CMS Manual System

Pub. 100-07 State Operations Provider Certification

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 244 **Date: June 26, 2026**

SUBJECT: Revisions to State Operations Manual (SOM), Chapter 7

I. SUMMARY OF CHANGES: CMS updated and revised guidance in chapter 7 of the SOM that includes, Survey Team Composition, Survey Procedures, Plans of correction, Verifying Corrections, Survey Revisit and Offsite Revisit Paper Review, Off-hours Survey, Federal Civil Penalties Inflation Reduction Act, Informal Dispute Resolution, and Independent Informal Dispute Resolution. CMS also added guidance previously found in Appendix P of the SOM as well various technical changes that include updates for accurate references.

NEW/REVISED MATERIAL - EFFECTIVE DATE: **June 26, 2026**
IMPLEMENTATION DATE: June 26, 2026

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
N	Table of Contents -Section 7203.3.2 Determining Health Severity and Scope of Deficiencies
D	Table of Contents- Section 7400.3.1 Matrix for Scope & Severity
N	Table of Contents Section 7513 Federal Civil Penalties Inflation Adjustment Act
R	7000 Introduction
R	7001 Definitions and Acronyms
R	7014.1 Special Waivers/ Under 42 CFR 483.35(e) and (f) of the Act,.....
R	7014.1.1 Skilled Nursing Facility (SNF) Waiver of Requirement for a Registered Nurse (RN) More than 40 Hours a Week
R	7014.1.2 - Nursing Facility (NF)-Only Waivers of Nurse Staffing Requirements in Nursing Facilities
R	7014.1.3 - Waivers of Nurse Staffing Requirements for Dually Participating Facilities (SNF/NFs)
R	7014.2 Waiver of Life Safety Code

R	7014.3 - Variations of Patient Room Size and/or Beds Per Room
R	7200 -Long-Term Care Survey Process (LTCSP)
R	7201.1 Survey Team Size
R	7201.2 Team Composition
R	7201.3 Length of Survey
R	7202.2.1 Prima Facie Conflicts of Interest
R	7203.1 Introduction
R	7203.2 Initial Certification Survey
R	7203.3 Survey for Recertification
N	7203.3.1 Exit Conference
N	7203.3.2 Determining Health Severity and Scope of Deficiencies
R	7203.4 Post Survey Revisit (Follow-Up)
R	7203.5 - Abbreviated Standard Survey
R	7203.6 - Extended Survey/Partial Extended Survey
R	7203.7 -State Monitoring Visits
R	7205.2 Scheduling and Conducting Surveys
N	7205.6 – Standard Survey Interval for Special Focus Facilities
R	7207.1 Introduction
R	7207.2 - All Surveys Must Be Unannounced
R	7207.2.2 - Variance in Timing (Time of Day, Day of Week, Time of Month)
R	7210 - Substandard Quality of Care and Extended and Partial Extended Surveys
R	7210.2 Expansion of the Survey Sample
R	7212.3 - Mandatory Elements of Informal Dispute Resolution
R	7213.5 Key Elements of Independent Informal Dispute Resolution
R	7213.6 - Qualifications of an Independent Informal Dispute Resolution Entity or Person(s)
R	7213.9 - Independent Informal Dispute Resolution Recommendation and Final Decision
R	7213.10 - Additional Elements for Federal Independent Informal Dispute Resolution (Independent IDR) Process
R	7301.1 - Immediate Jeopardy Exists
R	7301.2 - Immediate Jeopardy Does Not Exist
R	7304.1 - Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies
R	7304.2 Effective Dates for Immediate Imposition of Federal Remedies
R	7305.1.1 When No Immediate Jeopardy Exists, and an Opportunity to Correct will be Provided Before Remedies are Imposed.
R	7305.1.2 When No Immediate Jeopardy Exists and No Opportunity to Correct Will be Provided Before Remedies Are Imposed.
R	7305.4 Means of Sending Notice
R	7316.1 - Required Actions When There Is an Opportunity to Correct
R	7316.2 - Required Actions When There Is No Opportunity to Correct

R	7317 - Acceptable Plan of Correction
R	7317.1 - Verifying Facility Compliance
R	7317.2 – Revisits
R	7317.3 Noncompliance Cycles
R	7506.3 - Mandatory Denial of Payment for All New Admissions Remedy
R	7506.4- Duration and Resumption of Payments
R	7510 - Basis for Imposing Civil Money Penalties
R	7510.1- Determining Citation of Past Noncompliance at the Time of the Current Survey
R	7510.2 – Documentation of Past Noncompliance Citations on CMS-2567
R	7512.- Compliance with Section 1128A of the Social Security Act.
N	7513 – The Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015
R	7514 Special Procedures Regarding Compliance Decision and Overlap of Remedies
R	7516.1 - Range of Penalty Amounts
R	7516.2- Factors Affecting Amount of Penalty
R	7516.3 - Changing Amount of Civil Money Penalty
R	7518 - Effective Date of Civil Money Penalty
R	7522- Duration of Civit Money Penalty
R	7522.1 - Revisit Identifies New Noncompliance and Same Data Tag is Selected
R	7522.2 - Revisit Identifies New Noncompliance and a Different Data Tag is Selected
R	7522.3 - Noncompliance - Immediate Jeopardy Does Not Exist
R	7522.4 - Noncompliance - Immediate Jeopardy Exists
R	7526.2 - Facility Waiver of Right to Hearing
R	7528.1 – When a Civil Money Penalty Subject to Being Collected and Placed in an Escrow Account is Imposed
R	7528.3 - No Hearing Requested (Constructive Waiver)
R	7528.4 - After Waiver of Hearing
R	7528.6 After Effective Date of Termination
R	7530.2 - Method of Payment
R	7534.1 - Collected From Medicare or Dually-Participating Facility
R	7534.2 - Collected From Medicaid Facility
R	7534.3 –Imposed and Collected by a State from a Medicaid Facility
R	7534.4 – Collected Amounts from a Dually Participating Facility or Medicare Facility and Held in Escrow
R	7535 - Use of Civil Money Penalty Funds
N	7535.1 –Allowable and Non-Allowable of the Use of Civil Money Penalty Funds
N	7535.2 – State Civil Money Penalty Reinvestment Plans
R	7536- Loss of Nurse Aide Training and Competency Evaluation Program or Competency Evaluation Program as a Result of Civil Money Penalty

R	7536.2 - Effective Date for Prohibition of Nurse Aide Training and Competency Evaluation Program or Competency Evaluation Program When Civil Money Penalty of $5,000 or More Is Assessed
R	7550.1- Introduction
	7550.4 – Selection of Temporary Manager
R	7556- Termination Procedures for Skilled Nursing Facilities and Nursing Facilities when Facility is not in Substantial Compliance with Participation Requirements
R	7600.7- Facility Takes Corrective Action According to its Plan of Correction but Fails to Achieve Substantial Compliance
R	7700.1- Notification Procedures- Preliminary Determinations
R	7700.3- Reporting Findings
R	7701 - Reporting Abuse to Law Enforcement and the Medicaid Fraud Control Unit
R	7809.1 - Introduction

III. FUNDING: No additional funding will be provided by CMS; contractor activities are to be carried out within their operating budgets.

IV. ATTACHMENTS:

	Business Requirements
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**

State Operations Manual

Chapter 7 - Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities

Table of Contents

(Rev. 244; Issued: 06-26-26)

7000 - Introduction

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Chapter 7 implements the nursing home survey, certification, and enforcement regulations at *42 CFR Part 488*. No provisions contained in this chapter are intended to create any rights or remedies not otherwise provided in law or regulation.

The nursing home reform regulation establishes several expectations. The first 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. (See *§7317* for plan of correction requirements.)

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 Centers for Medicare and Medicaid Services (CMS) Location 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.

It should be noted that references to the State would be applicable, as appropriate to the CMS Location throughout this chapter when the CMS Location is the surveying entity. It should also be noted that in cases where the State is authorized by CMS and/or the State Medicaid Agency, the State may provide notice of imposition of certain remedies on their behalf, within applicable notice requirements.

It should be noted that failure of CMS or the State to act timely does not invalidate otherwise legitimate survey and enforcement determinations.

iQIES is the Internet Quality Improvement and Evaluation System used by CMS and all States for data entry and reporting on nursing home survey and enforcement activities.

7001 - Definitions and Acronyms

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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)NOTE: Abbreviated standard surveys may also be referred to as complaint investigations.*

Abuse - *The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm. (42 CFR 483.5)*

Act - the Social Security Act

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 - *C*ivil *M*oney *P*enalty.

CMPTS - Civil Money Penalty Tracking System.

CMS - Centers for Medicare & Medicaid Services.

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** - *D*enial of *P*ayment for *N*ew *A*dmissions.

DPoC - Directed *P*lan of *C*orrection.

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

Educational programs mean 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 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 *(SQC),* they should expand the survey to determine if *SQC* does exist.

Extended survey means a survey that evaluates additional participation requirements subsequent to finding *SQC* during a standard survey. *(42 CFR 488.301)*

Facility means a skilled nursing facility *(SNF) that meets the requirements of sections 1819(a), (b), (c), and (d) of the Act, or a* nursing facility *(NF) that meets the requirements of sections 1919(a), (b), (c), and (d) of the Act. "Facility" may include a* distinct part of a*n institution (as defined in §483.5 and specified in §440.40 and §440.155) but does not include an institution for individuals with intellectual disabilities or persons with related conditions described in §440.150 of this chapter. For Medicare and Medicaid purposes (including eligibility, coverage, certification, and payment), the "facility" is always the entity that participates in the program, whether that entity is comprised of all, or a distinct part of, a larger institution. For Medicare, a SNF, and for Medicaid, a NF may not be an institution for mental diseases as defined in §435.1010 of this chapter. (42 CFR 483.5)*

FSES – Fire Safety Evaluation System.

IDR – *I*nformal *Dispute R*esolution.

Immediate family *as defined in 42 CFR 488.301 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. NOTE: see guidance at tag F563 in Appendix PP under Resident Rights §483.10(f)(4)(ii)-(v) – "For purposes of this regulation, immediate family is not restricted to individuals united by blood, adoptive, or marital ties, or a State's*

common law equivalent. It is important to understand that there are many types of families, each of which being equally viable as a supportive, caring unit. For example, it might also include a foster family where one or more adult serves as a temporary guardian for one or more children to whom they may or may not be biologically related. Residents have the right to define their family."

Immediate *J*eopardy *(IJ)* 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)*

IIDR – Independent *I*nformal *D*ispute *R*esolution

Instance or instances of noncompliance *means a factual and temporal occurrence(s) when a facility is not in substantial compliance with the requirements for participation. Each instance of noncompliance is sufficient to constitute a deficiency and a deficiency may comprise of multiple instances of noncompliance. (42 CFR 488.401)*

IQIES *- Internet Quality Improvement and Evaluation System*

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 *of the facility, its employees or service providers* to provide goods and services *to a resident that are* necessary to avoid physical harm, *pain,* mental anguish, *or emotional distress*. *(42 CFR 483.5)*

New admission, for purposes of a denial of payment remed*y*, *new admission* 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. *Residents admitted before the effective date of the denial of payment, and taking temporary leave, are not considered new admissions, nor subject to the denial of payment. (42 CFR 488.401)* (See §7506 for examples of what does and does not constitute a new admission for purposes of the remedy.)

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

Noncompliance cycle - *See 7317.3 for definition.*

No Opportunity to Correct ***(NOTC)*** 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 a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in 42 CFR §488.301. (42 CFR 483.5)*

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 *subsequent to finding SQC* 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.

Plan of Correction (**PoC*****)*** *means a plan developed by the facility and approved by CMS or the State agency that describes the actions the facility will take to correct deficiencies and specifies the date by which those deficiencies will be corrected. (42 CFR 488.401)*

QIES - Quality Improvement and Evaluation System.

Resident **Representative** ***or Representative*** - *means any of the following:*

(1) An individual chosen by the resident to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other

personal information of the resident; manage financial matters; or receive notifications;

(2) A person authorized by State or Federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social or other personal information of the resident; manage financial matters; or receive notifications; or

(3) Legal representative, as used in section 712 of the Older Americans Act; or

(4) The court-appointed guardian or conservator of a resident.

(5) Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, State or Federal law, or a court of competent jurisdiction. (42 CFR 483.5)

Self-Reported Noncompliance- Noncompliance that is reported by a facility to the State 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 *(SNF)* means a Medicare-certified nursing facility that has a Medicare provider agreement. *(42 CFR 488.301)*

Standard survey *(Also known as a recertification 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 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 *(SMA)* means the entity in the State responsible for administering the Medicaid program.

Substandard *Q*uality of *C*are *(SQC)* means one or more deficiencies related to participation requirements under *42 CFR 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), (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); § 483.70 "Administration", paragraph (p), and § 483.80 "Infection control", paragraph (d), 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. (42 CFR 488.301)*

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. *(42 CFR 488.301)* Substantial compliance constitutes compliance with participation requirements.

7014 - Special Waivers Applicable to Skilled Nursing Facilities and Nursing Facilities

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

7014.1 - Waiver of Nurse Staffing Requirements

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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Under 42 CFR 483.35(e) and (f) of the Act, Medicaid-certified Nursing Facilities (NFs), Medicare-certified Skilled Nursing Facilities (SNFs), and dually-certified SNF/NFs may obtain a waiver of the requirements to have licensed nurses 24 hours a day and/or the requirement to have a registered nurse (RN) for 8 consecutive hours a day, 7 days a week, and provide the services of a RN more than 40 hours a week if the facility meets certain criteria.

To obtain a waiver, a facility must send a request to the state agency. A request may be submitted at any time, but prior to obtaining a waiver, a facility must be surveyed to determine if they meet the requirements to qualify for a waiver. During the survey:

- *If a facility has never been granted a waiver, or was granted a waiver in the past, but did not have a waiver after the last survey: the facility is cited for noncompliance with the applicable requirements, and the state agency will then determine if the facility meets the requirements to qualify for a waiver.*

    - *For NFs/SNFs, the applicable citation should **only** be reflective of the failure of the facility to meet the numerical requirements for having 24 hours of licensed nurses or eight consecutive hours per day of an RN and the deficiency must not be higher than a level 1 (no actual harm with a potential for minimal harm) as the waiver cannot endanger the health or safety of individuals staying in the facility, per483.35(e)(2)). For example, if the survey team finds the facility fails to provide sufficient staff to meet each resident's needs, resulting in a level 2 deficiency (no actual harm with potential for more than minimal harm), the waiver shall not be granted as the team has identified that the level of staffing has endangered the health and safety of residents.*
    - *For SNF-only facilities, only the requirement to have an RN onsite eight consecutive hours a day may be waived, and the survey team must verify the facility meets the criteria specified in 483.35(f)(1)(ii)*

- *If a facility was granted a waiver on the last survey: the surveyors will determine if the facility continues to meet the requirements to qualify for a waiver.*

    - *If the facility continues to meet the waiver requirements, the facility is not cited for the applicable deficiency and a renewal of the waiver may be granted.*
    - *If the facility no longer meets the requirements for a waiver, the facility is cited, and a waiver is not granted.*

The waiver(s) available to a facility is(are) based on the type of facility, as follows:

- *If a facility is a SNF-only, the facility may obtain a waiver of the requirement for an RN for 8 consecutive hours a day, 7 days a week, as long as the requirements in §483.35(g) are met.*
- *If a facility is a NF-only, the facility may obtain waivers of the requirement for an RN for at least 8 consecutive hours a day, 7 days a week, and/or the requirement to have licensed nurses 24 hours a day, as long as the requirements in §483.35(f) are met.*
- *If a facility is a dually-certified SNF/NF, both sets of waiver requirements in §483.35(f) and (g) apply, and the only waiver available is the waiver of the requirement for an RN for at least 8 consecutive hours a day, 7 days a week. This is because as a SNF, a waiver of the requirement to have licensed nurses 24 hours a day is not available. Additionally, both sets of requirements in §483.35(f) and (g) for a waiver must be met to be granted a waiver, and therefore, the limited requirements prevail. For example, a dually-certified SNF/NF must be located in a rural area with an inadequate supply of SNF services to qualify for a waiver of the RN for 8 consecutive hours a day, 7 days a week.*

More details on these waivers are described in the sections below.

Each state agency and CMS Location must accurately document any waiver granted under483.35(e) or (f). The information must be documented on the form CMS-671 and entered in the CMS survey and certification system, such as the Internet Quality Improvement and Evaluation System (iQIES), or subsequent system.

The state agency and CMS Locations must accurately document the following on the CMS-671 that is completed with the survey when a facility's qualifications for such waivers are assessed:

***When granting a waiver**:*

1. *Date the survey was completed to verify resident safety if the waiver was granted;*
2. *Date the waiver was granted;*
3. *Specific waiver granted; and*
4. *Number of hours waived each week.*

When a waiver request is denied or terminated , the state agency or the CMS Location must include the reason for the denial or termination in the Statement of Deficiencies, Form CMS-2567.

7014.1.1 – *Skilled Nursing Facility (SNF)*-Waiver of Requirement for *a Registered Nurse (RN) More than 40 Hours a Week*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

§483.35(f)
Waiver of the requirement to provide services of a registered nurse for more than 40 hours a week.

(1) The Secretary may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (b) of this section, if the Secretary finds that—

(i) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area;
(ii) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and
(iii) The facility either—
(A) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hours period or;

(B) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty;
(iv) The Secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with developmental disabilities or mental disorders; and
(v) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.

(2) A waiver of the registered nurse requirement under paragraph (f)(1) of this section is subject to annual renewal by the Secretary.

The CMS Location, acting on behalf of the Secretary, may waive the requirement *for services of an RN 8 consecutive hours a day, 7 days a week. However, the facility must still have an RN 40 hours a week (i.e., the waiver only permits the facility to not have an RN for a period of two days (48 hours). Also, CMS may waive the other requirement that*

the facility must designate an RN to serve as the director of nursing on a full-time basis. To grant a waiver on these requirements, the state agency obtains the following information below, which is then forwarded to the CMS Location:

a) The facility is located in a rural area and the supply of skilled nursing facility services is not sufficient to meet area needs. *Rural means all areas not delineated as "urban" by the Bureau of Census, based on the most recent census.*

b) The facility has one full-time registered nurse regularly on duty 40 hours a week. This may be the same individual or part-time individuals. This nurse may or may not be the Director of Nursing and may perform some Director of Nursing and some clinical duties if the facility so desires. *The facility must provide evidence of this, which may be in the form of a time-sheet/card or salary information showing an RN onsite for 40 hours a week (schedule of when an RN is supposed to work is not acceptable).*

c) The facility meets either of the following conditions:

i. The facility has residents whose physicians have indicated, through admission notes or physicians' orders, that the residents do not need RN or physician care for a *48-hour* period; or

ii. A physician or RN will spend the necessary time at the facility to provide the care that residents need during the days that an RN is not on duty. This requirement refers to clinical care of the residents who need skilled nursing services.

For facilities that were granted a waiver under section 483.35(f) the prior year: the facility must provide evidence that they notified the residents of the facility, their guardians or their resident representatives (where appropriate), and members of their immediate families of the waiver. If a facility does not have evidence of this, they may be granted another waiver if they meet all other requirements, as long as the facility provides evidence that the residents and their representatives have been notified of the waiver (e.g., within 30 days). If the facility does not provide this evidence, the waiver is rescinded.

The state agency forwards the above information to the CMS Location for review, and the CMS Location grants the waiver after confirming all of the requirements are met. If a waiver is granted, the CMS Location, must provide notice of the waiver to the State long-term care ombudsman and to the State protection and advocacy system for the mentally ill and intellectually disabled. The facility granted such a waiver must notify residents of the facility (or responsible guardians) and members of their immediate families of the waiver.

A waiver of the RN requirement is subject to annual renewal by the Secretary.

7014.1.2 - - *Nursing Facility (NF)-Only* Waivers of Nurse Staffing Requirements in Nursing Facilities

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

§483.35(e) Nursing facilities

Waiver of requirement to provide licensed nurses on a 24-hour basis.
To the extent that a facility is unable to meet the requirements of paragraphs (a)(2) and (b)(1) of this section, a State may waive such requirements with respect to the facility if—

> ***(1) The facility demonstrates to the satisfaction of the State that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel;***
>
> ***(2) The State determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility;***
>
> ***(3) The State finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility;***
>
> ***(4) A waiver granted under the conditions listed in paragraph (e) of this section is subject to annual State review;***
>
> ***(5) In granting or renewing a waiver, a facility may be required by the State to use other qualified, licensed personnel;***
>
> ***(6) The State agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the State for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency; and***
>
> ***(7) The nursing facility that is granted such a waiver by a State notifies residents of the facility and their resident representatives of the waiver.***

The requirements for long-term care facilities also require that nursing facilities provide 24-hour licensed nursing, *and* provide an RN for 8 consecutive hours a day, 7 days a week, . The State may waive these requirements *(either one, or both)* if the following conditions are met:

a. The facility demonstrates to the satisfaction of the State that it has made diligent efforts to recruit the appropriate personnel and is unable to do so. *To determine this, the facility must provide evidence of attempting to*

recruit RNs and/or licensed nurses, which may include advertisements or postings on online job boards. The facility also must show evidence that the compensation they are offering is similar to the compensation offered by the other providers in the same general area (e.g., county).

b. The State determines that a waiver will not endanger the health or safety of the residents in the facility. *This is determined by the state agency completing a standard survey before granting the waiver. Based on their assessment, the survey team will determine if the time that a licensed nurse or RN would normally be onsite, but now will not, endanger the health or safety of the residents in the facility. For example, if residents need to receive narcotic pain medication or insulin which must be administered by a licensed nurse during the time that licensed nurses will not be available, the state should not grant a waiver.*

c. The State finds that an RN or physician is obligated to respond immediately to phone calls from the facility for periods when licensed nursing services are not available. *This can be determined by interviewing the RN or physician and verifying that they will be available by phone during the time that an RN and/or licensed nurses will not be onsite.*

While considering granting a waiver, the state may require the facility to use other qualified, licensed personnel (per §483.35(e)(5)). This may include licensed respiratory therapist, licensed social workers, therapists, or other personnel the state deems necessary based on the needs of the residents.

For facilities that were granted a waiver(s) the prior year: the facility must provide evidence that they notified the residents of the facility, or their guardians or their legal resident representatives (as appropriate), and members of their immediate families of the waiver. If a facility does not have evidence of this notice from the prior year, they may be granted a waiver(s) if they meet all other requirements, and as long as the facility provides evidence that the residents, their guardians/representatives, and immediate family members have been notified of the current waiver (e.g., within 30 days). If the facility does not provide this evidence, the waiver(s) is(are) rescinded.

