

A Guide to Nursing Home Oversight & Enforcement

Exploring the state's role in assuring quality care.



The Long Term Care Community Coalition

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IMPORTANT NOTES ON THIS GUIDE

Content. This guide covers portions of the State Operations Manual (SOM) that we believe are most useful for supporting good care, accountability, and resident-centered advocacy. The section summaries are edited for brevity and clarity and may not contain all relevant information about a standard.

The SOM is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984>.

Formatting. Each component of this guide contains a descriptive title and SOM source (*i.e.*, *Survey Length [SOM 7201.3]*). Explanatory text provides a summary of the relevant SOM language. Wherever possible, it is comprised of language from the SOM (which may be lightly edited or paraphrased for clarity).

Updates. See the [Nursing Home 411 Reports Page](#) for updates to this guide if/when the State Operations Manual is revised. In addition, CMS periodically issues memoranda with revisions, clarification, and updates on specific regulatory issues. They are available at <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions>.

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For a more user-friendly experience, we recommend viewing the online version of this report at nursinghome411.org/survey-enforcement.

I. Introduction

The vast majority of nursing homes in the United States participate in the Medicare and/or Medicaid programs. In order to do so, they are required to meet the minimum standards laid out in the federal Nursing Home Reform Law and the federal regulations implementing that law. Fundamentally, the law requires that residents are provided the care and quality of life services sufficient to attain and maintain their highest practicable physical, emotional, and psychosocial well-being. The regulations, and sub-regulatory guidance, provide robust and extensive information on how these requirements must be realized in the lives of residents.

Despite the law and regulatory standards, serious nursing home problems are persistent and widespread. The reason for this is that, fundamentally, **care standards can only make a difference in the lives of residents when they are enforced by the state and federal agencies responsible for nursing home oversight.**

This guide aims to highlight and synthesize **key oversight responsibilities as detailed in the federal CMS State Operations Manual (SOM).** These responsibilities include surveys (inspections), enforcement, complaint responses, remedies, and other quality assurance functions.

The guide highlights important guidance from the following **six categories**:

- I. **Program Background and Responsibilities**
- II. **Survey Process**
- III. **State Oversight Performance Standards**
- IV. **Enforcement and Remedies**
- V. **Civil Money Penalties**
- VI. **Information Disclosure**

In a hurry? The Table of Contents has descriptive titles for each of the topics covered in the guide. Click on the title to go directly to section of interest.

The purpose of this guide is to clarify to long-term care consumers and other stakeholders (including family members, advocates and ombudsmen, and policymakers) what they should expect from their state health departments. By highlighting key guidance from the SOM, we hope to demonstrate that state agency responsibilities extend far beyond their annual facility inspections; states are required by law to carry out numerous responsibilities—outside of inspections—to ensure that residents are safe and that their care needs are met every day of the year.

II. Nursing Home Surveys

Who is responsible?

The Centers for Medicare & Medicaid Services (CMS) is the federal agency responsible for overseeing nursing home care and ensuring that residents receive the care and quality of life services they are entitled to, in compliance with federal minimum standards. CMS contracts with the states to conduct monitoring and oversight and ensure compliance with federal quality standards. These activities are carried out by state survey agencies (SAs)—usually a state department of health or department of public health—which is responsible for ensuring resident safety, dignity, and well-being 24 hours a day, every day of the year.

Primary activities of an SA include surveying (inspecting) facilities, responding to complaints about care, and responding to facility-reported incidents to evaluate performance and effectiveness in rendering safe and acceptable quality of care.

What facilities are surveyed?

Virtually all nursing homes in the U.S. participate in Medicaid and/or Medicare (i.e., receive funds from one or both programs). Participation in Medicaid/Medicare is voluntary. When a nursing home operator chooses to take Medicare/Medicaid funds, they agree to meet or exceed all federal standards and to be surveyed by their state survey agency and CMS to ensure compliance with those standards.

Why do surveys matter?

Surveys are the principal mechanism through which nursing home quality is assessed and compliance with standards is determined.

Surveys during COVID

In March 2020 in response to the COVID-19 pandemic, CMS restricted regular survey activities at nursing homes and introduced infection control surveys. As a result, state agencies conducted only 8,999 complaint surveys in 2020, approximately half the previous year's total (16,662). When nursing home residents were most in need, too many facilities were operating without oversight. ([Journal of the American Geriatrics Society](#)).

III. The State Operations Manual (SOM)

What is the State Operations Manual?

The **State Operations Manual (SOM)** is a federal document, issued by CMS, containing survey and certification rules and guidance. The [SOM includes 10 chapters](#) covering a range of topics such as skilled nursing facilities (nursing homes), laboratories, and home health. **This guide focuses on nursing homes** and largely on [Chapter 7, “Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities.”](#)

Survey protocols promote consistency in the survey process and assure that a facility’s compliance with regulations is reviewed **thoroughly, efficiently, and consistently.**

Why is the State Operations Manual important?

The SOM provides guidance to help surveyors assess whether nursing homes are complying with critical regulatory requirements.

The manual includes key survey protocols such as instructions, checklists, and other tools. These protocols can be used to identify relevant areas and issues to be surveyed as specified in each regulation, and, in some cases, the methods to be used. The survey protocols also promote consistency in the survey process and assure that a facility’s compliance with regulations is done so thoroughly, efficiently, and consistently.

SAs must follow the proper protocols when conducting surveys and then consider the requirements in the statutes and regulations to determine whether a citation is appropriate. The SA bases any deficiency on a violation of the statute or the regulations. Decisions relating to violations of a statute or regulation must be based upon findings related to the facility’s performance, practices, or conditions.

Categories of SOM Guidance

This guide focuses on State Operations Manual (SOM) guidance from the following six categories:

- I. Program Background and Responsibilities:** Certification and requirements for Medicare/Medicaid participation.
- II. Survey Process:** A “how to” for nursing home surveys.
- III. State Oversight Performance Standards:** The requirements which state survey agencies must meet to ensure nursing home compliance with federal standards.
- IV. Enforcement and Remedies for Nursing Homes:** CMS and state action when facilities are out of compliance.
- V. Civil Money Penalties:** Penalties and fines imposed by the regulatory agencies.
- VI. Information Disclosure:** Survey and certification information requiring public disclosure.

Each category features selected SOM guidance and a number referencing the SOM source. The guidance text either quotes directly from the SOM or is lightly edited or paraphrased for clarity.

Note: The State Operations Manual (SOM) is extremely comprehensive, containing 10 frequently overlapping chapters to provide additional guidance or examples. This guide draws information predominately from [Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities](#). It does **not** cover guidance related to other facilities, such as laboratories, hospitals, and home health services.

IV. Summary of Federal Law

All nursing homes that contract to provide Medicaid and/or Medicare services are required to meet federal standards of care for all residents in their facilities (whether or not the individual is a beneficiary of one of those programs). These standards are founded in the 1987 Omnibus Budget Reconciliation Act (aka “OBRA ‘87”), which contains the Nursing Home Reform Law.¹ The Reform Law requires all skilled nursing facilities that receive federal funding to conform to specific standards of care, including that nursing staff help residents attain and maintain their “highest practicable physical, mental, and psychosocial well-being,” based on their individual needs and personal goals. The emphasis on individualized, resident-centered care was intended to reduce widespread problems in long-term care facilities, including abuse and neglect, and improve quality of life. Unfortunately, many of these reforms have not been fully implemented in the lives of residents and, as a result, nursing homes can often be poor places to live and get care. An important example is the widespread inappropriate use of antipsychotic drugs in nursing homes, which has received much attention from news and government sources in recent years. The extent and duration of this problem typifies the weaknesses in implementation of the Reform Law, according to which residents have the right to be free from unnecessary drugs and chemical restraints, as well as the right to be informed about, participate in, and refuse treatment.

¹ Nursing Home Reform Law, 42 U.S.C. §§1395i-3(a)-(h), 1396r(a)-(h) (Medicare and Medicaid, respectively) (December 1987). The Reform Law’s text is available at: <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-G/part-483>.

V. Program Background & Responsibilities

Introduction:

This section of the guide explains the basic role of certification in ensuring that health care entities, such as nursing homes, meet the Medicare/Medicaid requirements. It outlines the functions and responsibilities of state agencies and, lastly, covers the role of the Centers for Medicare & Medicaid Services (CMS) in the process.

What you'll learn:

- Foundation for state agency activities
- Functions and responsibilities of state agencies
- Authority of the CMS Locations (aka Regional Offices)

Introduction – The Expectations of Nursing Homes & Oversight Agencies [SOM §7000]

The nursing home reform regulation establishes several expectations. The **first expectation** is that providers remain in [substantial compliance](#) with Medicare/Medicaid program requirements as well as state law. The regulation emphasizes the need for continued, rather than cyclical compliance. The enforcement process mandates that policies and procedures be established to remedy deficient practices and to ensure that correction is lasting; specifically, that facilities take the initiative and responsibility for continuously monitoring their own performance to sustain compliance. Measures such as the requirements for an acceptable plan of correction emphasize the ability to achieve and maintain compliance leading to improved quality of care.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

- [CFR §488.301](#)

The **second expectation** is that all deficiencies will be addressed promptly. The standard for program participation mandated by the regulation is substantial compliance. The state and the regional office will take steps to bring about compliance quickly. In accordance with [§7304](#), remedies such as civil money penalties, temporary managers, directed plans of correction, in-service training, denial of payment for new admissions, and state monitoring can be imposed before a facility has an opportunity to correct its deficiencies.

The **third expectation** is that residents will receive the care and services they need to meet their highest practicable level of functioning. The process detailed in these sections provides incentives for the continued compliance needed to enable residents to reach these goals.

Basis for State Agency (SA) Activities [SOM §1002]

[The Social Security Act \(the Act\), Section 1864\(a\)](#), directs the Secretary of the Department of Health and Human Services (the Secretary) to use the help of state health agencies or other appropriate agencies when determining whether health care entities meet federal standards. This helping function is termed “**certification**.”

Certification Significance [SOM §1012A]

Certification is when the SA officially recommends its findings regarding whether health care entities meet the Act’s provider or supplier definitions, and whether the entities comply with standards required by federal regulations. **SAs do not have Medicare determination-making functions or authorities; those authorities are delegated to CMS’s Regional Offices (ROs).** SA certifications are the crucial evidence relied upon by regional offices in approving healthcare entities to participate in Medicare. (See also [SOM §2000](#).)

Providers are parties who care for patients awaiting, receiving, or recuperating from treatment by intervening practitioners.

Suppliers includes those who furnish goods and services used in care and treatment.

- [SOM §2002](#)

SA Certification [SOM §1010]

The functions that the state SAs perform are referred to collectively as the certification process. This includes, but is not limited to:

- Identifying potential participants;
- Conducting investigations and fact-finding surveys;
- Explaining requirements and conducting periodic education programs for staff and residents, and their representatives, in order to present current regulations, procedures, and policies;
- Data entry of survey information into CMS data systems; and
- Maintaining survey, certification, statistical, or other records.

SA Administrative Responsibilities [SOM §4003]

The SA is responsible for:

- Establishing and maintaining organizational relationships with other state and local government groups as necessary for attaining program or related program goals;
- Keeping CMS advised of program needs and trends, and of responsive actions taken;
- Providing the material, equipment, and the training and support of personnel to perform the above functions; and
- Furnishing necessary records and accounting to provide justification for costs claimed for payment by the Secretary.

SA Staff Training and Development [SOM §4003.2]

All health facility surveyors employed in the Medicare and/or Medicaid programs must successfully complete the Basic Health Facility Surveyor Training Course *within the first year of employment*.

Each state is responsible for providing continuing education to its surveyors. Each SA provides the appropriate training through in-service education, state, regional, and/or national conferences, seminars and workshops, and related courses as needed and appropriate. The SAs are to assure that surveyors are trained to survey for all regulatory requirements and have the necessary skills to perform the survey.

The Basic Health Facility Surveyor Training Course provides training to federal and state surveyors on a wide variety of topics related to the survey and certification process. Subjects include regulatory, procedural, and issue-based information as well as practical skills, knowledge, and application.

In-Agency Training [SOM §4003.2B]

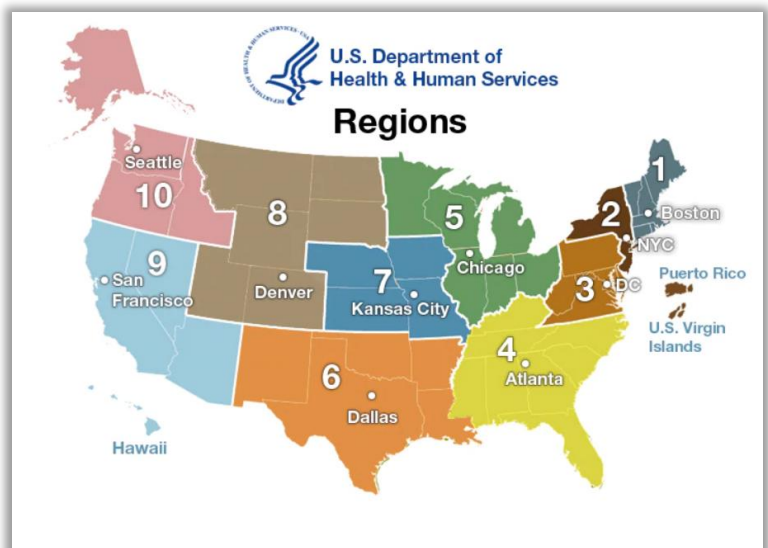
Each SA must have its own program of staff development that responds to the needs of new employees for orientation and basic training, and to the needs of experienced employees for continuing development and education.

CMS's Role [SOM §1006]

The primary mission of CMS is to administer the Medicare program and related provisions of the Social Security Act in a manner which:

- Promotes the timely and economic delivery of appropriate quality of care to eligible beneficiaries;
- Promotes beneficiary awareness of the services for which they are eligible; and
- Promotes efficiency and quality within the total health care delivery system.

CMS carries out its mission through a central office (CO) in Baltimore, which promulgates policies and provides monitoring, surveillance, and overall administrative control of the certification process (including its financial and surveyor training aspects), and 10 Regional Offices (ROs) which are responsible for assuring that health care providers meet applicable federal requirements. In relation to the responsibilities and activities of the state agencies (SAs), ROs are responsible for:



- Evaluating the performance of SAs;
- Providing liaison, direction, and technical assistance to SAs;
- Allocating SA funds for conducting certification activities; and
- Conducting surveillance and assessments of SA operations; reviewing SA certification actions; and providing feedback to states.

Surveyors must express deficiencies clearly and concisely with a regulatory citation for each.

Note: In 2020, CMS renamed the Regional Offices “Locations.” However, both names continue to appear on the [federal website](#) and CMS documents.

Approval and Correction of Deficiencies [SOM §1016]

Nursing homes are required to operate in compliance with a set of requirements known as the Requirements for Participation. This section of the SOM describes the fundamental activities of the SA in this role.

The SA ascertains, by a survey conducted by qualified health professionals, whether and how each standard is met. While an institution may fail to comply with one or more of the subsidiary standards during any given survey, it cannot participate in Medicare unless it... attains substantial compliance with requirements.

The SA prepares its certification for the RO, sends the institution a [“Statement of Deficiencies,” \[SoD\] Form CMS-2567](#). The institution is given 10 calendar days in which to respond with a Plan of Correction (PoC) for each cited deficiency and enters this response on the form containing the statement of deficiencies.

