SeniorCRE is the operator-controlled operating infrastructure for senior housing & care. It establishes one Operator-Controlled Operating Record above the systems operators already run. Govern first. Replace only by choice.

The operating record Evidence record

Source of record
CMS Quality, Safety & Oversight Group memorandum **QSO-26-14-NH**, "Nursing Home Risk-Based Survey National Implementation," issued **July 16, 2026**. Program start: **September 8, 2026**. First public qualified-facility disclosure expected **September 30, 2026**. Operators should verify current text and any subsequent revision directly in the CMS QSO memoranda library before acting; the criteria below reflect the memorandum and its Appendix A as issued.

One distinction determines how this should be read. QSO-26-14-NH is **not** a new set of Conditions of Participation and **not** a new final rule under 42 CFR Part 483. The substantive requirements of Part 483 remain fully applicable. What CMS has changed is *how it conducts the federally required recertification survey* for a defined subset of high-performing skilled nursing facilities and nursing facilities, using its existing survey authority under 42 CFR Part 488. The instrument is a streamlined **Risk-Based Survey (RBS)**.

Read narrowly, it is a survey-efficiency initiative. Read correctly, it is the first time CMS has defined — in machine-readable regulatory data — what a provably high-performing nursing home looks like, and then attached both a survey benefit and a public consumer-facing signal to that definition.

1. What the RBS Actually Changes

Every Medicare/Medicaid-certified nursing home still must receive a standard recertification survey at least once every **15 months**. That statutory cadence does not change. What changes is which survey protocol is used. Facilities meeting CMS's high-performance criteria can receive the shortened RBS instead of the traditional **Long-Term Care Survey Process (LTCSP)**.

Per CMS, the RBS generally takes about **half the time** of a traditional standard survey, requires **fewer surveyors**, and uses a **smaller resident sample**, while still evaluating compliance with the federal health and safety requirements. CMS tested the approach in **22 states across more than 100 facilities** before authorizing national implementation.

The framing operators should adopt

RBS status is **eligibility, not entitlement**. CMS states explicitly that a State Survey Agency may still use the traditional LTCSP at an otherwise RBS-qualified facility where health-and-safety concerns exist, including complaints, and that CMS itself can require the full survey. Qualification lowers expected survey intensity; it does not guarantee a shortened inspection.

2. The 11 Qualification Gates

Trade coverage of the memorandum has generally compressed this into "become five-star and get a shorter survey." Appendix A of QSO-26-14-NH contains **11 separate criteria**, all of which must be cleared. To qualify, a facility cannot have any of the following:

- **An overall Care Compare rating below 5 stars.**
- **A staffing rating below 3 stars.**
- **Any Actual Harm, Immediate Jeopardy, or Substandard Quality of Care citation during the last survey cycle** — which CMS defines as the last standard survey plus complaint investigations occurring during the previous year.
- **More than 18 months since its last standard survey.**
- **Any staffing waiver currently in effect** under the applicable CMS staffing provisions.
- **A failed Payroll-Based Journal (PBJ) staffing-data audit.**
- **A failed Minimum Data Set (MDS) resident-assessment audit.**

- **A Health Inspection Score worse than the 50th percentile within the state** — lower inspection scores indicate better performance, so this is a state-relative test, not a national one.
- **Two or more residents age 65+ coded with schizophrenia after admission** when they were not coded with that diagnosis upon admission.
- **A change of ownership since the last standard survey.**
- **Designation as a Special Focus Facility (SFF) candidate.**

Structurally, that is not a rating threshold. It is a **continuously maintained high-performance status** derived from survey history, staffing levels, staffing-data integrity, assessment-data integrity, complaint activity, resident diagnostic coding, ownership records, and state-relative inspection performance.

3. Quarterly Reevaluation

CMS will generate qualified-facility lists at the end of each calendar quarter — **March, June, September, and December**. Once placed on a list, a facility ordinarily remains RBS-eligible for **six months**, unless a disqualifying event occurs before the survey is conducted.
The practical consequence: eligibility is a rolling status with a look-back and a look-forward. A facility can be qualified on paper in September and disqualified in October by events that have nothing to do with a substantiated deficiency.