If a waiver is granted, the State must provide notice of the waiver to the State long-term care ombudsman and to the State protection and advocacy system for the mentally ill and intellectually disabled. The facility granted the waiver must notify residents of the facility (or responsible guardians) and members of their immediate families of the waiver.

Any waivers granted are subject to annual review.

7014.1.3 - Waivers of Nurse Staffing Requirements for Dually Participating Facilities *(SNF/NFs)*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If a facility dually participates in both the Medicare and Medicaid programs, it is subject to the waiver criteria for *SNFs and NFs*. *Because having a licensed nurse 24 hours each day cannot be waived for SNFs,* a *SNF/NF* may only have the 8 consecutive hours a day, 7 days a week requirement waived. *However, the facility must still have an RN 40 hours a week (i.e., the waiver only permits the facility to not have an RN for a period of two days (48 hours). For SNF/NFs*, the waiver is granted by the CMS Location. *To grant a waiver, the state obtains the following information, which is then forwarded to the CMS Location:*

a) *The facility is located in a rural area and the supply of skilled nursing facility services is not sufficient to meet area needs. Rural is defined as all areas not delineated as "urban`" by the Bureau of Census, based on the most recent census.*

b) *The facility has one full-time registered nurse regularly on duty 40 hours a week. This may be the same individual or part-time individuals. This nurse may or may not be the Director of Nursing and may perform some Director of Nursing and some clinical duties if the facility so desires. The facility must provide evidence of this to a surveyor, which may be in the form of providing timesheet/card or salary information showing an RN onsite for 40 hours a week (a schedule of when an RN is supposed to work, is not acceptable).*

c) *The facility meets either of the following conditions:*

   i) *The facility has residents whose physicians have indicated, through admission notes or physicians' orders, that the residents do not need RN or physician care for a 48-hour period. This is determined by reviewing the records of the residents sampled during the survey, and each resident's record reviewed must include this information.*
   ii) *A physician or RN will spend the necessary time at the facility to provide the care that residents need during the days that an RN is not on duty. This can be determined by interviewing the RN or physician and asking them when they will be in the facility during the days when an RN is not there 8 hours.*

d) *The facility demonstrates to the satisfaction of the State that it has made diligent efforts to recruit the appropriate personnel and is unable to do so. To determine this, the facility must provide evidence of attempting to recruit RN(s), which may include advertisements or postings on online job boards. The facility also must show evidence that the compensation they are offering is similar to the compensation offered by other providers in the same general area (e.g., county).*

e) *The State determines that a waiver will not endanger the health or safety of the residents in the facility. This is determined by the state completing a survey*

before a waiver is granted. Based on their assessment, the survey team will determine if the time that an RN would normally be onsite, but now will not, endanger the health or safety of the residents in the facility. For example, if residents will need the services of an RN during the time that an RN will not be available, the state should not forward this facility's information to the CMS Location for a waiver. Those services that must be performed by an RN include components of the nursing process (assessment, diagnosis, outcomes identification, planning, implementation, and evaluation). Examples include the assessment of a resident after a fall with injury, the subsequent development of a baseline care plan for the newly admitted resident, or the assessment and maintenance of an intravenous access that does not terminate in the arm (e.g., PICC or Central Venous lines).

While considering forwarding a facility to the CMS Location for a waiver, the state may require the facility to use other qualified, licensed personnel (per §483.35(e)(5)). This may include licensed social workers, therapists, or other personnel the state deems necessary based on the needs of the residents.

For facilities that were granted a waiver(s) the prior year: the facility must provide evidence that they notified the residents of the facility, or guardians and their resident legal representatives (as appropriate), and members of their immediate families of the waiver. If a facility does not have evidence of this, they may be granted a waiver(s) if they meet the other requirements, and as long as the facility provides evidence that the residents, their guardians/representatives, and immediate family members have been notified of the current waiver (e.g., within 30 days). If the facility does not provide this evidence, the waiver is rescinded.

The state forwards the above information to the CMS Location for review, and the CMS Location grants the waiver after confirming all of the requirements are met. If a waiver is granted, the CMS Location must provide notice of the waiver to the State long-term care ombudsman and to the State protection and advocacy system for the mentally ill and intellectually disabled. The facility granted such a waiver must notify residents of the facility (or responsible guardians) and members of their immediate families of the waiver.

A waiver of the RN requirement is subject to annual renewal by the Secretary.

7014.2 - Waiver of Life Safety Code

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(See *Chapter 2* and §7410.)

7014.3 - Variations of Patient Room Size and/or Beds Per Room

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Resident rooms may have no more than four beds per room. *However, for facilities that receive approval of construction or reconstruction plans by State and local authorities or are newly certified after November 28, 2016, bedrooms must accommodate no more than two residents. All resident rooms* must afford a minimum of 80 square feet per bed in multi-patient rooms. Single rooms must measure at least 100 square feet. *In 42 CFR 483.90(e)(3)* variations may be permitted in individual cases where the facility demonstrates in writing that the variations are in accordance with the special needs of the residents and will not adversely affect their health and safety.

- *If a facility has never been granted a waiver under this section, or was granted a waiver in the past, but did not have a waiver after the last standard survey: the facility is cited for noncompliance with the applicable requirements, and the state agency will then determine if the facility meets the requirements to qualify for a waiver.*

- *If a facility was granted a waiver on the last standard survey: the surveyor will determine if the facility continues to meet the requirements to qualify for a waiver.*

    - *If the facility continues to meet the requirements, the facility is not cited, and another waiver may be granted.*
    - *If the facility no longer meets the requirements for a waiver, the facility is cited, and a waiver is not granted. The facility must correct the noncompliance to meet the requirements at §483.90 (e)(1)(i) or (ii).*

The *CMS Location has jurisdiction to approve such waivers or variances and are subject to annual review by CMS. The State has jurisdiction to approve them in Medicaid-only NF cases. In either case, the approved waiver for the requirements at §483.90(e)(1)(i) and (ii) must be accurately documented in the CMS survey and certification system, such as ACO/ARO, or subsequent approved CMS system. When CMS or the state agency denies the request or terminates a variation / waiver under §483.90(e)(1)(i) or (ii), the state agency or the CMS Location must include the reason for the denial or termination in the Statement of Deficiencies form CMS-2567.*

The state agency determines that a variation/waiver will not endanger the health or safety of the residents in the facility by completing a standard survey. Based on their assessment, the survey team will determine if the variations of the patient room size or beds per room endanger the health or safety of the residents in the facility. The State Agency and CMS Location must accurately document any variation / waiver granted under §483.90(e)(1)(i) or (ii).

Survey Process

7200 -*Long-Term Care Survey Process (LTCSP)*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Skilled nursing facilities *(SNFs)* and nursing facilities *(NFs), and dually-participating facilities (SNF/NFs)* must be in compliance with the requirements in 42 CFR Part 483, Subpart B to receive payment under Medicare or Medicaid. *In order to* certify *compliance, State Survey Agencies must conduct both the Life Safety Code (LSC) and the Standard Health Surveys. Compliance with the Emergency Preparedness requirements (described in Appendix Z) will be determined in conjunction with the existing survey process for Standard Health surveys or LSC surveys for each facility.*

Follow the procedures in *the Long-Term Care Survey Process (LTCSP) Procedure Guide* for conducting all *standard health* surveys of *SNFs* and *NFs*, whether freestanding, distinct parts, or dually-participating. *Surveyors should refer to Appendix I for guidance when conducting a LSC survey.*

7201.1 - Survey Team Size

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Survey team size will vary, depending primarily on the size of the facility being surveyed. The State (or, for Federal teams, the CMS Location) determines how many members will be on the team *based on guidance provided in the LTCSP Procedure Guide, Attachment A – Sample Size, Recommended Team Size, and Initial Pool Size (located in the Survey Resources zip file located at https://www.cms.gov/medicare/provider-enrollment-and-certification/guidanceforlawsandregulations/nursing-homes).* 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.

7201.2 - Team Composition

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The State (or, for Federal teams, the CMS Location) decides what the composition of the survey team will be, *provided that* certain statutory and regulatory requirements are met. Sections *1819(g)(2)(E)* and *1919(g)(2)(E)* of the Act and 42 CFR 488.314 require that:

- Surveyors be 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. In other words, surveyors must successfully complete the CMS-approved training and pass the Surveyor Minimum Qualifications Test. (See *Chapter 4*).1 of this manual for additional information concerning Surveyor Minimum Qualifications Test requirements). *If a surveyor has not passed the SMQT or if the complexity of a*

resident's care requires expertise of more than one discipline, surveyors should work jointly to complete the review. A surveyor must successfully complete the SMQT to survey independently, however they can serve as a team member and complete survey tasks for which they have successfully demonstrated understanding as long as they are supervised by a qualified SMQT surveyor. The supervision of the newly trained surveyor should be as hands on or direct as needed to ensure all survey tasks are completed according to appropriate survey policy and procedures.

- *Regulations at§488.314 require that SNF* and *NF initial and recertification surveys be conducted by a multidisciplinary team of professionals, at least one of whom must be a registered nurse*. *Complaint investigations and on-site monitoring of compliance, including through revisits, are subject to the requirements of sections 1819(g)(4) and 1919(g)(4) of the Act and section 488.332, which allow the use a specialized investigative team that may include appropriate healthcare professionals as required to investigate the allegation or concern, but need not include a registered nurse.*

Within these parameters, the States (or, for Federal teams, the CMS Location) 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 CMS Location should consider using more than one registered nurse 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. For 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.

- *The State is responsible for determining which members of the survey team have the appropriate skills, clinical expertise, and licenses to make observations that include a resident's genital, rectal, or the breast area. This would likely be limited to surveyors with professional licenses, such as registered nurse, licensed physical or occupational therapists, physician assistants, physicians, etc. When making these observations, surveyors must attempt to obtain consent from the resident or their representative- See Resident Privacy Section below.*

Additionally, surveyors must be aware of any history of trauma, and honor the resident's preferences, including cultural and religious beliefs.

- 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, dieticians, sanitarians, engineers, licensed practical nurses, social workers, pharmacists, and gerontologists.

  NOTE: *Specialty Surveyors - All members of the survey team should enter the facility at the same time, if possible. Specialty surveyors participating in surveys (e.g., a pharmacist, physician, or registered dietitian) must be onsite during that portion of the survey dealing with their area of expertise. However, they must conduct that portion while the rest of the team is present. Before leaving the facility, at the completion of his/her portion of the survey, the specialty surveyor must meet with the team or team coordinator to discuss his/her findings and to provide supporting documentation. The specialty surveyor should also share any information he/she obtained that may be useful to other team members. If he/she is not present at the information analysis for deficiency determination, the specialty surveyor should be available by telephone at that time and during the exit conference.*

- 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. While it is desirable that all survey team members be fully qualified, CMS recognizes that trainees must be given opportunities to perform survey functions so that they can achieve "fully qualified" status. Participation in actual surveys is a valuable and integral part of a training program. In fact, in the orientation program designed for newly employed surveyors, CMS recommends that 3 weeks be spent in the field as part of the training.

7201.3 - Length of Survey

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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. *See guidance provided in the LTCSP Procedure Guide, Attachment A – Sample Size, Recommended Team Size, and Initial Pool Size.*

7202.2.1 - Prima Facie Conflicts of Interest

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Under *42 CFR 488.314(a)(4)*, any of the following circumstances disqualifies a surveyor for surveying a particular skilled nursing facility or nursing facility:

a. The surveyor currently works, or, within the past 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;

b. The surveyor has any financial interest or any ownership interest in the facility. (Indirect ownership, such as through a broad based mutual fund, does not constitute financial or ownership interest for purposes of this restriction.);

c. The surveyor has an immediate family member who has a relationship with a facility described in §7202. An immediate family member is defined in *42 CFR 488.301*; or. An immediate family member is defined in *42 CFR 488.301*; or

d. The surveyor has an immediate family member who is a resident in the facility.

7203.1 - Introduction

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

This protocol is established pursuant to *§1819(g)(2)(C)* and *§1919(g)(2)(C)* of the Act 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. It serves to explain and clarify the requirements for long-term care facilities and all surveyors measuring facility compliance with Federal requirements are required to use it. The purpose of this protocol is to provide suggestions, interpretations, checklists, and other tools for use both in preparation for the survey and when performing the survey onsite. *See the LTCSP Procedure Guide for additional instructions to surveyors for conducting the LTCSP.*

The interpretive guidelines merely define or explain the relevant statutes and regulations and do not impose any additional costs or place other burdens on any health care facility. (See *Chapter 2*, of this manual.)

7203.2 - Initial Certification Surveys

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(See also *Chapter 2* and §7300 of this manual.)

All initial surveys must verify substantial compliance with the regulatory requirements

contained in 42 CFR 483.5 through 42 CFR 483.95. *See LTCSP instructions for conducting the Initial Certification Survey. (See also Chapter 2)*

.During the initial survey, focus both on residents and the requirements that relate to qualification standards and resident rights notification, whether or not problems are identified during the information gathering tasks. Gather additional information to verify compliance with requirements. For example, during an initial survey, verify the qualifications of the social worker, dietitian, and activities professional. Also, review the rights notification statements on admissions contracts. Complete the Statement of Deficiencies and Plan of Correction (Form CMS-2567.)

If distinct part status is at issue, determine whether the facility meets the criteria for certification as a distinct part. (See *Chapter 2* .)

7203.3 - *Survey for Recertification*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Follow the procedures specified in *the LTCSP Procedure Guide* for standard and extended surveys.

The Standard Survey is a periodic, resident-centered inspection which gathers information about the quality of service furnished in a facility to determine compliance with requirements for participation. The survey is outcome-oriented and relies on a case-mix stratified sample of residents. Outcomes include both actual and potential negative outcomes, as well as failure of a facility to help each resident achieve and maintain their highest practicable level of well-being.

***General Survey Policy: Follow** procedures detailed in the LTCSP procedure guide to conduct the recertification survey. Key components of the survey process include conducting observations, interviews, and record reviews including reviewing for the accuracy of the residents' comprehensive assessment. This section contains CMS guidance and policy related to conducting the standard survey.*

***Resident Privacy: The** survey team must conduct the survey in a manner that allows for the greatest degree of confidentiality for residents, particularly regarding the information gathered during the interviews. Use the resident identifier (e.g., a code number assigned to each resident in the resident sample) on the Form CMS-2567 in place of the resident's name, which should never be used on the Form CMS-2567.*

When observing residents, respect their right to privacy, including the privacy of their bodies. If the resident's genital, rectal area, or breast area must be observed in order to document and confirm suspicions of a care problem, a member of the nursing staff must be present at this observation, and the resident must give clear consent.

If the resident is unable to give consent, e.g., is unresponsive, incompetent, and a health care proxy who can act on the resident's behalf or legal representative (as provided by State law) is available, ask this individual for consent.
An observation of a resident's rectal, genital or breast area may be made without a resident's or legal representative's consent, under the following conditions:

- *It is determined that there is a strong possibility that the resident is receiving less than adequate care, which can only be confirmed by direct observation;*
- *The resident is unable to give clear consent; and*
- *A legal representative is not immediately accessible.*

Basic Principles of Using Photography During the Survey [1]

Although the use of photography during the survey process is not required, the State Survey Agencies (SAs) may decide to collect photographic evidence to support a finding of noncompliance. The SA will be responsible for the acquisition, accountability, and security of the photography equipment (e.g., smart phone, camera) and data/images. Additionally, the SA should develop guidance for using photography during the survey process and train staff in the proper use of the camera. States should ensure that all photos are maintained in accordance with all applicable privacy and confidentiality laws and policies.

Surveyors may use photography as a tool, supplementing written documentation, to assure accurate and effective records of observations made during surveys with the intent to produce photographs that are relevant to possible deficiencies. However, without written documentation, photographs cannot stand alone.

Photographs may enhance findings of noncompliance by providing visual evidence of injury, scene, or other relevant components of a deficient practice. Photographs should not be included as part of the Form CMS-2567. Surveyors should only reference photographs in their surveyor notes and not in the statement of deficiencies.

When taking photographs during a survey, the following basic principles should be implemented:

1. *Request the Resident's or His/her Representative's Written Permission Prior to Photographing His/her*

   - *Before beginning, ask the individual's written permission to take a photograph, to the maximum extent feasible.*
   - *The health and dignity of the individual is always a paramount concern. A surveyor should respect an individual's refusal to be photographed.*
   - *If the individual's genital, rectal, or breast area is photographed in order to*

[1] Some material included in this guidance is from the Illinois Department of Public Health, Division of Long-Term Care Field Operations, "Guidelines for Photographic Evidence."

document and confirm suspicions of care problems, a member of the nursing staff must be present at the time of observation, and the individual must be asked to give written consent before the photograph may be taken.

- *If the individual is unable to give consent (e.g., is unresponsive, incompetent), and the individual's legal representative is present, ask the representative for written consent, unless the representative is the one suspected of abusing the individual.*
- *If the individual is unable to give consent and the individual's representative is not present in the facility, then the surveyor may use discretion in determining whether a photograph of the individual's rectal, genital or breast area is necessary to support a finding of noncompliance.*
- *Surveyors should avoid taking pictures that will reveal an individual's face or other uniquely identifying information that will interfere with that person's right to privacy.*

2. Get a Complete Series of Photographs

Generally, each relevant object in the scene should appear in at least three photographs: an overview, a mid- range photograph, and a close-up.

- *Because a close-up does not indicate where the object was located, the overview photograph should cover the entire scene to bring out the relationships between the objects. Leave measuring scales and labels out of the overview photograph.*
- *The mid-range photograph shows a relevant object and its immediate surroundings.*
- *Each close-up photograph shows a key detail clearly. Have a "standard" in the close-up photograph to indicate the actual size of what is being photographed.*
  - *Measure scales and labels may be added to the close-up photograph. For example, placing a ruler with readable graduations next to a pressure ulcer will show its actual size in the photograph.*
  - *Other standards include tape measures, coins, or a pencil.*

3. Documentation and Storage of Photographs

A surveyor must handle a photograph of the individual with as much confidentiality as a medical record. Only non-personal identifiers should be used to document the photograph. A reference in the surveyor notes should be made of each photograph even if it did not portray the expected image so there will be a sequential reference to all photographs taken.

In addition to proper documentation, photographs depicting residents must be stored properly. This means that any photographs taken to support deficient practice must contain non-personal identifiers and then be attached to the survey when uploaded to the survey software. Photographs must only be shared with those having a need to know, such as survey managers, SA officials, HHS Office of the General Counsel, or others as appropriate. When sharing photographs, it is imperative that secure or encrypted email is used, and proper chain of custody must be maintained. Chain of custody as defined by

the National Institute of Standards and Technology, is a process that tracks the movement of evidence through its collection, safeguarding, and analysis lifecycle by documenting each person who handled the evidence, the date/time it was collected or transferred, and the purpose for the transfer.

Immediately upon taking a photograph, document in surveyor notes the following:

- *Date;*
- *Time;*
- *The identity of the photographer;*
- *A photograph identifying number (even if just one photograph is taken);*
- *Facility name;*
- *Survey event number, as applicable; and*
- *Non-personal identifier.*

Note: Many conventional cameras and digital cameras have the capacity to imprint a date and time on the photographic image.

Do not modify an original photograph. A surveyor who wants to stress a key detail in a photograph should identify the detail by using a transparent overlay that can be removed to show the unaltered print.

Examples of Photographic Evidence:

- *Evidence of abuse, such as contusions, bruises, lacerations, or burns*
- *Evidence of improper and dangerous use of restraints or other devices*
- *Evidence of improper positioning such as leaning, or hypo- or hyper-extension of neck and/or trunk*
- *Pressure ulcers*
- *Contractures*
- *Safety hazards*
- *Evidence of extensive pest infestation*
- *Evidence of faulty or dirty equipment*

Confidentiality of Survey Materials

Surveyor notes and documentation collected during the survey process contain pre-decisional information and therefore, are not required to be disclosed to the facility at the time of the survey. If providers or other stakeholders are requesting additional information, they need to submit that request following the appropriate federal and state laws and/or processes for disclosure.

The survey team should maintain an open and ongoing dialogue with the facility throughout the survey process. This gives the facility the opportunity to provide additional information in considering any alternative explanations before making deficiency determinations. This, however, does not mean that a daily exit conference is

held with the facility, or every negative observation is reported to the facility on a daily basis. Moreover, if the negative observation relates to a routine that needs to be monitored over time to determine whether a deficiency exists, the survey team should wait until a trend has been established before notifying the facility of the problem.

Identification of Past Non-Compliance Citations: *Findings cited as past noncompliance (PNC) may be identified during any survey of a nursing home. See additional information on PNC at 7510.1. For PNC to exist, the following criteria must be met:*

- *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;*
- *The noncompliance occurred after the exit date of the last standard (recertification) survey and before the survey (standard, complaint investigation, 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(s), as referenced by the specific F-tag.*

When a citation of PNC is written, the facility does not provide a plan of correction as the deficiency is already corrected; however, the survey team documents the facility's corrective actions on Form CMS-2567. (Additional information about citations of PNC is found at 7510.1 – Determining Citations of Past Noncompliance at the Time of the Current Survey)

7203.3.1 – Exit Conference

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The general objective of the exit conference is to inform the facility of the survey team's observations and preliminary findings. The exit conference is a courtesy to the facility to provide the preliminary findings of the surveyors so that the facility can take swift corrective action to address any deficiencies. Surveyors must indicate that all findings are preliminary and are subject to supervisory review by the State and/or CMS Location. Deficiency citations are not final, and the CMS-2567 must not be given to the facility until after the State and/or CMS Location conduct a supervisory review and the report is finalized.

Conduct the exit conference with facility personnel. Ask the Administrator to invite the Medical Director to the exit conference. Invite the ombudsman and an officer of the organized resident group (e.g., resident council), if one exists, to the exit conference. Also, invite one or two residents to attend. If the ombudsman, officer of the resident group, or residents cannot attend in-person, they should be allowed to attend virtually via conference call or video conferencing. The team may provide an abbreviated exit conference specifically for residents after completion of the normal facility exit conference. If two exit conferences are held, notify the ombudsman and invite the ombudsman to attend either or both conferences.

It is important to provide clear information on the facility's noncompliance so the facility can develop an appropriate plan of correction.

If the provider asks for the regulatory basis or the specific deficiency tag, the surveyors should generally provide it (except as noted below), but always caution that such coding classifications are preliminary and are provided only to help the provider gain more insight into the compliance issues identified during the survey through the interpretive guidance at the related tag.

If the survey team is still deliberating as to which tags will be cited, the survey team should not speculate at the exit conference as to the specific tag coding that will be applied. For example, the team may still be deliberating as to whether a finding was a care planning deficiency or staff training deficiency. Similarly, the team may believe that additional consultation should occur with other State personnel (e.g., a pharmacist) before a specific tag number is assigned to the deficiency finding. In these cases, the survey team should describe the general area of noncompliance without identifying a specific tag code. This is a judgment to be the made by the survey team onsite. So, in preparation for the exit conference the team should deliberate as to the degree of detail that will be appropriate.