“The essence of what the SA certifies to CMS is a finding of whether an institution... substantially meets each requirement....”

If the institution has not come into compliance with all... Requirements... within the time period accepted as reasonable, the SA certifies noncompliance notwithstanding a PoC.

Statement of Deficiencies and Plan of Correction [SOM §2728]

The survey report form, [Statement of Deficiencies and Plan of Correction Form CMS-2567](#), is the federal form that must be used by the state to document inspections and surveys. It serves several important functions:

- It is the basic document disclosed to the public about the entity’s deficiencies and what is being done to remedy them;
- It documents the specific deficiencies cited;
- It documents any promises made by the provider/supplier, i.e., plans for correction and timeframes; and
- It provides an opportunity for the provider to refute survey findings and furnish documentation that requirements are met.

Statement of Deficiencies [SOM §2728A]

The surveyor prepares Form CMS-2567, and for each requirement not met, the surveyor makes a citation that includes the following:

- The prefix and data tag number ([see Appendix 1 of this guide](#));
- The deficiency that contains the [Code of Federal Regulations \(CFR\)](#) reference, the requirement that is not met, and an explicit statement to that effect; and
- The evidence to support the deficiency.

Sample → Statement of Deficiencies and Plan of Correction, Form CMS-2567:

Department of Health & Human Services Centers for Medicare & Medicaid Services		Printed: 01/20/2021 Form Approved OMB No. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 355125	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER Augusta Place, a Prospera Community		STREET ADDRESS, CITY, STATE, ZIP CODE 301 Lorrain Drive Bismarck, ND 58503	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</p> <p>Based on observation, record review, review of facility policy, and staff interview, the facility failed to ensure each resident received adequate supervision and/or assistive devices to prevent accidents for 1 of 1 sampled resident (Resident #22) with a current bed alarm. Failure to reassess the effectiveness of current interventions and need for additional interventions when necessary may result in falls.</p> <p>Findings include:</p> <p>Review of the facility policy titled Alarms: Bed, Chair, and Door occurred on 02/26/20. This policy, revised December 2019, stated, . Purpose: To ensure that use of alarms is dignified and appropriate based on the resident's condition. Review of the resident's condition will determine if the resident will benefit from the use of an alarm. The use of alarms will be reviewed on a regular basis but not less than quarterly by the interdisciplinary team.</p> <p>Review of Resident #22's medical record occurred on all days of survey. The current care plan stated, . The resident is at risk for falls R/T (related to) hx (history) of falls, Dx (diagnosis): [MEDICAL CONDITION], impaired mobility. Cognitive loss, poor safety awareness. falls risk score=16. Bed alarm in place for resident safety due to HX of self transferring and falls. Date Initiated: 05/15/2016. Revision on: 06/18/2018.</p> <p>Observation on 02/24/20 at 10:08 a.m., identified a bed alarm on Resident #22's bed.</p> <p>During an interview on 02/26/20 at 4:00 p.m., an administrative nurse (#1) stated she was unable to find documentation the bed alarm had been re-evaluated.</p> <p>The facility failed to reassess the effectiveness of and need for Resident #22's bed alarm.</p>		
Level of Harm - Minimal harm or potential for actual harm			
Residents Affected - Few			

Prefix Tag

Data Tag

CFR
ReferenceEvidence
to
Support
the
Deficiency

PoC Review [SOM §2728C]

The SA reviews the PoC for appropriateness, legibility, and completeness. If it is not properly completed or if there is a question about it, the SA contacts the facility representative to obtain clarification or an appropriate modification of the plan.

PoC Modifications [SOM §2728D]

The facility may submit evidence of correction or a modified PoC to the SA at any time. The SA retains a copy of the material and forwards the original to the regional office or state Medicaid office, as appropriate.

PoC Rejections [SOM §2728E]

If the SA finds that a PoC is unacceptable, it rejects it and seeks an acceptable PoC from the provider. Generally, changes must be made by the provider, but if adjustments required are minor, the SA may contact the provider by telephone, make the necessary adjustments, and submit the change to the provider. Changes to a PoC must be signed by the provider.

To certify a SNF to receive payment under Medicare and/or Medicaid, surveyors must complete at least:

- A life safety code survey; and
- A standard survey

Surveyors are to follow the procedures in [Appendix P](#) of the SOM for conducting all surveys of SNFs.

VI. Survey Process

Introduction:

This category of the guide is the core “how to” for nursing home surveys. Surveyors follow certain protocols to determine the appropriateness of a citation of non-compliance. The survey protocols and guidelines help surveyors in clarifying the intent of the regulations.

What you’ll learn:

- Survey team size and composition; survey frequency
- Conflicts of interest for surveyors
- Complaint/incident process and how state agencies manage complaints
- Types of surveys and how they are conducted
- Actions taken when a facility is not in substantial compliance

Presurvey Preparation [SOM §2704]

Prior to conducting a survey, the SA should review documents of record including:

- Licensure records;
- Fire inspection reports;
- Previous survey reports including Life Safety Code and complaints;
- Media reports about the facility; and
- Other publicly available information about the facility (e.g., its own website).

This information is helpful in determining composition of the survey team and the time required for the survey or resurvey.

Team Size, Team Composition, and Survey Length [SOM §7201, see also §2706]

Note: As the language in this section indicates, both the state agencies and CMS Regional Offices are expected to tailor the size and composition of survey teams, as well as the length of surveys, to ensure that they have both the time and the skills necessary to ensure that the needs of the residents in each facility are being met.

Team Size [SOM §7201.1]

Survey team size will vary, depending primarily on the size of the facility being surveyed. The state (or, for federal teams, the RO) determines how many members will be on the team. Survey team size is normally based upon the following factors:

- The bed size of the facility to be surveyed;
- Whether the facility has a historical pattern of serious deficiencies or complaints;
- Whether the facility has special care units; and
- Whether new surveyors are to accompany a team as part of their training.

Team Composition [SOM §7201.2]

The state (or, for federal teams, the RO) decides what the composition of the survey team will be, as long as certain statutory and regulatory requirements are met:

- Standard surveys conducted by a multidisciplinary team of professionals, *at least one of whom must be a registered nurse (RN)*;
- Surveyors free of conflicts of interest (see [§7202](#)); and
- Surveyors successfully complete a training and testing program in survey and certification techniques that has been approved by the Secretary.

Surveyors must successfully complete the CMS-approved training and pass the Surveyor Minimum Qualifications Test.

Within these parameters, the states (or, for federal teams, the ROs) are free to choose the composition of each team, and it is the state that determines what constitutes a professional. However, **CMS offers the following guidance:**

- The state or RO should consider using more than one RN on teams that will be surveying a facility known to have a large proportion of residents with complex nursing or restorative needs.
- Because of the strong emphasis on resident rights, the psychosocial model of care, and rehabilitative aspects of care in the regulations and the survey process, the team should include social workers, registered dietitians, pharmacists, activity professionals, or rehabilitation specialists, when possible.

- It is important, to the extent practical, to utilize team members with clinical expertise and knowledge of current best practices that correspond to the resident population’s assessed needs, the services rendered in the facility to be surveyed, and the type of facility to be surveyed.
 - **Example:** If the facility has a known problem in dietary areas, there should be an effort to include a dietitian on the team; if a known problem in quality of life, a social worker. If the facility specializes in the care of residents with post-trauma head injuries and strokes, a physical therapist may be included on the team.
- In addition to members of individual disciplines routinely included as members of the survey team, consideration should be given to the use of individuals in specialized disciplines who may not routinely participate as team members. These individuals would be available to assist the survey team when specific problems or questions arise.
 - Consultants in these suggested disciplines include, but are not limited to, physicians, physician assistants, nurse practitioners, physical, speech, and occupational therapists, dietitians, sanitarians, engineers, licensed practical nurses, social workers, pharmacists, and gerontologists.
- In order to comply with the requirement that “No individual shall serve as a member of a ... team (surveying a SNF or NF) unless the individual has successfully completed (the CMS-approved) training and testing program,” surveyors in training, i.e., those who have not successfully completed the required training, must be accompanied on-site by a surveyor who has successfully completed the required training and testing.

“Because of the strong emphasis on resident rights, the psychosocial model of care, and rehabilitative aspects of care in the regulations and the survey process, the team should include social workers, registered dietitians, pharmacists, activity professionals, or rehabilitation specialists, when possible.”

Survey Length [SOM §7201.3]

The length of a standard survey in terms of person hours is expected to vary, based on the size and layout of the facility and the number and complexity of concerns that need to be investigated onsite.

Survey Scheduling [SOM §7205, see also §§2008F, 2700B]

Scheduling and Conducting Surveys [SOM §7205.2]

States must complete standard surveys no later than 15 months after the previous standard survey. Facilities with excellent histories of compliance may be surveyed less frequently to determine compliance, but no less frequently than every 15 months and the state-wide standard survey average must not exceed 12 months.

Changes that may prompt a survey include: a change of ownership, management firm, administrator, or director of nursing. **Facilities with poor histories of compliance may be surveyed more frequently to ensure residents are receiving quality care.**

The state may conduct surveys as frequently as necessary to determine if a facility complies with the participation requirements as well as to determine if the facility has corrected any previously cited deficiencies.

Unannounced Surveys [SOM §7202.2, see also §2700A]

The state has the responsibility to keep surveys unannounced and their timing unpredictable. This way, surveyors will be more likely to observe conditions and care practices that are typically present. To increase the opportunity for unpredictability in standard surveys, states should incorporate the following procedures when planning facility surveying:

- Facilities, within a given geographical area, should not be surveyed in the same order as was conducted in the previous standard survey [SOM § 7207.2.1]; and
- The time of day, day of the week, and time of month should be varied from the time of the previous standard survey [SOM § 7207.2.2].

Nursing home surveys, including standard surveys, complaint surveys, and onsite revisit surveys, are to be:

- Unannounced;
- Nonsequential; and
- Varied in timing.

CMS Review of State Scheduling [SOM §7207.3]

Regional offices review annually state's procedures for assuring that surveys are not announced through the methods by which they are scheduled or conducted.

Mandatory Sanction Time Frames [SOM §7205.1.1]

These dates should be set based on full months rather than on a number of days.

Example: If a survey ended on January 15, the 3-month effective date for the mandatory denial of payment for new admissions remedy is April 15, and the 6-month mandatory termination date is July 15.

Civil Money Penalties [SOM §7207.4]

If any individual has, in any way, given prior notification to a facility of the date of a *standard survey*, the state or CMS is to contact the regional Office of the Inspector General (OIG) and report the name of the individual and what has occurred. The OIG will further investigate and determine whether to impose a federal civil money penalty of up to \$2,000.

Actions to Ensure SA's Compliance with Standard Survey Interval [SOM §7205.5]

No action is necessary if the standard survey interval for a provider is not greater than 15 months and the state-wide average is not greater than 12 months.

If the standard survey interval for a provider is greater than 15 months and/or the state-wide average interval is greater than 12 months, the regional office will notify the state, determine if a problem exists, and take appropriate action. This action is specified in [Chapter 8](#) of this manual.

Survey Protocols [SOM §2713]

Accompanying Surveyors [SOM §2713A]

The surveyors may allow, or refuse to allow, facility personnel to accompany them during a survey. Each case is at the SA and surveyor's discretion and is to be addressed with facility management. Facility personnel may be helpful in that they may answer questions or point out certain concerns. Conversely, facility personnel may hinder the surveyor by arguing about observed problems.

Physical Contact with Patients/Residents [SOM §2713B]

The health and dignity of the resident is always of paramount concern and accordingly, a surveyor must respect an individual's right to be observed. A surveyor is not to touch or examine a resident by themselves. However, in certain circumstances when it is permissible and necessary to determine the physical condition of residents, surveyors must obtain the resident's (or representative's) permission prior to any resident examination..

The health and dignity of the resident is always of paramount concern.

Example: If the surveyor believes that blankets or clothing are hiding bedsores, bruises, or incontinence, they may remove the coverings and make a determination based on observation.

Interviewing Key Personnel [SOM §2714]

Surveyors will usually meet with the administrator, the director of the facility, or supervisors from other departments to outline the survey plan.

The surveyor interviews the administrator or director of the facility first since they are the key person in the institution. However, even if the administrator feels that they can answer most of the questions, **the surveyor must verify the facts through review of source documents and interviews.**

The SA investigation must be complete enough to document whether **a)** the standards are met, and **b)** the provider is in compliance with all requirements.

The surveyor should use a few well-phrased questions to elicit the desired information.

Example: "If you smelled smoke, what would you do?"

Interviewing Residents [SOM §2715]

Surveyors are to interview residents, family members, or legal guardians to evaluate their impressions about the facility's care. However, residents, family members, and legal guardians have the right to refuse interviews. **Surveyors must respect the confidentiality of information provided during these interviews.**

Facility personnel should not accompany the surveyors during resident interviews unless the resident, their family, or their guardian requests the facility personnel's presence. Surveyors should refrain from moving or handling residents during the interviews. Any

moving or handling of residents during the interview should be done by a member of the facility staff.

Exit Conference [SOM §2724]

Surveyors conduct an exit conference with the facility's administrator and other invited staff to informally communicate preliminary survey team findings and to provide an opportunity for the interchange of information. **The exit conference is conducted as a courtesy to the provider.**

It is critical that surveyors establish and maintain control throughout the exit conference.

The surveyor may, however, refuse to continue an exit conference. Below are examples of situations in which a surveyor may refuse:

- If the provider is represented by counsel, surveyors may refuse to continue the exit conference if the provider's attorney attempts to turn it into an evidentiary hearing; or
- Any time the provider creates an environment that is hostile, overly intimidating, or inconsistent with the informal and preliminary nature of an exit conference.

Conflicts of Interest [SOM §§4008, 7202]

Conflicts of interest may arise for nursing home surveyors (inspectors) and their supervisors when their positions as public employees produce potential for private gain or unfair advantages. To protect the integrity of the nursing home certification program, state and federal employees should declare any outside interests and update that declaration as necessary.

SA administrators should require employees to make a declaration of any outside interests and update this declaration periodically. The SA should evaluate the need for preventive measures to protect the integrity of the certification program. In cases where certification work is performed by agencies other than the designated SA, the SA administrators and the subagency administrators have a shared responsibility for such surveillance.

It is not necessary for the SA to inform the RO of all potential and apparent conflict situations. However, if an overt abuse requires corrective action, the SA should inform the RO.

Examples of Potential Conflicts of Interest [SOM §§4008B, 7202.2.2]

The following are examples of situations that may raise a question of possible conflicts of interest, but they do not necessarily constitute conflicts of interest:

- Participation in ownership of a health facility located within the employing state;
- Service as a director or trustee of a health facility;
- Service on a utilization review committee;

- Private acceptance of fees or payments from a health facility or group of health facilities or association of health facility officers for personal appearances, personal services, consultant services, contract services, referral services, or for furnishing supplies to a health facility;
- Participation in a news service disseminating trade information to a segment of the health industry; and
- Having members of one's immediate family engaged in any of the above activities.

"CMS and the States must consider all relevant circumstances that may exist... to ensure that the integrity of the survey process is preserved."

