VIII. Enforcement and Remedies for Nursing Homes

Introduction:

This category of the guide covers enforcement actions and remedies by state agencies and CMS when facilities are found to be out of compliance with federal requirements.

What you'll learn:

- Types of remedies CMS or the state may impose on facilities
- Actions taken in immediate jeopardy situations
- Requirements for reporting abuse

Enforcement Remedies for SNFs, NFs, and Dually Participating Facilities [SOM §7400]

CMS or the state may impose one or more remedies in addition to, or instead of, termination of the provider agreement when the state or CMS finds that a facility is out of compliance with federal requirements. Enforcement protocols/procedures are based on the premise that all requirements must be met and take on greater or lesser significance depending on the specific circumstances and resident outcomes in each facility.

Federal Enforcement Remedies [SOM §7400.1]

- Termination of provider agreement;
- Temporary management;
- Denial of payment for all Medicare and/or Medicaid residents by CMS;
- Denial of payment for all new Medicare and/or Medicaid admissions;
- Civil money penalties;
- State monitoring;
- Transfer of residents;
- Transfer of residents with closure of facility;
- Directed POC;
- Directed in-service training; and
- Alternative or additional state remedies approved by CMS.

Selecting Remedies [SOM §7400.6]

In order to select the appropriate remedy(ies) for a facility's noncompliance, the seriousness of the deficiencies must first be assessed because **specific levels of seriousness correlate with specific categories of enforcement responses.**

The state SA is authorized by the RO to both recommend and impose one or more category 1 remedies. Select at least one **category 1** remedy when there:

- Are isolated deficiencies that constitute no actual harm with a potential for more than minimal harm but not immediate jeopardy (IJ); or
- Is a pattern of deficiencies that constitutes no actual harm with a potential for more than minimal harm but not IJ.

Category 1 Remedies:
- Directed plan of correction;
- State monitoring; and
- Directed in-service training.

Note: A state SA may only impose category 1 remedies *if* authorized by the CMS RO.

Select at least one **category 2** remedy when there are:

- Widespread deficiencies that constitute no actual harm with a potential for more than minimal harm but not IJ; or
- One or more deficiencies (regardless of scope that constitute actual harm that is not IJ.

Note: Except when the facility is in substantial compliance, one or more of the category 2 remedies may be applied to any deficiency.

Category 2 Remedies:
- Denial of payment for new admissions;
- Denial of payment for residents, imposed only by the RO;
- Lower range per day CMPs;
- Per instance CMPs.

Select at least one **category 3** remedy when:

- There are one or more deficiencies that constitute IJ to resident health or safety.

Note: Termination or temporary management, or both, **must** be selected when there are one or more deficiencies that constitute IJ.

Category 3 Remedies:
- Temporary management;
- Termination;
- CMPs of $3,050-10,000 per day;
- CMPs of $1,000-10,000 per instance.

Directed Plan of Correction [SOM §7500]

Use of a directed plan of correction (POC) should be dependent upon causes identified by the state, regional office, or temporary manager. For example, a directed POC may be an appropriate sanction when a facility has no system in place for detecting abuse and neglect.

A directed POC differs from a traditional POC in that the state, not the facility, develops the POC. Achieving compliance is the facility's responsibility. If it fails to do so, the state may impose another alternative sanction(s) until the facility achieves substantial compliance. (SOM §3006.2A)

- **Example**: A directed POC may be appropriate when a facility's heating system fails. The directed POC would specify that the heating system must be repaired or replaced within a specific time frame. If the cause of noncompliance was a specific structural problem, the facility could be directed to implement identified structural repairs such as a new roof, or renovations such as replacement of rusted sinks in common bathrooms.

A **directed plan of correction** is a plan that the state or regional office develops to require a facility to take action within specified time frames. Its purpose is to achieve correction and continued compliance with federal requirements.

Directed In-Service Training [SOM §7502]

Directed in-service training may be used when the state, CMS, or the temporary manager believe that education is likely to correct the deficiencies and help the facility achieve substantial compliance. This remedy requires the facility staff to attend an in-service training program to gain basic knowledge to achieve and remain in compliance with federal requirements.