4. The Five Interim Disqualifiers

This is the part of the memorandum with the most direct operational consequence. Even after CMS places a facility on the RBS-qualified list, the facility **loses RBS eligibility before the survey** if any of the following occurs:

- An intake investigation results in **Actual Harm, Immediate Jeopardy, abuse at any level, or Substandard Quality of Care**.
- There is a **pending complaint/intake investigation triaged as Immediate Jeopardy**.
- There are **more than three active non-IJ complaints or Facility Reported Incidents triaged at medium or higher**.
- The facility obtains a **CMS-approved nursing waiver**.

- There has been a **change in ownership since the last standard survey**.

Where any of these conditions exists, CMS states that the State Survey Agency **“MUST”** convert the RBS to a traditional LTCSP standard survey.

> **Why this changes complaint management**
> Complaint volume is now strategically material **before** any deficiency is substantiated. More than three qualifying pending intakes at medium-or-higher triage — none of them yet proven — is sufficient to remove a five-star facility from the streamlined pathway. Intake triage level, intake aging, and intake resolution velocity become survey-regime variables, not just risk-management metrics.

5. A New Public High-Performer Signal

CMS will place a **special icon on the Nursing Home Care Compare profile** of RBS-qualifying facilities. Functionally, this is a new public quality signal layered above the traditional five-star rating: it encodes staffing-data integrity, assessment-data integrity, complaint posture, ownership stability, and state-relative inspection performance — none of which the star rating alone conveys.

The icon remains until the facility is no longer RBS-eligible. CMS will also disclose when an inspection was performed using the RBS methodology through the survey-results webpage, the CMS-2567, and the Provider Data Catalog. CMS expects public qualified-facility information to begin appearing **September 30, 2026**, with regular updates thereafter.

For referral sources, families, hospital discharge planners, managed-care networks, lenders, and REIT asset-management teams, that icon becomes a low-cost screening heuristic. Sales, marketing, and capital narratives should expect to be measured against it.

6. Only About 12% Qualify

CMS’s June 2026 modeling included **14,682 nursing facilities**, of which **1,560 — 12.01%** — met the RBS criteria. The failure distribution is where the strategic signal sits:

- **78.39%** had an overall rating below five stars.
- **29.43%** had a staffing rating below three stars.

- **19.61%** had an Actual Harm citation during the relevant survey cycle.
- **11.54%** had an Immediate Jeopardy citation.
- **11.24%** had a Substandard Quality of Care citation.
- **Roughly 50%** failed the state-relative Health Inspection Score test.

Facilities can fail multiple criteria, so those percentages are not additive. The state-relative inspection test deserves separate attention: because it is defined against a 50th-percentile cutoff within each state, roughly half the field fails it *by construction*, regardless of national improvement. Qualification is therefore partly a competitive-position problem inside a state, not only an absolute-performance problem.

7. The Schizophrenia-Coding Criterion Deserves More Attention

A facility can lose RBS eligibility because **two or more long-stay residents age 65+ received a schizophrenia diagnosis after admission** when schizophrenia was not recorded at admission. CMS is plainly using this as a data-quality and inappropriate-antipsychotic-use risk signal, consistent with its long-standing scrutiny of post-admission schizophrenia coding.

The operational implication is a visibility requirement across a chain that most operators cannot currently see end-to-end in one place:

- admission diagnosis
- → MDS coding
- → medication administration
- → diagnosis changes during stay
- → antipsychotic utilization
- → CMS submission

This is no longer solely a clinical documentation matter. Two coding events can now affect the facility's public high-performer status and its survey regime.

8. Data Accuracy Is Now a Survey-Status Issue

PBJ and MDS accuracy are explicitly tied to RBS eligibility. A facility that otherwise delivers excellent care can lose eligibility because CMS cannot verify its submitted staffing or resident-assessment information during an audit. The failure mode is not care quality — it is **unverifiable data**.

That produces a genuine shift in how compliance should be organized. PBJ submissions, MDS assessments, staffing levels and waivers, survey history, complaint and FRI intakes, ownership records, and diagnostic coding should be treated as **one regulatory dataset** with one reconciliation discipline — not as seven separate compliance functions reporting on different cadences to different leaders.