Prima Facie [SOM §7202.2.1]

Any of the following circumstances disqualifies a surveyor for surveying a particular facility:

- The surveyor currently works, or, within the last 2 years, has worked as an employee, as employment agency staff at the facility, or as an officer, consultant, or agent for the facility to be surveyed;
- The surveyor has any financial interest or any ownership interest in the facility;
- The surveyor has an immediate family member (defined in [42 CFR 488.301](#)) who has a relationship with a facility described in SOM §7202; or
- The surveyor has an immediate family member who is a resident in the facility.

Federal and state employees are required to declare any outside interests and update that declaration as necessary.

Report and Investigation Improper Acts [SOM §7202.3]

Any acts of employees in violation of federal or state laws or regulations regarding conflicts of interest should be handled in accordance with applicable federal or state procedures. **In the case of state employees, conflicts of interest violations must be reported to the RO,** and the RO must be kept advised of the corrective actions. States should ask for assistance or advice in the case of any impropriety involving a conflict of interest that cannot be handled immediately under an applicable state procedure. The regional office of the Inspector General, along with the CMS RO, will then work in close cooperation with the responsible state officials until the matter is resolved.

Types of Surveys [SOM §7203]

The following protocols are established to provide guidance to surveyors conducting surveys of long-term care facilities participating in the Medicare and Medicaid programs. The protocol consists of survey procedures, worksheets, and interpretive guidelines. Its purpose is to provide suggestions, interpretations, check lists, and other tools for use both in preparation and performance as well as to promote consistency in the survey process.

Initial Certification Surveys [SOM §7203.2, see also §2005 and Appendix P]

The state is responsible for certifying a non-state operated facility's compliance or noncompliance with federal participation requirements. The state conducts the certification survey for state-operated facilities, but the RO is tasked with certifying compliance or noncompliance and determining whether a facility will participate in Medicare and Medicaid programs.

During the initial survey, the focus is on both the residents and the structural requirements that relate to qualification standards and resident rights notification, whether or not problems are identified during the information gathering tasks. (See Appendix P.)

Example: surveyors should verify the qualifications of social workers, dietitians, and activities professionals. (See also [SOM §2000](#).)

Post Survey Revisit (Follow-Up) [SOM §§2732A, 7203.4, 7317.2]

A surveyor may conduct a post survey revisit if, during a previous survey, the surveyor cited deficiencies. The intent is to verify correction of those deficiencies, and if so, the surveyor can determine if the facility now meets the requirements for participation. In some cases, the cited deficiencies may be of a nature that a mail or telephone contact will suffice as long as the SA has no reason to question the validity of the reported corrections. **However, an onsite visit is generally required for deficiencies concerning quality of care.**

If substandard care is identified during a revisit, the surveyor is to complete a partial extended survey if a partial extended or extended survey had not been conducted as the result of the prior standard or abbreviated standard survey.

Abbreviated Standard Survey [SOM §7203.5]

An abbreviated standard survey does not cover all of the aspects covered in a standard survey, but instead focuses on specific area of concern.

- **Examples:**
 - If review of a complaint allegation concludes that one or more violations of requirements may have occurred, the surveyor should conduct a standard or abbreviated standard survey.

An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern.

- If a facility notifies a surveyor of a change in the organization or management, the surveyor should review the change(s) to ensure compliance with the regulations by requesting copies of relevant documents, if not already submitted. If the change(s) raise questions of continued compliance, the surveyor should conduct a survey to determine whether deficiencies are present.

Extended Survey/Partial Extended Survey [SOM §7203.6]

If, as a result of its findings during the standard survey or abbreviated standard survey, the team suspects substandard quality of care, it expands the survey. **If the expanded survey verifies substandard quality of care, the state or RO conducts an extended survey or a partial extended survey.**

Extended surveys should be conducted within 14 days after completion of the standard survey, and only when substandard quality of care is identified.

State Monitoring Visits [SOM §§7203.7, 7504]

State monitoring visits are visits by the state to oversee a provider's compliance status. These visits may occur:

- During bankruptcy;
- After a change of ownership;
- During or shortly after removal of immediate jeopardy; and
- In other circumstances, as authorized by the CMS RO.

Complaint and Incident Management [SOM §5000]

Mission: To protect Medicare/Medicaid beneficiaries from abuse, neglect, exploitation, inadequate care, or supervision.

The goal of the federal complaint/incident process is to establish a system that will assist in promoting and protecting the health, safety, and welfare of residents, patients, and clients receiving health care services.

There are three objectives of the complaint/incident management system:

- **Protective oversight:** This is accomplished by analyzing the complaint allegations and reported incidents received to identify and respond to those that appear to pose the greatest potential for harming beneficiaries.
- **Prevention:** Complaints/incidents that do not allege a threat of serious harm are investigated to determine if a problem exists that could have a negative impact on the healthcare services provided. The investigation is designed to identify and correct less serious situations to prevent escalation.
- **Promote efficiency and quality:** Complaints/incidents that are not directly related to federal requirements are forwarded to the appropriate agencies for follow-up and investigation.

Overview [SOM § 5000.2]

All the procedures in this [chapter](#) are followed when complaints and reported incidents, including referrals from public entity, are made against a nursing home.

The investigation and resolution of complaints are critical certification activities. The CMS, the state Medicaid agency (SMA), and the state survey agency (SA) are responsible for ensuring that participating providers/suppliers of health care services continually meet federal requirements. This **requires that the SA promptly reviews complaints/incidents, conducts unannounced onsite investigations of reports alleging noncompliance,** and informs the CMS Regional Office (RO) and/or the SMA any time certification requirements are found to be out of compliance.

Since there are multiple activities associated with the management of complaints and incidents, responsibilities often cut across organizational lines. Thus, **the SA must demonstrate clear-cut accountability for each step of the process and a focal coordinating/controlling responsibility to assure timely and appropriate action. The SA's responsibilities cannot be delegated.**

General Intake Process [SOM §5010]

Complaints

A complaint is an allegation of noncompliance with federal and/or state requirements.

- If the SA determines that the allegation(s) falls within the authority of the SA, the SA determines the severity and urgency of the allegations, so that appropriate and timely action can be pursued.
- Each SA is expected to have written policies and procedures to ensure that the appropriate response is taken for each complaint. This structure needs to include response timelines and a process to document actions taken by the SA in response to complaints.
- If a state's time frames for the investigation of a complaint/incident are more stringent than the Federal time frames, the intake is prioritized using the state's timeframes.
- The SA is expected to be able to share the logic and rationale that was utilized in prioritizing the complaint for investigation.

The SA response must be designed to protect the health and safety of all residents, patients, and clients.

The SA response must be designed to protect the health and safety of all residents, patients, and clients.

Besides the SA, other public entities receive information and/or perform investigations. These entities include the office of the coroner or medical examiner, end-stage renal disease (ESRD) networks, quality improvement organizations (QIOs), law enforcement, the ombudsman's office, and protection and advocacy systems. **At times, these public entities will forward information to the SA if there are concerns about the health and safety of**

residents, patients, and clients. The SAs are required to manage and investigate these referrals as complaints.

Allegations

An allegation is an assertion of improper care or treatment that could result in the citation of a federal deficiency.

- The **point of receipt of the allegation is a critical fact-finding and decision-making point.**
- Information regarding the care, treatment and services provided to beneficiaries can come from a variety of sources, including beneficiaries themselves, beneficiaries' family members, health care providers, concerned citizens, public agencies, or media reports.
- Report **sources may be verbal or written.**
- In some instances, the complainant may request anonymity. **The SA discloses the complainant's identity only to those individuals with a need to know who are acting in an official capacity to investigate the complaint.**
- In addition to these Federal requirements, the SA abides by any state procedures not in direct conflict with CMS instructions. The SA notifies the RO if state regulations conflict directly with any part of these complaint procedures.

Information from Complainant [SOM §5010.1]

The **SA should collect comprehensive information necessary to make important decisions about the allegations, such as proper prioritization**, including:

- Name, address, telephone, etc. for the complainant;
- Individuals involved and affected;
- A narrative of the complainant's concerns including the date and time of the allegation;
- The complainant's views about the frequency and pervasiveness of the allegation;
- Name of the provider/supplier including location (e.g., unit, room, floor) of the allegation;
- How/why the complainant believes the alleged event occurred;
- Whether the complainant initiated other courses of action, such as reporting to other agencies, discussing issues with the provider, and obtaining a response/resolution; and
- The complainant's expectation/desire for resolution/remedy.

Information regarding the care, treatment, and services provided to beneficiaries can come from a variety of sources, including beneficiaries themselves, family members, and others.

Information Provided to Complainant [SOM §5010.2]

The complaint intake process assists the complainant in resolving his/her conflicts. As part of the intake process the SA provides the following:

- Policies and procedures for handling intakes including the scope of the SA's regulatory authority and any considerations pertaining to confidentiality;
- The course of action that the SA or RO will take and the anticipated time frames;
- Information about other appropriate agencies that could provide assistance including the name and telephone number of a contact person, if available; and
- A SA contact name and number for follow-up by the complainant.

CMS RO's Responsibility for Monitoring SA Management of Complaints and Incidents [SOM §5050]

CMS ROs are responsible for monitoring the SAs' management of complaints and incidents to assure that the SAs are complying with the provisions set forth in federal regulations, the SOM [State Operations Manual], and CMS policy memoranda. As part of the monitoring process, the SAs will be evaluated in accordance with the criteria set forth by the State Performance Standard Review. Many states have state laws and regulations that specify how to manage complaints and incidents. Whenever possible, state and federal requirements should be integrated to avoid unnecessary duplication.

Editor's Note: In October 2019, CMS announced that it had begun to implement changes to improve the State Performance Standards System (SPSS) process. This includes plans to significantly enhance oversight of how SAs handle complaints and facility-reported incidents (FRIs), such as how each state prioritizes reports of abuse or neglect, the timeliness of the investigation of reports, and the quality of these investigations. According to CMS, abuse and neglect are never acceptable and CMS included updates in the SPSS guidance that will strengthen its oversight.²

Priority Assignment of Nursing Home Complaints & Incidents [SOM §5070]

An assessment of each complaint or incident intake must be made by an individual who is professionally qualified to evaluate the nature of the problem based upon his/her knowledge of federal requirements and his/her knowledge of current clinical standards of practice. In situations where a determination is made that immediate jeopardy may be present and ongoing, the SA is required to start the on-site investigation within two business days of receipt of the complaint or incident report.

Editor's Note: From a consumer perspective, the proper assignment of priority is important since this will determine the type or investigation a state agency will undertake.

² Fiscal Year (FY) 2020 State Performance Standards System (SPSS) Guidance, Memo #20-02-ALL (October 17, 2019). <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Administrative-Information-Memos-to-the-States-and-Regions-Items/AdminInfo-20-02-ALL>.

For nursing homes, an onsite survey may not be required if there is sufficient evidence that the facility does not have continuing noncompliance and the alleged event occurred before the last standard survey. In cases where the SA or RO has noted a pattern of similar complaints about a specific provider or supplier, each of which on its own merits would be triaged at a medium or low level, the SA or RO has the discretion to assign a higher triage level to a current intake.

Immediate Jeopardy [SOM §5075.1]

The regulations define immediate jeopardy as, “A situation in which the provider’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.” [Appendix Q](#) contains the Guidelines for Determining Immediate Jeopardy. Intakes are assigned this priority if the alleged noncompliance indicates there was serious injury, harm, impairment or death of a patient or resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment or death of a patient or resident unless immediate corrective action is taken.

Non-Immediate Jeopardy - High Priority [SOM §5075.2]

Intakes are assigned a “high” priority if the alleged noncompliance with one or more requirements may have caused harm that negatively impacts the individual’s mental, physical and/or psychosocial status and are of such consequence to the person’s well-being that a rapid response by the SA is indicated. Usually, specific rather than general information (such as: descriptive identifiers, individual names, date/time/location of occurrence, description of harm, etc.) factors into the assignment of this level of priority.

When the SA makes the determination that a higher level of actual harm may be present, the investigation is to be initiated in accordance with §5075.9. The initiation of these types of investigations is generally defined as the SA beginning an onsite survey.

NOTE: [Exhibit 22](#) provides additional guidance to distinguish between the priorities of “immediate jeopardy” and “non-immediate jeopardy - high” for nursing home complaints/incidents.

Non-Immediate Jeopardy – Medium Priority [SOM §5075.3]

Intakes are assigned a “medium” priority if the alleged noncompliance with one or more requirements caused or may cause harm that is of limited consequence and does not significantly impair the individual’s mental, physical and/or psychosocial status or function.

Non-Immediate Jeopardy – Low Priority [SOM §5075.4]

Intakes are assigned this priority if the alleged noncompliance with one or more standards may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage.

Administrative Review/Offsite Investigation [SOM §5075.5]

Intakes are assigned an “administrative review/offsite investigation” priority if an onsite investigation is not necessary. However, the SA or RO conducts and documents in the provider file an offsite administrative review (e.g., written/verbal communication or documentation) to determine if further action is necessary. Where an administrative review/offsite investigation is conducted by the SA, the SA may confirm the findings at the next onsite survey.

Referral – Immediate [SOM §5075.6]

Intakes are assigned a “Referral – Immediate” priority if the nature and seriousness of a complaint/incident or state procedures requires the referral or reporting of this information for investigation to another agency **without delay**. This priority may be assigned **in addition to** one of the priorities in §§5075.1-5075.5. [Bold in original text.]

When the SA refers the complaint/incident to another agency or entity (e.g., law enforcement, Ombudsman, licensure agency, etc.) for action, the SA must request a written report on the results of the investigation by the outside entity. Referral to an outside entity does not relieve the SA of the responsibility to assess compliance with federal conditions or requirements, when applicable. The timeframes for investigation are not altered by the referral.

Referral – Other [SOM §5075.7]

Intakes are assigned a “Referral – Other” priority when they are referred to another agency, board, or ESRD network for investigation or for informational purposes. This priority may be assigned in addition to one of the priorities in §§5075.1-5075.5.

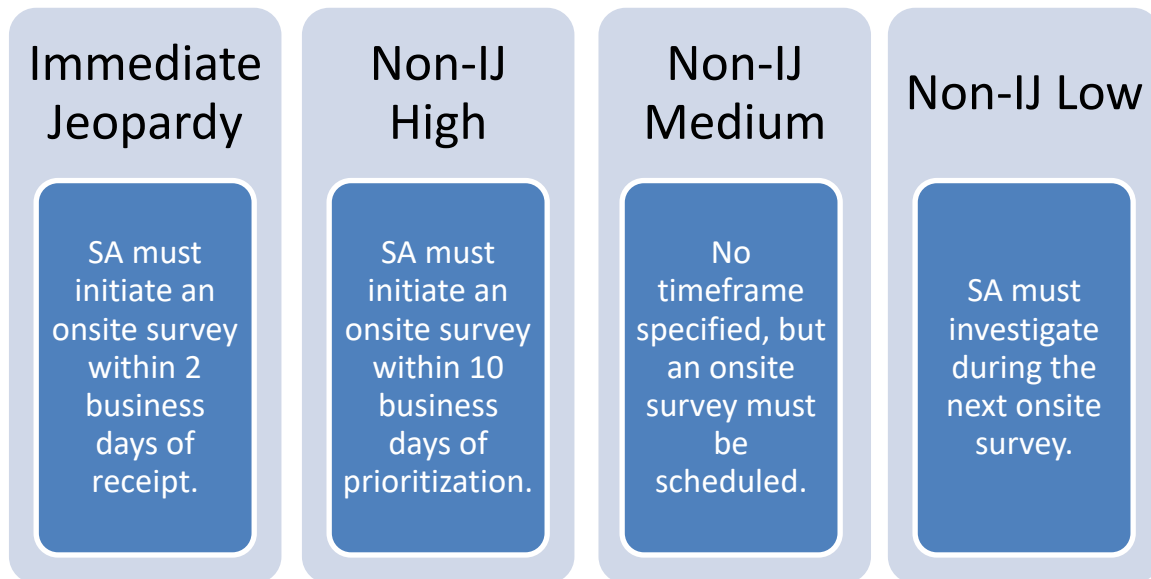
When the SA refers the complaint/incident to another agency or entity (e.g., law enforcement, Ombudsman, licensure agency, etc.) for action, the SA must request a written report on the results of the investigation by the outside entity. **Referral to an outside entity does not relieve the SA of the responsibility to assess compliance with federal conditions or requirements, when applicable.** The time frames for investigation are not altered by the referral.

