LeadingAge
Illinois & Iowa

Planning & Implementing Care Guidance

Overview

Under F552, the Centers for Medicare & Medicaid Services (CMS) requires that nursing homes notify residents and/or their representatives of their right to be informed of and participate in their treatment which includes but is not limited to being fully informed in a manner they understand of their total health status such as their medical condition, being fully informed in advance of the care to be furnished and the type of caregiver who will furnish the care, and the risks and benefits of proposed care, treatment and/or alternatives, and be allowed to chose the option they prefer.

This guidance correlates with the associated spreadsheet for providers to use to evaluate compliance. Since this regulation may be very broad, this guidance is best used periodically to review resident records for various aspects that the nursing home may involve residents in their care and ensure they are allowed to make decisions when applicable.

To aid in reviewing resident records the following definitions should be considered (as found in Appendix PP of the State Operations Manual (SOM):

Total health status includes functional and nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

Treatment refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.

Monitoring Guidance

A1 - The numerator in this monitor should include a review of the nurse's progress notes to ensure that if the resident needs alternate communication measures (such as non-English speaking, braille, etc) documentation is included that the information was provided in the format outlined in the resident's care plan.

A3 – The numerator in this monitor should include any written documentation (such as education information on vaccinations, informed consents, etc) are easy to understand and don't include medical jargon that may not be understood by the resident or their representative.

A5 – This numerator includes review of the nurse's progress notes to ensure that whenever a new treatment is indicated, the resident or their representative is provided the opportunity to make an informed decision. A written informed consent is not necessarily required for every decision, however, documentation should be sufficient to support that the resident or their responsible party was afforded the opportunity to

understand the treatment risks, benefits, options, and alternatives. Additionally, this information should be provided to them at a time when it is most useful such as when they are asking questions, expressing concerns, or when treatment is being proposed. The resident or their representative must be allowed the ability to choose the option they prefer. **Note this has been cited more often regarding psychotropic medication use.

References:

CMS (Retrieved 2026, April 16). *Medicare State Operations Manual Appendix PP.* https://www.cms.gov/files/document/appendix-pp-state-operations-manual.pdf.