9. Ownership Transactions Now Carry a Survey Consequence

CMS lists **a change in ownership since the last standard survey** as a qualification bar, and ownership change appears again as an interim disqualifying event after qualification. An otherwise pristine five-star SNF acquired by another organization may therefore temporarily lose access to the high-performer survey pathway — and, with it, the Care Compare icon — until the relevant survey cycle catches up.

For private-equity sponsors, REITs, and multi-facility operators, this belongs in acquisition regulatory diligence alongside licensure, CHOW timing, and Medicare/Medicaid provider-agreement mechanics. It is a quantifiable, time-bounded post-close consequence of transaction structure and timing — including for portfolio transactions where a single CHOW event resets status across many buildings at once. See our related work on M&A integration and REIT-facing reporting posture.

10. What CMS Has Actually Created: Regulatory Segmentation

The clearest way to characterize QSO-26-14-NH is as a new **regulatory segmentation system**:

- **Lower observable regulatory risk** → RBS → smaller resident sample → fewer surveyors → roughly half the survey time → public high-performer indicator.
- **Higher observable regulatory risk** → traditional LTCSP → normal survey intensity → survey resources concentrated there.

- **Emerging adverse signal** → facility can be removed from RBS before the inspection begins.

The operative word is *observable*. CMS is segmenting on the data it already holds. An operator whose internal view of that same data is slower or less accurate than CMS's view is, by definition, managing its survey exposure retrospectively.

11. The Operating Scorecard

Consolidated from the memorandum and Appendix A, the practical RBS dashboard is:

CMS signal	Target
Overall Care Compare rating	5 stars
Staffing rating	≥ 3 stars
Actual Harm citations	0
Immediate Jeopardy citations	0
Substandard Quality of Care	0
Last standard survey	≤ 18 months
Staffing waiver	None
PBJ audit	Pass
MDS audit	Pass
State Health Inspection Score	Better than or equal to the 50th-percentile cutoff
Post-admission schizophrenia cases, 65+	< 2
CHOW since last standard survey	None
SFF candidate designation	No

Pending IJ investigation	None
Pending medium-or-higher non-IJ intakes / FRIs	≤ 3

Fifteen monitored signals: the 11 qualification gates plus the interim disqualifiers that can remove a qualified facility before the surveyor arrives.

12. Why This Is Strategically Important

The change is larger than shortened inspections. CMS is defining provable high performance in data it already receives, and the qualification decision is derived almost entirely from information sitting across **PBJ, MDS, Care Compare, survey deficiency records, complaint and intake systems, ownership filings, and staffing data**.
Which means an operator should, in principle, know before CMS does whether each facility is:

- **RBS Qualified → At Risk → Disqualified**
- what specifically caused the change
- and which of those causes is correctable inside the current quarter

Almost no operator can do that today, because those seven data domains live in seven systems with seven owners and seven refresh cadences. Quarterly CMS determination becomes the operator's first notification — after the window to correct has closed.

13. Where SeniorCRE Fits — Stated Precisely

SeniorCRE is the operator-controlled operating infrastructure for senior housing & care. Its architectural premise is directly relevant here: the 15 signals above are not one vendor's data. They span the EHR, the MDS/assessment pipeline, payroll and scheduling, the complaint and incident log, the survey record, and corporate ownership filings. Any capability that answers "are we still RBS-eligible?" must reason *across* those systems, which is precisely the layer the operator — not a point vendor — should control.

How SeniorCRE helps skilled nursing providers succeed under QSO-26-14-NH

The Risk-Based Survey is a cross-system eligibility problem. SeniorCRE's platform for skilled nursing is built to keep the EHR, payroll, scheduling, MDS, and survey systems you already use, then govern the reconciled operating record above them. The goal is not another dashboard — it is one place where the 15 RBS signals can be monitored, reconciled, and acted on before CMS publishes its quarterly list.

- PBJ staffing compliance reconciles submitted hours against payroll and scheduling actuals, so a failed PBJ audit does not surprise you after the quarter closes.
- Census integrity connects admission records, MDS coding, and orders — the same chain CMS uses for the post-admission schizophrenia criterion.
- Clinical intelligence surfaces medication administration, diagnosis changes, and antipsychotic utilization so two coding events do not become a disqualifier.
- Quality Occupancy ties survey posture, staffing capacity, and NOI together — because RBS status is now a public quality signal with capital-market consequences.
- AI governance defines the human-in-the-loop, audit-trail, and version-control posture any cross-system eligibility agent must meet before it touches production data.