No Action Necessary [SOM §5075.8]

Intakes are assigned a “No Action Necessary” priority if the SA or RO determines with certainty that no further investigation, analysis, or action is necessary.

For example, no action is necessary if a previous survey investigated the exact same event(s) and either did not find noncompliance, or noncompliance was previously identified and subsequently corrected by the provider/supplier. This category would also be used for intakes concerning an event that occurred more than 12 months in the past, unless the SA determines that a complaint investigation is nevertheless warranted.

Maximum Time Frames for Onsite Investigations of Complaints/Incidents [SOM §5075.9]



Report to the Complainant [SOM §5080.1]

The SA/RO provides the complainant a written report of the investigation findings as a summary record of the investigation.

The following principles guide preparation of the report to the complainant:

- Acknowledge the complainant's concern(s);
- Identify the SA's regulatory authority to investigate the complaint/incident and any statutory or regulatory limits that may bear on the authority to conduct an investigation;
- Provide a summary of investigation methods (e.g., on-site visit, written correspondence, telephone inquiries, etc.);
- Provide date(s) of investigation;
- Provide an explanation of the SA's decision-making process including definitions of terms used (i.e., substantiated or validated, unsubstantiated or not validated, etc.);
- Provide a summary of the SA's finding;
- Identify follow-up action, if any, to be taken by the agency (i.e., follow-up visit, plan of correction review, no further action, etc.); and
- Identify appropriate referral information (i.e., other agencies that may be involved).

Complaint Survey Exit Conference and Report to the Provider [SOM §5080.2]

Generally, the SA conducts an exit conference with the provider at the completion of the on-site portion of the complaint investigation survey. The SA informs the provider of the survey findings, including a general description of any deficiencies found. The description should be detailed enough to inform the provider of the types of activities that require the provider's corrective action.

Complaint Investigations [SOM §5300]

Section [42 CFR 488.332](#) [of the federal code] provides the federal regulatory basis for the investigation of complaints about nursing homes.

[**Note:** [42 CFR 488.332](#) explicitly states that the SA “**must establish procedures and maintain adequate staff to investigate complaints**” and **conduct “on-site monitoring on an as necessary basis** when (1) A facility is not in substantial compliance with the requirements and is in the process of correcting deficiencies; (2) A facility has corrected deficiencies and verification of continued substantial compliance is needed; or (3) The survey agency has reason to question the substantial compliance of the facility with a requirement of participation” (emphases added).]

If necessary, a specialized team may be used to investigate complaints. Team members may include, but are not limited to, an attorney, auditor, and appropriate health professionals.

The SA must review all complaint allegations and conduct a standard or an abbreviated standard survey to investigate complaints of violations of requirements if its review of the allegation concludes that:

- A deficiency in one or more of the requirements may have occurred; and
- Only a survey can determine whether a deficiency or deficiencies exist.

The timing, scope, duration, and conduct of a complaint investigation are at the discretion of the SA, *except* when a determination is made that IJ may be present and ongoing, or a higher level of actual harm may be present.

In most cases, the following tasks, or portion of tasks, should be performed during a complaint investigation:

- **Offsite survey preparation:** Review any information about the facility that would be helpful to know in planning the investigation. Contact the ombudsman to discuss the nature of the complaint and whether there have been any similar complaints reported to and substantiated by the ombudsman. Review the related regulatory requirements or standards that pertain to the complaint. [SOM §5300.1]
- **Entrance conference/onsite preparatory activities:** Onsite complaint investigations should always be unannounced. Upon entrance, advise the facility's administrator of the general purpose of the visit. It is important for the surveyor to let the facility know why

they are there but protect the confidentiality of those involved in the complaint. [SOM §5300.2]

- **Information gathering:** Conduct comprehensive, focused, and/or closed record reviews as appropriate. Observe the physical environment, situations, procedures, patterns of care, delivery of services to residents, and interactions related to the complaint. [SOM §5300.3]
- **Information analysis:** Review all information collected, and if there are inconsistencies, do additional data collection as needed. Determine whether the allegations are substantiated or unsubstantiated; the facility failed to meet any of the regulatory requirements; and the facility practice or procedure that contributed to the complaint has been changed to achieve and/or maintain compliance.

To cite past noncompliance, all of the following **three criteria** must be met:

- 1) The facility was not in compliance with the specific regulatory requirement(s) at the time the situation occurred;
- 2) The noncompliance occurred after the exit date of the last standard recertification survey and before the survey (standard, complaint, or revisit) currently being conducted; and
- 3) There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey. [SOM §5300.4]

Action on Complaints of Resident Neglect and Abuse, and Misappropriation of Resident Property [SOM §5310]

- The state must have written procedures for the timely review and investigation of allegations of resident abuse and neglect, and misappropriation of resident property. [SOM §5310.1]
- The state reviews all allegations of resident neglect and abuse and misappropriation of resident property regardless of the source of the complaint. [SOM §5310.2]
- If there is reason to believe, either through oral or written evidence, that an individual used by a facility to provide services to residents could have abused or neglected a resident or misappropriated a resident's property, the state must investigate the allegation. During the investigation, the SA should evaluate how the facility developed policies and procedures to prevent the abuse, and after the abuse occurred, how the facility took action to report and investigate the allegations while ensuring the safety of the residents. [SOM §5310.3]

Reporting Abuse to Law Enforcement and the Medicaid Fraud Control Unit [SOM §5330]

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

RO Oversight of Complaint-Related Processes [SOM §5390]

1. The RO considers any complaint data in targeting look-behind surveys or reviews.
2. The RO monitors data in summary form - either through a log or data system. See [§5060](#) [relating to the federal ASPEN Complaints/Incidents Tracking System (ACTS), excerpted in [Appendix 7](#)].

These records should include:

- Identification of region or state-wide patterns;
- Pinpointing of problem providers or states;
- Evaluation of SA processing times, workloads, performance, etc.; and
- Identification of overall SA workloads, including unsubstantiated and Medicaid-only complaint volumes.

Limitation on Technical Assistance to a Nursing Home [SOM §2727]

SAs are encouraged to communicate with the nursing home industry and the states are required to “conduct periodic educational programs for staff and residents (and their representatives)... in order to present current regulations, procedures, and policies.” However, when a violation of minimum standards is identified, “it is not the surveyor’s responsibility to delve into the facility’s policies and procedures to determine the root cause of the deficiency or to sift through various alternatives to suggest an acceptable remedy.”

Editor’s Note: This provision of the SOM is important because it makes clear that the SA is responsible for quality assurance and accountability, not basic training. The requirement that nursing homes have the appropriate supplies and sufficient staff (with the necessary knowledge and skills) to meet the clinical and psycho-social needs of every resident is fundamental to participation in Medicare/Medicaid. Residents, families, and the general public depend on this requirement being met when a resident enters a facility, not taught to a facility after something bad happens.

Nevertheless, substandard care is a serious, widespread, and persistent problem. To circumvent accountability for resident harm when minimum standards are violated, the nursing home industry lobbies for training, aka “technical assistance,” to help them learn how to comply with the minimum standards they are already paid to achieve. This provision of the SOM makes clear that the surveyor’s role is to assure quality and accountability, not assist poorly performing facilities.

Substandard Quality of Care and Extended and Partial Extended Surveys [SOM §7210]

Editor’s Note: “Substandard quality of care” (SQS) has a specific meaning under the federal guidelines. See [Appendix 6](#) for more information.

Survey expansion [SOM §7210.2]

When a surveyor suspects substandard quality of care but does not have sufficient information to confirm or refute the substandard quality of care, the survey may be expanded. This expansion does not necessarily constitute an extended or partial extended survey.

The only time an extended or partial extended survey is conducted is when substandard care is identified.

Time frames [SOM §7210.5]

An extended or partial extended survey should be conducted immediately, but, if delayed, not later than 14 calendar days after completion of a standard or abbreviated standard survey.

Notices [SOM §7210.6, see also §7320 for more on substandard care]

When substandard quality of care is identified, the state must issue notices to:

- The state board responsible for the licensing of the nursing home administrator; and
- The attending physician of each resident who was identified as having been subject to substandard care.

Nurse Aide Training and Competency Evaluation Program and Competency Evaluation Program [SOM §7210.7]

The nurse aide training and competency evaluation program and competency evaluation program *must be denied or withdrawn* when an extended or partial extended survey is conducted.

Informal Dispute Resolution [SOM §7212]

Regulations require that facilities have the opportunity to dispute cited deficiencies. The informal dispute resolution (IDR) process, as established by the state or CMS RO, must be in writing so that it is available for review upon request.

States should be aware that CMS holds them accountable for the legitimacy of the informal dispute resolution process including the accuracy and reliability of conclusions that are drawn with respect to survey findings. This means that while states may have the option to involve outside persons or entities they believe to be qualified to participate in this process, it is the states, not outside individuals or entities that are responsible for informal dispute resolution decisions. So, when an outside entity conducts the informal dispute resolution process, the results may serve only as a recommendation of noncompliance or compliance to the state. The state will then make the final informal dispute resolution decision and notify the facility of that

decision. CMS will look to the states to assure the viability of these decision-making processes, and holds states accountable for them. (See SOM § 7212.3 for more information on independent informal dispute resolution.)

Certification of Compliance or Noncompliance for SNFs [SOM §7300]

State agencies have the responsibility for certifying a SNF's compliance or noncompliance with federal regulations, *except in the case of state-operated facilities*. **The state's certification is subject to CMS's approval.**

"Certification of compliance" means that a facility's compliance with federal participation requirements is ascertained. If a facility is found to be in compliance, the state certifies and recommends that the RO and/or state Medicaid agency enter into an agreement with the facility. If a facility is not found to be in compliance, the state recommends denial of participation in the Medicare and/or Medicaid programs. In addition to certifying a facility's compliance or noncompliance, the state also recommends appropriate enforcement actions.

Effect of CMS' Validation Authority [SOM §7300.4]

The RO may make independent findings of compliance or noncompliance based on its own validation survey or review of the state's certification. The RO's finding of noncompliance is binding and takes precedence over the state's certification of compliance.

State/Federal Disagreements [SOM §7807]

Only one entity certifies noncompliance and implements enforcement remedies. These procedures are established to provide guidance when the RO's findings do not agree with the state SA's findings. **In the case of state-operated facilities**, the RO's decision always prevails because the state SA does not make the certification of compliance or noncompliance nor does it make any recommendations of enforcement actions. **In the case of SNFs**, the RO's decision always prevails.

Facility Compliance [SOM §7807.2]

If the state SA finds that a facility is not in substantial compliance, but the RO finds that the facility is in substantial compliance, the state SA's finding prevails.

If the state SA finds that a facility is in substantial compliance, but the RO finds that the facility is not in substantial compliance, the RO's finding prevails.

When the RO's finding of noncompliance prevails, it may:

- Impose remedies as specified in §7400;
- Terminate the provider agreement; and/or
- Stop federal financial participation to the state for a nursing facility at the end of six months.

Termination [SOM §7807.3]

When both the state SA and the RO agree that a facility is not in substantial compliance, but disagree as to whether to terminate a facility's provider agreement, the following rules apply:

- If the RO wants to terminate, but the state SA does not, the RO and the SMA impose the alternative remedies and follow the procedures in §7600.
- If the SMA wants to terminate, but the RO does not, the SMA's decision to terminate a nursing facility prevails as long as the termination date is no later than six months after the last day of the standard health survey; and
- If the facility is dually participating, the decision made for the Medicaid portion is applied to the Medicare portion and the RO imposes the decision for both programs.

Remedies [SOM §7807.5]

Either the state or the RO may impose additional or alternative remedies. If the state decides to terminate a provider agreement and the RO chooses to impose a CMP in addition to the termination, both remedies would be imposed. If the state chooses termination and another remedy, the additional remedy would be imposed. However, if both the state and the RO want to impose an additional remedy, only the RO's remedy would be applied.

Notice Requirements [SOM §7305]***No Immediate Jeopardy and an Opportunity to Correct [SOM §7305.1.1]***

When no IJ exists and opportunity to correct *will be provided* before remedies are imposed, the surveying entity sends an initial notice to the facility notifying of the following:

- The deficiencies cited;
- The mandatory remedy which must be imposed if the facility fails to achieve substantial compliance at 6 months;
- The approved PoC will establish the outside date by which correction must be made;
- May serve as the formal notice of the imposition of any category 1 remedy;
- The state's proposed remedies will be forwarded to CMS and/or the SMA if correction is not achieved at the first revisit;
- Provides that an acceptable PoC is required in response to the deficiencies;
- Informs the facility of the opportunity for informal dispute resolution (see SOM §7212);
- Specifies that if an acceptable PoC is not timely received, the state will recommend remedies other than category 1 and/or denial of payment for new admissions;
- Provides elements of an acceptable PoC;
- Informs the facility of the disapproval of its nurse aide training program;
- The information the facility must provide when substandard quality of care is determined; and

- When no formal notification of remedies is being provided in this initial notice, language must be inserted to make it clear that the initial notice is not the notice that triggers the imposition of remedies and that any such determination will be provided in a separate notice.

No Immediate Jeopardy and No Opportunity to Correct [SOM §7305.1.2]

When no IJ exists and opportunity to correct *will not be provided* before remedies are imposed, the surveying entity sends an initial notice to the facility notifying of the following:

- Deficiencies cited;
- Provides notice of the provider agreement termination;
- May provide that this notice serves as a formal notice of the imposition of denial of payment for new admissions and/or any category 1 remedy;
- Provides an acceptable PoC is required in response to deficiencies;
- Informs the facility of the opportunity for informal dispute resolution (see SOM §7212);
- Specifies that if an acceptable PoC is not timely received, the state will recommend remedies other than category 1 and/or denial of payment for new admissions;
- Informs the facility of the disapproval of its nurse aide training program;
- The information the facility must provide when substandard quality of care is determined;
- Provides elements of an acceptable PoC; and
- When no formal notification of remedies is being provided in this initial notice, language must be inserted to make it clear that the initial notice is not the notice that triggers the imposition of remedies and that any such determination will be provided in a separate notice.

For more information on notice requirements, including formal notice of remedies, see SOM §7305.2.