In-Service Training Program Resources [SOM §7502.3]

Facilities should use programs developed by well-established centers of geriatric health services education such as schools of medicine or nursing, centers for the aging, and area health education centers which have established programs in geriatrics and geriatric psychiatry. Facilities may utilize the ombudsman program to provide training about residents' rights and quality of life issues.

Further Responsibilities [SOM §7502.4]

The facility bears the expense of the training. After completion, the state will assess whether compliance has been achieved. If the facility has still not achieved substantial compliance, additional remedies may be imposed.

Directed In-Service Training [SOM §7502.5]

Directed in-service training may be imposed 15 calendar days after the facility receives notice of non-IJ situations and two calendar days after the facility receives notice in IJ situations.

State Monitoring [SOM §7504]

Purpose [SOM §7504.2]

A state monitor oversees the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred.

Qualifications [SOM §7504.3]

Monitors are identified by the state as appropriate professionals to monitor cited deficiencies. Monitors must meet the guidelines regarding conflicts of interest in §7202 and:

- Is an employee or contractor of the state;
- Is not an employee or contractor of the monitored facility; and
- Does not have an immediate family member who is a resident of the facility.

A **state monitor** oversees the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred.

When to Impose State Monitoring Remedy [SOM §7504.4]

The Act requires state monitoring if a facility has been found on three consecutive standard surveys to have provided substandard quality of care. Some situations in which state monitoring may be appropriate include, but are not limited to, the following:

- Poor facility compliance history, e.g., a pattern of poor quality of care, many complaints, etc.;
- State concern that the situation in the facility has the potential to worsen;
- IJ exists and no temporary manager can be appointed;
- If the facility refuses to relinquish control to a temporary manager, a monitor may be imposed to oversee termination procedures and transfer of residents; or
- The facility seems unable or unwilling to take corrective action for cited substandard quality of care.

State monitoring ***must be imposed*** if a facility has been found on three consecutive standard surveys to have provided substandard quality of care.

Frequency [SOM § 7504.5] and Duration [SOM §7504.6]

Monitoring may occur anytime in a facility, e.g., 24 hours a day, 7 days a week, or periodically. Factors used to determine how often a facility is monitored may include, but are not limited to, the following:

- The nature and seriousness of the deficiencies as specified by the state; and
- The timing and frequency of when the problems occurred, (e.g., mealtimes, evening shifts, daily, etc.).

State monitoring is *discontinued* when:

- The facility's provider agreement is terminated; or
- The facility has demonstrated to the satisfaction of CMS or the state that it is in substantial compliance with the requirements and, if imposed for repeated substandard quality of care, that it will remain in substantial compliance.

Denial of Payment [SOM §7506]

This remedy may, and in certain circumstances, must, be imposed by CMS or the state Medicaid agency (SMA). Denial of payment for new admissions must be imposed alone or in combination with other remedies to encourage quick compliance. Formal notice of the imposition and rescission of this remedy may also be provided by the state, as authorized by the regional office (RO) and/or the SMA.

Sections 1819(h) and 1919(h) of the Act and 42 CFR 488.419 provide for the denial of payment for all new Medicare and Medicaid admissions when a facility is not in substantial compliance.

Optional Denial of Payment for All New Admissions [SOM §7506.2]

This remedy may be imposed anytime a facility is found to be out of substantial compliance, as long as the facility is given written notice at least two calendar days before the effective date in immediate jeopardy (IJ) situations and at least 15 calendar days before the effective date in non-IJ situations.

- Medicare Facilities: CMS must deny payment to the facility for all new Medicare admissions.
- Medicaid Facilities: The SMA must deny payment to the facility, and CMS must deny federal financial participation to the SMA for all new Medicaid admissions.

Mandatory Denial of Payment for All New Admissions [SOM §7506.3]

Regardless of any other remedies that may be imposed, denial of payment must be imposed when the facility is not in substantial compliance three months after the last day of the survey identifying deficiencies, or when a facility has been found to have furnished substandard quality of care on the last three consecutive standard surveys (see 42 CFR 488.414).