Surveyors must not provide the Scope and Severity level of a given deficiency finding (unless it is an immediate jeopardy), as such levels of detail should await supervisory review. Instead, survey teams may describe the general seriousness (e.g., harm) or urgency that, in the preliminary view of the survey team, a particular deficiency may pose to the well-being of residents. This is a survey-specific decision based on the evidence gathered. As described below, states must follow the federal survey process. State licensure laws do not override the procedures outlined in the federal process. If a provider asks whether the noncompliance is isolated, a pattern, or widespread, the surveyor should respond with the facts (i.e., noncompliance was found affecting X number of residents).

Surveyors should not make general statements such as, "Overall the facility is very good." Surveyors should also not assume intent for noncompliance or assign blame to the facility or individual staff. Also, surveyors should not provide consultation, such as explaining how the facility can be compliant. Only discuss the facts. Do not rank requirements. Treat requirements as equally as possible. Cite problems that clearly violate regulatory requirements. The survey team must not discuss survey results in a manner that reveals the identity of an individual resident.

After describing the team's preliminary deficiency findings to the facility, let the facility know they will receive an official report of the survey which will contain any deficiencies that have been cited following supervisory review (Form CMS-2567, Statement of Deficiencies). If your state provides the sample list during the exit, follow instructions in the LTCSP Procedure Guide.

If an extended survey is required and the survey team cannot complete all or part of the extended survey prior to the exit conference, inform the facility Administrator that the deficiencies, as discussed in the conference, may be amended upon completion of the extended survey. (See Chapter 2 for additional information concerning exit conferences.) During the exit conference, provide the facility with the opportunity to discuss and supply additional information that they believe is pertinent to the identified findings. Because of the ongoing dialogue between surveyors and facility staff during the survey, there should be few instances where the facility is not aware of surveyor concerns or has not had an opportunity to present additional information prior to the exit conference.

7203.3.2 Determining Health Severity and Scope of Deficiencies
(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Guidance on Severity: *After the survey team decides to cite a deficiency(ies), evaluate the deficient practice's impact on the resident(s) and the prevalence of the deficient practice. Review deficiency statements, and results of team discussions for evidence on which to base these determinations. The team may base evidence of the impact or prevalence for residents of the deficient practices on record reviews, interviews and/or observations. Whatever the source, the evidence must be credible.*

NOTE: *The survey team must always assess the level of severity of noncompliance beginning with the highest level of harm, and if the outcome doesn't reach that level of harm, to proceed to review the other levels in consecutive order until a determination of severity has been made.*

Assessment Factors Used to Determine the Seriousness of Health Deficiencies Matrix

	Isolated	***Pattern***	***Widespread***
Immediate jeopardy to resident health or safety (Level 4)	***J*** [redacted] *PoC Required SQC* [redacted]	***K*** [redacted] *PoC Required SQC* [redacted]	***L*** [redacted] *PoC Required SQC* [redacted]
Actual harm that is not immediate jeopardy (Level 3)	***G*** *PoC Required*	***H*** [redacted] *PoC Required SQC* [redacted]	***I*** [redacted] *PoC Required SQC* [redacted]

No actual harm with potential for more than minimal harm that is not immediate jeopardy (Level 2)	***D*** *PoC Required*	***E*** *PoC Required*	***F*** [redacted] *PoC Required SQC* [redacted]
No actual harm with potential for minimal harm (Level 1)	***A*** ***No*** *PoC Required* [redacted] *Substantial compliance No remedies Commitment to Correct Not on CMS-2567*	***B*** *PoC Required* [redacted] *Substantial compliance*	***C*** *PoC Required* [redacted] *Substantial compliance*

[redacted] ***Substandard quality of care***

[redacted] ***Substantial compliance***

There are four severity levels which are defined accordingly:

- ***Level 4 - Immediate Jeopardy to resident health or safety****: Noncompliance with the Requirements for Participation that results in Immediate Jeopardy to resident health or safety in which immediate corrective action is necessary because the provider's noncompliance with one or more of those requirements has caused, or is likely to cause, serious injury, harm, impairment or death to a resident receiving care in a facility. (See Appendix Q)*
- ***Level 3 - Actual harm that is not Immediate Jeopardy:*** *Noncompliance with the Requirements for Participation that results in actual harm to residents that is not immediate jeopardy.*
- ***Level 2 No actual harm with a potential for more than minimal harm that is not immediate jeopardy:*** *Noncompliance with the Requirements for Participation that results in the potential for no more than minimal physical, mental, and/or psychosocial harm to the resident and/or that result in minimal discomfort to the residents of the facility, but has the potential to result in more than minimal harm that is not immediate jeopardy.*
- ***Level 1 - No actual harm with potential for minimal harm:*** *A deficiency that has the potential for causing no more than a minor negative impact on the resident(s).*

Guidance on Scope: *After determining the severity level of a deficient practice, determine the scope of the noncompliance which reflects the number of residents actually or potentially affected by the provider's noncompliance*

*Scope is **isolated** when one or a very limited number of residents are affected and/or one or a very limited number of staff are involved, and/or the situation has occurred only occasionally or in a very limited number of locations within the facility.*

*Scope is a **pattern** when more than a very limited number of residents are affected, and/or more than a very limited number of staff are involved, and/or the situation has occurred in several locations of the facility, and/or the same resident(s) have been affected by repeated occurrences of the same deficient practice. The effect of the deficient practice is not found to be pervasive (affect many locations) throughout the facility.*

*Scope is **widespread** when the problems causing the deficiencies are pervasive in the facility and/or represent systemic failure that affected or has the potential to affect a large portion or all of the facility's residents. Widespread scope refers to the entire facility population, not a subset of residents or one unit of a facility. In addition, widespread scope may be identified if a systemic failure in the facility (e.g., failure to maintain food at safe temperatures) would be likely to affect a large number of residents and is, therefore, pervasive in the facility.*

***NOTE:** If the evidence gathered during the survey for a particular requirement includes examples of various severity or scope levels, surveyors should generally classify the deficiency at the highest level of severity. For example, if there is a deficiency in which one resident suffered a severity 3 while there were widespread findings of the same deficiency at severity 2, then the deficiency would be classified as severity 3, isolated. In these situations, the survey team should expand the sample to rule out the presence of SQC.*

***When Immediate Jeopardy (IJ) Exists:** Identification of IJ triggers additional survey tasks and should be determined while the team is onsite.*

IJ as defined at §488.301, means 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.

At any time during the survey, if one or more survey team members identify possible IJ, the survey team leader must be immediately notified so that the survey team can gather to discuss the IJ concern and, if necessary, conduct further investigation. The survey team must use its professional judgment and evidence gathered from observations, interviews, and record reviews to carefully consider each key component of IJ.

Survey teams must use the IJ Template (found in Appendix Q) to document evidence of each component of IJ and to convey information to the entity. In order to determine that IJ exists, the team must verify that all three components of IJ have been established:

1. *Noncompliance: An entity has failed to meet one or more federal health, safety, and/or quality regulations; AND*

2. *Serious Adverse Outcome or Likely Serious Adverse Outcome: As a result of the identified noncompliance, serious injury, serious harm, serious impairment or death has occurred, is occurring, or is likely to occur to one or more identified recipients at risk; AND*
3. *Need for Immediate Action: The noncompliance causes a serious adverse outcome or likely serious adverse outcome and creates a need for immediate corrective action by the entity to prevent serious injury, serious harm, serious impairment or death from occurring or recurring.*

Survey teams must use the IJ Template to determine if IJ exists and use the template to communicate the finding of IJ to the entity. When the surveyor/survey team determines the entity's noncompliance has caused a serious adverse outcome, or has made a serious adverse outcome likely, and immediate action is needed to prevent serious harm from occurring or recurring, the survey team must consult with their SA for confirmation that IJ exists and seek direction. In some cases, it may be necessary for the survey team to stop all other investigations due to the need for additional investigation into the IJ situation.

When there is agreement from the SA (and/or CMS Location) that IJ exists, the survey team must immediately:

- *Notify the administrator (or appropriate staff member who has full authority to act on behalf of the entity) that IJ has been identified and provide a copy of the completed IJ template to the entity; and*
- *Request a written IJ removal plan, which is the immediate action(s) the entity will take to address the noncompliance that resulted in or made serious injury, serious harm, serious impairment, or death likely.*

The administrator/designee should immediately begin to take action to remove the IJ. If the IJ is not removed prior to the end of the survey, an onsite revisit must be conducted for determination of removal of the IJ. The SA and/or CMS Location will invoke appropriate termination procedures. See Appendix Q for additional guidance regarding determination of IJ.

When IJ is removed: *Appendix Q states, "When IJ has been identified and removed during the current survey or the revisit, the SA must ensure the core components of IJ and the actions taken by the entity to remove the IJ are documented on the Form CMS-2567. The documentation must identify and describe the following information:*

- *The date the IJ began (the date entity's noncompliance caused a serious adverse outcome,* ***or*** *made a serious adverse outcome likely), if known;*
- *The date the entity was notified;*
- *The specific requirement that has been violated, including a description of the noncompliance and the serious adverse outcome that occurred, or was likely to occur;*

- *Identification of recipients that were affected or were identified at risk of serious injury, harm, impairment, or death within the deficient practice statement;*
- *Date when the IJ was removed, as confirmed by an onsite verification by surveyor(s); and*
- *A statement of the seriousness of the remaining noncompliance, if any (i.e. Condition/ Standard/Element-level, or scope/severity).”*

***Lowering Severity when IJ is removed**: As noted above, once IJ has been removed, surveyors must identify the level of severity any remaining noncompliance poses at the tag cited for IJ. When the facility has taken action to remove IJ, such that no further serious injury, serious harm, serious impairment, or death is occurring to the resident(s) involved and is not likely to occur to any other resident(s), any remaining noncompliance for that tag should be lowered to severity level 2 (No actual harm with potential for more than minimal harm that is not immediate jeopardy). If there are multiple occurrences of noncompliance at the same tag involving different residents with one cited at IJ and the other cited at harm, once IJ is removed, the remaining noncompliance is lowered to harm.*

Example at 483.25(d), Accidents and Supervision:
During a recertification survey, IJ was determined to exist for Resident A who was seriously harmed when the facility failed to supervise this resident’s smoking break, resulting in Resident A being seriously burned. During the same survey, Resident B was found to have been harmed (not serious harm at IJ) when the facility failed to ensure the resident environment was free of accident hazards, resulting in Resident B sustaining a laceration which required sutures after slipping on spilled water near the water fountain.

The IJ was removed when the facility put a plan in place to ensure all residents are supervised on their smoke breaks, but the plan did not address correction of the accident hazards. Once that IJ removal plan was implemented, and it was determined that no further residents were being seriously harmed or had the likelihood to be seriously harmed, the next remaining level of noncompliance would be actual harm at severity level 3 until substantial compliance is achieved.

7203.4 - Post Survey Revisit (Follow-Up)

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When deficiencies *are cited,* the state agency *must* conduct *either an onsite or offsite* post survey revisit to determine if the facility now meets the requirements for participation *and to verify correction of deficiencies.*

In accordance with the guidance at §7317 of this chapter, the SA conducts a revisit to confirm that cited deficiencies have been corrected, and the facility is in substantial compliance and has the ability to remain in compliance. The purpose of the post-survey revisit (follow-up) is to re-evaluate the specific findings of care and services that were cited as noncompliant during the original standard, abbreviated standard, extended or partial extended survey(s).

Because the long-term care survey process focuses on the care of the resident, on-site revisits are generally necessary to determine if deficient practices have been corrected. The nature of the noncompliance dictates the scope of the revisit. For example, do not perform another drug pass if no drug distribution related deficiencies were cited on the initial survey. Do interviews and closed record reviews, as appropriate. Prior to the revisit, review appropriate documents, including the plan of correction, to focus the revisit review.

Refer to the LTCSP Interim Revisit Instructions for technical directions on conducting an on-site revisit, including obtaining the sample size for the revisit. Conduct as many survey tasks as needed to determine compliance. Always conduct the QAPI/QAA review. However, the team is not prohibited from gathering information related to any requirement during a post-survey revisit.

Focus on selecting residents who are most likely to have those conditions/needs/problems cited in the original survey. If possible, include some residents identified as receiving SQC during the prior survey. If, after completing the revisit, it is determined that the cited incidence(s) of noncompliance was not corrected, inform the SA and/or CMS Location as applicable. The SA and/or CMS Location are responsible for initiating enforcement action, as appropriate.

7203.5 - Abbreviated Standard Survey

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The abbreviated standard survey focuses on particular tasks *used for substantial changes in a facility's organization and management.* It does not cover all the aspects covered in the standard survey, but rather concentrates on a particular area of concern.

1. **Substantial Changes in a Facility's Organization and Management -** If a facility notifies *the SA* of a change in organization or management, *including a change of ownership, administration, management or the director of nursing,* review the change to ensure compliance with the regulations. Request copies of the appropriate documents, e.g., written policies and procedures, personnel qualifications and agreements, etc., if they were not submitted. If changes in a facility's organization and management are significant and raise questions of its continued substantial compliance, determine, through a survey, whether *certain changes have caused a decline in quality of care furnished by a SNF or NF and determine whether* deficiencies have resulted. Collect information about changes in the facility's organization and management on the "Medicare and other Federal Care Program General Enrollment," Form CMS-855.

   Surveyors may investigate any area of concern *to* make a compliance decision regarding any regulatory requirement, whether it is related to the original purpose of the survey complaint. *The abbreviated standard survey may be expanded to*

cover additional areas, or to conduct a full standard survey if evidence is found that warrants a more extensive review.

2. ***Complaint Investigations*** *– If the State's review of a complaint allegation(s) concludes that one or more violations may have occurred, and only an onsite investigation can determine whether a deficiency(ies) exist, conduct a complaint investigation using the procedures for either a standard or abbreviated standard survey, depending on the nature of the complaint allegation. (See also Chapter 5 of this manual and 42 CFR 488.334.)*

7203.6 - Extended Survey/Partial Extended Survey

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If, as a result of its findings during the standard survey or abbreviated standard survey, the team suspects substandard quality of care as defined in *42 CFR 488.301*, it expands the survey *sample*. If the expanded survey *sample* verifies substandard quality of care, the State or CMS Location conducts an extended survey or a partial extended survey in accordance with procedures in *the LTCSP Procedure Guide*. (See §7210.2 and *the LTCSP Procedure Guide*.)

Extended Survey: *An extended survey is conducted when SQC has been verified. The purpose is to explore the extent to which structure and process factors may have contributed to systemic problems causing SQC. This is accomplished by further evaluating the facility's compliance with all provisions. (Refer to the Extended Survey Pathway for more information). An extended survey includes all of the following:*

- *Review of a larger sample of resident assessments than the samples used in a standard survey;*
- *Review of the staffing and in-service training;*
- *If appropriate, examination of the contracts with consultants;*
- *A review of the policies and procedures related to the requirements for which deficiencies exist; and*
- *Investigation of any Requirement for Participation at the discretion of the SA.*

Conduct an extended survey:

- *Prior to the exit conference, in which case the facility will be provided with findings from the standard and extended survey; or,*
- *After the standard survey, but no later than 14 calendar days after the completion of the standard survey. Advise the facility's Administrator that there will be an extended or partial extended survey conducted and that an exit conference will be held at the completion of the survey.*

Partial Extended Survey: *Must be conducted after SQC is found during an abbreviated standard survey or during a revisit, when SQC was not previously identified.*

7203.7 -State Monitoring Visits

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

"State monitoring visits" are visits by the State to oversee a provider's compliance status and are not done as part of the State monitoring remedy. Some CMS Locations and States call these State monitoring visits "monitoring visits". For example, these visits may occur:

- During bankruptcy, in those cases in which CMS has authorized such visits.
- After a change of ownership, as authorized by the CMS Location;
- During or shortly after removal of immediate jeopardy when the purpose of the visit is to ensure the welfare of the residents by providing an oversight presence, rather than to perform a structured follow-up visit; and
- In other circumstances, as authorized by the CMS Location.

When a State monitoring visit results in a Federal deficiency, the State will identify the survey in *iQIES* as "complaint" and create an intake and survey record. (See Chapter 5 of this manual for additional instructions.)

7205.2 - Scheduling and Conducting Surveys

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The State must complete a standard survey of each skilled nursing facility and nursing facility not 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.

1 - Changes That May Prompt Survey

If the State is concerned that a change of ownership, management firm, administrator, or Director of Nursing may have caused a decline in the quality of care or services furnished by a skilled nursing facility or nursing facility, it may conduct a standard or abbreviated standard survey within 60 days of the change.

Facilities with poor histories of compliance may be surveyed more frequently to ensure that residents are receiving quality care in a safe environment.

2 - Frequency

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. There is no required minimum time which must elapse between surveys.

3 - Conducting Complaint Surveys

Refer to complaint investigation procedures in *Chapter 5* of this manual.

7205.6 – Standard Survey Interval for Special Focus Facilities

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Sections 1819(f)(8) and 1919(f)(10) of the Act require CMS to conduct a Special Focus Facility (SFF) program which focuses on enforcement of requirements on facilities that have a persistent record of noncompliance leading to poor quality of care. CMS' SFF program requires the persistently poorest performing facilities selected in each state to be surveyed no less than once every six months.

7207.2 - All Surveys Must Be Unannounced

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The State has the responsibility for keeping surveys unannounced and their timing unpredictable. This gives the State agency doing the surveying greater ability to obtain valid information because it increases the probability that the surveys will observe conditions and care practices that are typically present. While the Act and implementing regulations referenced in §7207.1 require that standard surveys be unannounced, it is CMS' intention and expectation to not announce **any** type of nursing home survey such as abbreviated, onsite revisit, or complaint surveys. Therefore, if CMS conducts standard surveys or validation surveys, the CMS Location must follow the same procedures as required of the States to not announce surveys. The only exceptions to this policy would be if, for instance, some additional documentation was required and the most efficient way to obtain it would be through making an appointment and revisiting the facility or asking that it be provided via electronic means. The State should notify the State ombudsman's office according to the protocol developed between the State and the State ombudsman's office. This protocol must ensure strict confidentiality concerning the survey dates. (See *the LTCSP Procedure Guide*.)

*Survey teams are expected to remain in the facility after entrance for a **minimum** of five consecutive hours. This applies to all standard health surveys and helps to ensure that the surveys remain unannounced. For example, a survey team should not enter a facility, conduct a brief entrance conference, then leave the facility only to return the next day. Additionally, a survey should not enter a facility on a Friday and not return until the following Monday. If all required first day activities (per the LTCSP procedure guide and entrance conference form) have been completed in under five hours, or there is an emergency, the survey team may leave sooner, but this should be a rare occurrence.*

At a minimum, the first two days of a survey must be conducted on consecutive calendar days from the day of entrance. The only exception would be an emergency situation, which should be rare, or a competing IJ at another location requiring the survey team's immediate attention. To increase the opportunity for unpredictability in standard surveys, the State survey agencies and Federal surveyors *should* incorporate the following procedures when planning facility surveying:

7207.2.2 - Variance in Timing (Time of Day, Day of Week, Time of Month)

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(Refer to the LTCSP Procedure Guide for additional off-hour guidance.)

When facilities are surveyed, the day of the week and time of month should be varied from the time of the previous standard survey. *The month in which a survey begins should not, if possible, coincide with the month in which the previous standard survey was conducted.*

At least 10 percent of standard health surveys must *be conducted as off-hour surveys. These off-hour surveys are aimed at providing better insight into how a facility is staffed and operates outside of business hours, as well as* reducing the predictability of when a survey will occur. *Off-hour surveys* begin either *on the weekend or* before *6*:00 a.m. or after *5*:00 p.m. on weekdays.

When entering a facility during residents' routine sleeping hours, surveyors are to proceed with survey activities while also respecting the residents' need for sleep. During off-hour surveys, the team coordinator (TC) is to complete the Entrance Conference with the designated person in charge and then conduct a follow-up Entrance Conference with the administrator, as needed, upon his/her arrival at the facility.

The survey team should not wait for the resident roster or matrices to begin screening residents. Additionally, the survey team that has entered the facility during off-hours should be alert to situations that might indicate concerns with the following:

- *sufficient staff;*
- *infection control;*
- *medication errors;*
- *compliance with medication storage;*
- *abuse/neglect;*
- *pain management;*
- *behavioral health;*
- *restraints;*
- *accidents/hazards/smoking; and*
- *environment.*

While concerns with compliance in these areas may exist during normal business hours, survey teams may gain a more realistic view of facility activities during the early morning or late evening time of day.

During off-hour surveys, modify the Initial Pool Process as necessary to accommodate the residents' activities occurring at the time of entry. Surveyors must respect residents' need for sleep, by taking care not to be intrusive or wake the resident. Observations of the resident and the room may be made, but interview status may have to wait until the resident is awake. If residents are found to be awake, surveyors should introduce themselves. Members of the survey team may be able to start some facility level tasks that wouldn't disturb residents (e.g., sufficient and competent staffing, medication storage, kitchen, medication administration observation, infection control).

Additionally, a minimum of 50 percent of the 10 percent of off-hour standard health surveys must begin on a weekend day (Saturday or Sunday). Facilities for weekend surveys must be selected using the list provided by CMS. State Agencies may do more than a minimum of 50 percent.

Survey time on holidays can be counted toward the 10 percent of off-hour surveys to be conducted ."Holidays" are defined as those days that are recognized by the State as a State or Federal holiday.

NOTE: If the survey is commencing during off-hours (before 6:00 a.m. or after 5:00 p.m. or on a Saturday or Sunday), once onsite, announce the survey, ascertain who is in charge, ask the person to notify the administrator that a survey has begun. Conduct Step 12 in the LTCSP Procedure Guide with the designated person in charge and complete the task and the onsite preparatory activity as appropriate within the context of the survey. Conduct a follow-up Entrance Conference with the administrator, as needed upon his/her arrival at the facility.

All standard health surveys, including those conducted to satisfy the 10 percent *off-hours* requirement, ***must*** be conducted *with the survey team onsite for a minimum of two* **consecutive *calendar* days** *after entrance*. Consecutive *calendar* days include Saturdays, Sundays, and Holidays. For example, a survey *that begins* at 8:00 a.m. on a *Friday* morning ***must*** be continued *for two* consecutive *calendar days*.

7210 - Substandard Quality of Care and Extended and Partial Extended Surveys

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(See also *LTCSP Procedure Guide*.)