Immediate Jeopardy [SOM §7305.1.3]

When an IJ situation exists, the surveying entity sends an initial notice to the facility which must include the following:

- The nature of the IJ;
- Requests an allegation of removal of IJ, including evidence of steps taken to remove IJ;
- Consequences of failure to submit an allegation of removal (e.g., provider agreement termination);
- Remedies recommended with effective dates;
- Opportunity for informal dispute resolution (see SOM §7212);

- Opportunity for independent informal dispute resolution (see SOM §7213) if a CMP subject to being collected and placed in an escrow account is imposed;
- Disapproval of nurse aide training and competency evaluation program and competency evaluation program and appeal rights if the program loss is based on a finding of substandard quality of care;
- When substandard quality of care is determined, the facility must provide the state with a list of physicians of the residents affected; and
- When no formal notification of remedies is being provided in this initial notice, language must be inserted to make it clear that the initial notice is not the notice that triggers the imposition of remedies and that any such determination will be provided in a separate notice; or
- This initial notice can serve as the formal notice of the imposition of any category 1 remedy, which includes directed PoC, state monitoring, and directed in-service training. See SOM §7400.6.1.

Acceptable Plan of Correction [SOM §7317]

Except in cases of past noncompliance, facilities having deficiencies (other than those at scope and severity level A) must submit an acceptable plan of correction. Acceptable plan of correction (PoC), must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practices;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and
- Include dates when corrective action will be completed.

The plan of correction serves as the facility's allegation of compliance and, without it, CMS and/or the state have no basis on which to verify compliance. A plan of correction must be submitted within 10 calendar days from the date the facility receives its Form CMS-2567. If an acceptable plan of correction is not received within this timeframe, the state notifies the facility that it is recommending to the RO and/or the state Medicaid agency that remedies be imposed effective when notice requirements are met. The requirement for a plan of correction is in [42 CFR 488.402\(d\)](#). Further, [42 CFR 488.456\(b\)\(ii\)](#) requires CMS or the state to terminate the provider agreement of a facility that does not submit an acceptable plan of correction.

A facility is not required to provide a plan of correction for a deficiency cited as past noncompliance because that deficiency is corrected at the time it is cited; however, the survey team must document the facility's corrective actions on [Form CMS-2567](#).

Verifying Facility Compliance [SOM §7317.1]

While the plan of correction serves as the facility's allegation of compliance in non-immediate jeopardy cases, substantial compliance cannot be certified and any remedies imposed cannot be lifted until facility compliance has been verified. The chart in [Appendix 8](#) provides a course of action for certifying compliance based on the seriousness of the noncompliance and the number of revisits that have already occurred. It represents a continuum, ranging from accepting the latest correction date on the facility's approved plan of correction as the date of compliance without an onsite revisit, to conducting an onsite revisit to establish that date. The chart also indicates the circumstances under which revisits must occur and remedies must be imposed, as well as provides policy for conducting revisits, lifting remedies, and certifying compliance. It is important to remember that: revisits may be conducted anytime for any level of noncompliance subject to the allowed number of revisits (see §7317.2, below); remedies may be imposed anytime for any level of noncompliance; and revisits are not assured before termination can occur.

Revisits [SOM §7317.2]

When the SA cites deficiencies during the course of a survey, the SA may conduct a revisit to determine if the facility has achieved substantial compliance.

Mandatory onsite revisits are required when a facility's:

- Beginning survey or first onsite revisit finds deficiencies that constitute substandard quality of care, harm, or IJ.
- Second onsite revisit finds any noncompliance.

No guarantee of revisit: A facility is not entitled to any revisits. When conducted, one revisit will normally be conducted after a survey which found noncompliance and another before the expiration of the six-month period by which a facility must be in substantial compliance to avoid termination of its provider agreement.

Number of onsite revisits: Two onsite revisits are permitted without prior approval from the RO.

Timing of revisit: When conducted, onsite revisits occur any time between the last correction date on the PoC and the 60th day from the survey date to confirm that the facility is in substantial compliance and, in certain cases, has the ability to remain in substantial compliance.

Correction of level A, B, and C deficiencies: While facilities are expected to correct deficiencies at levels A, B, and C, deficiencies at these levels are within the substantial compliance range and, therefore, need not be reviewed for correction during subsequent revisits within the same noncompliance cycle.

Revisits to surveys for which substandard quality of care, harm, and IJ are cited: Onsite revisits must continue for these deficiencies even if they lessen to lower levels of noncompliance.

New owner: If a new operator assumes the existing provider agreement, they are responsible for assuring that corrections are made within the revisit policy.

Noncompliance Cycles [SOM §7317.3]

A noncompliance cycle begins with a recertification, complaint, or temporary waiver revisit survey that finds noncompliance and ends when substantial compliance is achieved, or the facility is terminated (or voluntarily terminates) from the Medicare or Medicaid program. The noncompliance cycle cannot exceed six months. Once a remedy is imposed, it continues until the facility is in substantial compliance or is terminated from the programs.

Readmission to Medicare or Medicaid Program After Termination [SOM §7321]

A Medicare provider terminated may not be reinstated into the Medicare program until it has been verified through the “reasonable assurance” process that the provider is capable of achieving **and** maintaining substantial compliance with all applicable participation requirements. (See SOM § 2016B for more information on the reasonable assurance concept.)

Reasonable Assurance Surveys [SOM §7321.3, see also §2016D]

Two surveys are required to verify that the reason for termination no longer exists and that the facility has maintained continued compliance.

- The **first visit** only needs to determine whether the deficiencies that led to the termination have been corrected (i.e., are they now completely removed or at the level of substantial compliance).
- The **second visit** will typically be a full standard survey. However, the RO may instruct the state to conduct the full survey during the first visit and the partial survey at the second.

VII. State Oversight Performance Standards

Introduction:

This category of the guide covers the requirements which state survey agencies must meet in respect to their responsibility for ensuring that nursing homes provide care in compliance with federal standards.

What you'll learn:

- The definition of inadequate survey performance
- Performance standards required in the §1864 Agreement (contract between CMS and state governments for a state agency to carry out quality assurance and oversight)
- CMS's evaluation process

State Performance Standards [SOM §8000]

The Social Security Act, the Code of Federal Regulations, and the State Operations Manual contain the regulatory authority for the state performance standards and protocols.

Definition of Inadequate State Survey Performance [SOM §8000C]

CMS monitors state surveying procedures and functioning through the Federal Monitoring Program.³ CMS considers survey performance to be inadequate if the state demonstrates a pattern of failure to:

- Identify deficiencies;
- Cite only valid deficiencies (i.e., the state cites unfounded deficiencies);
- Conduct surveys in accordance with the requirements;
- Use federal standards, protocols, and the forms, methods, procedures, policies and systems specified by CMS in instructions;
- Utilize enforcement actions to assure continued compliance;
- Input online data timely and accurately;
- Conduct surveys in accordance with required timeframes;
- Respond to complaints in accordance with requirements;
- Lead in the implementation by providers of federally required patient assessment instructions or data sets; and/or
- Operate federally required systems for the collection of patient assessment data.
- Fails to identify an immediate jeopardy situation.

³ <https://nursinghome411.org/wp-content/uploads/2017/03/LTCCC-Report-CMS-Oversight-2010.pdf>.

Performance Standards [SOM §8000D]

- Organization and staffing of the agency to fulfill functions required under the [§1864 Agreement](#);
- Surveys are planned, scheduled, conducted, and processed timely;
 - 42 CFR [488.307](#); [488.308](#); [488.7](#)
 - [SOM §7207.B.2](#)
 - [§1819\(g\)\(2\)\(A\)\(iii\)](#) and [§1919\(g\)\(2\)\(A\)\(iii\)](#) of the Act
 - [§1891\(c\)\(2\)\(A\)](#) of the Act
 - [§1864\(c\)](#) and [§1865](#) of the Act
- Survey findings are supportable;
 - [42 CFR 488.318](#)
 - [Principals of Documentation of the SOM, Exhibit 7A](#)
- Certifications are fully documented, and consistent with applicable law, regulations, and general instructions;
 - [§1819\(g\)\(3\)\(A\)](#) and [§1919\(g\)\(3\)\(A\)](#) of the Act
- Current written internal operating procedures and policies are consistent with program requirements;
- A plan of correction is requested from a provider/supplier;
- When certifying noncompliance, adverse action procedures set forth in regulations and general instructions are adhered to;
 - [§1819\(h\)\(2\)\(A\)\(1\) of the Act](#)
 - [§§1919\(h\)\(1\)\(A\) and 1919\(h\)\(3\)\(B\)\(1\) of the Act](#)
 - [§1866\(b\) of the Act](#)
 - 42 CFR [488.410](#); [489.53](#)
- Supervisory reviews and evaluations of surveyor performance are made routinely;
- Required financial and budget reports are submitted on time and completed in accordance with general instructions;
 - [§1864](#) and [§1902](#) of the Act
- All expenditures and changes to the program are substantiated to the Secretary's satisfaction;
 - [§1864](#) and [§1902](#) of the Act
- Actual survey and certification activities are consistent with the annual activity plan and workload estimate approved by CMS;
- The performance of agencies utilized to perform specific functions under this agreement are monitored;
- Ongoing surveyor training programs develop and maintain surveyor proficiency;
- Results of complaint investigations against providers and supplier are considered in making certification decisions;

- Scope and severity decisions for nursing home deficiencies are accurate and supportable;
- Updates, training, and technical assistance about patient assessment instruments/data sets are supplied to providers as appropriate;
- The conduct and reporting of complaint investigations is timely and accurate;
 - [SOM Chapter 5](#)
 - [§1819\(g\)\(4\) of the Act](#)
 - [§1919\(g\)\(4\) of the Act](#)
 - [42 CFR 488.332](#)
 - [Article II \(A\)\(2\) and Article II\(J\) of the §1864 Agreement](#)
- Survey teams include surveyors with required qualifications and/or certifications;
- Accurate and timely data is entered into online survey and certification systems; and
 - [Article II\(J\) of the §1864 Agreement](#)
- Information on certification findings is provided to the public as required in instructions.

Performance Criteria [SOM §8000F]

All standards for adequate state performance will be measured against “threshold” criteria that may be expressed in quantifiable terms, or in some cases, narrative descriptors. Threshold criteria describe the point at which CMS will impose a sanction or remedy/alternative sanction on the state.

- **Example:** The threshold for failure to identify deficiencies could be expressed (quantified) as a 20 percent disparity rate between federal and state deficiency citations on any given federal survey, or the failure of a state to identify any single (one) instance of “Immediate Jeopardy” would be another quantifiable threshold.
- **Example:** An example of threshold criteria explained in narrative terms would be applied to the standard: “The state uses the results of complaint investigations in making certification decisions.” An appropriate descriptor in this instance could be: “State provider files do not reflect the appropriate documentation of complaints.”

Available Sanctions/Remedies [SOM §8000G]

CMS will take one or more of the following actions when there is inadequate state survey performance:

- Remedies/Alternative Sanctions:
 - Provide for training of survey teams;
 - Directed Quality Improvement Plan;
 - Provide technical assistance on scheduling and procedural policies;
 - Require the state to undertake improvements specified in a plan of correction; and
 - Provide CMS directed scheduling.
- Sanctions:

- Place state on compliance for failure to follow the Medicaid State Plan;
- Meet with the Governor and other responsible state officials;
- Reduce federal financial participation for survey and certification of nursing facilities (See §§ [8000G](#), [I](#) below); and
- Initiate action to terminate the agreement between the Secretary and the state under § 1864 of the Act, either in whole or in part.

Sanctions Other Than Federal Financial Participation Reduction [SOM §8000H]

The RO may use the results of oversight and monitoring survey activities to identify inadequate state performance. Generally, the RO will consider that there is inadequate state survey performance when enough survey data have been analyzed to indicate that there is a systemic problem in some aspect of state performance.

However, even a single failure to identify an IJ situation will be considered inadequate state survey performance. The RO will select one or more sanctions appropriate to the inadequacy, but may not select federal financial participation reduction to respond to any inadequacy other than a pattern of failure to identify deficiencies in nursing facilities. The RO will notify the state in writing of the sanctions it plans to impose and the reasons for their imposition.

Reducing Federal Financial Participation for Pattern of Failure to Identify Deficiencies [SOM §8000I]

Federal financial participation will *only be reduced* when the state demonstrates a pattern of failure to identify or accurately classify deficiencies in nursing facilities. The Act does not allow for imposition of this sanction when the failure to identify or accurately classify deficiencies occurs in Medicare-only facilities when the nature of the inadequacy is anything other than a failure to identify deficiencies. The RO should use the following process to determine whether a pattern of failure to identify deficiencies in nursing facilities exists:

- After each federal survey/review of a facility, the RO should calculate the percentage of the discrete tags that were identified by the RO but that did not appear on Form CMS-2567. The RO should average all percentages calculated in the state at the end of each quarter of the fiscal year.
- If the quarterly disparity rate is less than 20 percent, the RO may impose those remedies and/or sanctions that do not result in a reduction of federal financial participation.
- If the quarterly disparity rate is greater than 20 percent in at least three of the last four quarters for which disparity rates were calculated, the RO should confer with the state to seek the root causes of the disparities. The state will have the remainder of the quarter in which the root causes were identified as well as the succeeding quarter to correct the root causes. Federal surveys performed in the quarter following the correction period will ascertain whether the state has been successful.

If the federal survey/review(s) yield a disparity rate of less than 20 percent, the RO should not conclude that the state demonstrated a pattern of failure to identify deficiencies in nursing facilities and should not reduce federal financial participation.

If the disparity rate is again greater than 20 percent, the RO should advise the state that unless it can rebut the findings used to calculate the disparity rate, or can offer compelling reasons for the regional office to excuse the rate, the RO intends to consider there to be a pattern of failure to identify deficiencies in nursing facilities, and to reduce the federal financial participation made to the state during this quarter of the fiscal year as it is the quarter in which the determination of inadequate state survey performance is actually made. The RO will calculate the amount of the federal financial participation reduction in accordance with subsection G, and will forward this information to the CMS Operations, Central Office, for processing.

Federal Financial Participation Reduction Formula [SOM §8000J]

To calculate the reduction in the federal financial participation made to the state under [§1903\(a\)\(2\)\(D\) of the Act](#) for the survey and certification of nursing facilities, the regional office uses the formula specified in [§1919\(g\)\(3\)\(C\) of the Act](#), which is 33 percent multiplied by a fraction:

- The numerator of which is equal to the total number of Medicaid residents in those nursing facilities that CMS found to be noncompliant during validation surveys in the quarter, but that the state found to be in substantial compliance; and
- The denominator of which is equal to the total number of Medicaid residents in all of the nursing facilities (in the state) in which CMS conducted validation surveys during the quarter.

Termination of the §1864 Agreement [SOM §8000K]

The §1864 Agreement may be terminated at any time by mutual written consent of the parties to the Agreement. States may terminate the Agreement at any time upon 180 days written notice to CMS. If CMS determines that the state is not able or willing to carry out part or all of the functions under this Agreement (including a determination that the state has fails to meet the performance standard(s) detailed in Section D), CMS may unilaterally terminate the Agreement in whole or in part or otherwise limit or decrease its scope.

Informal Dispute Resolution [SOM §8000L]

In the RO's notice to the state of its determination of inadequate state survey performance and its intent to impose sanctions, the RO will offer the state an opportunity to dispute the determination. The state must submit its request in writing along with information that refutes the apparent inadequacy. The informal dispute resolution process will be conducted by one level above the decision-maker. When sanctions are imposed as described in G.2 of this section, a state is entitled to Consortium Administrator review.