See the full platform overview at SeniorCRE Operating Record and the platform features page for a capability-by-capability view.

Disclosure on capability status

An **RBS Eligibility / CMS Survey Risk Intelligence** capability — continuously computing the 11 qualification gates and the 5 interim disqualifiers across a SNF portfolio — is a specified capability on the SeniorCRE roadmap. It is described here as a specification and design target, not as a shipped, operator-production feature. No vendor, payor, or state-survey-system integration is live today. Operators evaluating this article should treat the CMS criteria as authoritative and the SeniorCRE capability description as forward-looking.

What the specification calls for is consistent with the rest of the platform's posture: keep the systems already in the building, and govern the reconciled operating record above them. Concretely, that means one place where PBJ-submitted hours reconcile against scheduling and payroll actuals; where MDS-coded diagnoses reconcile against admission records, orders, and antipsychotic administration; where intake triage levels and aging are counted against the "more than three" threshold in real time; and where a pending CHOW is modeled for its survey-status consequence before the transaction closes rather than after.
Related work on the platform: PBJ staffing compliance, census integrity, clinical intelligence, Quality Occupancy, workforce intelligence, and AI governance.

14. What Operators Should Do Before September 8, 2026

- **Score every facility against all 15 signals now.** Do it manually if necessary. The output is a portfolio triage list: qualified, one gate away, structurally disqualified.
- **Audit PBJ and MDS submissions for verifiability, not just timeliness.** The criterion is a failed audit, which is a reconciliation problem between submitted data and source records.
- **Pull the post-admission schizophrenia coding report for residents 65+.** Two cases is the threshold. Review the admission diagnosis, the MDS entry, the ordering rationale, and antipsychotic utilization together.
- **Instrument complaint and FRI intake counts by triage level with aging.** The "more than three at medium or higher" test is a live counter, not a quarterly report.
- **Check state-relative Health Inspection Score position, not national.** The cutoff is intrastate.
- **Add RBS status impact to acquisition diligence and CHOW timing.** Model the loss of the pathway and the Care Compare icon as a known post-close cost.
- **Verify staffing waiver status.** Any waiver in effect is disqualifying, and obtaining one after qualification is an interim disqualifier.
- **Assign one accountable owner for the RBS dataset.** If seven functions each own one signal, no one owns eligibility.

CMS launches this nationally on September 8, 2026. For high-performing operators, RBS is a genuine operational benefit and a public differentiator. For

everyone else, it is a published specification of what CMS believes provable quality looks like — expressed entirely in data the operator already generates. The gap between how fast CMS can read that data and how fast an operator can read its own is now a regulatory exposure with a date on it.

Primary and related sources: CMS QSO Policy & Memoranda to States and Regions · 42 CFR Part 488 (Survey, Certification, and Enforcement) · 42 CFR Part 483 (Requirements for Long Term Care Facilities) · Medicare Nursing Home Care Compare · CMS Provider Data Catalog · Five-Star Quality Rating System technical users' guide · Payroll-Based Journal (PBJ) staffing data submission

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Key Takeaways for Operators and Investors

- QSO-26-14-NH changes survey methodology under 42 CFR Part 488, not the underlying Part 483 requirements.

- All 11 qualification gates must be cleared; the 15-month standard survey cadence is unchanged.
- More than three pending medium-or-higher non-IJ intakes can remove a five-star facility before any deficiency is substantiated.
- Failed PBJ or MDS audits disqualify — unverifiable data is now a survey-status issue, not just a compliance issue.
- The Health Inspection Score test is state-relative at the 50th percentile, so roughly half the field fails it by construction.
- Two post-admission schizophrenia codings among residents 65+ are enough to lose eligibility.
- A CHOW resets eligibility, making RBS status a quantifiable post-close cost in acquisition diligence.
- Only 12.01% of 14,682 modeled facilities qualified in CMS June 2026 analysis.
- SeniorCRE's platform for skilled nursing is designed to govern the reconciled operating record above existing EHR, payroll, scheduling, and MDS systems.

These insights are derived from publicly available industry research and cited sources.

Frequently Asked Questions

What is QSO-26-14-NH?