7210.2 Expansion of the Survey *Sample*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When the State or CMS Location conducts a standard survey or abbreviated standard survey and suspects substandard quality of care but does not have sufficient information to confirm or refute the substandard quality of care, the survey *sample must* be expanded. (See *LTCSP Procedure Guide and* §7210.*1* of this manual.) This expansion of the standard or abbreviated standard survey *sample* does not necessarily constitute an extended or partial extended survey.

If the expanded survey does not verify substandard quality of care but finds noncompliance, the State or CMS Location prepares Form CMS-2567 and follows the procedures required in §7305.

If the expanded survey verifies substandard quality of care, the State or CMS Location conducts an extended survey or a partial extended survey in accordance with procedures in *the LTCSP Procedure Guide*.

7212.3 - Mandatory Elements of Informal Dispute Resolution

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The following elements must be included in each informal dispute resolution process offered:

1. Upon their receipt of the official Form CMS-2567, facilities must be offered an informal opportunity, to dispute deficiencies with the entity that conducted the survey.

2. Facilities may not use the informal dispute resolution process to delay the formal imposition of remedies or to challenge any other aspect of the survey process, including the:

    - Scope and severity assessments of deficiencies with the exception of scope and severity assessments that constitute substandard quality of care or immediate jeopardy;

    - Remedy(ies) imposed by the enforcing agency;

    - Alleged failure of the survey team to comply with a requirement of the survey process;

    - Alleged inconsistency of the survey team in citing deficiencies among facilities;

- Alleged inadequacy or inaccuracy of the informal dispute resolution process.

3. Facilities must be notified of the availability of informal dispute resolution in the letter transmitting the official Form CMS-2567. (See Exhibit 139 in this manual for transmission of Form CMS-2567.) Notification of this process should inform the facility:

    - That it may request the opportunity for informal dispute resolution, and that if it requests the opportunity, the request must be submitted in writing along with an explanation of the specific deficiencies that are being disputed. The request must be made within the same 10 calendar day period the facility has for submitting an acceptable plan of correction to the surveying entity;

    - Of the name, address, and telephone number of the person the facility must contact to request informal dispute resolution;

    - How informal dispute resolution may be accomplished in that State, e.g., by telephone, in writing, or in a face-to-face meeting.

    - Of the name and/or the position title of the person who will be conducting the informal dispute resolution, if known.

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.

Since CMS has ultimate oversight responsibility relative to a State's performance, it may be appropriate for CMS to examine specific informal dispute resolution decisions or the overall informal dispute resolution process to determine whether a State is arriving at a correct result. For dually participating or Medicare-only facilities, informal dispute findings are in the manner of recommendations to CMS and, if CMS has reason to disagree with those findings, it may reject the conclusions from informal dispute resolution and make its own binding determinations of noncompliance.

4. *The informal dispute resolution process will be completed within 60 calendar days of a facility's request, if an informal dispute resolution is requested timely by*

the facility. Failure to complete informal dispute resolution timely will not delay the effective date of any enforcement action against the facility.

5. When a facility is unsuccessful during the process at demonstrating that a deficiency should not have been cited, the surveying entity must notify the facility in writing that it was unsuccessful. *The final informal dispute resolution decision to the facility shall contain the result for each deficiency challenged and a brief summary of the rationale for that result.*

6. When a facility is successful during the informal dispute resolution process at demonstrating that a deficiency should not have been cited:

    - On the CMS Form-2567, annotate deficiency (ies) citations as "deleted" and/or change deficiency (ies) citation findings, as recommended. A State agency manager or supervisor will sign and date the revised CMS Form-2567.

    - Adjust the scope and severity assessment for deficiencies, if warranted and in accordance with CMS policy.

    - The State agency will promptly recommend to CMS that any enforcement action(s) imposed solely because of deleted or altered deficiency citations be reviewed, changed or rescinded.

The facility has the option to request a clean (new) copy of the Form CMS-2567. However, the clean copy will be the releasable copy only when a clean (new) plan of correction is both provided and signed by the facility. The original Form CMS-2567 is disclosable when a clean plan of correction is not submitted and signed by the facility. Any Form CMS-2567 and/or plan of correction that is revised or changed as a result of informal dispute resolution must be disclosed to the ombudsman in accordance with §7904.

Deficiencies pending informal dispute resolution should be entered into *iQIES* within ten (10) calendar days of receiving the request for an informal dispute resolution. This information however will not be *used to calculate the facility's star rating* until informal dispute resolution has been completed.

7. A facility may request informal dispute resolution for each survey that cites deficiencies. However, if informal dispute resolution is requested for deficiencies cited at a subsequent survey, a facility may not challenge the survey findings of a previous survey for which the facility either received informal dispute resolution or had an opportunity for it. The following table indicates when informal dispute resolution may be requested based on the results of a revisit or as a result of the previous informal dispute resolution outcome.

Situation	Eligibility for Informal Dispute Resolution
Continuation of same deficiency at revisit	Yes
New deficiency (i.e., new or changed facts, new tag) at revisit or as a result of an informal dispute resolution	Yes
New instance of deficiency (i.e., new facts, same tag) at revisit or as a result of an informal dispute resolution.	Yes
Different tag but same facts at revisit or as a result of an informal dispute resolution	No, unless the new tag constitutes substandard quality of care

8. Written description of the surveying entity's informal dispute resolution process must be made available to a facility upon the facility's request.

9. States are encouraged to include in the informal dispute resolution process, at least one person as part of the decision making process who was not directly involved in the survey. This may include, but is not limited to, another surveyor, ombudsman, a member of another survey team, etc.

7213.5- Key Elements of Independent Informal Dispute Resolution

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

At a minimum, the Independent IDR process must provide for the following:

1. **Offer of Independent IDR:** The opportunity for Independent IDR must be provided within 30 calendar days of CMS's notice of imposition of a civil money penalty that is subject to being collected and placed in an escrow account. The CMS Location will communicate the offer for an Independent IDR in its initial Notice of Imposition of a Penalty letter to a facility. In addition, the CMS notice will provide the State agency contact information, including the name, address, and telephone number of the person and/or agency or office that the facility must contact to request an Independent IDR. The Notice of Imposition of a Penalty may be sent by e-mail and/or fax. The Statement of Deficiencies (Form CMS-2567) may be included with the Notice of Imposition of a Penalty letter. The CMS Location must confirm receipt by the facility of such notice letter. A copy of this letter will also be sent to the State agency.

Upon a facility's timely request for an Independent IDR, the State agency, or the Independent IDR entity or person (as appropriate) will provide the following information to the facility:

- Information on the Independent IDR process including where, when and how the process may be accomplished, e.g., *virtually*, in writing, or in a face-to-face meeting, and

- Contact information, i.e. the name, address, phone number and e-mail of the person(s) who will be conducting the Independent IDR, if appropriate.

As with the current IDR process, the Independent IDR process will be available to a facility at no charge. Collected civil money penalty funds may not be used to cover State expenses for IDR or Independent IDR. IDR and Independent IDR are part of the survey and certification process.

2. **Timing:** The Independent IDR is conducted only upon the facility's timely request. The facility must request an Independent IDR within 10 calendar days of receipt of the offer. The facility's request will be considered timely if the request is dated within 10 calendar days of the receipt of the CMS offer, and, in the case of the request being mailed, the postmark verifies that it was mailed within that same 10-day time period. The facility must submit its request in writing to the State agency, or the approved Independent IDR entity or person, as appropriate. The facility's request should also include copies of any documents, such as facility policies and procedures, resident medical record information that are redacted to protect confidentiality and all patient identifiable information, or other information on which it relies in refuting the survey findings.

§488.431(a)(1) require that the Independent IDR be completed within 60 days of the facility's request. Every effort must be made to comply with this time frame, however, failure to comply with the Independent IDR process does not invalidate any cited deficiencies or any remedies imposed.

The Independent IDR process should be completed as soon as practicable but no later than 60 calendar days of receipt of the facility's request. The Independent IDR process is considered completed if a facility does not timely request or chooses not to participate in the Independent IDR process or when a final decision has been made, a written record has been generated, AND the State agency has sent written notice of this final decision to the facility.

3. **Opportunity to Comment:** Once a facility requests an Independent IDR, the State must notify the involved resident or resident representative, as well as the State's long term care ombudsman, that they have an opportunity to submit written comment. The State should request information from the long-term care ombudsman program, asking for specific information based on the ombudsman program's direct involvement or knowledge and directly related to the deficiency

(ies) being disputed by the facility. Information about the facility or provider in general but not related to the deficiency(ies) at issue, is not relevant to the Independent IDR process. This notification must be done before the Independent IDR review begins and with sufficient time for the resident or their representative to provide comment. At a minimum, this notification must include:

- A brief description of the findings of noncompliance for which the facility is requesting Independent ID, a statement about the CMP imposed based on these findings, and reference to the relevant survey date;

- Contact information for the State agency, or the approved Independent IDR entity or person as appropriate regarding when, where and how potential commenters must submit their comments;

- A designated contact person to answer questions/concerns;

- For residents and/or resident representatives, contact information for the State's long term care ombudsman.

4. **Written Record:** The Independent IDR entity or person must generate a written record as soon as practicable but no later than within 10 calendar days of completing its review. The Independent IDR entity or person will forward the written record to the State agency, for retention by the surveying entity. The State agency will provide the final decision to the facility as soon as practicable but no later than 10 calendar days of its receipt of the written record. The final Independent IDR decision to the facility shall contain the result for each deficiency challenged and a brief summary of the rationale for that result. The written record from the Independent IDR entity or person shall include:

    - List of each deficiency or survey finding that was disputed;

    - A summary of the Independent IDR recommendation for each deficiency or finding at issue and the justification for that result;

    - Documents submitted by the facility to dispute a deficiency, to demonstrate that a deficiency should not have been cited, or to demonstrate a deficient practice should not have been cited as immediate jeopardy or substandard quality of care; and,

    - Any comments submitted by the State's long-term care ombudsman and/or residents or resident representatives, as appropriate, taking care to protect confidentiality and protected health information.

7213.6 - Qualifications of an Independent Informal Dispute Resolution Entity or Person(s)

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

In order to be approved as an Independent IDR entity or person, whether it is a State agency or an outside organization contracted by the State agency, the entity or person must meet the following requirements:

Expertise and Training: The entity or person has an understanding of:

- Medicare and Medicaid program requirements including, but not limited to:

  a) 42 CFR Part 483, Subpart B, and 42 CFR Part 488, Subparts A, E and F;
  b) The State Operations Manual (SOM), including;
  1) Chapter 7, Definitions and §§ 7212, 7213 and 7900;
  2) *The LTCSP Procedure Guide*, Appendix PP, Appendix Q; and

- Applicable health care standards of practice, health care management, and/ or life safety code knowledge and experience, relevant to the disputed issues.

Independence: The entity or person –

- Has no financial or other conflict of interest;

- May be a component of an umbrella State agency provided that the component is organizationally separate from the State agency;

- May be an independent entity or person with an understanding of specific Medicare and Medicaid program requirements selected by the State and approved by CMS.

Examples of possible conflict of interest include, but are not limited to, individuals who:

a) Were employed by the State agency or the State ombudsman program within the past year;

b) Have a family member who is either a resident or an employee of the facility involved in the Independent IDR;

c) Is currently employed by the facility or organization involved in the Independent IDR;

d) Have worked within the past year as an employee, consultant or volunteer for the facility or a related corporation, involved in the Independent IDR;

e) Have ownership interest or currently serves or within the past year has served on the Board of Directors or Governing Body of a facility or organization involved in the Independent IDR; or

f) Have acted within the past year as legal counsel for or against the facility involved in the Independent IDR.

7213.9 - Independent Informal Dispute Resolution Recommendation and Final Decision

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. Upon receipt of the Independent IDR written record, the State agency, will review the Independent IDR recommendation(s) and:

    (a) If the State agency, agrees with the Independent IDR recommendation(s) and no changes will be made to the disputed survey findings, the State agency will send written notification of the final decision to the facility within 10 calendar days of receiving the written record from the Independent IDR entity or person.

    (b) If the State agency disagrees with one or more of the recommendations of the Independent IDR entity or person, the complete written record will be sent to the applicable CMS Location for review and final decision. The State agency should identify the portion(s) of the Independent IDR recommendation with which it disagrees, the basis for its disagreement including any relevant survey documents that support its recommendation to the CMS Location. As soon as practicable, but no later than 10 calendar days, the CMS Location will review the Independent IDR recommendation and records along with the State's written disagreement of the Independent IDR's recommendation and will provide written notification to the State agency of the final decision. The CMS review will be conducted by persons familiar with LTC requirements but who have not had any input or activity with respect to the survey or deficiencies at issue. The agency will then send written notification of the final decision to the facility within 10 calendar days of receiving the final decision from the CMS Location.

NOTE: Regulations at §488.431(a) (1) require that an Independent IDR will be completed within 60 days of a facility's timely request. **Completed** means that a final decision from the Independent IDR process has been made, a written record generated AND the State agency has sent written notice of the Independent IDR recommendation to the facility. The Independent IDR process is also considered completed if a facility does not timely request or chooses not to participate in the Independent IDR process.

2. If the State agency agrees with the Independent IDR recommendation(s) or has received a final decision from the CMS Location and changes will need to be made to the disputed survey findings, the State agency will *complete the following* within 10 calendar days of receiving the written record:

a) Change deficiency(ies) citation content findings, as recommended;

b) Adjust the scope and severity assessment for deficiencies, if warranted by CMS policy after taking into consideration recommendations from the Independent IDR regarding the deficiency(ies);

c) Annotate deficiency(ies) citations as "deleted or amended as recommended", where appropriate;

d) Have a State agency manager or supervisor sign and date the revised CMS Form-2567;

e) Promptly recommend to CMS that any enforcement action(s) imposed solely because of deleted or altered deficiency citations be reviewed, changed or rescinded as appropriate; and

f) Provide written notification of the final decision to the facility.

NOTE: Based on a final Independent IDR recommendation and final State and CMS action, if one or more deficiencies on the Form CMS-2567 have been changed, deleted or altered, the facility has the option to request a clean (new) copy of the Form CMS-2567. However, the clean copy will be the releasable copy only when a clean (new) plan of correction is both provided and signed by the facility. The original Form CMS-2567 is disclosable when a clean plan of correction is not submitted and signed by the facility. Any Form CMS-2567 and/or plan of correction that is revised or changed as a result of informal dispute resolution must be disclosed to the ombudsman in accordance with §7904.

Deficiencies pending Independent IDR should be entered into *iQIES* within ten (10) calendar days of receiving the request for an independent informal dispute resolution.

IDR or Independent IDR requests from the facility should be entered in *iQIES* within 10 working days of the IDR or Independent IDR request and necessary changes should be entered in *iQIE*S within 10 working days of completion of the IDR or Independent IDR process.

Specific instructions are provided in the current iQIES Survey & Certification User Manuals

7213.10 - Additional Elements for Federal Independent Informal Dispute Resolution *(Independent IDR)* Process

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

In the case where a Federal survey, conducted solely by Federal surveyors, or its contractors, results in the imposition of a civil money penalty (CMP) that is subject to being collected and placed in escrow, the CMS Location will offer the facility the

opportunity for an Independent IDR. The CMS Location will follow the applicable elements cited in §7213. The CMS Location should advise the facility that all requests for an Independent IDR should be directed in writing to the CMS Location and an electronic copy of the request should also be sent to the CMS mailbox at QualityAssurance@cms.hhs.gov. The facility should send any and all documentation, such as facility policies and procedures, resident medical record information or other information on which it relies in disputing the survey findings directly to the entity contracted by CMS to provide the Federal Independent IDR process. The facility must also send a copy of the supporting documentation to the CMS Location with its request.

The CMS Location must also inform the involved resident or resident representative as well as the State's long term care ombudsman to submit any written comments directly to the Federal Independent IDR entity. This Independent IDR will be a paper review performed by the Federal Independent IDR entity under contract with CMS, Survey & Certification Group, Division of Nursing Homes. The Independent IDR will be completed within 60 calendar days of the facility's timely request. Upon completion of the review the Federal Independent IDR entity will send all documents submitted by the facility and any comments submitted by the State's long term care ombudsman and/or residents or resident representatives to the respective CMS Location along with its final written record/report.

In the event that any conflict of interest exists between the facility and the contracted Federal Independent IDR entity, or in the event that the Federal Independent IDR entity is unavailable, the Independent IDR will be conducted by CMS *Baltimore*. In this case, the facility should be instructed to send all documentation *with all PII redacted* to: *Qua*lityAssurance@cms.hhs.gov .

This Independent IDR will be a paper review performed by a panel of CMS *Baltimore* employees who meet the criteria for an Independent IDR entity. The Independent IDR will be completed within 60 calendar days of the facility's timely request. Upon completion of the review, CMS *Baltimore* will send all documents submitted by the facility and any comments submitted by the State's long term care ombudsman and/or residents or resident representatives to the respective CMS Location along with their final written record/report.

Upon receipt of a facility's request for an Independent IDR the CMS Location should enter the appropriate information into *the Internet Quality Improvement and Evaluation System* (*IQIES).*

Upon receipt of the Independent IDR written record, the CMS Location, will review the Independent IDR recommendation(s) and:

1. If the CMS Location agrees with the Independent IDR recommendation(s) and no changes will be made to the disputed survey findings, the CMS Location will send

written notification of the final decision to the facility within 10 calendar days of receiving the written record from the Independent IDR entity or person.

2. If the CMS Location disagrees with one or more of the recommendations of the Independent IDR entity or person, the complete written record will be sent to CMS *Baltimore* for review and final decision. The CMS Location should identify the Independent IDR recommendation with which it disagrees, the basis for its disagreement and any relevant survey documents to CMS *Baltimore*. . *All documentation should be sent to* QualityAssurance@cms.hhs.gov . As soon as practicable, but no later than 10 calendar days, CMS *Baltimore* will review the Independent IDR recommendation and corresponding records along with the CMS Location's written disagreement of the Independent IDR's recommendation and will provide written notification to the CMS Location of the final decision. The CMS Location will then send written notification of the final decision to the facility within 10 calendar days of receiving the final decision from *CMS Baltimore*.

NOTE: The regulations at §*488.431(a) (1)* require that an Independent IDR will be completed within 60 days of a facility's timely request. **Completed** means that a final decision from the Independent IDR process has been made, a written record generated AND the CMS Location has sent written notice of the Independent IDR recommendation to the facility.

3. If the CMS Location agrees with the Independent IDR recommendation(s) or has received a final decision from CMS *Baltimore* and changes are to be made to the disputed survey findings, the CMS Location will, within 10 calendar days of receiving the written record:

    a) Change deficiency (ies) citation content findings, as recommended;

    b) Adjust the scope and severity assessment for deficiencies, if warranted by CMS policy after taking into consideration approvable recommendations from the Independent IDR regarding the deficiency (ies);

    c) Annotate deficiency (ies) citations as "deleted or amended as recommended "where appropriate;

    d) Have a CMS Location manager or supervisor sign and date the revised CMS Form-2567;

    e) Ensure that any enforcement action(s) imposed solely because of deleted or altered deficiency citations will be reviewed, changed or rescinded, as appropriate; and

    f) Provide written notification of the final decision to the facility.

NOTE: Based on a final Independent IDR recommendation and final State and CMS action, if one or more deficiencies on the Form CMS-2567 have been revised or removed, the facility has the option to request a clean (new) copy of the Form CMS-2567. However, the clean copy will be the releasable copy only when a clean (new) plan of correction is both provided and signed by the facility. The original Form CMS-2567 is disclosable when a clean plan of correction is not submitted and signed by the facility. Any Form CMS-2567 and/or plan of correction that is revised or changed as a result of IDR must be disclosed to the ombudsman in accordance with §7904.

Deficiencies pending Independent IDR should be entered into the *Internet Quality Improvement and Evaluation System* (*iQIES*) and the *iQIES* Informal Dispute Resolution (IDR) Manager.

IDR or Independent IDR requests from the facility and necessary changes should be entered in the *iQIES* system within 10 working days of the IDR or Independent IDR request and necessary changes should be entered in the *iQIES* system within 10 working days of completion of the IDR or Independent IDR process.

Specific instructions are provided in the current *iQIES* Users Guide.

The *iQIE*S will be enabled to include the Independent IDR process for enforcement actions with survey cycles that begin on or after January 1, 2012.

7301.1 - Immediate Jeopardy Exists

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(See also §7307 and Appendix Q of this manual.)

When immediate jeopardy exists:

1. The CMS Location or State Medicaid Agency will impose termination and/or temporary management in as few as 2 calendar days (one of which must be a working day) after the survey which determined immediate jeopardy. In all cases of immediate jeopardy, the provider agreement must be terminated by CMS or State Medicaid Agency no later than 23 calendar days from the last day of the survey if the immediate jeopardy is not removed.

2. The CMS Location or State Medicaid Agency should impose another remedy in addition to termination when immediate jeopardy has been determined. Immediate imposition of an alternative remedy should be considered even if the facility successfully removes the immediate jeopardy but is still not in substantial compliance.

3. The CMS Location or State Medicaid Agency may impose a *(CMP)* between $3,050 and $10,000 per day of immediate jeopardy or a "per instance" civil money penalty from $1,000 to $10,000 for each *instance of noncompliance, or both*

per day and per instance CMPs may be imposed for the same survey (as adjusted for inflation under 45 CFR 102.3). The specific procedures for *CMPs* can be found in §7510-§7536. *In cases when multiple per instance civil money penalties are imposed for a survey, the total dollar amount of all civil money penalties for noncompliance on **any single day** may not exceed the statutory and regulatory maximum amount and may not be less than the applicable statutory and regulatory minimum amount for each day. When multiple per instance civil money penalties are imposed for **different days** of noncompliance, the total amount of all civil money penalties imposed for the survey may exceed the statutory and regulatory maximum (the statutory maximum only applies to the civil money penalty amount for any single day).*

Examples:

A) *F-tags F686 & F689 were cited on a survey and the noncompliance **occurred on the same day**. A per instance civil money penalty of $5,000* is imposed for F686 and a per instance civil money penalty of $5,000* is imposed for F689. No civil money penalty could then be imposed for additional deficiencies on that day because the total civil money penalty, consisting of any per instance and/or per day civil money penalties, must not exceed the statutory and regulatory maximum for **each day**.*

B) *F-tags F684 & F687 were cited on a survey and the noncompliance **occurred on different days**. A per instance civil money penalty of $10,000* is imposed for F684 and a per instance civil money penalty of $10,000* is imposed for F687. If noncompliance **occurs on different days**, two (or more) per instance civil money penalties at the maximum amount may be imposed for the same survey if the maximum statutory and regulatory amount is not exceeded for each day.*

C) *F-tag F689 was cited on a survey and the noncompliance began two months prior to the start of the survey. A per instance civil money penalty of up to $10,000* may be imposed for noncompliance related to F689 that started prior to the survey start date. A per day civil money penalty may also be imposed for noncompliance related to F689 that exists beginning on the survey start date, and it would continue to accumulate per day until substantial compliance is achieved.*

**Note: The CMP amounts referenced in the examples above are noted as the original statutory maximum amounts per day. However, the current maximum amounts are adjusted annually for inflation and published in 45 CFR 102.3 as required under the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. The amounts above are being used for illustrative purposes only. Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool.*

4. The CMS Location or State Medicaid Agency may impose other remedies as described in §7500. Except for State monitoring, which requires no notice, the CMS Location or State Medicaid Agency may impose remedies 2 calendar days (one of which must be a working day) from the date the facility receives notice.