Appeal of Federal Financial Participation Reduction [SOM \$8000M]

When a state is dissatisfied with CMS' determination to reduce federal financial participation, the state may appeal the determination to the Departmental Appeals Board, using the procedures specified in [45 CFR Part 16](#).

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.

- 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](#)).

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.

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 hearing 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 it 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](#).

IX. Civil Money Penalties

Introduction:

This category of the guide discusses federal Civil Money Penalties (CMPs) and state CMPs/fines. CMPs and fines are imposed by the regulatory agencies that license nursing homes if a nursing home does not comply with regulatory standards. These fines can be used to fund innovative programs to improve the lives of nursing home residents, among other things.

What you'll learn:

- Basis for CMPs
- How CMPs are determined
- When CMPs are due and payable
- How CMPs are collected and used

Basis for Civil Money Penalties [SOM §7510]

CMS or the state may impose a civil money penalty (CMP) for the number of days that a facility is not in substantial compliance with one or more participation requirements, or for each instance that a facility is not in substantial compliance, regardless of whether the deficiencies constitute IJ. Additionally, the per day or per instance CMP may be imposed for past noncompliance.

CMP amounts (for more information see §7516.1):

- Between \$3,050 and \$10,000 per day of IJ;
- Between \$50 and \$3,000 per day of non-IJ; or
- A “per instance” CMP from \$1,000 to \$10,000 for each deficiency.

If imposed, a facility cannot avoid the remedy. The CMP may be imposed immediately or after a facility is given an opportunity to correct and a revisit finds that the facility remains out of compliance. States and regional offices are encouraged to develop methods to ensure that CMP amounts are applied consistently within the broad ranges identified in [42 CFR 488.408](#).

Determining Citations of Past Noncompliance [SOM §7510.1]

Past noncompliance may be identified during any survey. To cite past noncompliance with a specific survey data tag ([F-tag](#) or K-tag), all of the following three criteria **must be met**:

- The facility was not in compliance with the specific regulatory requirement at the time the situation occurred;

- The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted; and
- There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement.

Regulations provide that a CMP may be imposed for past noncompliance. **CMS strongly urges states to recommend the imposition of a CMP for past noncompliance cited at the level of II.** When a CMP is recommended, the state SA notifies the CMS RO and/or SMA within 20 days from the last day of the survey that determined past noncompliance of its recommendation to impose a CMP. The CMS RO and/or SMA responds to the recommendation within 10 days, and if accepted, sends out the formal notice.

Determining Amount of Civil Money Penalty [SOM §7516]

Note: On November 2, 2015, the president signed into law the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (Sec. 701 of the Bipartisan Budget Act of 2015, Pub. L. 114-74). The Act requires agencies to adjust the level of applicable CMPs with an initial “catch-up” adjustment and make subsequent annual adjustments for inflation. For more information and details on the annual adjustments, see <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Civil-Monetary-Penalties-Annual-Adjustments>.

Penalty Amount [SOM §7516.2]

Once the decision is made to impose a CMP for facility noncompliance, the following factors are considered in determining the specific amount to impose:

- The facility’s history of noncompliance, including repeated deficiencies;
- The facility’s financial condition;
- Seriousness and scope of the deficiencies (see [Appendix P](#) and [Appendix Q](#));
- The relationship of one deficiency to other deficiencies;
- The facility’s degree of culpability; and
- Any other remedies being imposed in addition to the CMP.

Changes in Civil Money Penalty [SOM §7516.3]

Decreasing Per Day Civil Money Penalty Range: If a CMP is imposed for a situation of IJ and the IJ is removed but the noncompliance continues, CMS or the state will shift the penalty amount to the lower range of penalty amounts.

Increasing Per Day Civil Money Penalty Range: Before the hearing, and following a revisit showing continued noncompliance, CMS or the state may propose to increase the penalty amount for facility noncompliance, which after imposition of a lower penalty amount, becomes sufficiently serious to pose IJ.

Note: When the per instance CMP has been selected, the provision for changing the amount of the CMP does not apply and no opportunity to correct is provided.

- If a CMP is imposed, **CMS and the state must increase the penalty amount for any repeated deficiencies** for which a lower level penalty amount was previously imposed, **regardless of whether** the increased amount would exceed the range otherwise reserved for deficiencies when IJ does not exist.

CMP Reductions for Self-Reporting and Prompt Corrections [SOM §7516.4]

CMS will reduce a CMP by 50% when a facility self-reports and promptly corrects a deficiency for which a CMP is imposed by CMS provided all of the following conditions are met:

- The facility must have self-reported the noncompliance to CMS or the state before it was identified by CMS or the state and before it was reported to CMS or the state by means of a complaint lodged by a person other than an official representative of the nursing home;
- Correction of the noncompliance must have occurred on the earlier of either 15 calendar days from the date of the self-reported circumstance or incident that later resulted in a finding of noncompliance or 10 calendar days from the date a CMS was imposed;
- The facility waives its right to a hearing;
- The noncompliance that was self-reported and corrected did not constitute a pattern of harm, widespread harm, IJ, or result in the death of a resident;
- The CMP was not imposed for a repeated deficiency that was the basis of the CMP that previously received a 50% reduction; and
- The facility has met mandatory reporting requirements for the incident or circumstance upon which the CMP is based as required by federal and state law.

Effective Date of CMP [SOM §7518]

The per day CMP may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the state. The effective date of the per day CMP will

often be the date of the survey because it may be difficult to document precisely when noncompliance begins if before the date of survey.

A CMP cannot be collected until a facility has an opportunity for a hearing if it properly requests one.

CMP Notification [SOM §7520]

The state notifies the facility of the possibility of a CMP being imposed for noncompliance in its initial letter to the facility after the survey. The state may:

- Recommend that the RO and/or the SMA impose a CMP promptly as a result of noncompliance found during a standard, complaint, or revisit survey;
- Recommend that a CMP accrue from the date of the noncompliance as a result of a revisit substantiating the facility's failure to correct the noncompliance;
- Recommend that the RO and/or SMA impose a CMP for each instance that results in a deficiency during a survey; and
- Recommend a CMP upon identification of past noncompliance. (See [SOM §7306](#).)

CMP Settlement [SOM §7524]

The RO has the authority to settle cases at any time prior to a final administrative decision when it imposed the CMP. The state has the authority to settle cases at any time, prior to the evidentiary hearing decision when the SMA imposed the CMP. **If a decision is made to settle, the settlement should not be for a better term than had the facility opted for a 35% reduction.**

CMP Collection [SOM §7528]

When a CMP Subject to Being Collected and Placed in an Escrow Account is Imposed [SOM §7528.1]

When the RO imposes a CMP that is subject to being collected and placed in an escrow account, payment is due on whichever the following occurs first if the facility files an appeal of the enforcement action:

- The date on which the independent informal dispute resolution process is completed; or
- The date which is 90 calendar days after the date of the notice of imposition of the penalty.

CMP Disposition [SOM §7534]

Within certain federally mandated parameters, **federal CMP funds can be used for a variety of activities and projects to benefit nursing home residents.** Funds may be granted to any entity permitted under state law and approved by CMS. **Funds cannot be provided to nursing homes to meet existing Medicare/Medicaid requirements** or other statutory and regulatory requirements.

Medicare or Dually-Participating Facility [SOM §7534.1]

The specific use of CMP funds collected from long-term care facilities as a result of federally imposed CMPs must be approved by CMS on behalf of the Secretary. Collected CMP funds may be used for:

- To support activities that benefit residents, including assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility);
- Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities; and
- Facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

The vast majority of U.S. nursing homes are Medicare or Dually-Participating, meaning that a portion of the CMPs derived from substandard care in these facilities can be used for activities or projects that benefit residents.

Medicaid-Only Facility [SOM §7534.2]

A CMP collected by a state from a Medicaid facility that the state or CMS finds deficient must be applied to the protection of the health or property of residents of nursing facilities that the state or CMS finds deficient. Statutory examples of appropriate uses include:

- State costs related to the operation of a facility pending correction of the deficiencies or closure;
- Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents. Established procedures for the reimbursement of residents are followed; and/or
- Payment for the cost of relocating residents to other facilities.

CMS does not have the authority to endorse, approve, disapprove, or otherwise make determinations about suggested uses for CMPs. States have the authority to determine which activities constitute acceptable and beneficial uses of the funds.

Dually Participating Facility [SOM §7534.3]

A CMP collected from a dually participating facility is apportioned commensurate with the relative proportions of Medicare and Medicaid beds at the facility actually in use by residents covered by the respective programs on the date the CMP begins to accrue, per resident census data the time of the survey.

- The Medicare portion of the collected CMP is deposited as miscellaneous receipts of the US Treasury in the Fines, Penalties, and Forfeitures Account.
- The Medicaid portion of the collected CMP is returned to the state.

Dually Participating Facility or Medicare Facility and Held in Escrow [SOM §7534.4]

A CMP collected from a dually participating facility is apportioned between Medicare and Medicaid commensurate with the relative proportions of Medicare and Medicaid beds at the facility actually in use by residents covered by the respective programs on the date the CMP begins to accrue, per resident census data at the time of the survey.

Ten percent of the collected CMP funds that are subject to be held in escrow and that remain after a final administrative decision will be deposited with the Department of the Treasury. **The remaining 90% may not be used for survey and certification operations but must be used entirely for activities that protect or improve the quality of care for residents.**

Use of Civil Money Penalties [SOM §7535]

The Act provides that CMP funds may be used to support **activities that benefit residents**. These include, but are not limited to:

- Assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified (including offsetting costs of relocating residents to home and community-based settings or another facility);
- Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities; and
- Facility improvement initiatives approved by the Secretary (including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, the appointment of temporary management firms, and other activities approved by the Secretary).

CMS, states, and others are in general agreement about the types of expenditures that should be considered **inappropriate for CMP funds**. These include, but are not limited to:

- Making capital improvements to a facility;

- Paying for items or services that are already the responsibility of the nursing home;
- Funding projects, items or services that are not related to improving the quality of life and care of nursing home residents;
- Projects for which a conflict of interest or the appearance of a conflict of interest exists;
- Long-term projects (greater than three years);
- Temporary manager salaries; and
- Supplementary funding of federally required services.

Editor's Note: For more information on the use of CMPs, please see [LTCCC's National Study on Use of Civil Money Penalties to Protect Nursing Home Residents](#).

X. Information Disclosure

Introduction:

This category of the guide discusses the survey and certification information that must be disclosed to the public. The public may request information in accordance with disclosure procedures specified in [45 CFR part 5](#).

What you'll learn:

- What and when information must be made available to the public
- Information that must be provided to long-term care ombudsmen
- Information that must be furnished by facilities with substandard quality of care

Public Information [SOM §7900]

The state SA, the SMA, or CMS must make the following information available to the public, **upon the public's request**, for all surveys and certifications of SNFs and NFs:

- The fact that a facility does or does not participate in the Medicare/Medicaid program;
- The official "Statement of Deficiencies and Plan of Correction", [Form CMS-2567](#);
 - If it contains the name of any individual, medical information about any identifiable resident, the identity of a complainant, or the address of anyone other than an owner of the facility, that information must be blocked out before the Form CMS-2567 is released to the public.
- Approved PoC;
 - If the PoC contains the name of any individual, medical information about any identifiable resident, the identity of a complainant, or the address of anyone other than an owner of the facility, that information must be blocked out before the Form CMS-2567 is released to the public.
- When applicable, a "Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm (Form A)" will be included with the Form CMS-2567;
- Facility comments;
- Statements that the facility did not submit an acceptable PoC or failed to comply with the conditions of imposed remedies, if appropriate;
- Official notices of provider terminations;
- Statistical data on facility characteristics that does not identify any specific individual;
- Final appeal results;
- Medicare and Medicaid cost reports; and

- Names of individuals with direct or indirect ownership interest in a SNF or NF who have been found guilty by a court of law of a criminal offense in violation of Medicare or Medicaid law.

If the public requests copies of the records and information described above from CMS, there will generally be a charge.

Timely Disclosure [SOM §7903]

Upon the public's request, the state SA, RO, or SMA, where appropriate, must make the following information available to the public within 14 calendar days after each item is made available to the facility:

- "Statements of Deficiencies and Plan of Correction" ([Form CMS-2567](#));
- Separate listings of any Notice of Isolated Deficiencies Which Cause No Actual Harm with the Potential for Minimal Harm (Form A); and
- Approved plans of correction which contain any facility response to the statement of deficiencies.

State Long-Term Care Ombudsman [SOM §7904, see also §3000B]

The state SA must provide the state's long-term care ombudsman with the following:

- A Statement of Deficiencies reflecting facility noncompliance and, if applicable, a separate list of isolated deficiencies that constitute no actual harm with the potential for minimal harm;
- Reports of adverse actions imposed on a facility;
- Any written response by the facility, including PoCs and facility requests for informal dispute resolution; and
- A facility's request for an appeal and the results of any appeal.

The Long-Term Care Ombudsman Program is an advocate and resource for individuals who reside in LTC facilities such as nursing homes, assisted living, adult care facilities, and family type homes. They also provide support to families so that they have a better understanding of residents' rights and care standards and are able to make their voices heard on behalf of residents.

Federal Surveys [SOM §7904.2]

CMS will contact the state SA and provide the information needed for the state to notify the ombudsman on CMS's behalf.

Substandard Quality of Care [SOM §7905]

A facility must provide the SA with a list of the following not later than 10 working days after receiving a notice of substandard quality of care:

- Each resident in the facility with respect to whom a finding of substandard quality of care was made; and
- The name and address of their attending physician.

Federal Surveys [SOM §7905.3]

In the case of a finding of substandard quality of care based on a federal survey, the RO will instruct the facility to provide the necessary information to the SA.

State Medicaid Fraud Control Unit (MFCU) [SOM §7907]

The state SA must provide access to any survey and certification information incidental to a facility's participation in Medicare or Medicaid to a state Medicaid Fraud Control Unit (MFCU) consistent with current state law and the operating agreement between the state SA and the state MFCU.

MFCUs investigate and prosecute Medicaid fraud as well as patient abuse and neglect in health care facilities. The [MFCU](#) in the majority of states is housed in the state's attorney general's office.

XI. Appendices

Appendix 1: F-Tag List

F-tags (“F” for “federal”) constitute the system through which federal nursing home regulations are identified in the survey process. Generally, each regulatory provision is assigned a corresponding F-tag number and surveyors use these numbers to indicate on the Statement of Deficiencies when a facility has failed to meet (or exceed) a given standard. The following list provides short descriptions of all the F-tags.

Editor’s Note: The list is in two parts, on this and the following page.

