted wound care, therapy, and dietary vendors. Plaintiffs are also using AI tools to comb through huge records and ownership filings.

That puts a premium on sorting out who was responsible for what. Nursing staff own the daily work: assessments, carrying out the care plan, turning and repositioning, skin checks, meals and fluids, and telling the physician and family when something changes (§ 483.10(g)(14)). A contracted wound care provider owns its visit frequency, its wound assessments, and its recommendations, and whether it communicated them. The dietitian owns the nutrition assessment, catching weight loss, and recommending supplements. The attending physician owns the response to calls and the medical plan. The medical director owns clinical policies and physician oversight. The management company or owner owns the budget, the staffing plan, the supply decisions, and the quality oversight.

A single timeline showing who knew what, when, and what each did is what lets you name the right parties, and what lets a party whose role was appropriate get out.

A FICTIONAL CASE

She's 78, with dementia and diabetes, admitted after a hospital stay. Over three months she develops a sacral pressure injury that goes full thickness. She loses weight. She ends up hospitalized with an infection. Two months before she arrived, the facility had been cited for pressure injury care. An outside wound care company saw her weekly. A dietary contractor handled nutrition.

AVOIDABLE OR NOT

CMS's surveyor guidance for pressure injuries (F686) gives both sides a useful framework. An injury counts as unavoidable only if the facility evaluated her condition and risk factors, put in place interventions that fit her needs and accepted standards of practice, watched whether those interventions were working, and changed course when they weren't. If the facility missed any of those steps, the guidance treats the injury as avoidable.

So work through it in order. Line up each Braden score against the care plan. Line up each care plan intervention against proof it happened: turning records, the support surface, nutrition interventions, the treatment administration record. Then check whether the plan changed when the wound got worse. For a plaintiff, the gaps are the case. For a defendant, an unbroken chain is strong evidence the injury wasn't avoidable, especially in a resident who was declining at end of life or had poor circulation and failing organs.

UNSAFE DISCHARGE

Federal rules (§ 483.15) limit the reasons a facility can discharge someone against their will, generally require 30 days' written notice with appeal rights, and require documentation and a plan that addresses the resident's needs. With unsafe discharge now an immediate jeopardy example, ask where she went, whether that place could care for her, what records and medications went with her, and what happened after.

| SURVEY HISTORY

The CMS-2567 and the plan of correction can show the facility already knew about the exact problem that hurt your client. A pressure injury citation before admission, followed by the same failure in her care, suggests a known problem that wasn't fixed. Whether survey findings come in at trial varies by state, and QA records may be privileged.

| A WORD ABOUT AI-ASSISTED RECORD REVIEW

These tools can find documentation gaps fast. But a gap can mean the care wasn't done or just that nobody wrote it down, and telling those apart takes clinical judgment and other evidence: staffing records, family observations, how the wound actually progressed. The software speeds up the reading. It doesn't do the thinking.

| RECORDS WORTH REQUESTING

- The full clinical record: MDS assessments, care plans, progress notes, MAR and TAR, ADL documentation, weights, labs
- The admission packet, including any arbitration agreement, and admission-day assessments (BIMS, capacity notes)
- The facility assessment and PBJ data for the relevant period; daily assignment sheets
- Survey history (CMS-2567s), plans of correction, CMPs, and complaint investigations
- Contracts with wound care, therapy, dietary, and medical director providers, and their records for this resident
- Policies on pressure injury prevention, nutrition, change of condition, and discharge
- Ownership and management disclosures from CMS enrollment data and Care Compare

| SOURCES

- CMS, QSO-26-03-NH, *Revisions to State Operations Manual Chapters 5 and 7* (Jan. 30, 2026; revised Apr. 3, 2026)
- CMS, *Repeal of Minimum Staffing Standards for Long-Term Care Facilities*, Interim Final Rule, Federal Register Doc. 2025-21792 (Dec. 3, 2025)
- 42 C.F.R. §§ 483.10, 483.15, 483.35, 483.70, 483.71; State Operations Manual, Appendix PP (F686)
- CMS, *Revision of Requirements for Long-Term Care Facilities: Arbitration Agreements*, 84 Fed. Reg. 34718 (July 18, 2019)
- Skilled Nursing News, "As AI Enters the Courtroom, Nursing Home Operators Brace for New Legal Threats in 2026" (Jan. 2026); Health Dimensions Group, "CMS 2026 Survey Changes"

This newsletter is for education only and isn't medical or legal advice. The case is fictional.

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Lexcura Clinical Intelligence provides integrated clinical and regulatory analysis for attorneys handling healthcare litigation. If you have a nursing home case with several defendants and want each party's role laid out on one timeline and measured against the rules as they stand today, we'd welcome the conversation.

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