5. The CMS Location, State Medicaid Agency, or State (as authorized by CMS) may impose State monitoring immediately without notice.

6. The State, as authorized by CMS, may also provide notice of the imposition of denial of payment for new admissions effective 2 calendar days (one of which must be a working day) from the date the facility receives notice. (See also §7314, and §7506.1.)

7. The State will require that the facility submit an allegation that the immediate jeopardy has been removed as well as provide sufficient detail to demonstrate how the immediate jeopardy has been addressed so that the State can verify onsite the removal of the immediate jeopardy. A plan of correction should be deferred until the facility has successfully demonstrated removal of immediate jeopardy. Facilities should be cautioned that the allegation of removal of the immediate jeopardy does not guarantee a revisit before the effective date of termination.

8. The State will require an acceptable plan of correction for all deficiencies cited after it conducts the revisit to confirm removal of the immediate jeopardy.

9. The State is authorized to recommend and impose category 1 remedies. When authorized by the CMS Location, the State may also provide notice of imposition and rescission of the denial of payment for new admissions remedy. (See also §7314 and §7506.1.)

7301.2 - Immediate Jeopardy Does Not Exist

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(See also §7310)

When immediate jeopardy does not exist:

1. CMS or the State must determine whether the facility will be given an opportunity to correct its deficiencies before remedies are imposed (see §7304).

2. The CMS Location or State Medicaid Agency should impose another remedy in addition to termination for a facility not being given an opportunity to correct.

3. The CMS Location or State Medicaid Agency terminates the Medicare and/or Medicaid provider agreements that are in effect no later than 6 months from the date of the survey that determined noncompliance if noncompliance still exists (see §7600). Except for State monitoring, which requires no notice, the CMS

Location or State Medicaid Agency may impose these remedies 15 calendar days from the date the facility receives notice.

4. When there is an opportunity to correct before remedies are imposed, the State will request an acceptable plan of correction, provide initial notice of recommended remedies (including recommendation for subsequent termination, conduct a revisit if applicable, then provide formal notice of denial of payment for new admissions (if authorized by the CMS Location) and other remedies if noncompliance continues at revisit. While formal notice of imposition of denial of payment for new admissions by the State (if authorized by the CMS Location) is generally provided in the revisit letter, the State may provide such notice in its initial notice to the facility. (See also §7305.1, §7314, §7316.2 and §7506.1.)

5. The CMS Location or State Medicaid Agency must impose denial of payment for new admissions no later than 3 months after the last day of the survey that identified the noncompliance if substantial compliance is not achieved.

6. The CMS Location or State Medicaid Agency (or State, as authorized by CMS) may impose State monitoring without notice.

~~7.~~ The CMS Location or State Medicaid Agency may impose a per day *CMP* between $50 and $3,000 per day or a "per instance" civil money penalty between $1,000 and $10,000 for each *instance of noncompliance, or both per day and per instance CMPs may be imposed for the same survey not to exceed the maximum daily amount when combined*, as adjusted under 45 CFR 102.3. The specific procedures for civil money penalties can be found in §7510-§7536. *In cases when multiple per instance civil money penalties are imposed for a survey, the total dollar amount of all civil money penalties for noncompliance on **any single day** may not exceed the statutory and regulatory maximum amount and may not be less than the statutory and regulatory minimum amount for each day. When multiple per instance civil money penalties are imposed for **different days** of noncompliance, the total aggregate amount of all civil money penalties imposed for the survey may exceed the statutory and regulatory maximum (the statutory maximum only applies to the civil money penalty amount for any single day).*

Examples:

*A) F-tags F686 & F689 were cited on a survey and the noncompliance **occurred on the same day**. A per instance civil money penalty of $5,000* is imposed for F600 and a per instance civil money penalty of $5,000* is imposed for F607. No civil money penalty could then be imposed for additional deficiencies on that day because the total civil money penalty, consisting of any per instance and/or per day penalties, must not exceed the statutory and regulatory maximum for **each day**.*

*B) F-tags F684 & F687 were cited on a survey and the noncompliance **occurred on different days**. A per instance civil money penalty of $10,000* is imposed for F600 and a per instance civil money penalty of $10,000* is imposed for F607. If noncompliance **occurs on different days**, two (or more if each instance of noncompliance occurs on a different day) per instance civil money penalties at the maximum amount may be imposed on the same survey if the maximum statutory and regulatory amount is not exceeded for each day.*

C) F-tag F689 was cited on a survey, and the noncompliance began two months prior to the start of the survey. A per instance civil money penalty of $10,000 could be imposed for noncompliance related to F689 that started prior to the survey. A per day civil money penalty could also be imposed for noncompliance related to F689 that exists on the survey start date, and it would continue to accumulate until substantial compliance is achieved.*

***Note:** The regulatory maximum CMP amounts referenced in the examples above are noted as the original statutory maximum amounts per day. However, the current maximum amounts have been are adjusted annually for inflation and published in 45 CFR 102.3 based as required under on the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. The amounts above are being used for illustrative purposes only. Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool.*

8. The State is authorized to recommend and impose category 1 remedies. When authorized by the CMS Location, the State may also provide notice of imposition and rescission of the denial of payment for new admissions remedy. (See also §7314 and §7506.1.)

7304.1 - Criteria for Mandatory Immediate Imposition of Federal Remedies Prior to the Facility's Correction of Deficiencies

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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:

- Immediate Jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; **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 (SQC); **OR**
- Any deficiency at "G" or above on the current survey **AND** if there were any

deficiencies at "G" or above on the previous standard health or LSC survey **or** if there was any deficiency at "G" or above on any type of survey between the current survey and the last standard health or LSC survey. These surveys (standard health or LSC, complaint, revisit) must be separated by a certification of compliance, i.e., they must be from different noncompliance cycles. For instance, level G or above deficiencies from multiple surveys within the same noncompliance cycle must not be combined to make this a "double G or higher" determination; **OR**

- A facility classified as a Special Focus Facility (SFF) **AND** has a deficiency citation at level "F," (excluding any level "F" citations under tags F812, F813 or F814) or higher for the current health survey or "G" or higher for the current Life Safety Code (LSC) survey.

The remedies to be imposed by statute do not change, (e.g., 3-month automatic Denial of Payment for new admissions (DPNA), 23-day termination when IJ is present and 6-month termination). In addition to these statutory remedies, the CMS Location **must also** immediately impose one or more additional remedies for any situation that meets the criteria identified above. The State Survey and/or Medicaid Agencies **shall not** permit changes to this policy.

Use of Federal Remedies in Immediate Jeopardy (IJ) Citations - When IJ is identified on the current survey that resulted in serious injury, harm, impairment or death, a CMP **must** be imposed.

For IJ citations where there is **no resultant** serious injury, harm, impairment or death but the likelihood is present, the CMS Location must impose a remedy or remedies that will best achieve the purpose of attaining and sustaining compliance. CMPs may be imposed, but they are not required.

NOTE: "Current" survey is whatever Health and/or LSC survey is currently being performed, e.g., standard, revisit, or complaint. "Standard" survey (which does not include complaint or revisit surveys) is 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.

Process for State Enforcement Recommendations - While States are not required to recommend the types of remedies to be imposed, they are encouraged to do so since States may be more familiar with a facility's history and the specific circumstances in the case at hand. The CMS Location will consider these recommendations but ultimately makes the enforcement determination. To ensure effective communication and exchange of information, CMS encourages that all documentation is included in *iQIES* or any subsequent system.

Regardless of a State's recommendation, the CMS Location must take the necessary actions to impose a remedy or multiple remedies, based on the seriousness of the deficiencies following the criteria set forth in 42 C.F.R. §488.404. Also refer to

§§7400.5.1 and 7400.5.2 of this chapter. In addition to any statutorily imposed remedy, additional remedies should be selected that will bring about compliance quickly and encourage facilities to achieve and maintain compliance. When making remedy choices, the CMS Location should consider the extent to which the noncompliance is the result of a one-time mistake, larger systemic concerns, or an intentional action of disregard for resident health and safety. The surveyor investigation and corresponding CMS-2567 should provide evidence to assist with that determination.

The State Agency is authorized to both recommend and impose one or more Category 1 remedies, in accordance with §7314 of this Chapter. **CATEGORY 1** remedies include:

- Directed plan of correction,
- State monitoring, and
- Directed in-service training.

Types of Remedies - The choice of remedy is made that best achieves the purpose of attaining and sustaining compliance based on the circumstances of each case and recommendations from the State. Federal remedies are summarized below. Refer to §§7500 - 7556 of this chapter for more detail on these remedies.

Civil Money Penalties (CMPs) - Federal CMPs may only be imposed by the CMS Location. If a CMP is imposed, it must be done in accordance with instructions in the CMP Analytic Tool and §§7510 through 7536 of this chapter.

Directed In-Service Training – Refer to §7502 of this chapter. Consider this remedy in cases where the facility has deficiencies where there are knowledge gaps in standards of practice, staff competencies or the minimum requirements of participation and where education is likely to correct the noncompliance. Depending on the topic(s) that need to be addressed, and the level of training needed, facilities should consider using programs developed by well-established centers of geriatric health services 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. If it is willing and able, a State may provide special consultative services for obtaining this type of training. The State or CMS Location may also compile a list of resources that can provide directed in-service training and could make this list available to facilities and interested organizations. Facilities may also utilize the ombudsman program to provide training about residents' rights and quality of life issues.

Directed Plan of Correction - Refer to §7500 of this chapter. This remedy provides for directed action(s) from either the State or CMS Location that the facility must take to address the noncompliance or a directed process for the facility to more fully address the root cause(s) of the noncompliance. Achieving compliance is ultimately the facility's responsibility, whether or not a directed plan of correction is followed.

Temporary Management - Refer to 42 CFR §§488.408 and 488.410. This is the

temporary appointment by CMS or the State of a substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation. A temporary manager may be imposed anytime a facility is not in substantial compliance but may also be imposed when a facility's deficiencies constitute IJ or widespread actual harm and a decision is made to impose an alternative remedy in lieu of termination. It is the temporary manager's responsibility to oversee correction of the deficiencies and assure the health and safety of the facility's residents while the corrections are being made. The temporary manager's term can extend beyond the time which deficiencies are corrected by agreement of the facility and the temporary manager. A temporary manager remedy may also be imposed to oversee orderly closure of a facility. The State will select the temporary manager when the State Medicaid Agency is imposing the remedy and will recommend a temporary manager to the CMS Location when CMS is imposing the remedy. Each State should compile a list of individuals who are eligible to serve as temporary managers. These individuals do not have to be located in the State where the facility is located.

Denial of Payment for all New Medicare and Medicaid Admissions (DPNA) - See §7506 of this chapter. This remedy may be imposed alone or in combination with other remedies to encourage quick compliance. Regardless of any other remedies that may be imposed, a mandatory denial of payment for new admissions **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).

Timeliness of Mandatory DPNA Notification for Nursing Homes – The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. The SA must transfer the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA to the provider by the 70th day (as authorized by CMS). However, there may be other instances in which cases should be immediately transferred to the CMS Location (i.e. enhanced enforcement). Contact your CMS Location for additional information. This excludes cases involving Medicaid-only nursing homes.

Denial of all Payment for all Medicare and Medicaid Residents (DPAA) (Discretionary). - See §7508 of this chapter. Only CMS has the authority to deny all payment for Medicare and/or Medicaid residents. This is in addition to the authority to deny payment for all new admissions (discretionary) noted above. This is a severe remedy. Factors to be considered in selecting this remedy include but are not limited to:

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

State Monitoring - Refer to §7504 of this chapter. 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. Consider imposing this remedy when, for example, there are concerns that the situation in the facility has the potential to worsen or the facility seems unable or unwilling to take corrective action. A State monitor **must** be used when a facility has been cited with substandard quality of care (SQC) deficiencies on the last three consecutive **standard health** surveys.

Termination of Provider Agreement - See §7556 of this chapter. While this remedy may be imposed at any time the circumstances warrant regardless of whether IJ is present; regardless of any other remedies that may be imposed, termination of a facility's provider agreement **must** be imposed when the facility is not in substantial compliance six months after the last day of the survey identifying deficiencies or within no more than 23 days if IJ is identified and not removed.

Mandatory Criteria for Immediate Imposition of Federal Remedies

Mandatory Criteria for Immediate Imposition of Federal Remedies	Immediate Jeopardy is identified on the current survey	*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*	Deficiencies of actual harm are identified on the current survey AND deficiencies of immediate jeopardy OR actual harm were identified on any type of survey between the current survey and the last standard survey	Facilities classified as a SFF AND has a deficiency citation of "F" level or higher for the current health survey or G or higher for the current LSC survey
Types of Remedy(ies) that, at a minimum, should be considered for immediate imposition by CMS <u>in addition to</u> the CMPs when immediate jeopardy is cited, mandatory 3-month DPNA for new admissions or mandatory 6-	1. Termination 2. CMPs[1] <u>must</u> be imposed immediately 3. DDPNA[2] 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for ALL Individuals[3]	1. Termination 2. CMPs 3. DDPNA 4. Directed Plan of Correction 5. Directed In-service Training 6. Denial of Payment for All Individuals	1. Termination 2. CMPs 3. DDPNA 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for All Individuals	1. Termination 2. CMPs 3. DDPNA 4. Temp. Mgmt. 5. State Monitoring 6. Directed Plan of Correction 7. Directed In-service 8. Denial of Payment for All Individuals

[1] Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool
[2] DDPNA = Discretionary Denial of Payment for New Admissions
[3] This remedy shall ONLY be imposed by CMS and may not be imposed by a State Medicaid Agency. A state survey agency may only impose Category 1 remedies if authorized by the CMS Location.

month termination, as required. NOTE: Multiple remedies may be imposed for any situation as appropriate.				
Decisions, Responsibilities & Actions (refer to §7304.3)	Within 5 business days from when the initial notice was sent to the facility the survey agency must assure that all cases that meet the criteria outlined in 7304.1 above are entered into *iQIES* and that all of these cases are referred to the CMS Location for their imposition of remedies. The CMS Location must take the necessary action to impose remedies as appropriate, regardless of a State's recommendation for imposition of remedies, based on the seriousness of the deficiencies following the criteria set forth in 42 C.F.R. §488.404 - Factors to be considered in selecting remedies. Civil Money Penalties (CMPs) must be imposed in accordance with instructions in the CMP Tool.			

NOTE: Denial of Payment for New Admissions - Whenever a State's remedy is unique to its State plan and has been approved by CMS, then that remedy may also be imposed by the CMS Location against a dually participating facility in that State. Therefore, if a State's ban on admissions remedy is determined to be an acceptable State alternative, it must be understood that in dually participating facilities, CMS can impose a State's ban on admissions remedy only with regard to all Medicare/Medicaid residents. Only the State can ban admissions of private pay residents.

7304.2 - Effective Dates for Immediate Imposition of Federal Remedies

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Once a remedy is imposed, it becomes effective as of the date specified in the notice letter for the remedy being imposed. All remedies remain in effect and continue until the facility has demonstrated and is determined to be in substantial compliance. Substantial compliance must be verified in accordance with §7317 of this chapter. Substantial compliance may be determined to occur anytime between the latest correction date on the approved Plan of Correction (PoC) up until the date of the revisit. The date of substantial compliance is determined by the date on which the evidence provided by the facility supports correction of deficiencies as determined by the *State* Agency.

For Immediate Jeopardy (IJ) Situations: A facility's removal of the conditions that caused the IJ may, at CMS's discretion, result in the rescission of the 23-day termination. A per day CMP must be lowered when the *state* agency has verified that the IJ has been removed but deficiencies at a lower level continue. Refer to the CMP Analytic Tool instructions for determining the dates of a per day CMP. However, CMS **shall not** rescind any other remedies imposed until the facility achieves substantial compliance or is terminated. Remedies imposed must remain in effect, irrespective of

when the IJ is removed, unless otherwise rescinded or revised as a result of legal proceedings. Remedies will be immediately imposed and effectuated whether the IJ was:

- removed during the survey, or,
- removed in a subsequent IJ removal revisit before the 23rd day.

7304.3 - Responsibilities of the State Agency and the CMS Location when there is an Immediate Imposition of Federal Remedies

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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

- Within five (5) business days after the last day of the current survey when any of the criteria in §7304.1 is met the *state* agency **must** notify the CMS Location their review and action; and,
- The CMS Location will review these cases within five (5) business days of receipt from the *state* agency and decide if an immediate imposition of remedies is appropriate.

Timeliness is important to ensure that remedies are imposed, and notices are sent to the facility before the effective dates of the remedies to be imposed and meet the timelines for notices as outlined in §7305 of this chapter.

The *state* agency (State or Federal) must enter all of these cases as a NO opportunity to correct into the *iQIES* within five (5) business days of sending the initial notice to the facility. The State Agency and the CMS Location must have systems in place to routinely check and monitor the *iQIES* database to identify cases that may require enforcement action or additional follow-up, as needed.

7305.1.1 – When No Immediate Jeopardy Exists and an Opportunity to Correct Will be Provided Before Remedies Are Imposed

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When no immediate jeopardy exists and an opportunity to correct will be provided before remedies are imposed, the surveying entity sends out an initial notice notifying the facility of the following (and the State sends a copy of this notice to the State Medicaid Agency and the CMS Location):

a. Transmits deficiencies cited (those listed on the Form CMS-2567, as well as those isolated deficiencies which cause no harm and potential for only minimal harm);

b. Provides notice of the mandatory remedy which must be imposed if the facility fails to achieve substantial compliance at 6 months, (i.e., termination of provider agreement and consequent cessation of payments);

c. Provides that the approved plan of correction will establish the outside date by which correction must be made.

d. May serve as the formal notice of the imposition of any category 1 remedy, as authorized by CMS or the State Medicaid Agency, to be effective on (date the State expects correction based on the outside correction date on the facility's approved plan of correction, but no earlier than 15 calendar days from date of receipt of notice by the facility). Also, if authorized by the CMS Location, the State may provide formal notice to the facility of imposition of denial of payment for new admissions in the initial notice rather than in the first revisit letter, to be effective on (date the State expects correction based on the outside correction date on the facility's approved plan of correction) but in no case later than 3 months from the date of the survey if the facility fails to achieve substantial compliance; (See also §7301, §7314, §7316.2, and §7506.1.)

e. Provides that the State's proposed remedies will be forwarded to CMS and/or the State Medicaid Agency if correction is not achieved at the first revisit. Civil money penalties will be effective as of the date that *non*compliance began, usually the date of the survey (see also §7518). All other remedies can be imposed as soon as the 15-day notice requirement is met. The remedies for which the State has provided notice, as authorized by CMS and the State Medicaid Agency, will take effect without further notice from the CMS Location or State Medicaid Agency;

f. Provides that an acceptable plan of correction is required in response to deficiencies listed on the Form CMS-2567 and must be received within 10 calendar days of the facility's receipt of the CMS2567 (see §7317). The plan of correction will serve as the facility's allegation of compliance;

g. Informs the facility of the opportunity for informal dispute resolution;

h. Specifies that if an acceptable plan of correction is not received within 10 calendar days of the facility's receipt of the CMS-2567, the State will notify the facility that it is recommending to the CMS Location and/or the State Medicaid Agency that remedies other than category 1, and/or denial of payment for new admissions, be imposed effective as soon as notice requirements are met. As authorized by CMS and/or the State Medicaid Agency, formal notice of imposition of category 1 remedies may be officially provided in this initial notice, and notice of imposition of denial of payment for new admissions may be officially provided in this notice or in the first revisit letter; (See also §7301, §7314, §7316.2, and §7506.1.)

i. Provides elements of an acceptable plan of correction (See §7317);

j. Informs the facility of the disapproval of its nurse aide training and competency evaluation program and competency evaluation program, as well as its appeal rights if the program loss is based on a finding of substandard quality of care (see §7809); and

k. Provides that when substandard quality of care is determined, the facility must provide a list of physicians for residents identified with substandard quality of care on the survey. The State must notify each physician and refer the administrator to the State's licensing board. *(See also §7310 and §7320).*

l. When no formal notification of remedies is being provided in this initial notice, the following language will be inserted in **bold type** in the letter 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: **"Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. If it is determined that termination or any other remedy is warranted, you will be provided with a separate formal notification of that determination."**

7305.1.2 – When No Immediate Jeopardy Exists and No Opportunity to Correct Will be Provided Before Remedies Are Imposed

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When no immediate jeopardy exists, and no opportunity to correct will be provided before remedies are imposed, the surveying entity sends an initial notice which:

a. Transmits deficiencies cited (those listed on the Form CMS-2567, as well as those isolated deficiencies which cause no harm and potential for only minimal harm);

b. Provides notice of the provider agreement termination that must be imposed if the facility has not achieved substantial compliance 6 months from the last day of the survey that found the noncompliance;

c. 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, as authorized by CMS and/or the State Medicaid Agency, to be effective no sooner than 15 calendar days from date of receipt of this notice by the facility, but in no case later than 3 months from the date of the survey; (See also §7314 and §7506.1.)

d. Provides than an acceptable plan of correction is required in response to deficiencies listed on the Form CMS-2567 and must be received within 10 calendar days of the facility's receipt of the CMS-2567. The plan of correction will serve as the facility's allegation of compliance;

e. Informs the facility of the opportunity for *an* informal dispute resolution;

f. Specifies that when an acceptable plan of correction is not submitted within 10 calendar days, the State may propose to the CMS Location and/or State Medicaid Agency that remedies be imposed immediately within applicable notice requirements;

g. Informs the facility of the disapproval of its nurse aide training and competency evaluation program and competency evaluation program, as well as its appeal rights if the program loss is based on a finding of substandard quality of care;

h. Provides that when substandard quality of care is determined, the facility must provide a list of physicians for residents identified with substandard quality of care on the survey. The State must notify each physician and refer the administrator to the State's licensing board;

i. Provides elements of an acceptable plan of correction. (See §7317) and,

j. When no formal notification of remedies is being provided in this initial notice, the following language will be inserted in **bold type** in the letter 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: **"Please note that this notice does not constitute *a* formal notice of imposition of alternative remedies or termination of your provider agreement. If it is determined that termination or any other remedy is warranted, you will be provided with a separate formal notification of that determination."**

7305.4 - Means of Sending Notice

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The notice shall be in writing and shall be addressed directly to the provider/facility; or to an individual, an officer, managing or general agent, or other agent authorized by appointment or law to receive the notice.