Federal Regulatory Groups for Long Term Care					
*Substandard Quality of Care = one or more deficiencies with s/s levels of F, H, I, J, K, or L in Red					
** Tag to be cited by Federal Surveyors Only					
F540	Definitions	483.12	Freedom from Abuse, Neglect, and Exploitation	483.24	Quality of Life
483.10	Resident Rights	F600	*Free from Abuse and Neglect	F675	*Quality of Life
F550	*Resident Rights/Exercise of Rights	F602	*Free from Misappropriation/Exploitation	F676	*Activities of Daily Living (ADLs)/ Maintain Abilities
F551	Rights Exercised by Representative	F603	*Free from Involuntary Seclusion	F677	*ADL Care Provided for Dependent Residents
F552	Right to be Informed/Make Treatment Decisions	F604	*Right to be Free from Physical Restraints	F678	*Cardio-Pulmonary Resuscitation (CPR)
F553	Right to Participate in Planning Care	F605	*Right to be Free from Chemical Restraints	F679	*Activities Meet Interest/Needs of Each Resident
F554	Resident Self-Admin Meds-Clinically Appropriate	F606	*Not Employ/Engage Staff with Adverse Actions	F680	*Qualifications of Activity Professional
F555	Right to Choose/Be Informed of Attending Physician	F607	*Develop/Implement Abuse/Neglect, etc. Policies	483.25	Quality of Care
F557	Respect, Dignity/Right to have Personal Property	F608	*Reporting of Reasonable Suspicion of a Crime	F684	Quality of Care
F558	*Reasonable Accommodations of Needs/Preferences	F609	*Reporting of Alleged Violations	F685	*Treatment/Devices to Maintain Hearing/Vision
F559	*Choose/Be Notified of Room/Roommate Change	F610	*Investigate/Prevent/Correct Alleged Violation	F686	*Treatment/Svcs to Prevent/Heal Pressure Ulcers
F560	Right to Refuse Certain Transfers	483.15	Admission, Transfer, and Discharge	F687	*Foot Care
F561	*Self Determination	F620	Admissions Policy	F688	*Increase/Prevent Decrease in ROM/Mobility
F562	Immediate Access to Resident	F621	Equal Practices Regardless of Payment Source	F689	*Free of Accident Hazards/Supervision/Devices
F563	Right to Receive/Deny Visitors	F622	Transfer and Discharge Requirements	F690	*Bowel/Bladder Incontinence, Catheter, UTI
F564	Inform of Visitation Rights/Equal Visitation Privileges	F623	Notice Requirements Before Transfer/Discharge	F691	*Colostomy, Urostomy, or Ileostomy Care
F565	*Resident/Family Group and Response	F624	Preparation for Safe/Orderly Transfer/Discharge	F692	*Nutrition/Hydration Status Maintenance
F566	Right to Perform Facility Services or Refuse	F625	Notice of Bed Hold Policy Before/Upon Transfer	F693	*Tube Feeding Management/Restore Eating Skills
F567	Protection/Management of Personal Funds	F626	Permitting Residents to Return to Facility	F694	*Parenteral/IV Fluids
F568	Accounting and Records of Personal Funds	483.20	Resident Assessments	F695	*Respiratory/Tracheostomy care and Suctioning
F569	Notice and Conveyance of Personal Funds	F635	Admission Physician Orders for Immediate Care	F696	*Prostheses
F570	Surety Bond - Security of Personal Funds	F636	Comprehensive Assessments & Timing	F697	*Pain Management
F571	Limitations on Charges to Personal Funds	F637	Comprehensive Assmt After Significant Change	F698	*Dialysis
F572	Notice of Rights and Rules	F638	Quarterly Assessment At Least Every 3 Months	F699	*{PHASE-3} Trauma Informed Care
F573	Right to Access/Purchase Copies of Records	F639	Maintain 15 Months of Resident A ssessments	F700	*Bedrails
F574	Required Notices and Contact Information	F640	Encoding/Transmitting Resident Assessment	483.30	Physician Services
F575	Required Postings	F641	Accuracy of Assessments	F710	Resident's Care Supervised by a Physician
F576	Right to Forms of Communication with Privacy	F642	Coordination/Certification of A ssessment	F711	Physician Visits- Review Care/Notes/Order
F577	Right to Survey Results/Advocate Agency Info	F644	Coordination of PASARR and Assessments	F712	Physician Visits-Frequency/Timeliness/Alternate NPPs
F578	Request/Refuse/Discontinue Treatment;Formulate Adv Di	F645	PASARR Screening for MD & ID	F713	Physician for Emergency Care, Available 24 Hours
F579	Posting/Notice of Medicare/Medicaid on Admission	F646	MD/ID Significant Change Notification	F714	Physician Delegation of Tasks to NPP
F580	Notify of Changes (Injury/Decline/Room, Etc.)	483.21	Comprehensive Resident Centered Care Plan	F715	Physician Delegation to Dietitian/Therapist
F582	Medicaid/Medicare Coverage/Liability Notice	F655	Baseline Care Plan	483.35	Nursing Services
F583	Personal Privacy/Confidentiality of Records	F656	Develop/Implement Comprehensive Care Plan	F725	Sufficient Nursing Staff
F584	*Safe/Clean/Comfortable/Homelike Environment	F657	Care Plan Timing and Revision	F726	Competent Nursing Staff
F585	Grievances	F658	Services Provided Meet Professional Standards	F727	RN 8 Hrs/7 days/Wk, Full Time DON
F586	Resident Contact with External Entities	F659	Qualified Persons	F728	Facility Hiring and Use of Nurse
		F660	Discharge Planning Process	F729	Nurse Aide Registry Verification, Retraining
		F661	Discharge Summary	F730	Nurse Aide Perform Review – 12Hr/Year In- service
				F731	Waiver-Licensed Nurses 24Hr/Day and RN Coverage
				F732	Posted Nurse Staffing Information

Figure 1 - F-tag List Part 1

Federal Regulatory Groups for Long Term Care***Substandard Quality of Care = one or more deficiencies with s/s levels of F, H, I, J, K, or L in Red****** Tag to be cited by Federal Surveyors Only**

483.40	Behavioral Health	F811	Feeding Asst -Training/Supervision/Resident	483.90	Physical Environment
F740	Behavioral Health Services	F812	Food Procurement, Store/Prepare/Serve - Sanitary	F906	Emergency Electrical Power System
F741	Sufficient/Competent Staff-Behav Health Needs	F813	Personal Food Policy	F907	Space and Equipment
F742	*Treatment/Svc for Mental/Psychosocial Concerns	F814	Dispose Garbage & Refuse Properly	F908	Essential Equipment, Safe Operating Condition
F743	*No Pattern of Behavioral Difficulties Unless Unavoidable	483.65	Specialized Rehabilitative Services	F909	Resident Bed
F744	*Treatment /Service for Dementia	F825	Provide/Obtain Specialized Rehab Services	F910	Resident Room
F745	*Provision of Medically Related Social Services	F826	Rehab Services- Physician Order/Qualified Person	F911	Bedroom Number of Residents
483.45	Pharmacy Services	483.70	Administration	F912	Bedrooms Measure at Least 80 Square Ft/Resident
F755	Pharmacy Svcs/Procedures/Pharmacist/ Records	F835	Administration	F913	Bedrooms Have Direct Access to Exit Corridor
F756	Drug Regimen Review, Report Irregular, Act On	F836	License/Comply w/Fed/State/Local Law/Prof Std	F914	Bedrooms Assure Full Visual Privacy
F757	*Drug Regimen is Free From Unnecessary Drugs	F837	Governing Body	F915	Resident Room Window
F758	*Free from Unnec Psychotropic Meds/PRN Use	F838	Facility Assessment	F916	Resident Room Floor Above Grade
F759	*Free of Medication Error Rate sof 5% or More	F839	Staff Qualifications	F917	Resident Room Bed/Furniture/Closet
F760	*Residents Are Free of Significant Med Errors	F840	Use of Outside Resources	F918	Bedrooms Equipped/Near Lavatory/Toilet
F761	Label/Store Drugs & Biologicals	F841	Responsibilities of Medical Director	F919	Resident Call System
483.50	Laboratory, Radiology, and Other Diagnostic Services	F842	Resident Records - Identifiable Information	F920	Requirements for Dining and Activity Rooms
F770	Laboratory Services	F843	Transfer Agreement	F921	Safe/Functional/Sanitary/ Comfortable Environment
F771	Blood Blank and Transfusion Services	F844	Disclosure of Ownership Requirements	F922	Procedures to Ensure Water Availability
F772	Lab Services Not Provided On-Site	F845	Facility closure-Administrator	F923	Ventilation
F773	Lab Svs Physician Order/Notify of Results	F846	Facility closure	F924	Corridors Have Firmly Secured Handrails
F774	Assist with Transport Arrangements to Lab Svcs	F847	Enter into Binding Arbitration Agreements	F925	Maintains Effective Pest Control Program
F775	Lab Reports in Record-Lab Name/Address	F848	Select Arbitrator/Venue, Retention of Agreements	F926	Smoking Policies
F776	Radiology/Other Diagnostic Services	F849	Hospice Services	483.95	Training Requirements
F777	Radiology/Diag. Svcs Ordered/Notify Results	F850	*Qualifications of Social Worker >120 Beds	F940	{PHASE-3} Training Requirements - General
F778	Assist with Transport Arrangements to Radiology	F851	Payroll Based Journal	F941	{PHASE-3} Communication Training
F779	X-Ray/Diagnostic Report in Record-Sign/Dated	483.75	Quality Assurance and Performance Improvement	F942	{PHASE-3} Resident's Rights Training
483.55	Dental Services	F865	QAPI Program/Plan, Disclosure/Good Faith Attempt	F943	Abuse, Neglect, and Exploitation Training
F790	Routine/Emergency Dental Services in SNFs	F866	{PHASE-3} QAPI/QAA Data Collection and Monitoring	F944	{PHASE-3} QAPI Training
F791	Routine/Emergency Dental Services in NFs	F867	QAPI/QAA Improvement Activities	F945	{PHASE-3} Infection Control Training
483.60	Food and Nutrition Services	F868	QAA Committee	F946	{PHASE-3} Compliance and Ethics Training
F800	Provided Diet Meets Needs of Each Resident	483.80	Infection Control	F947	Required In-Service Training for Nurse Aides
F801	Qualified Dietary Staff	F880	Infection Prevention & Control	F948	Training for Feeding Assistants
F802	Sufficient Dietary Support Personnel	F881	Antibiotic Stewardship Program	F949	{PHASE-3} Behavioral Health Training
F803	Menus Meet Res Needs/Prep in Advance/Followed	F882	Infection Preventionist Qualifications/Role		
F804	Nutritive Value/Appear, Palatable/Prefer Temp	F883	*Influenza and Pneumococcal Immunizations		
F805	Food in Form to Meet Individual Needs	F884	**Reporting – National Health Safety Network		
F806	Resident Allergies, Preferences and Substitutes	F885	Reporting – Residents, Representatives & Families		
F807	Drinks Avail to Meet Needs/P references/ Hydration	F886	COVID-19 Testing-Residents & Staff		
F808	Therapeutic Diet Prescribed by Physician	F887	COVID-19 Immunization		
F809	Frequency of Meals/Snacks at Bedtime	483.85	Compliance and Ethics Program		
F810	Assistive Devices - Eating Equipment/Utensils	F895	{PHASE-3} Compliance and Ethics Program		

Figure 2 - F-tag List Part 2

Appendix 2: Scope and Severity Grid

CMS and state survey agencies use the Scope and Severity Grid for rating the seriousness of nursing home deficiencies, i.e., of violations in minimum standards of care or other requirements. For each deficiency identified, the surveyor is charged with indicating the level of harm to the resident(s) involved and the scope of the problem within the nursing home. The surveyor then assigns an alphabetical scope and severity value to the deficiency. "A" is the least serious rating and "L" is the most serious rating. Information on deficiencies for all licensed nursing homes is available on Care Compare. When assessing a facility's survey performance, it is important to keep in mind that numerous studies have found that surveyors often fail to identify nursing home problems adequately, including serious care problems.⁴

The following chart is from the CMS [Nursing Home Data Compendium 2015 Edition](#).⁵

	Isolated	Pattern	Widespread
Immediate Jeopardy to Resident Health or Safety	J	K	L
Actual Harm that is Not Immediate Jeopardy	G	H	I
No Actual Harm with Potential for More than Minimal Harm that is Not Immediate Jeopardy	D	E	F
No Actual Harm with Potential for Minimal Harm	A	B	C

Note: "Double G" cases refer to a CMS policy intended to identify and address facilities with a historical pattern of high-level noncompliance. Double G cases are established when surveyors cite G-level (or higher) deficiencies on a current survey and a prior survey. Facilities with Double G must face specific and automatic penalties.

⁴ See, for example, U.S. Department of Health and Human Services Office of Inspector General, States Continued to Fall Short in Meeting Required Timeframes for Investigating Nursing Home Complaints: 2016-2018, OEI-01-19-00421 (September 2020). Available at <https://oig.hhs.gov/oei/reports/OEI-01-19-00421.pdf>.

⁵ Available at https://www.cms.gov/Medicare/Provider-Enrollment-and-certification/CertificationandCompliance/Downloads/nursinghomedatacompendium_508-2015.pdf.

Appendix 3: CMS Summary of Certification and Compliance for Nursing Homes

Following is an overview of nursing home oversight and compliance, which appears on the Centers for Medicare & Medicaid Services (CMS) website:

(<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/NHs.html>).

Nursing Homes

This page provides basic information about being certified as a Medicare and/or Medicaid nursing home provider and includes links to applicable laws, regulations, and compliance information. Below, in the downloads section, we also provide related nursing home reports, compendia, and the list of Special Focus Facilities (i.e., nursing homes with a record of poor survey [inspection] performance on which CMS focuses extra attention).

Skilled nursing facilities (SNFs under the Medicare Provision) and nursing facilities (NFs under the Medicaid Provision) are required to be in compliance with the requirements in [42 CFR Part 483, Subpart B](#) to receive payment under the Medicare or Medicaid programs. To certify a SNF or NF, a state surveyor completes at least a Life Safety Code (LSC) survey (See [SOM Appendix I](#) for LSC survey procedures, §§ 2470-2490), and a Standard Survey.

SNF/NF surveys are not announced to the facility. States conduct standard surveys and complete them on consecutive workdays, whenever possible. They may be conducted at any time including weekends, 24 hours a day. When standard surveys begin at times beyond the business hours of 8:00 a.m. to 6:00 p.m., or begin on a Saturday or Sunday, the entrance conference and initial tour should be modified in recognition of the residents' activity (e.g., sleep, religious services) and types and numbers of staff available upon entry.

The state has the responsibility for certifying a skilled nursing facility's or nursing facility's compliance or noncompliance, except in the case of state-operated facilities. However, the state's certification for a skilled nursing facility is subject to CMS approval. "Certification of compliance" means that a facility's compliance with federal participation requirements is ascertained. In addition to certifying a facility's compliance or noncompliance, the state recommends appropriate enforcement actions to the state Medicaid agency for Medicaid and to the regional office for Medicare.

The CMS regional office determines a facility's eligibility to participate in the Medicare program based on the state's certification of compliance and a facility's compliance with civil rights requirements.

The following entities are responsible for surveying and certifying a skilled nursing facility's or nursing facility's compliance or noncompliance with federal requirements:

- State-Operated Skilled Nursing Facilities or Nursing Facilities or State-Operated Dually Participating Facilities - The state conducts the survey, but the CMS regional office certifies

compliance or noncompliance and determines whether a facility will participate in the Medicare or Medicaid programs.