- Medicare Facilities: CMS must deny payment to the facility for all new Medicare admissions.
- Medicaid Facilities: The SMA must deny payment to the facility, and CMS must deny federal financial participation to the SMA for all new Medicaid admissions.

Duration and Resumption of Payments [SOM §7506.4]

Generally, if the facility achieves substantial compliance and it is verified in accordance with §7317, CMS or the SMA must resume payments to the facility **prospectively** from the date it determines that substantial compliance was achieved.

However, when payment is denied for repeated instances of substandard quality of care, the remedy may not be lifted until the facility is in substantial compliance and the state or CMS believes that the facility will remain in substantial compliance. No payments are made to reimburse the facility for the period of time between the date the remedy was imposed and the date that substantial compliance was achieved.

CMS accomplishes the denial of payment remedy through written instructions to the appropriate Medicare Area Contractor in Medicare cases, and in Medicaid cases, through written instructions from the RO.

Effect of Remedy on Status of Residents [SOM §7506.5]

The resident's status on the effective date of the denial of payment for new admissions remedy is the controlling factor in determining whether readmitted residents are subject to the sanction. Guidelines follow:

- Medicare and Medicaid residents admitted and discharged before the effective date of the denial of payment for new admissions remedy are considered new admissions if they are readmitted on or after the effective date. Therefore, they are subject to the sanction.
- Medicare and Medicaid residents admitted on or after the effective date of the denial of payment for new admissions remedy are considered new admissions. If readmitted after being discharged, they continue to be considered new admissions and are subject to the sanction.
- Medicare and Medicaid residents admitted before and discharged on or after the effective date of the denial of payment for new admissions remedy are considered new admissions if subsequently readmitted. Therefore, they are subject to the sanction.
- Medicare and Medicaid residents admitted on or after the effective date of the denial of payment for new admissions remedy who take temporary leave are not considered new admissions when they return but continue to be subject to the sanction.
- Private pay residents admitted after the effective date of the denial of payment for new admissions remedy and then become eligible for Medicare or Medicaid, are subject to the sanction.
- Medicare and Medicaid residents admitted before the effective date of the denial of payment for new admissions remedy who take temporary leave before, on, or after the effective date of the denial of payment remedy are not considered new admissions upon return and, therefore, are not subject to the sanction.
- Private pay residents in a facility prior to the effective date of the denial of payment for new admissions remedy who become eligible for Medicare or Medicaid on or after the effective date of the denial of payment for new admissions remedy are not subject to the sanction.

"Temporary leave" refers to residents who leave temporarily for any reason and expect to return to the facility.

"Discharge" refers to individuals who left the facility and there is no expectation that they will return.

Secretarial Authority to Deny All Payment [SOM §7508]

If a facility has not met a requirement, the Secretary may deny any further payment to the facility for all Medicare residents, and to a SMA for all Medicaid residents in the facility. This is

in addition to the authority to deny payment for all new admissions discussed in § 7506. Only CMS has the authority to deny all payment for Medicare and/or Medicaid residents. The denial of all payment remedy may be imposed anytime the facility is found to be out of substantial compliance, as long as the facility is given written notice at least two calendar days before the effective date in IJ situations and at least 15 calendar days before the effective date in non-IJ situations. CMS will provide the state with timely notification whenever it decides to impose this remedy.

Although the Secretary may impose this remedy whenever a facility has not met a requirement, it is a severe sanction. Factors to be considered in selecting this remedy could include:

- Seriousness of current survey findings;
- Noncompliance history of facility; and
- Use of other remedies that have failed to achieve or sustain compliance.

Duration and Resumption of Payments [SOM §7508.2]

Generally, if a facility achieves substantial compliance, CMS resumes payments to the facility **prospectively** from the date that it verifies (in accordance with §7317) as the date that the facility achieved substantial compliance. No payments are made to reimburse the facility for the period of time between the date the remedy was imposed and the date that CMS verifies as the date that the facility achieved substantial compliance. When CMS denies payment for all Medicare residents for three consecutive findings of substandard quality of care, the denial of payment cannot be lifted until the facility achieves substantial compliance and CMS believes that the facility will remain in substantial compliance.