The notice shall be dispatched through first-class mail, or other reliable means. Other reliable means refers to the use of alternatives to the United States mail in sending notices. Electronic communication, such as facsimile transmission, *secured electronic mail (email), or electronic plan of correction (ePOC) are* equally reliable and on occasion more convenient than the United States mail. If electronic means are employed to send notice, the sender should maintain a record of the transmission to assure proof of transmission if receipt is denied.

7316.1 - Required Actions When There Is an Opportunity to Correct

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. By no later than the 10th working day after the last day of the survey, the State must forward to the facility Form CMS-2567, and an initial letter and other documents and information in accordance with §7305.1.1.

2. By the 10th calendar day after the facility receives Form CMS-2567, it submits its plan of correction to the State addressing all of the required elements as described in §7304.

3. If the facility does not submit an acceptable plan of correction by the 10th calendar day after it receives the Form CMS-2567, the State notifies the facility that it is recommending to the CMS Location and/or the State Medicaid Agency that remedies be imposed effective as soon as notice requirements are met and/or to effectuate category 1 remedies and/or denial of payment for new admissions. (Civil money penalties may be imposed retroactively, predating the initial notice.)

4. If the State finds the plan of correction acceptable, it notifies the facility by phone, e-mail, etc. The State sends written notice to the facility if the plan of correction is unacceptable. The letter also states recommended remedies if substantial compliance is not verified in accordance with the instructions for verifying compliance in §7317. (See §7305 for notice requirements.)

5. The CMS Location and/or State Medicaid Agency may provide formal notice of imposition of category 1 remedies and/or denial of payment for new admissions.

6. The State may provide formal notice as authorized by the CMS Location and/or State Medicaid Agency, of imposition of category 1 remedies and/or denial of payment for new admissions, if applicable. However, such formal notice of imposition of denial of payment for new admissions will most often be provided in the revisit letter rather than in the initial letter. (See also §7301, §7305.1, ,§7314, and §7506.1)

7. Except in the case of category 1 remedies and denial of payment for new admissions, if applicable, the CMS Location and State Medicaid Agency **must** provide notice before enforcement actions are imposed and effective in accordance with §7305.

8. If the State provides formal notice of imposition of a category 1 remedy and/or denial of payment for new admissions, if applicable, it notifies the CMS Location and/or the State Medicaid Agency 2 calendar days (at least one of which is a working day) before notice is sent to the facility.

9. If denial of payment for new admissions has not already been imposed and the facility is still out of compliance at the 3rd month after the last day of the survey, the CMS Location and/or State Medicaid Agency must impose a mandatory denial of payment for all new admissions to be effective 3 months after the last day of the survey. (See §7506.) Formal notice of this remedy may have already

been provided in the State's initial letter to the facility (see §7305). *The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. The SA must transfer the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA (as authorized by CMS) to the provider by the 70th day. However, there may be other instances in which cases should be immediately transferred to the CMS Location (i.e., enhanced enforcement). Contact your location for additional information. This excludes cases involving Medicaid-only nursing homes.*

10. No later than the 6th month after the last day of the survey, termination is effective, **or** if an agreement to repay is signed for Medicare, Federal funding is stopped. (See §7600.)

11. The facility may request informal dispute resolution during the same 10 calendar days it has for submitting its plan of correction to the surveying entity; and

7316.2 - Required Actions When There Is No Opportunity to Correct

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. By no later than 10 working days after the last day of the survey, the State must forward to the facility Form CMS-2567, an initial letter, and other documents and information in accordance with §7305.1.2. This letter may also provide official notice for imposition of category 1 remedies and/or denial of payment for new admissions by the State, as authorized by CMS and/or the State Medicaid Agency. (See §7305.)

2. If the State provides formal notice of imposition of a category 1 remedy and/or denial of payment for new admissions, if applicable, it notifies the CMS Location and/or the State Medicaid Agency 2 calendar days (at least one of which is a working day) before notice is sent to the facility. (See also §7314, and §7506.1)

3. Within the same 10 working days and when the State is not imposing any remedies, as authorized by CMS and/or the State Medicaid Agency, the State forwards notice to the CMS Location and/or State Medicaid Agency of its recommendation(s) for immediate remedies.

4. The CMS Location or State Medicaid Agency must provide formal notice of the remedies imposed unless official notice has already been provided by the State, as authorized by CMS and/or the State Medicaid Agency.

5. By the 10th calendar day after the facility receives Form CMS-2567, it submits its plan of correction to the State addressing all of the core elements as described in §7304.

6. The State may provide notice, as authorized by the CMS Location or State Medicaid Agency, of imposition of category 1 remedies and/or denial of payment for new admissions.

7. If denial of payment for new admissions has not already been imposed and the facility is still out of compliance at the 3rd month after the last day of the survey, the CMS Location and/or State Medicaid Agency must impose a mandatory denial of payment for new admissions to be effective 3 months after the last day of the survey. *The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. The SA must transfer the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA (as authorized by CMS) to the provider by the 70th day. However, there may be other instances in which cases should be immediately transferred to the CMS Location (i.e., enhanced enforcement). Contact your location for additional information. This excludes cases involving Medicaid-only nursing homes.*

8. If the facility has still failed to substantially comply no later than the 6th month after the last day of the survey, termination is effective and Federal funding is stopped.

9. Substantial compliance must be verified in accordance with §7317 in order to stop any remedy(ies) imposed.

10. The facility may request informal dispute resolution during the same 10 calendar day period it has for submitting a plan of correction to the surveying entity.

7317 - Acceptable Plan of Correction

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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. An acceptable plan of correction must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- 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 corrective action completion dates must be acceptable to the State. If the plan of correction is

unacceptable for any reason, the State will notify the facility in writing. If the plan of correction is acceptable, the State will notify the facility by phone, e-mail, etc. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely.

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.

Nursing Home Official Signing the POC

When a POC is submitted, it must be signed by a facility representative, who should be the Administrator. However, other facility representatives may include the Director of Nursing, or a corporate representative. The facility representative signing the POC should have management authority and responsibility. Some SAs use the electronic POC (ePOC), which has a place for the written signature, which is generated electronically. Regardless of using a hard copy or electronic copy signature format, a nursing home official with authority and responsibility for operations of the facility should be the one who is submitting their signature on the facility's allegation of compliance.

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.

7317.1 - Verifying Facility Compliance

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

While the plan of correction *(PoC)* 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 date of substantial compliance is determined first by evaluating whether the credible written evidence provided by the facility supports the date it alleges that all deficiencies have been corrected and that it is capable of remaining in substantial compliance as determined by the survey agency. While the date of substantial compliance may not always be the date specified by the facility in the approved POC, it also is not necessarily the date of the revisit (onsite or paper-review). In some cases, a revisit may determine that a facility was able to correct all deficiencies and return to substantial compliance with the requirements before the alleged correction date on the approved POC.

In these cases, the facilities may provide credible evidence that they achieved substantial compliance on a date prior to the alleged correction date on the POC, and/or the date of the most recent revisit, regardless of the number of revisits that have already occurred. The facility is responsible for ensuring credible evidence provided to surveyors (for either onsite revisit, or offsite review) clearly establishes the date the facility returned to substantial compliance. Any evidence presented by the facility should establish the timing or dates of actions taken by the facility and how those actions corrected the noncompliance and will prevent recurrence of such noncompliance. If the facility does not provide documentation, or evidence that supports an earlier date, surveyors will consider the alleged date of compliance in the POC, or a later date supported by evidence found during a revisit, in determining the date of substantial compliance.

If noncompliance exists at the time of a revisit, it will be considered continued noncompliance unless the facility provides evidence acceptable to CMS or the State that there was a period of substantial compliance between the time that the previous deficiencies were fully corrected and the time new deficiencies began. The new noncompliance would then begin a new enforcement cycle.

*R*evisits *to determine if the facility has returned to substantial compliance* may be conducted anytime for any level of noncompliance, subject to the allowed number of revisits (see §7317.2, below). *R*emedies may be imposed anytime for any level of noncompliance *in accordance with CMS enforcement regulations and policies. R*evisits are not assured *to* occur *within a certain timeframe. Facilities are ultimately accountable for their own compliance, even in situations in which notifications about the acceptability of their plan of correction or written credible evidence are not immediately provided.* Also, it should be noted that this guidance applies to prospective, as well as currently participating, facilities.

In accordance with 42 C.F.R. § 488.454(a), any enforcement remedies imposed will continue until either:

1. *The facility has achieved substantial compliance, as determined by CMS or the State based upon an on-site revisit or after an examination of credible evidence that can be verified without an on-site revisit; or*

2. *CMS or the State terminates the provider agreement.*

7317.2 - Revisits

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

*P*aper reviews and onsite reviews are considered to be revisits *however*, only onsite revisits are considered in the revisit count for purposes of the revisit policy.

1. ***Onsite versus Offsite Revisits***

   a. **Mandatory onsite revisits.** An onsite revisit is *only* required when a facility's beginning survey finds deficiencies that constitute substandard quality of care, harm, or immediate jeopardy.

   b. ***Discretionary onsite revisits:*** *States may use their discretion to conduct an onsite revisit at any time. This may be done to assess the nature of the corrections and the extent to which they address and correct the deficiencies. For deficiencies involving Quality of Care, Quality of Life, Abuse or Neglect, or repeat deficiencies, which may be indicative of systemic problems, it may be necessary to observe staff practices and interview residents before determining a facility has returned to substantial compliance.*

   c. ***Offsite revisits:*** *When onsite revisits are not required, or when CMS or States have determined an onsite revisit is not warranted, credible evidence is used to conduct an offsite revisit (see section below on credible evidence).*

2. **No guarantee of revisit**. A facility is not entitled to any revisits; revisits are performed in accordance with guidelines provided in this section and at the discretion of CMS or the State. When conducted, however, one revisit will normally be conducted after a survey which found noncompliance and another before the expiration of the 6-month period by which a facility must be in substantial compliance to avoid termination of its provider agreement. Authorization must be obtained from the *CMS Location* for more than two onsite revisits for Medicare-only and dually participating facilities.

3. **Purpose of revisit**. The purpose of a revisit is to determine whether substantial compliance has been achieved.

4. **Number of onsite revisits**. Two onsite revisits are permitted, at the State's discretion, without prior approval from the *CMS Location* ; a third onsite revisit may be approved only at the discretion of the *CMS Location* . *The CMS Locations* are limited to approving only this one additional onsite revisit. This policy applies to Medicare-only, dually participating, and State-operated facilities. For Medicaid-only facilities, CMS can neither limit the number of revisits nor require States to obtain approval from the *CMS Location* or the State Medicaid Agency for a third onsite revisit; however, States should follow this policy so that the Medicare and Medicaid programs are run consistently.

   a. The effect of specific survey activities on the onsite revisit count *is as* follows:

      - **Complaint *investigations***. *C*omplaint investigation visits, *which occur before the alleged compliance date from the original survey*

Plan of Correction (PoC), regardless of whether *deficiencies are cited* or not, are not included in the onsite revisit count. However, when the complaint *investigation* is conducted at the same time as the onsite revisit, the revisit is included in the onsite revisit count. This also applies to Federal complaint guidelines.

- When a complaint is received and the complaint *investigation* is conducted **after** the third onsite revisit but **before** the 6-month termination date, any deficiencies identified by the complaint *investigation* should be cited and *may* provide additional evidence in support of the termination action. Since three onsite revisits have already been conducted, another onsite revisit cannot be conducted without consultation with the *CMS Location* . Situations such as this should be discussed with the CMS *Location* since it may have already sent a termination letter.

- **Life safety code surveys**. When the onsite revisit is for the sole purpose of **either** the health survey or the life safety code survey, **but not both**, there are separate revisit counts toward each survey, regardless of the timing of the two surveys and regardless of whether the same entity is performing the surveys and onsite revisits. When the onsite revisit is for both the health survey and the life safety code survey, both surveys are covered by the same onsite revisit count.

  - **Visits to determine removal of immediate jeopardy**. An onsite visit to determine if immediate jeopardy has been removed will be included in the onsite revisit count. (See §7308 for documentation requirements.)

  - **Visits to special focus facilities**. The onsite revisit policy applies to Special Focus Facilities as it does to all other facilities, but the *additional standard surveys (i.e., one every six months)* do not count against the onsite revisit count.

  - **State monitoring**. Monitoring visits are not included in the onsite revisit count because no survey is being performed. State monitoring is a remedy to oversee the correction of cited deficiencies and ensure that residents are protected from harm; onsite revisits are onsite visits specifically intended to verify correction of deficiencies cited in a previous survey.

5. **Timing of revisit**. When conducted, onsite revisits occur any time between the last *alleged* correction date on the plan of correction 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. Conducting a revisit before the 60th day allows time for a notice of a mandatory denial of

payment for new admissions at the 3rd month, if necessary. If the facility is found to be in substantial compliance, the State will certify compliance.

6. **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.

7. **Revisits to surveys for which substandard quality of care, harm, and immediate jeopardy are cited**. When substandard quality of care, actual harm, or immediate jeopardy is cited*, then an* onsite revisit *i*s m*andatory. If the onsite revisit determines the original noncompliance remains, but at a lowered scope and severity that no longer meets the criteria for an onsite revisit, States may use their discretion to either conduct an onsite or offsite revisit (see #1 above).*

8. ***New Noncompliance identified before or during on-site revisit surveys.*** *In some cases, surveyors identify new noncompliance before facilities have been certified as having returned to substantial compliance. This can occur when complaints are investigated before the alleged date of compliance or on the revisit. New noncompliance can also be identified during the course of conducting the on-site revisit. New noncompliance may have an impact on accruing remedies such as civil money penalties, or mandatory remedies such as Denial of Payment for New Admission, and mandatory termination. In situations where it is determined that the provider clearly establishes through credible evidence that they have returned to substantial compliance, AND the newly identified noncompliance occurred on a date after the original noncompliance was corrected (i.e., alleged date of compliance), AND the noncompliance is different (regardless if it is the same F-tag) from findings on the original survey, the SA and/or the CMS Location should return the provider to substantial compliance for the original survey. This would end the enforcement cycle for the original survey and start a new enforcement cycle for the newly identified noncompliance.*

Key Points to be considered:

- *New noncompliance must always be documented on a Form CMS-2567.*

- *It is the provider's responsibility to establish the date on which it returned to substantial compliance. Surveyors should always attempt to establish the earliest date of noncompliance when conducting their investigations. If the survey team cannot determine a date before the alleged date of compliance on the approved POC, that is the date that will be used.*
- *Determination of a period of substantial compliance can only be made after any new allegations have been appropriately investigated.*

- *For purposes of this guidance, SAs/CMS Locations would generally consider noncompliance to be different if they were cited at different Ftags or regulatory groupings. However, in some cases, citations at the same Ftag can also be different, and would require a different POC. This can occur at Ftags that cover broad areas of noncompliance, such as Quality of Care citations at F684, or Accidents/Supervision at F689, Infection Prevention and Control at F880, among others.*

- *If newly identified noncompliance which occurs on or after the alleged date of compliance is the same or similar to the noncompliance cited on the original survey, and the facility has not been returned to substantial compliance, it is reasonable to assume the provider did not correct the original deficient practice, regardless of an allegation that the provider returned to substantial compliance. In these cases, the original enforcement cycle will not end and it will continue until the state agency confirms the facility is in substantial compliance by the original or amended alleged date of compliance.*

- *If newly identified noncompliance which occurs before the alleged date of compliance is the same or similar to the noncompliance cited on the original survey, the survey team should cite the new noncompliance. The original enforcement cycle would continue until the facility submits a plan of correction for all identified noncompliance and the facility can provide evidence that the noncompliance has been corrected.*

9. New Owner. If a new operator assumes the existing provider agreement, he or she is responsible for assuring that corrections are made within the revisit policy.

Post-Survey Offsite Revisit Paper Reviews

An offsite desk paper review revisit may be conducted if the deficiencies are less serious (deficiencies with findings at a D, E, and F without substandard quality of care) and when those deficiencies do not require on-site observations to evaluate the corrective action. For more serious deficiencies (e.g. substandard quality of care or G or higher) the SA must conduct the revisit onsite. An onsite revisit is also generally required for deficiencies concerning quality of care.

For the offsite desk paper review, the State Agency (SA) follows up on deficiencies identified in the accepted Plan of Correction (PoC). The PoC serves as the facility's allegation of compliance however, facility compliance must still be verified. The SA must review evidence and verify that the nursing home corrected the identified deficiencies and is capable of remaining in compliance. The nursing home must be in substantial

compliance with Federal requirements for participation in order to maintain certification.

Substantial compliance exists when deficiencies are cited at a level that represents no actual harm with potential for minimal harm. The SA completes appropriate verification before documenting that a deficiency is corrected. In some cases, the cited deficiencies may be such that a paper review will suffice in place of an onsite visit. In these cases, a paper review is performed and documentation of this review must be maintained by the SA. The SA should have a policy to ensure that Personal Health Information is protected through communications with the facility.

The nursing home is required to submit a PoC to the SA, however the PoC itself does not serve as confirmation of substantial compliance. The SA must obtain evidence of the correction of deficiencies from the nursing home. To help ensure the health and safety of nursing home residents, SAs must properly verify the correction of deficiencies and maintain sufficient documentation to support the verification of corrections and how those actions will prevent recurrence of noncompliance.

The SA should verify and maintain sufficient evidence that deficiencies identified during surveys have been corrected. The SA must ensure that deficiencies have been corrected before determining that the nursing home is in substantial compliance. The SA must maintain evidence of the review of the plan of correction and any documents that were provided by the nursing home. SAs must not accept nursing homes' PoCs as confirmation of substantial compliance with Federal requirements of participation without first obtaining from nursing homes the required evidence that each deficiency has been corrected and will prevent recurrence of such noncompliance. The correction of deficiencies must be verified through means beyond reviewing the PoC. For information on evidence that can be requested and reviewed to verity correction, see the section below, "Supporting Evidence."

Supporting Evidence

*The SA makes a request of the facility for the documentation specified in the facility's accepted POC. All five components of the accepted POC must be reviewed. (See **7317 - Acceptable Plan of Correction**) What the deficiencies were and what the facility stated in their POC will affect the specifics of what needs to be collected to support correction of the identified deficiencies. While the POC itself is not credible evidence of compliance, supporting evidence must align with the POC.*

Use of the ePOC allows the facility representative user to sign the POC electronically.

Verification of correction of deficiencies often involves reviewing in-service/training completed by the facility. It is important to review all materials addressed in the POC and ensure they are specific to the noncompliance identified during the survey. Sometimes evidence of correction includes but is not limited to specific staff. For example, in reviewing the list of in-service attendees, the reviewer must determine that

the specific staff originally involved in the deficient practice were included in the list of those who attended the training, unless the staff is no longer working at the facility.

During a paper review, the surveyor is to request documentation depending on the specifics located in the accepted POC. Request additional information if the facility has not provided sufficient evidence to support substantial compliance. If the facility fails to provide credible evidence, then an onsite visit may be required.

The surveyor conducting the paper review should be a qualified surveyor (e.g. SMQT/Life Safety Code). Best practice is having a member of the original survey team conduct the paper review. The surveyor prepares by reviewing the CMS-2567 findings and the accepted POC. The POC is compared with evidence the facility submits that addresses the specific deficient practice. The documentation is reviewed against the facility's POC to ensure the facility provided evidence according to the submitted and approved plan.

If the material received is incomplete or inadequate, then communication (e.g. phone call, encrypted e-mail, secure fax, or ePOC) is required to gather all of the needed information. Some SAs use the ePOC system to document acceptance of the evidence of correction submitted by a provider. The surveyor is to review all of the documentation sent by the facility as evidence the action items in the accepted POC were completed, compliance was achieved, and that compliance can be maintained. Additionally, the SA should be sure to document all conversations with the facility.

Compliance is determined based on evidence submitted that confirms the POC was implemented and the facility was able to correct all deficiencies. Acceptable supporting documentation is required to ensure the verification process.

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

1. *Copies of In-service/Training/Education Records Documenting What Was Covered (actual training materials) and Who Attended, Including but not Limited to Specific Staff Who Were Involved in the Original Deficiency*

    - *Interviews with multiple staff who took part in a training to determine whether staff understood the topics presented and took any action, as necessary*
    - *Results from pre- and post-training tests*

2. *Staff Termination Letter*
3. *Documentation of the hiring of new staff*
4. *New or Revised Policies and Procedures*
5. *Purchase Order/Invoice/Receipt for New Equipment*
6. *Receipts Showing Repairs-contractor inspections, evidence of work completed and/or ordered on contractor letterhead*
7. *Photos-if it related to a repair or cleaning issue*

8. *Documentation/Log Showing Inspections, Monitoring and auditing results*
9. *Revised Shower or Bathing Schedule*
10. *Documentation of Grievance Resolution*
11. *Communication to Residents Encouraging Them to Bring in Personal Items*
12. *Change In/Removal of Physical or Chemical Restraint*
13. *Revised resident assessment (minimum data set (MDS))*
14. *Revised/Developed Care Plan*
15. *Health Care Professional Consultation or Outside Physician/Dental Appointment*
16. *Change in Medication*
17. *Documentation of Lab Test or X-ray.*
18. *New Physician's Order*
19. *Temperature Recordings of Refrigerators and Steam Food Table*
20. *Internal Quality Assurance Audit Results (e.g. root cause analysis/documentation of improved performance), QAPI Monitoring Tools*
21. *Revised or New Contracts Related to the Concern Identified*
22. *Revised or New Facility Forms Related to the Concern Identified*
23. *Changes in Physician Orders*
24. *Revised Menus*
25. *Medication Administration Records*
26. *Treatment Administration Records*
27. *Records Related to the Prevention, Plan, Development, Care, Size, and Treatment of Pressure Ulcers*
28. *Records Related to the Prevention, Plan, Care, and Treatment of Falls*
29. *Records Related to Supervision, Wandering, Monitoring, Plan, and Care*
30. *Revised Facility Assessment*
31. *Staff Interviews*
32. *Updated Infection Prevention and Control Plan*
33. *Revised/Developed QAPI Plan*
34. *Updated Facility Assessment*
35. *Updated Policy/Procedure for Emergency Preparedness*
36. *Communications Plan for Emergency Preparedness*
37. *Temperature Control Logs of the Air or Water*
38. *Revised Arbitration Agreement*

Documentation and Record Retention

SAs should gather and maintain documented evidence of the verification of corrected deficiencies. The documentation must explicitly indicate how the surveyor verified the facility's corrected deficiencies identified on the CMS-2567. At a minimum, the document should include:

- *Date of Revisit Survey*
- *Identify if any or all of the revisit survey was conducted on-site or off-site.*
- *2567 issued to the facility*
- *Accepted POC*
- *Alleged Date of Compliance*

    - *(Noting if different for individual requirement for participation)*
- *Obs/Int/RR (explicitly indicate how a survey agency verified correction of deficiencies)*
- *Supporting Evidence Reviewed*

The SA is responsible for documenting verified correction and the information reviewed from the POC. The SA should have a system to ensure that this review and documentation take place and that these records are maintained. All evidence should be organized and retrievable. See S&C-10-22-ALL for guidance regarding Records Retention.