A CMS Quality, Safety & Oversight Group memorandum titled "Nursing Home Risk-Based Survey National Implementation," issued July 16, 2026. It is not a new set of Conditions of

Participation and not a new final rule under 42 CFR Part 483. CMS is using its existing survey authority under 42 CFR Part 488 to create a streamlined Risk-Based Survey (RBS) for a subset of high-performing SNFs and NFs. National implementation begins September 8, 2026.

How is a Risk-Based Survey different from the traditional LTCSP?

Per CMS, the RBS generally takes about half the time of the traditional Long-Term Care Survey Process, requires fewer surveyors, and uses a smaller resident sample, while still evaluating compliance with federal health and safety requirements. Every certified nursing home still receives a standard recertification survey at least once every 15 months. CMS tested the approach in 22 states and more than 100 facilities before national implementation.

What are the 11 RBS qualification criteria?

A facility cannot have: an overall Care Compare rating below 5 stars; a staffing rating below 3 stars; any Actual Harm, Immediate Jeopardy, or Substandard Quality of Care citation during the last survey cycle (last standard survey plus complaint investigations in the previous year); more than 18 months since its last standard survey; any staffing waiver in effect; a failed Payroll-Based Journal (PBJ) audit; a failed Minimum Data Set (MDS) audit; a Health Inspection Score worse than the 50th percentile within the state; two or more residents age 65+ coded with schizophrenia after admission when not coded at admission; a change of ownership since the last standard survey; or designation as a Special Focus Facility candidate.

What can disqualify a facility after it is already on the RBS-qualified list?

Five interim events: an intake investigation resulting in Actual Harm, Immediate Jeopardy, abuse at any level, or Substandard Quality of Care; a pending complaint/intake investigation triaged as Immediate Jeopardy; more than three active non-IJ complaints or Facility Reported Incidents triaged at medium or higher; obtaining a CMS-approved nursing waiver; or a change in ownership since the last standard survey. CMS states the State Survey Agency MUST then convert the RBS to a traditional LTCSP standard survey.

How many nursing homes qualify for the Risk-Based Survey?

CMS June 2026 modeling included 14,682 nursing facilities, of which 1,560 — 12.01% — met the RBS criteria. Barriers included 78.39% with an overall rating below five stars, 29.43% with staffing below three stars, 19.61% with an Actual Harm citation, 11.54% with an Immediate Jeopardy citation, 11.24% with a Substandard Quality of Care citation, and roughly 50% failing the state-relative Health Inspection Score test. Facilities can fail multiple criteria, so the percentages are not additive.

Does RBS qualification appear publicly?

Yes. CMS will place a special icon on the Nursing Home Care Compare profile of RBS-qualifying facilities, and the icon remains until the facility is no longer eligible. CMS will also disclose when an inspection used the RBS methodology through the survey-results webpage, the CMS-2567, and the Provider Data Catalog. Public qualified-facility information is expected to begin appearing September 30, 2026, with regular updates thereafter.

How does a change of ownership affect RBS eligibility?

A change in ownership since the last standard survey is both a qualification bar and an interim disqualifying event after qualification. An otherwise five-star SNF acquired by another organization may temporarily lose access to the shortened survey pathway and the Care Compare icon until the relevant survey cycle catches up — which makes RBS status impact part of acquisition regulatory diligence and CHOW timing for PE sponsors, REITs, and multi-facility operators.

Does SeniorCRE calculate RBS eligibility today?

No. An RBS Eligibility / CMS Survey Risk Intelligence capability — continuously computing the 11 qualification gates and 5 interim disqualifiers across a SNF portfolio — is roadmap — not built. No vendor, payor, or state-survey-system integration runs in operator production today. The SeniorCRE platform for skilled nursing is designed to let operators retain selected systems and govern the reconciled operating record above them; see /for-skilled-nursing, /operating-record, and /platform-features for the current capability set.

Which SeniorCRE platform capabilities map to the RBS signals?

PBJ staffing compliance reconciles submitted hours against payroll and scheduling actuals. Census integrity connects admission records, MDS coding, and orders. Clinical intelligence surfaces medication administration, diagnosis changes, and antipsychotic utilization. Quality Occupancy ties survey posture, staffing capacity, and NOI together. AI governance defines the human-in-the-loop and audit-trail posture required for any cross-system eligibility agent.

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