Action for Substandard Quality of Care [SOM §7320]

Action to be Taken When a Facility is Found to Have Provided Substandard Quality of Care on Last Three Standard Surveys [SOM §7320.1.1]

CMS or the state Medicaid agency, as appropriate, must, regardless of other remedies:

- Deny payment for all new admissions no later than three months from the last day of the third consecutive survey in accordance with §7506;
- Impose state monitoring in accordance with §7504; and
- Provide notification in accordance with §7210.6.

Temporary Management [SOM §7550]

A temporary manager (TM) may be imposed anytime a facility is not in substantial compliance. Temporary management is **required** when a facility's deficiencies constitute IJ or widespread actual harm and a decision is made to impose an alternative remedy to termination.

The temporary manager is responsible for overseeing correction of the deficiencies and assuring the health and safety of the facility's residents while the corrections are being made. A temporary manager may also be imposed to oversee orderly closure of a facility.

Authority [SOM §7550.3]

A temporary manager has the authority to:

- Hire, terminate, or reassign staff;
- Obligate facility funds;
- Alter facility procedures; and
- Otherwise manage a facility to correct deficiencies identified in the facility's operation.

Temporary management is **required** when a facility's deficiencies constitute IJ or widespread actual harm and a decision is made to impose an alternative remedy to termination.

Selection [SOM §7550.4]

The state will select the temporary manager when the SMA is imposing the remedy and will recommend a temporary manager to the RO when CMS is imposing the remedy. Each state should compile a list of individuals who are eligible to serve as temporary managers.

The following individuals are *not eligible* to serve as temporary managers:

- Any individual who has been found guilty of misconduct by any licensing board or professional society in any state;
- Any individual who has, or whose immediate family members have, any financial interest in the facility to be managed. Indirect ownership does not constitute financial interest for the purpose of this restriction; or
- Any individual who currently serves or, within the past 2 years, has served as a member of the staff of the facility.

Orienting and Supervising [SOM §7550.6]

The state should provide the temporary manager with an appropriate orientation that includes a review of the facility's deficiencies. The state may request that the temporary manager periodically report on the actions taken to achieve compliance and on the expenditures associated with these actions.

Duration [SOM §7550.8]

Temporary management continues until a facility is terminated, achieves substantial compliance and is capable of remaining in substantial compliance, or decides to discontinue the remedy and reassume management control before it has achieved substantial compliance.

Federal Remedies [SOM §7304]

Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies [SOM §7304.1]

CMS will impose federal remedies and the survey will be identified as a "No Opportunity to Correct" if the situation meets any one or more of the following criteria:

- The current survey identifies IJ (scope and severity levels J, K, and L); OR
- Any deficiency from the current survey at levels G, H, or I that falls into any of the regulatory sections that constitute substandard quality of care; OR
- Any deficiency at G or above AND if there were any at G or above on the previous survey or if there was any at G or above on any type of survey between the current and last standard survey ("double G"); OR
- A facility classified as a Special Focus Facility (SFF) AND has a deficiency at level F or higher.

> **"Scope"** refers to the number of residents affected or threatened by a deficiency.
>
> **"Severity"** refers to the seriousness of the deficiency.
>
> - SOM §8000D(15)

SA and CMS Regional Office (RO) Responsibilities when federal remedies are imposed [SOM §7304.3]

When federal remedies are to be immediately imposed as outlined in §7304:

- Within five business days after the last day of the current survey when any of the criteria in §7304.1 (above) is met, **the SA must notify the CMS RO** their review and action; and
- The CMS RO will review these cases within five business days of receipt from the SA and decide if an immediate imposition of remedies is appropriate.

Resident Transfers [SOM §7552]

Responsibility for Transferring Residents [SOM §7552.2]

The state has the ultimate responsibility for transferring Medicare and Medicaid residents when a facility is terminated. The goal must be to minimize the period of time during which residents are receiving less than adequate care.