If the facility is in compliance, the correction dates are entered into iQIES. The length of time that the records are maintained should be outlined in the SA's policy and procedure and be reflective of CMS policy in Chapter 4. (See §7317.2 for Examples of Acceptable Credible Evidence)

SAs may utilize different approaches such as documenting on an 807 form and maintaining documents received from the facility. Other examples include using a SA developed Quality Assurance tool document or a POC review form to track review and then to file that document in the state's electronic records database, using the ePOC and making a copy for files.

The surveyor will need to complete the necessary steps in the CMS system to indicate dates of compliance in the system. Whether the state uses hard copy files or an electronic format, the SA is responsible for maintaining evidence that a paper review was conducted, beyond reviewing the POC. Credible evidence of compliance must be obtained, confirmed and retained. Once the documentation has been verified as acceptable for proof of compliance, completion of a paper review is entered into the iQIES and a 2567B is created to clear the deficiencies. The CMS 1539 is completed. A compliance CMS-2567 form and notice letter are created and sent to the facility.

7317.3 - Noncompliance Cycles

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

A noncompliance cycle begins with a recertification *survey*, complaint *investigation,* 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. (See also §7001.) The noncompliance cycle cannot exceed 6 months. Once a remedy is imposed, it continues until the facility is in substantial compliance (and in some cases, until it can demonstrate that it can remain in substantial compliance), or is terminated from the programs.

7319.1 - Non-State Operated Skilled Nursing Facilities and Nursing Facilities or Dually Participating Facilities

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. The State conducts the survey and certifies compliance.

2. The State sends the facility Form CMS-2567 and if applicable, the "Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm" (Form A), within 10 working days of the last day of survey.

3. If the facility is in substantial compliance, but deficiencies constitute a pattern or widespread findings causing no actual harm and potential for only minimal harm, the State instructs the facility to submit a plan of correction to the State's office. (This must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.) There is no requirement for the State to conduct a revisit to verify correction, but the facility is expected to comply with its plan of correction.

4. If the facility is in substantial compliance, but has deficiencies that are isolated with no actual harm and potential for only minimal harm, the State records the deficiencies on the Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm (Form A). A plan of correction is not required for these deficiencies, but facilities are expected to correct them.

5. The State enters the certification information into the *iQIES* . This can occur as soon as substantial compliance is achieved.

7319.2 - State-Operated Facilities

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. The State conducts the survey and documents its findings on Form CMS-2567 and if applicable, on the Notice of Isolated Deficiencies Which Cause No Actual Harm With the Potential for Minimal Harm (Form A).

2. The State forwards its survey findings to the regional office within 10 working days of the last day of the survey.

3. If the facility has deficiencies that are widespread or constitute a pattern and which cause no actual harm and potential for only minimal harm, the regional office instructs the facility to submit its plan of correction to the regional office. The plan of correction must be submitted within 10 calendar days after the facility has received its Statement of Deficiencies.

4. The regional office enters the certification information into the *iQIES*.

7506.3 - Mandatory Denial of Payment for All New Admissions Remedy

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions *(DPNA)* must be imposed when the facility is not in substantial compliance 3 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 State Medicaid Agency must deny payment to the facility, and CMS must deny Federal financial participation to the State Medicaid Agency for all new Medicaid admissions to the facility.

Timeliness of Mandatory DPNA Notification for Nursing Homes – The SA must adhere to enforcement processing timeframes so that mandatory DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. The SA must transfer the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA (as authorized by CMS) to the provider by the 70th day. However, there may be other instances in which cases should be immediately transferred to the CMS Location (i.e. enhanced enforcement). Contact your location for additional information. This excludes cases involving Medicaid-only nursing homes.

7506.4 - Duration and Resumption of Payments

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Generally, if the facility achieves substantial compliance and it is verified in accordance with §7317, CMS or the State Medicaid Agency 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 *Administrative* Contractor in Medicare cases, and in Medicaid cases, through written instructions from the CMS Location.

Civil Money Penalties

7510 - Basis for Imposing Civil Money Penalties

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The following procedures incorporate *§1819(h)(1) and (2)(B) and §1919(h)(1) of the Act and 42 CFR 488.430 through 488.444*. CMS or the State may impose a *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, *or both,* regardless of whether the deficiencies constitute immediate jeopardy. Additionally, per instance *CMPs* may be imposed for past noncompliance. An "instance *or instances of noncompliance" means a factual and temporal occurrence(s) when a facility is not in substantial compliance with the requirements for participation. Each instance of noncompliance is sufficient to constitute a deficiency and a deficiency may comprise of multiple instances of noncompliance*. There can be more than one instance of noncompliance identified during a survey. (See §7510.2 for guidance on past noncompliance.)

The CMS Location or State Medicaid Agency may impose a *CMP* between $3,050 and $10,000♦ per day of immediate jeopardy, or between $50 and $3,000♦ per day of non-immediate jeopardy *for each deficiency*, and/or "per instance" civil money penalties from $1,000 to $10,000 *(as adjusted for inflation at 45 CFR 102.3)* for each *instance of noncompliance*. *CMS and the State may impose a per day civil money penalty, a per instance civil money penalty, or both, in addition to the remedies specified in § 488.408(e)(2)(i). When a survey contains multiple instances of noncompliance, CMS and the State may impose any combination of per instance or per day CMPs, regardless of whether the deficiencies constitute immediate jeopardy (the aggregate daily amounts may not exceed the maximum amount). (See 7301.1 and 7302.1 for guidance on the civil money penalty amounts that may be imposed.)*

A civil money penalty is a valuable enforcement tool because it can be imposed, under certain circumstances, for each day that a facility is out of compliance with participation requirements or for each instance of noncompliance. If imposed, a facility cannot avoid the remedy. The civil money penalty 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. However, a menu of remedies from which to choose exists, and a civil money penalty may not be the most appropriate choice of remedy in every situation of noncompliance. The imposition of a civil money penalty may be most appropriate when a facility is not given an opportunity to correct, when immediate jeopardy exists, when noncompliance is at levels G, H, I, or when there is a finding of substandard quality of care. States and CMS Locations are encouraged to develop methods to ensure that civil money penalty amounts are applied consistently within the broad ranges identified at *42 CFR 488.408*.

♦ *Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool. Note that the CMP amount ranges that are noted here reflect the original statutory and regulatory amounts however, the amounts are subject to annual inflation adjustments under 45 CFR 102.3, see §7513 for more information.*

7510.1 – Determining Citations of Past Noncompliance at the Time of the Current Survey

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Past noncompliance may be identified during any survey. For the purpose of making determinations of current noncompliance or past noncompliance, the survey team is expected to follow the investigative protocols and surveyor guidance. To cite past noncompliance with a specific survey data tag (F-tag or K-tag), all of the following three criteria must be met:

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.

A nursing home does not provide a plan of correction for a deficiency cited as past noncompliance because the deficiency is already corrected; however, the survey team documents the facility's corrective actions on the CMS-2567.

Regulations at *42 CFR 488.430(b)* provide that a Civil Money Penalty (CMP) may be imposed for *previously cited* noncompliance since the last *three* standard survey*s*. When a CMP is recommended, the State Agency notifies the CMS Location and/or State Medicaid Agency within 20 days from the last day of the survey that determined past noncompliance of its recommendation to impose a CMP. The CMS Location and/or State Medicaid Agency responds to the recommendation within 10 days, and if accepted, sends out the formal notice in accordance with the notice requirements in §7305 and §7520.

7510.2 – Documentation of Past Noncompliance Citations on the CMS-2567

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Past noncompliance may be cited on health and/or life safety code surveys of nursing homes. Past noncompliance may be cited on any type of survey (standard, recertification,

abbreviated standard, e.g., complaint and revisit). Data about past noncompliance tags are not carried forward to subsequent revisit surveys.

Past noncompliance is documented at the actual deficiency tag (F-tags for health deficiencies or K-tags for life safety code deficiencies) where past noncompliance is identified. A scope and severity determination is assigned to a past noncompliance citation. Surveyors document on the CMS-2567 the nursing home's actions to correct the past noncompliance.

CMS or the State indicates in the appropriate data field in the *iQIES* whether a citation is past noncompliance. Tags cited as past noncompliance will appear in tag number order on the CMS-2567. The provider's plan of correction column on the CMS-2567 will print "Past noncompliance-no plan of correction required" for tags identified as past noncompliance.

The *iQIES CMS iQIES Survey & Certification User Manuals* include technical information about past noncompliance citations. This guide is located at the following Web site address: *https://qtso.cms.gov/software/iqies/reference-manuals.*

7512 - Compliance *w*ith Section 1128A of the Social Security Act

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The CMS Location consults with the CMS Location attorney's office to ensure compliance with *§1128A* of the Act and Department of Justice requirements. *Section 1128A* of the Act requires CMS to offer a hearing before collecting, **but not before imposing**, a civil money penalty.

For nursing facilities, *§1919(h)(2)* of the Act require States to implement remedies by either State statute or regulation. State law may include additional specific requirements that must be met. *Section 1919(h)(8)* of the Act requires States to offer a hearing before collecting a civil money penalty.

7513 – The Federal Civil Penalties Inflation Adjustment Act Improvement Act of 2015

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015 (the 2015 Act) requires federal agencies to publish annual penalty inflation adjustments (see sec. 701 of the Bipartisan Budget Act of 2015, Pub. L. 114-74). The 2015 Act amends the Federal Civil Penalties Inflation Adjustment Act of 1990 (Pub. L 101-410) which was enacted to improve the effectiveness of federal CMPs and to maintain their deterrent effect. The 2015 Act adjustments only affects specific CMP amounts and not other related provisions, such as the factors reviewed for assessing CMPs. For SNFs, NFs and SNF/NFs, the CMP Analytic Tool instructions and calculations are updated to reflect the annual adjustments

for inflation. For more information visit the CMS Civil Monetary Penalties (Annual Inflation Adjustment) webpage and https://qcor.cms.gov/main.jsp.

7514 - Special Procedures Regarding Compliance Decision and Overlap of Remedies

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If CMS and the State Medicaid Agency both want to impose civil money penalties on any given facility, only CMS's civil money penalty is imposed. Special procedures specified in §7807 implement the provisions of *§1919(h)(6) and §1919(h)(7)* of the Act as well as *42 CFR 488.452* regarding whether the State or Federal remedy decision takes precedence in non-immediate jeopardy situations involving non-State operated nursing facilities and dually participating facilities.

7516.1 - Range of Penalty Amounts

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Civil money penalties are imposed in increments of $50.00 ♦.

1. Lower Range of Penalty Amounts for Per Day Civil Money Penalty

Penalties in the range of $50 to $3,000 ♦ per day may be imposed when immediate jeopardy does not exist, but the deficiencies either caused actual harm, or caused no actual harm, but have the potential for more than minimal harm. A civil money penalty may not be less than $50.00 per day ♦.

2. Upper Range of Penalty Amounts for Per Day Civil Money Penalty

Penalties in the range of $3,050 to $10,000 ♦ per day may be imposed for deficiencies constituting immediate jeopardy. Penalties may also be in the upper range of penalty amounts for deficiencies when immediate jeopardy does not exist if a penalty in the lower range of penalty amounts was previously imposed and the deficiencies in the same regulatory grouping are repeated. Repeated deficiencies are defined in §7516.3.

3. Range of Per Instance Penalty Amounts

Penalties in the range of $1,000 to $10,000 ♦ per instance(s) may be imposed for noncompliance that constitutes actual harm, or for noncompliance that has the potential for more than minimal harm. The terminology "per instance" is not used to suggest that only one instance of noncompliance may be assigned a *CMP*. There can be more than one instance of noncompliance identified during a survey where the State utilizes the per instance *CMP* as an enforcement remedy. The total dollar amount of the civil money penalties for noncompliance *on **any single day*** may not exceed *the statutory and regulatory maximum amount and may not be less than the statutory and regulatory minimum amount for each day. When multiple per instance civil money penalties are*

*imposed for **different days** of noncompliance, the total aggregate amount of all civil money penalties imposed for the survey may exceed the statutory and regulatory maximum (the statutory maximum only applies to the civil money penalty amount for any single day).*

NOTE: In situations of past noncompliance, see §7510.1 and §7510.2.

♦ *Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool. Note that the CMP amount ranges that are referenced here are the original statutory and regulatory amounts, but these amounts are subject to annual inflation adjustments that are published at 45 CFR 102.3. See §7513 for more information.*

7516.2 - Factors Affecting Amount of Penalty

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

(Also see §7400.) Once the decision is made to impose a civil money penalty for facility noncompliance, regardless of whether the noncompliance is current or past, the following factors are considered in determining the specific amount of the civil money penalty to impose within the appropriate range:

1. The facility's history of noncompliance, including repeated deficiencies. This information may be obtained from:

    a. Provider files maintained in the State or the CMS Location from the current survey and the past three surveys, and,

    b. Facility-specific reports maintained in the *iQIES* system *or subsequent system,* and the Certification and Survey Provider Enhanced Reporting system (CASPER), from the current survey and the past three surveys;

2. The facility's financial condition. The following is only a suggested list of sources for this information and is not intended to represent exclusive or mandatory sources of information:

    a. Resources available to the facility;

    b. Information furnished by the facility (e.g., in the letter notifying the facility that civil money penalties are being imposed, ask the facility to provide any information that could have an impact on the amount of the civil money penalty);

    c. Consultation with the Medicare *Administrative* Contractor (e.g., ask for pertinent facility financial information before CMS sends the notice to the facility to impose civil money penalties); or

d. Consultation with the State Medicaid Agency (e.g., ask for pertinent facility financial information before CMS sends the notice to impose civil money penalties);

3. Seriousness and scope of the deficiencies. *Sections 7203.3.1 and 7410.2* of this manual provides guidance about the seriousness and scope of the identified deficiencies. Appendix Q of this manual provides guidance about determining the existence of immediate jeopardy.

4. The relationship of one deficiency to other deficiencies.

5. The facility's degree of culpability. A facility is always responsible for the health and safety of its residents. A facility is culpable if noncompliance causing harm or placing a resident at risk of harm is intentional or is a product of neglect, indifference, or disregard.

6. Any other remedies being imposed in addition to the civil money penalty.

7516.3 - Changing Amount of Civil Money Penalty

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When the per instance civil money penalty has been selected as an enforcement remedy, the provision for changing the amount of the civil money penalty does not apply and no opportunity to correct is provided.

The amount of a per day civil money penalty can be adjusted within a given civil money penalty range.

The range of a per day civil money penalty amount may be decreased or increased in accordance with the guidance that follows:

1. Decreasing Per Day Civil Money Penalty Range

If a civil money penalty is imposed for a situation of immediate jeopardy and the immediate jeopardy is removed but the noncompliance continues, CMS or the State will shift the penalty amount to the lower range of penalty amounts. *When the civil money penalty amount is lowered following an immediate jeopardy, the lower level amount will accrue until substantial compliance or unless increased due to new noncompliance.*

2. 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 level penalty amount, becomes sufficiently serious to pose immediate jeopardy.

If a civil money penalty 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 penalty amount would exceed the range otherwise reserved for deficiencies when immediate jeopardy does not exist.

3. Repeated Deficiencies

(See *42 CFR 488.438(d)(3)*. These are deficiencies *in the same regulatory grouping of requirements cited since the last standard survey for which a CMP was previously imposed, subsequently corrected, and found again at the next survey. This includes any deficiencies cited on an intervening abbreviated standard survey for which a CMP was previously imposed since the last standard survey.* For example, a civil money penalty is imposed and sustained in some amount for deficiencies under Quality of Care related to hydration (see *42 CFR 483.25(g))* during a standard survey. These deficiencies are corrected at the time of the revisit. However, at the next survey, the facility has deficiencies in Quality of Care related to nutrition. (See *42 CFR 483.25(g)*)In this situation, if a civil money penalty is imposed for the repeated noncompliance, it should be higher than the civil money penalty that was previously imposed for the Quality of Care deficiencies pertaining to hydration.

7518 - Effective Date of Civil Money Penalty

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The per day civil money penalty may start accruing as early as the date that the facility was first out of compliance, as determined by CMS or the State. The per instance civil money penalty is for *an instance or instances of noncompliance* within a specific survey (i.e., standard, revisit, complaint) up to a maximum of $10,000♦ for ***each day*** *of noncompliance (see sections 7301.1 and 7301.2 for examples)*. The effective date of the per day civil money penalty 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. For purposes of recording the imposition of the per instance civil money penalty, the date of occurrence of the noncompliance may be used. However, for purposes of recording the deficiency on the Form CMS-2567, the effective date of the per instance civil money penalty must be the last day of the survey that identified the noncompliance against which it is being imposed. This will permit the input of deficiencies into the *iQIES, or subsequent system*.

A civil money penalty cannot be collected until a facility has an opportunity for a hearing if it properly requests one. Allowing an effective date for the accrual of a per day civil money penalty to be as early as the date of the noncompliance permits the noncompliance to be sanctioned promptly and requires that the facility be notified promptly of the imposition of the civil money penalty. However, if there is undue delay in notifying the

facility of the civil money penalty, it is possible that the effective date of the penalty could be moved to a date later than the date of the noncompliance.

♦ *Federal CMPs are imposed in accordance with the instructions in the CMP Analytic Tool. Note that the CMP amount ranges that are referenced here are the original statutory and regulatory amounts, but these statutory and regulatory amounts are subject to annual inflation adjustments under 45 CFR 102.3. See §7513 for more information.*

7522 - Duration of Civil Money Penalty

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The per day civil money penalty *may* accrue for the number of days of noncompliance from the date that the deficiency starts until the date that the facility achieves substantial compliance or, if applicable, the date of termination. For example, if a facility is found in substantial compliance or its provider agreement is terminated on May 18, the accrual of the civil money penalty stops on May 17.

The per instance civil money penalty is imposed for each instance of noncompliance based on a deficiency during a specific survey. It is applied to as many instances as is deemed appropriate during a specific survey up to a total of $10,000 *for each day of noncompliance (as adjusted for inflation by 45 CFR 102.3)*.

7522.1 - Revisit Identifies New Noncompliance and Same Data Tag is Selected

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If the *F*-tag is selected to identify noncompliance, the State (or the CMS Location) could choose to utilize either the per instance or per day civil money penalty*, or both,* as an enforcement remedy. It would not matter whether the same data tag was selected to identify the new noncompliance. The issue is whether noncompliance is present and whether the deficient practice rises to a level that will support selecting a civil money penalty as an enforcement remedy. For *example*, noncompliance was identified at *F689* during the original survey. During the revisit survey, a different problem dealing with the elopement of three residents was cited at *F*689. The per instance or per day civil money penalty*, or both, could* be selected for the noncompliance identified at *F689*. *A per instance civil money penalty may be imposed for each instance of noncompliance (refer to 7301.1)*.

7522.2 - Revisit Identifies New Noncompliance and a Different Data Tag is Selected

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If a revisit identifies new deficiencies at a different data tag, a per instance or per day civil money penalty*, or both,* could be selected as an enforcement remedy.

7522.3 - Noncompliance - Immediate Jeopardy Does Not Exist

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

For noncompliance that does not pose immediate jeopardy, the per day civil money penalty is imposed for the days of noncompliance, i.e., from the day the penalty starts (and this may be prior to the notice), until the facility achieves substantial compliance or the provider agreement is terminated. However, if the facility has not achieved substantial compliance at the end of 6 months from the last day of the original survey, the CMS Location terminates and the State may terminate the provider agreement. The accrual of the civil money penalty stops on the date that the provider agreement is terminated.

For noncompliance that does not pose immediate jeopardy, the per instance civil money penalty is imposed for the number of *instances of noncompliance* during a survey for which the civil money penalty is determined to be an appropriate remedy. *For examples of per instance civil money penalties, see sections 7301.1 and 7301.2.*

7522.4 - Noncompliance - Immediate Jeopardy Exists

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

For noncompliance that poses immediate jeopardy, CMS or the State must terminate the provider agreement within 23 calendar days after the last day of the survey that identified the immediate jeopardy if the immediate jeopardy is not removed. If the life safety code survey found the immediate jeopardy, CMS or the State must terminate the provider agreement within 23 calendar days after the last day of the life safety code survey. The accrual of the per day civil money penalty stops on the date that the provider agreement is terminated. The per instance civil money penalty is limited to *the regulatory maximum amount for each day of noncompliance.*

7526.2 - Facility Waiver of Right to Hearing

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

A facility *is considered to have w*aive*d its* right to a hearing *when CMS has not received a request for a hearing* within 60 calendar days from the date of the notice of imposition of the civil money penalty. (See 42 CFR 488.436).

If a facility waives its right to a hearing, the CMS Location or the State Medicaid Agency reduces the civil money penalty amount by 35 percent.

NOTE: Each time a survey is conducted within an already running noncompliance cycle and a civil money penalty is imposed, the facility is given appeal rights and may exercise its waiver of right to a hearing.

When a per day civil money penalty is imposed and then increased or decreased at subsequent surveys during an already running noncompliance cycle, a facility may elect to either appeal each separate imposition of civil money penalty or waive the right to appeal each imposition. Each civil money penalty imposition is computed separately for a set number of days. The final civil money penalty amount is established after the final administrative decision.

EXAMPLE: A civil money penalty is imposed for 10 days at $1,000 per day. The amount is increased to $3,500 per day for 4 days after a revisit finds immediate jeopardy. The civil money penalty is reduced, after the immediate jeopardy has been removed, to $100 per day for 20 days of noncompliance after which the facility is found to be in substantial compliance. The total amount of the penalty is $26,000 [($1,000 x 10 days) + ($3,500 x 4 days) + ($100 x 20 days) = $26,000.] The facility chooses to appeal the first and third civil money penalty amounts imposed, $10,000 + $2,000, and to waive the right to appeal the second civil money penalty imposed, $14,000. The $14,000 amount is reduced by 35 percent and the amount due is $9,100. The final amount of the first and third civil money penalty amounts imposed ($10,000 and $2,000) is established after a final administrative decision on the appeal.

When several per instance civil money penalties are imposed during a noncompliance cycle, a facility may choose to appeal or waive the right to appeal one or more of the civil money penalties, in the same manner as illustrated above for the per day civil money penalties.