- Non-State Operated Skilled Nursing Facilities - The state conducts the survey and certifies compliance or noncompliance, and the CMS regional office determines whether a facility is eligible to participate in the Medicare program.
- Non-State Operated Nursing Facilities - The state conducts the survey and certifies compliance or noncompliance. The state's certification is final. The state Medicaid agency determines whether a facility is eligible to participate in the Medicaid program.
- Non-State Operated Dually Participating Facilities (Skilled Nursing Facilities/Nursing Facilities) - The state conducts the survey and certifies compliance or noncompliance. The state's certification of compliance or noncompliance is communicated to the state Medicaid agency for the nursing facility and to the CMS regional office for the skilled nursing facility. In the case where the state and the regional office disagree with the certification of compliance or noncompliance, there are certain rules to resolve such disagreements.

CMS's website provides links to important information relating to nursing homes, including:

- (1) The [current list of Special Focus Facilities](#) (pdf). ("Special Focus Facilities" are nursing homes identified as among the worst in the country and targeted for special oversight and possible removal from Medicaid/Medicare if they fail to make substantial improvements);
- (2) [Survey and enforcement process requirements for nursing homes](#) (pdf); and
- (3) The 2015 [Nursing Home Data Compendium](#) (pdf).

Appendix 4: Terms & Acronyms used in the State Operations Manual

Abbreviated Standard Survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern. (42 CFR 488.301)

Abuse – means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. (42 CFR 488.301)

ACO – Automated Survey Processing Environment (ASPEN) Central Office.

Act – the Social Security Act

AEM – Automated Survey Processing Environment (ASPEN) Enforcement Manager.

ASPEN – Automated Survey Processing Environment.

CASPER – Certification and Survey Provider Enhanced Reporting.

Certification of Compliance means that the facility is in at least substantial compliance and is eligible to participate in Medicaid as a nursing facility, or in Medicare as a skilled nursing facility, or in both programs as a dually participating facility.

Certification of Noncompliance means that the facility is not in substantial compliance and is not eligible to participate in Medicaid as a nursing facility, or in Medicare as a skilled nursing facility, or in both programs as a dually participating facility.

CFR – Code of Federal Regulations.

CMP – civil money penalty.

CMPTS – Civil Money Penalty Tracking System.

CMS – Centers for Medicare & Medicaid Services (formerly HCFA).

Deficiency means a skilled nursing facility's or nursing facility's failure to meet a participation requirement specified in the Act or in 42 CFR Part 483 Subpart B. (42 CFR 488.301)

DoPNA or DPNA – denial of payment for new admissions.

DPoC – directed plan of correction.

Dually Participating Facility means a facility that has a provider agreement in both the Medicare and Medicaid programs.

Educational programs means programs that include any subject pertaining to the long-term care participation requirements, the survey process, or the enforcement process.

Enforcement action means the process of imposing one or more of the following remedies: termination of a provider agreement; denial of participation; denial of payment for new admissions; denial of payment for all residents; temporary manager; civil money penalty; state monitoring; directed plan of correction; directed in-service training; transfer of residents;

closure of the facility and transfer of residents; or other CMS-approved alternative state remedies.

Expanded survey means an increase beyond the core tasks of a standard survey. A standard survey may be expanded at the surveying entity's discretion. When surveyors suspect substandard quality of care they should expand the survey to determine if substandard quality of care does exist.

Extended survey means a survey that evaluates additional participation requirements subsequent to finding substandard quality of care during a standard survey. (42 CFR 488.301)

Facility means a skilled nursing facility or nursing facility, or a distinct part of a skilled nursing facility or nursing facility, in accordance with 42 CFR 483.5. (42 CFR 488.301) §7008 (See for entities that qualify as skilled nursing facilities and nursing facilities.)

FSES – Fire Safety Evaluation System.

IDR – informal dispute resolution.

IJ – immediate jeopardy.

Immediate family means a husband or wife; natural or adoptive parent, child or sibling; stepparent, stepchild, stepbrother, or stepsister; father-in-law, mother-in-law, son-in-law, daughter-in-law, brother-in-law, or sister-in-law; grandparent or grandchild. (42 CFR 488.301.)

Immediate jeopardy means 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. (42 CFR 488.301)

Independent IDR – Independent informal dispute resolution

LSC – Life Safety Code.

MAC means Medicare Area Contractor.

Misappropriation of resident property means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent. (42 CFR 488.301)

NATCEP – Nurse Aide Training and Competency Evaluation Program.

Neglect means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. (42 CFR 488.301)

New admission, for purposes of a denial of payment remedy, means a resident who is admitted to the facility on or after the effective date of a denial of payment remedy and, if previously admitted, has been discharged before that effective date. (See §7506 for examples of what does and does not constitute a new admission for purposes of the remedy.) (42 CFR 488.401)

NF – nursing facility.

Noncompliance means any deficiency that causes a facility not to be in substantial compliance. (42 CFR 488.301)

No Opportunity to Correct means the facility will have remedies imposed immediately after a determination of noncompliance has been made.

Nurse aide means any individual providing nursing or nursing-related services to residents in accordance with 42 CFR 483.75(e)(1)(CFR 42 488.301) .

Nursing facility means a Medicaid nursing facility. (42 CFR 488.301)

OBRA '87 – the Omnibus Budget Reconciliation Act of 1987.

Opportunity to Correct (OTC) means the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed.

Partial extended survey means a survey that evaluates additional participation requirements and verifies the existence of substandard quality of care during an abbreviated standard survey. (42 CFR 488.301.)

Past Noncompliance (PNC) means a deficiency citation at a specific survey data tag ([F-tag](#) or K-tag), that meets all of the following three criteria:

- 1) The facility was not in compliance with the specific regulatory requirement(s) (as referenced by the specific F-tag or K-tag) at the time the situation occurred;
- 2) The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint, or revisit) currently being conducted, and
- 3) There is sufficient evidence that the facility corrected the noncompliance and is in substantial compliance at the time of the current survey for the specific regulatory requirement(s), as referenced by the specific F-tag or K-tag.

Per day civil money penalty means a civil money penalty imposed for the number of days a facility is not in substantial compliance.

Per instance civil money penalty means a civil money penalty imposed for each instance of facility noncompliance.

PoC – plan of correction. (42 CFR 488.401)

QIES – Quality Improvement and Evaluation System.

Representative – for purposes of educational programs, means family members, legal guardians, friends, and ombudsmen assigned to the facility; for purposes of Independent IDR, means either the resident's legal representative or the individual filing a complaint involving or on behalf of a resident.

Self-Reported Noncompliance – Noncompliance that is reported by a facility to the state survey agency before it is identified by the state, CMS, or reported to the state or CMS by an entity other than the facility itself.

SFF – Special Focus Facility.

Skilled nursing facility means a Medicare-certified nursing facility that has a Medicare provider agreement. (42 CFR 488.301)

SMA – state Medicaid agency.

SNF – skilled nursing facility.

Standard survey means a periodic, resident-centered inspection that gathers information about the quality of service furnished in a facility to determine compliance with the requirements of participation. (42 CFR 488.301)

State survey agency (SA) means the entity responsible for conducting most surveys to certify compliance with the Centers for Medicare and Medicaid Services' participation requirements.

State Medicaid agency means the entity in the state responsible for administering the Medicaid program.

Substandard quality of care (SQC) means one or more deficiencies related to participation requirements under 42 CFR 483.13, resident behavior and facility practices, 42 CFR 483.15, quality of life, or 42 CFR 483.25, quality of care, that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F). (42 CFR 488.301) [**Editor's Note:** See separate [appendix](#), below, for detailed information in SQC.]

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements. ([42 CFR 488.301](#))

Appendix 5: National and General Resources

- Centers for Medicare & Medicaid Services ([CMS](#))⁶ – The federal agency responsible for overseeing care and quality of life in nursing homes (as well as for other providers that participate in Medicare and/or Medicaid).
- [Long-Term Care Ombudsman Program \(LTCOP\)](#)⁷ – The LTCOP is a federally-mandated program that provides, within each state and locality, nursing home monitoring and advocacy for residents' rights and quality care. In addition, ombudsmen educate consumers and providers, work to resolve residents' complaints, and make information available to the

⁶ <https://www.cms.gov/>.

⁷ <https://www.acl.gov/programs/protecting-rights-and-preventing-abuse/long-term-care-ombudsman-program>. (See also <http://ltcombudsman.org/>).

public on nursing homes and other long-term care facilities and services. Also see below under New York State Resources.

- Medicaid Fraud Control Units (MFCU)⁸ – MFCUs investigate and prosecute abuse, neglect and fraud committed by hospitals, nursing homes, pharmacies, and other providers. There are MFCUs in the District of Columbia and every state.
- Care Compare⁹ – The federal website (previously “Nursing Home Compare”) with quality-of-care, staffing, ownership, and other information for all licensed nursing homes in the United States. Care Compare includes the 5-Star Nursing Home Quality Rating System, which provides a star rating for each nursing home based on its (1) health inspections, (2) staffing levels, and (3) quality measures. Though Care Compare has its weaknesses, it is widely considered to be, by far, the most reliable resource for information on a facility’s quality of care.
- ProPublica Nursing Home Inspect¹⁰ – This web-based tool enables users to compare nursing homes in a state based on the deficiencies cited by regulators and the penalties imposed in the past three years. One can also search over 60,000 nursing home inspection reports to look for trends or patterns.
- U.S. Office of Inspector General (OIG)¹¹ – The OIG, part of the Department of Health and Human Services, has responsibility for fighting waste, fraud, and abuse in Medicare and Medicaid services. This work includes auditing for the appropriateness of services billed to Medicaid/Medicare. The OIG website has a searchable database of individuals and entities excluded from providing Medicaid/Medicare services.
- U.S. Code of Federal Regulations: Requirements for Nursing Homes.¹²
- CMS State Operations Manual (SOM)¹³ – The SOM for state survey agency operations is provided in numerous chapter and appendix files (PDF) on the CMS website.

⁸ <https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/>

⁹ <https://www.medicare.gov/nursinghomecompare/search.html>

¹⁰ <http://projects.propublica.org/nursing-homes/>.

¹¹ <https://oig.hhs.gov>.

¹² <https://www.ecfr.gov/cgi-bin/retrieveECFR?gp=&SID=371b56d5eda767bbbbc9625cce48c146&mc=true&n=pt42.5.483&r=PART&ty=HTML#p42.5.483.b>.

¹³ <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html>. For Appendix PP, Interpretive Guidelines, see:

https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltc.pdf.

- Requirements for Reporting Suspicion of Crime in Nursing Homes to Law Enforcement (PDF)¹⁴ – The 2010 Affordable Care Act set forth important requirements regarding reporting suspicion of crime against nursing home residents. Because this is such a serious issue, the law sets forth significant fines if a facility employee or owner (including care staff, administrative staff and contractors) fails to report when there is suspicion of a crime against a nursing home resident.

Appendix 6: Federal Definition of “Substandard Quality of Care”

The following definition and explanation of Substandard Quality of Care (SQC) is from the CMS memo, S&C: 17-27-NH (May 12, 2017).¹⁵

New Definition for SQC

A new definition of SQC was added to 42 CFR 488.301 by the Final Rule to reform the requirements for long-term care facilities that went into effect on November 28, 2016 (81 FR 68688). There were no substantial or substantive changes to the content of what types of deficient practices would result in SQC, however, the regulatory citations to the relevant requirements have changed. The new definition reflects this general reorganization of the regulations. Also, some regulations may have been moved from their previous regulatory grouping to a new regulatory group.

The new definition of SQC in § 488.301 provides that substandard quality of care means one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to participation requirements under:

- §483.10 “Resident rights,” paragraphs:
 - (a)(1) through (a)(2),
 - (b)(1) through (b)(2),
 - (e) (except for (e)(2), (e)(7), and (e)(8)),
 - (f)(1) through (f)(3) and (f)(5) through (f)(8), and
 - (i)
- §483.12 “Freedom from abuse, neglect, and exploitation;”
- §483.24 “Quality of life;”
- §483.25 “Quality of care;”
- §483.40 “Behavioral health services,” paragraphs (b) and (d);
- §483.45 “Pharmacy services,” paragraphs (d), (e), and (f);

¹⁴ <http://nursinghome411.org/policy-brief-reporting-nursing-home-crime/>.

¹⁵ <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-17-27.pdf>.

- §483.70 “Administration,” paragraph (p), and
- §483.80 “Infection control,” paragraph (d).

Appendix 7: ASPEN Complaints/Incidents Tracking System (ACTS)

The ASPEN Complaints/Incidents Tracking System (ACTS) is designed to track, process, and report on complaints and incidents reported against health care providers and suppliers regulated by CMS. It is designed to manage all operations associated with complaint/incident processing, from initial intake and investigation through the final disposition.

The ACTS must be used for the intake of all allegations against Medicare/Medicaid-certified providers/suppliers and CLIA. The ACTS is a federal system and data entered into ACTS is subject to federal laws governing disclosure and the protection of an individual’s right to privacy.

A complaint/incident record is created in ACTS based on how the allegation is received by the SA or RO. For example, if one person calls with ten allegations about one provider/supplier, this is counted as one complaint record. If six people call with the same allegation, this is counted as six telephone calls and is counted as six complaint records. If one letter is received with one or many allegations and is signed by 20 people, this is counted as one complaint record.

1 - Data Entry

The SAs and ROs are required to enter into ACTS:

- All complaint information gathered as part of federal survey and certification responsibilities, regardless if an onsite survey is conducted; and
- All self-reported incidents that require a federal onsite survey.

The information recorded in ACTS reflects the allegation furnished by the complainant at the time of the intake. At a minimum, if the intake information requires an onsite survey and the allegation may involve both federal and state licensure requirements, a federal onsite survey is completed and entered into ACTS.

If an investigation finds one or more violations of federal requirements, the findings must be cited under the appropriate tags and entered into the federal system even if the information is entered into a state licensure data system. Since this information is essential to the effective management of the survey and certification program, it is important that SAs complete the required fields in ACTS in a timely manner.

Appendix 8: Chart on Revisit/Date of Compliance Policy

Revisit/Date of Compliance Policy

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F(SQC), harm or LJ	Noncompliance continues	Any noncompliance
1st revisit	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st onsite revisit, or correction occurred sooner than the latest correction date on the PoC.	<p>1. A 2nd onsite revisit is discretionary if acceptable evidence is provided.</p> <p>When evidence is accepted with no 2nd onsite revisit, compliance is certified as of the date confirmed by the evidence.</p> <p>2. When a 2nd onsite revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.</p>	<p>1. A 2nd onsite revisit is required.</p> <p>2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.</p>	<p>1. A 2nd onsite revisit is required.</p> <p>2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered as the compliance date.</p>	
2nd revisit	Compliance is certified as of the date of the 2nd onsite revisit or the date confirmed by the acceptable evidence, whichever is sooner.				<p>1. A remedy must be imposed if not already imposed.</p> <p>2. Either conduct a 3rd onsite revisit or proceed to termination.</p>
A 3rd REVISIT IS NOT ASSURED AND MUST BE APPROVED BY THE RO					
3rd revisit	Compliance is certified as of the date of the 3rd onsite revisit.				Proceed to termination.

Examples of acceptable evidence may include, but are not limited to:

Givens:

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-services training.
- Interviews with more than 1 training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.
- An approved PoC is required whenever there is noncompliance;
- Remedies can be imposed anytime for any level of noncompliance;
- Onsite revisits can be conducted anytime for any level of noncompliance;