State's Prerogative to Close Facility and Transfer Residents [SOM §7552.3]

A finding of IJ will not, in and of itself, require the state to close a facility and transfer residents. It could, however, result in the immediate termination of a Medicare and/or Medicaid provider agreement and the subsequent transfer of residents. During an emergency, the state can permanently or temporarily transfer residents to another facility until the original facility is able to care for its residents.

Out of Compliance Facilities [SOM §7301]

Immediate Jeopardy (IJ) [SOM §7301.1, see also §7307]

Immediate jeopardy (IJ) is a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. **In an IJ situation, *immediate action is required* to remove the IJ to resident health or safety and to subsequently correct the deficiencies.** Temporary management or termination, or both, is required to address IJ situations. The enforcement action for noncompliant facilities with IJ deficiencies is intended to be swift, though the use of additional remedies is allowed.

Key Components of Immediate Jeopardy

(1) Noncompliance

(2) caused or created a likelihood that serious injury, harm, impairment, or death to one or more recipients would occur or recur; and

(3) immediate action is necessary to prevent the occurrence or recurrence of serious injury, harm, impairment, or death to one or more recipients.

- The RO or state Medicaid agency (SMA) will impose termination and/or temporary management in as few as two calendar days after the survey which determined IJ. In all cases of IJ, the provider agreement must be terminated by CMS or SMA no later than 23 calendar days *if the IJ is not removed*;
- The RO or SMA should impose another remedy in addition to termination;
- The RO or SMA may impose a civil money penalty (CMP) between $3,050 and $10,000 per day of IJ or a "per instance" CMP from $1,000 to $10,000 for each deficiency;
- The RO or SMA may impose other remedies as described in §7500;
- The RO, SMA, or state (as authorized by CMS) may impose state monitoring immediately without notice;
- The state may also provide notice of the imposition of denial of payment for new admissions effective two calendar days from the date the facility receives notice;
- The state will require that the facility submit an allegation that the IJ has been removed as well as provide sufficient detail to demonstrate how the IJ has been addressed;
- The state will require an acceptable PoC for all deficiencies cited after it conducts the revisit to confirm removal of the IJ; and
- The state is authorized to recommend and impose category 1 remedies (see SOM §7304.1).

No Immediate Jeopardy [SOM §7301.2]

- CMS or the state must determine whether the facility will be given an opportunity to correct its deficiencies before remedies are imposed (see SOM §7304);
- The RO or SMA should impose another remedy in addition to termination for a facility not being given an opportunity to correct;
- The RO or SMA terminates the Medicare and/or Medicaid provider agreements that are in effect no later than six months from the date of the survey that determined noncompliance;
- When there is an opportunity to correct before remedies are imposed, the state will request an acceptable PoC, provide initial notice of recommended remedies, and other remedies if noncompliance persists;
- The RO or SMA must impose denial of payment for new admissions no later than three months after the last day of the survey that identified noncompliance;
- The RO or SMA may impose state monitoring without notice;
- The RO or SMA may impose either a per day CMP between $50 and $3,000 or a per instance CMP between $1,000 and $10,000 for each deficiency (see SOM §§7510-7536); and
- The state is authorized to recommend and impose category 1 remedies, which include:
    - Directed PoC;
    - State monitoring; and
    - Directed in-service training.

Noncompliance may occur for a variety of reasons and can result in harm to residents or put residents at risk for harm. When facilities do not maintain substantial compliance, CMS may use various enforcement remedies to address a facility's responsibility to promptly achieve, sustain, and maintain compliance with all federal requirements. (See SOM §7304).

Immediate Jeopardy Enforcement [SOM §7308]

If the survey team agrees that deficiencies pose an IJ, the team leader must contact, while on-site, its management to discuss the findings. If it is determined that IJ exists, the team must notify the facility administration, while on-site, of the IJ findings.

- The SA must notify the CMS RO or the state Medicaid agency, or both, as appropriate, so that either agency terminates the provider agreement within 23 calendar days of the last date of the survey and/or appoints a temporary manager in as few as two calendar days who must remove the IJ within the 23 days.

- When IJ is identified that resulted in serious harm, impairment or death, a CMP must be imposed. For IJ deficiencies where there is no resultant serious harm, impairment, or death, but the likelihood is present, a remedy must be imposed.

When IJ is identified, the facility must submit an allegation that includes a plan of sufficient detail to demonstrate how and when the IJ has been removed. A PoC for the deficiencies should be deferred until a revisit is conducted to verify removal of the IJ. (See SOM §7317.2.)

Termination Procedures for Facilities Out of Compliance [SOM §7556]

Immediate Jeopardy [SOM §7556.2]

When there is IJ to resident health or safety, the enforcing agency must complete termination procedures within 23 days from the last day of the survey which found the IJ if it is not removed before then. The procedure must not be postponed or stopped unless the IJ is removed, as verified through onsite verification or review of verifiable documentation. If there is written and timely credible allegation that the IJ has been removed, CMS or the state will conduct a revisit prior to termination, if possible.

Nurse Aide Registry and Abuse, Neglect, or Misappropriation of Property [SOM §7700]

Notification – Preliminary Determinations [SOM §7700.1]

If the state makes a preliminary determination, based on oral or written evidence and its investigation, that resident neglect, abuse, or misappropriation of property has occurred, the state completes the following notification procedures:

Individuals Notified – the state notifies the following in writing within 10 working days of the investigation:

- Individual(s) implicated in the investigation; and
- The current administrator of the facility in which the incident occurred.

Notice Information – the following is included:

- Nature of the allegation (specific facts);
- Date and time of the occurrence;
- A statement that the individual implicated in the investigation has a right to a hearing and must request the hearing within 30 days from the date of the notice. Provide the individual with the specific information needed to request a hearing, such as the name and address of a contact in the state to request a hearing;
- Statement that if the individual fails to request a hearing, the presumed substantiated findings will be reported to the nurse aide registry or the appropriate licensure authority;
- The intent to report findings substantiated by a hearing in writing to the nurse aide registry and/or to the appropriate licensure authority;

- Consequences of waiving the right to a hearing;
- Consequences of a finding through the haring process that the resident abuse or neglect, or misappropriation of property did occur; and
- Right of the accused individual to be represented by an attorney at the individual's own expense.

Conduct of Hearing for Nurse Aides [SOM §7700.2]

Time frame to complete hearing: The state must complete the hearing and the hearing record within 120 days from the day is receives the request for a hearing.

Hearing location: The state must hold the hearing in a manner consistent with state practice at a reasonable place and time convenient for the individual.

Reporting Findings [SOM §7700.3]

Reporting to Entities: If the individual waives the right to a hearing or the time to request a hearing has expired, or if the hearing finding is that the individual neglected or abused a resident or misappropriated a resident's property, the substantiated findings must be reported in writing within 10 working days to:

- The individual;
- Current administrator of the facility in which the incident occurred;
- The administrator of the facility that currently employs the individual, if it is not the same facility in which the incident occurred;
- Applicable licensing authorities; and
- The nurse aide registry for nurse aides.

Information Submitted to the Nurse Aide Registry: The following must be included and remain in the registry permanently unless the finding was made in error, the individual was found not guilty, or the state is notified of the individual's death:

- Documentation of the investigation;
- The date of the hearing and its outcome; and
- A statement by the individual disputing the allegation if the individual chose to make one.

Information Retained in the Nurse Aide Registry Permanently: The registry removes entries for individuals who have performed no nursing or nursing-related services for 24 consecutive months, *unless* the individual's registry entry includes documented findings of abuse, neglect, or misappropriation of resident property.

Reporting Abuse [SOM §§5330, 7701]

When the RO or SA substantiates a finding of abuse, the RO or SA must report the findings to local law enforcement and, if appropriate, the Medicaid Fraud Control Unit.

Editor's Note: Know Your Rights! Far too much resident abuse goes unreported, despite longstanding requirements for nursing homes to report allegations of abuse or neglect to the state SA. To help address the problem, the Affordable Care Act established important requirements for the reporting of any reasonable suspicion of a crime against a nursing home resident. To learn more about these requirements and addressing abuse in nursing homes, check out LTCCC's Abuse, Neglect, and Crime Reporting Center.