After the facility achieves substantial compliance or its provider agreement is terminated, it is notified of the revised civil money penalty amount due.

7528.1 – When a Civil Money Penalty Subject to Being Collected and Placed in an Escrow Account is Imposed

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When the CMS Location imposes a civil money penalty that is subject to being collected and placed in an escrow account as specified at *42CFR 488.431*, payment is due on whichever of the following occurs first if the facility files an appeal of the enforcement action:

1. The date on which the independent informal dispute resolution process is completed; or

2. The date which is 90 calendar days after the date of the notice of imposition of the penalty.

NOTE: *Payment is not due until after the facility's opportunity to waive its right to appeal has passed and in accordance with 42 CFR 488.442. If there is no appeal, CMS's*

determination becomes final and the CMP amount becomes due and payable in accordance with the process in §7213.

3. **NOTE:** The collection of a per day civil money penalty may be a two-step process. Under §488.431(b)(2), in instances when a facility has not achieved substantial compliance at the time a per day civil money penalty can be collected and placed in an escrow account, the penalty amount that has accrued from the effective date of the penalty through the date of collection would be collected. Another collection would occur later in the process for any final balance determined to be due and payable once the facility achieves substantial compliance or is terminated from the program. This two-step process may also occur if a revisit results in a per day civil money penalty being reduced to a scope and severity level below a G and thus not collected and held on an escrow account. In this case, the amount accrued from the effective date of the penalty through the date of the revisit survey would be collected and placed in escrow.

7528.3 - No Hearing Requested *(Constructive Waiver)*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Payment of a civil money penalty is due 15 calendar days after the time period for requesting a hearing has expired and a hearing request was not received when:

1. The facility achieved substantial compliance before the hearing request was due; or

2. The effective date of termination occurred before the hearing request was due.

7528.4 - After Waiver *of* Hearing

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Payment of a civil money penalty is due 15 calendar days *after the 60 day timeframe that a facility has to request* a hearing *has passed* when:

1. The facility achieved substantial compliance before *the facility waived* its right to a hearing;

2. A per instance civil money penalty has been imposed. Since no opportunity to correct is available for the noncompliance against which a per instance civil money penalty is imposed, allowing time for the facility to achieve substantial compliance is not a factor in determining when the civil money penalty is due; or

3. The effective date of termination occurred before *the facility waived* its right to a hearing.

7528.6 – After Effective Date of Termination

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Payment of a civil money penalty is due 15 calendar days after the effective date of termination, if before the effective date of termination:

1. The final administrative decision was made upholding the imposition of the civil money penalty; *or*

The time for requesting a hearing has expired and the facility did not request a hearing

7530.2 - Method of Payment

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. The civil money penalty is payable *via Automated Clearing House (ACH) using the pay.gov portal or* by check to CMS if the *payment* is rendered by the due date.

2. After the due date of the penalty, the CMS Location or the State Medicaid Agency deducts the civil money penalty plus any accrued interest from money owed to the facility.

7534.1 - Collected From Medicare or Dually-Participating Facility

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

A Federal civil money penalty (CMP) collected by CMS 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 obtained at the time of the survey.

After this apportionment is made, the Medicaid portion of the CMP is returned to the State. For the Medicare portion, ten percent of the CMP funds that are subject to being held in escrow and that remain after a final administrative decision are deposited with the Department of the Treasury. The remaining ninety percent of the Medicare portion of the CMP funds that are subject to being held in escrow, and that remain after a final administrative decision, are subject to the same uses as the Medicaid-portion of the Federal CMP that is returned to the State (see §7535). For a Medicare-only facility, the entire collected CMP amount is still subject to the 10%/90% split. These Federal CMP funds may not be used for survey and certification operations or State expenses, except that reasonable expenses necessary to administer, monitor, or evaluate the effectiveness of projects utilizing CMP funds may be permitted. Funds must be used entirely for activities that protect or improve the quality of care or life of residents. These activities must be approved as specified under §7535.1).

EXAMPLE: *In a dually-participating facility that has the capacity to provide care for 100 residents, 70 residents are in the facility on the date that the CMP begins to accrue. Of the 70 residents, Medicare is the primary payer for 15 residents, Medicaid is the primary payer for 45 residents, and 10 residents pay for their own care. Thirty of the total 100 beds are empty. There are 60 Medicare and Medicaid residents. The amount of the CMP is apportioned as follows:*

- *75 percent (45/60 residents= 75%) is returned to the State to benefit nursing home residents consistent with §7535 and 25 percent is the federal share;*
- *10 percent of the 25 percent (15/60= 25%) federal share of the CMP would be returned to the Department of the Treasury; and*
- *The remaining 90 percent of the 25 percent (15/60) federal share is used by CMS in accordance with §7535 for activities that protect or improve the quality of care or life of residents.*

NOTE: *All Federal CMPs are subject to being held in escrow and are disbursed as described above upon final administrative decision."*

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. Sections *1819(h)(2)(B)(ii)(IV)(ff)* and *1919(h)(3)(C)(ii)(IV)(ff)* of the Act provide that collected CMP funds may be used 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).

1. Requests for approval must be sent to the appropriate CMS Location for review and final approval. No later than 45 calendar days after receiving a request for approval, CMS will respond with either:

    a) An approval;

    b) A denial, with explanation; or

    c) A request for more information. If CMS requests more information within the 45-day period, then the period needed for project approval will be extended. CMS will undertake further review and a final decision will be provided to the State by the CMS Location within 30 calendar days of the date CMS receives the additional information.

NOTE: If none of the above three actions occurs within 45 days of confirmed CMS receipt of a complete project description and request for approval package, the State should contact both the CMS Location and QualityAssurance@cms.hhs.gov for priority processing.

2. Requests for approval should contain a description of the proposed use/project that includes:

    a) **Purpose and Summary:** Project title, purpose, and project summary;

    b) **Expected Outcomes:** Short description of the intended outcomes, deliverables, and sustainability;

    c) **Results Measurement:** A description of the methods by which the project results will be assessed (including specific measures);

    d) **Benefits to NH Residents:** A brief description of the manner in which the project will benefit nursing home residents;

    e) **Non-Supplanting:** A description of the manner in which the project will not supplant existing responsibilities of the nursing home to meet existing Medicare/Medicaid requirements or other statutory and regulatory requirements;

    f) **Consumer and other Stakeholder Involvement:** A brief description of how the nursing home community (including resident and/or family councils and direct care staff) will be involved in the development and implementation of the project;

    g) **Funding:** The specific amount of CMP funds to be used for this project, the time period of such use, and an estimate of any non-CMP funds that the State or other entity expects to be contributed to the project;

    h) **Involved Organizations:** List all organizations that will receive funds through this project (to the extent known), and organizations that the State expects to carry out and be responsible for the project;

    i) **Contacts:** Name of the State contact person responsible for the project and contact information.

NOTE: States must provide information and obtain prior approval from its CMS Location for any project for which the State wishes to use CMP funds, and CMS reserves the right to disapprove such projects (with prior notice and reconsideration opportunity for the State should CMS disapprove the requested project or use).

3. States may contract with, or grant funds to, any entity permitted under State law and approved by CMS provided that the funds are used for CMS approved projects to protect or improve nursing home services for nursing home residents, and provided that the responsible receiving entity is:

    a) Qualified and capable of carrying out the intended project(s) or use(s);

    b) Not in any conflict of interest relationship with the entity(ies) who will benefit from the intended project(s) or use(s);

    c) Not a recipient of a contract or grant or other payment from Federal or State sources for the same project(s) or use(s);

    d) Not paid by a State or Federal source to perform the same function as the CMP project(s) or use(s). CMP funds may not be used to enlarge or enhance an existing appropriation or statutory purpose that is substantially the same as the intended project(s) or use(s).

NOTE: States may target CMP resources for projects or programs available through various organizations that are knowledgeable, skilled, and capable of meeting the project's purpose in its area of expertise as long as the above criteria are met and the use is consistent with Federal law and policy. Examples of organizations that could qualify include, but are not limited to, consumer advocacy organizations, resident or family councils, professional or State nursing home associations, State Long-term Care Ombudsman programs, quality improvement organizations, private contractors, etc.

7534.2 - Collected From Medicaid Facility

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

One-hundred percent of the Federal civil money penalty collected from a nursing facility is returned to the State. These Federal CMP funds may not be used for survey and certification operations or State expenses, except that reasonable expenses necessary to administer, monitor, or evaluate the effectiveness of projects utilizing civil money penalty funds may be permitted. Funds must be used entirely for activities that protect or improve the quality of care for residents (see §7535). These activities must be approved by CMS as provided in §1919(h)(3)(C)(ii)(IV)(ff) of the Social Security Act and 42 CFR 488.433.

7534.3 –*Imposed and Collected by a State from a Medicaid Facility*

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

A civil money penalty imposed and collected by a State from a Medicaid certified facility (either dually certified for Medicare and Medicaid, or Medicaid-only certified) that the State or CMS find deficient must be applied to the protection of the health or property of residents of nursing facilities that the State or CMS find deficient (see §1919(h)(2)(A)(ii) of the Social Security Act). Per statute and regulation (42 CFR 488.442(g)), appropriate uses by the State of the collected civil money penalty funds include:

1. *State costs related to the maintenance of operations of a facility pending correction of deficiencies or closure;*

2. *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,*

3. *Payment for the cost of relocating residents to other facilities.*

In contrast to funds collected under Federal authority, CMS does not have the authority to endorse, approve, disapprove, or otherwise make determinations about suggested uses for civil money penalties collected by a State. Instead, States have the authority to determine which activities constitute acceptable uses of the funds, as long they are applied to the protection of the health or property of residents of nursing facilities.

7534.4 – Collected Amounts from a Dually Participating Facility or Medicare Facility and Held in Escrow

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

A civil money penalty 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 civil money penalty begins to accrue, per resident census data in the *iQIES* at the time of the survey.

After this apportionment is made, ten percent of the Medicare portion of collected civil money penalty 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 ninety percent of the collected civil money penalty funds that are subject to be held in escrow and that remain after a final administrative decision 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. These activities must be approved by CMS as provided in Sections *1819(h)(2)(B)(ii)(IV)(ff)* and *1919(h)(3)(C)(ii)(IV)(ff)* of the Act.

7535 - Use of Civil Money Penalty Funds

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Sections 1819(h)(2)(B)(ii)(IV)(ff) and 1919(h)(3)(C)(ii)(IV)(ff) of the Act incorporate specific provisions of the Patient Protection and Affordable Care Act (the Affordable Care Act) pertaining to the collection and uses of CMPs imposed by CMS when nursing homes do not meet requirements for Long Term Care Facilities.

1. *42 CFR §488.433 further specifies that all activities and plans for utilizing federal civil money penalty funds, including any expense to administer projects*

utilizing civil money penalty funds must be approved in advance by CMS. The Act provides that collected CMP funds may be used to support activities that benefit residents *and* include, but are not limited to:

a) 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);

b) Time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed (voluntarily or involuntarily) or downsized pursuant to an agreement with the State Medicaid agency;

c) Projects that support resident and family councils and other consumer involvement in assuring quality care in facilities; and

d) 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).

e) Development and maintenance of temporary management or receivership capability, such as but not limited to recruitment, retention, training, or other system infrastructure expenses. However, as specified in §488.415(c), a temporary manager's salary must be paid by the facility. In rare situations, if the facility is closing, CMS plans to stop or suspend continued payments to the facility under 42 CFR § 489.55 during the temporary manager's duty period, and CMS determines that extraordinary action is necessary to protect the residents until relocation efforts are successful, CMP funds may be used to pay the manager's salary (for unique situations, see exceptions in Section 3 below).

For more details about allowable uses of CMP funds within the regulatory provisions listed above, see section 7535.1 below (Allowable and Non-Allowable of the Use of Civil Money Penalty Funds)

Civil Money Penalty Use Applications

The specific use of CMP funds collected from SNF, NF, or SNF/NF as a result of Federally imposed CMPs must be approved in advance by CMS on behalf of the Secretary.

2. *Project application and budget requests are required to be submitted to the State Agency for initial review and recommendation. State Agencies make the initial decision if the requested project benefits nursing home residents and protect or improve their quality of care or quality of life. After the State Agency determines applications meet State requirements, the application and budget requests are*

sent to the CMS CMPRP team for review and final approval. After review of the application and budget request, CMS will provide one of the following notifications within 45 days of receipt:*

a) *An approval. The application has met all application and CMP funding criteria and is approved for the use of CMP funding;*
b) *A denial, with an explanation. The application has not met all application and CMP funding criteria and cannot be approved for the use of CMP funding. The reason for the application denial is specific to the prohibited uses of CMP funding, and the applicant cannot resubmit the application; or*
c) *Request for additional information through corrective actions. When CMS identifies issues or additional application information is required, CMS will request up to two corrective actions for the applicant to respond to the requested information within a 45-day period. If all information is not received with the time period, the application will be returned and will need to be resubmitted as a new application.*

**CMS generally provides a final application decision within 45 days of receipt of the application. However, CMS may delay or place applications on hold to ensure that the intent of the CMP funds is spent appropriately and in accordance with 42 CFR §488.433.*

***NOTE:** For questions related to the status of an application, the State should contact the CMP-Info@cms.hhs.gov mailbox.*

3. *Applications for CMP fund approval should contain a description of the proposed use/project that may include but is not limited to the information below.*

***NOTE**: An application template is available on the CMS Civil Money Penalty Reinvestment Resource website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment.html*:

a) ***Applicant Contact Information:** contact information of the applicant;*
b) ***Applicant Organization Information:** contact information for the organization requesting CMP funds;*
c) ***Organization History:** describe the history of the organization requesting CMP funds;*

d) ***Organization capabilities:** Describe the organization's capabilities, including products and services relevant to the proposed CMP project.*
e) ***Organization Website:** Provide the website address for the organization requesting CMP funds, if available.*
f) ***Other Funding Sources:** indicate whether the applicant or collaborating partners receive Federal or State funds or whether other funding sources,*

such as Federal or State funds have been requested or applied for and/or granted.

g) ***Total CMP Fund Requested Amount:*** *The specific amount of CMP funds to be used for this project;*

h) ***Detailed Line-Item Budget:*** *detailed line-item budget to outline specific cost requirements for the project;*

i) ***Budget Narrative:*** *justify the indirect cost and cost sharing amounts included in the budget for the project;*

j) ***Project Title:*** *provide the title/name of the project;*

k) ***Project Time Period:*** *provide the numbers of years and specific dates of the project;*

l) ***Project Category:*** *identify the category that describes the focus of the project;*

m) ***Summary of the Project and its Purpose:*** *Describe the problem, gap, or nursing home need the project is aiming to address, provide goals and objectives;*

n) ***Benefits to Nursing Home Residents:*** *Describe how this project will directly benefit nursing home residents.*

o) ***Nursing Home and Community Involvement:*** *Describe how the nursing home community (including resident and/or family councils and direct care staff) will be involved in the development and implementation of the project. If the organization applying is not a nursing home, letters of support from all participating nursing homes are provided with the application submission.*

p) ***Other Partnering Entities:*** *Provide any other collaborating entity(ies) that will be partnering with the applicant on the project (e.g., individuals, organizations, associations, facilities);*

q) ***Project Deliverables:*** *List any items that will be deliverables as a result of funding the project (e.g., electronics, training materials, curricula);*

r) ***Performance Monitoring and Evaluation:*** *A description of the methods by which the project results will be monitored or evaluated (including specific metrics) and the intended outcomes. If the applicant and project have previously been approved for CMP funding, results from the prior project should be submitted with the current application;*

s) ***Duplication of Effort:*** *Provide information that demonstrates the project will not duplicate or overlap with the responsibility of the nursing home to meet existing Medicare and Medicaid requirements and other statutory and regulatory requirements, nor duplicate Federal or State services;*

t) ***Risks:*** *Potential risks or barriers associated with implementing the project and a plan to address these concerns;*

u) ***Sustainability:*** *A description of how the project will be sustained after CMP funding concludes; and*

v) ***Signature and Date:*** *Provide the name and signature of the applicant along with the date of the signature.*

NOTE: *State Agencies should provide information to and obtain prior approval from its CMS CMPRP team for any project for which the State wishes to use CMP funds, including projects greater than three years. CMS reserves the right to disapprove such projects.*

4. *State Agencies may contract with, or grant funds to, any entity permitted under State law and approved by CMS provided that the funds are used for CMS-approved projects to protect or improve nursing home services for nursing home residents, and provided that the responsible receiving entity is:*

   a) Qualified and capable of carrying out the intended project(s) or use(s);

   b) Not in any conflict of interest relationship, including but not limited to one with the entity(ies) who will benefit from the intended project(s) or use(s); and

   c) Not a recipient of a contract, grant or other payment from Federal or State sources for the same project(s) or to perform the same function as the CMP project(s) or use(s). CMP funds may not be used to enlarge or enhance an existing appropriation or statutory purpose that is substantially the same as the intended project(s) or use(s).

NOTE: *States may target CMP resources for projects or programs available through various organizations that are knowledgeable, skilled, and capable of meeting the project's purpose in its area of expertise as long as the above criteria are met and the use is consistent with Federal law and policy. Aside from nursing homes, examples of organizations that could qualify include, but are not limited to, consumer advocacy organizations, resident or family councils, professional or State nursing home associations, private contractors, etc.*

NOTE: *States may review resources for submitting CMP applications on the CMS Civil Money Penalty Reinvestment Resource website available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment.html.*

7535.1 –Allowable and Non-Allowable of the Use of Civil Money Penalty Funds

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1) ***Allowable uses of CMP funds***

   Examples of generally allowable uses of CMP funds are listed below. While the purpose of the project may be allowable, specific details of the project might not be not be allowable. Also, CMS may establish maximum funding amounts for projects. However, CMS will not automatically approve the maximum amount allowable for a project. Applicants must continue to clearly demonstrate the need and reasonableness for any funds requested. CMS will consider adjusting the dollar amounts over time (e.g., for inflation). Information on maximum funding

amounts is available at the CMS Civil Money Penalty Reinvestment Program (CMPRP) CMS CMPRP website.

For applicants proposing to implement projects in nursing homes, letters of support from all participating nursing homes should be submitted with the application. The commitment letter must display the project title, time frame, the nursing home's CMS certification number (CCN), and the signature of an individual authorized to commit the nursing home. In the instance of a corporation submitting a project request on behalf of its nursing home(s), a single letter containing the above criteria for all participant facilities will suffice. Exceptions in rare cases to reduce or eliminate the need for letters of support may be available for programs such as state-based conferences where all nursing homes are invited to attend.

CMP funds may be generally used for projects within the following categories:

a) ***Resident or Family Councils:*** *CMP funds may be used for projects by not-for-profit resident advocacy organizations that:*

- *Assist in the development of new independent family councils;*
- *Assist resident and family councils in effective advocacy on their family member's behalf;*
- *Develop materials and training sessions for resident and family councils on state implementation of new federal or state legislation.*

b) ***Consumer Information****: CMP funds may be used to develop and disseminate information that is directly useful to nursing home residents and their families in becoming knowledgeable about their rights, nursing home care processes, and other information useful to a resident.*

c) ***Training to Improve Quality of Care****: CMP funds may be considered for training in facility improvement initiatives that are open to multiple nursing homes, including joint training of facility staff and surveyors, technical assistance for facilities implementing quality assurance programs, training for resident and/or family councils, LTC ombudsman or advocacy organizations and other activities approved by CMS.*

d) ***Activities to Improve Quality of Life****: CMP funds can be used for projects to foster social interaction, movement, and minimize loneliness.*

e) ***Emergency Use for States:*** *States can use CMP funds for time-limited assistance to support and protect residents of a facility that closes (voluntarily or involuntarily) or is decertified. Funding cannot be used for meeting regulatory requirements (e.g., see 42 CFR §483.73 Emergency preparedness). Allowable uses for emergency activities to assist and protect*

residents when a facility closes or is decertified may include, but are not limited to:

- *Resident expenses such as food, supplies, medical equipment or medications necessary during the transfer and relocation process;*
- *Expenses for seeking resident guardianship for purpose of transfer, if required;*
- *State insurance expenditures, workmen's compensation, general liability insurance;*
- *Resident and family interactions to discuss transfer;*
- *Information for residents about facilities and working with facilities to discuss residents who may be transferring;*
- *Receivership costs (e.g., staff salaries, vendor payments). See subsection (j) (CMP Funds During Facility Closure Or Receivership) below for more information on receivership;*
- *Medical records copying; and,*
- *Transportation expenses if needed for resident and family to visit other facilities.*

Other requested uses not listed above must be reviewed by CMS to determine if they are appropriate and allowable or prohibited. Please see the Civil Money Penalty Reinvestment State Plans section (§7535.2) for further detail.

NOTE: States must obtain prior approval of use of CMP funds from CMS except for temporary use in the case of sudden nursing home relocations, natural disasters, or similar emergencies. In such emergency cases, the State must seek CMS approval within 10 working days of the emergency use of CMP funds. States shall report all CMP funds spent on emergencies in accordance with its approved plan for the effective use of CMP funds. States shall report all CMP funds spent on emergencies (see §7535.2 State Plans,2(e) Emergency Reserve Fund Plans). CMP funding cannot be used for meeting regulatory requirements (e.g., see 42 CFR §483.73 Emergency preparedness) or for functions states are required to perform.

f) ***Administrative Use for States****: CMP funds can be requested by the state for certain reasonable costs of administering the CMP funds as part of the annual CMP State Plan process. For example, states may request funds for personnel required to solicit and review CMP Applications. The request should include adequate detail and justification for the requested amount including position descriptions and the breakdown of salary and benefits for each position. Funds may not be used for survey and certification*

operations or state expenses other than a reasonable amount for the actual administration of grant awards including the tracking, monitoring, and evaluating of approved projects.

g) ***Travel Costs**: Travel costs are permitted when it is required to implement the project and must not exceed the maximum funding per category. Travel expenses must be reasonable. Examples of reasonable rates include, but are not limited to, the published U.S. government allowance rates (available from the www.gsa.gov website) for mileage and per diem; and standard commercial rates for airfare. Nursing home staff ,may not apply for travel costs. Travel for state staff will be evaluated with each application.*

***h) Temporary Manager Salaries**: A temporary manager (or State appointed manager or monitor for a nursing home or other form of State administrative management) salary cannot be paid with CMP funds* except *as allowable under facility closure section below.*

i) ***CMP Funds During Facility Closure Or Receivership**: CMP funds can be used, only upon CMS approval, in those rare situations where a facility is closing or in receivership and CMS determines that extraordinary action is necessary to protect the residents until relocation efforts are successful or Medicare and Medicaid payments can be accessed. While in receivership, the limitation of the use of CMP funds will be decided on a case- by- case basis.*

In rare situations, if the facility is closing, CMS plans to stop or suspend continued payments to the facility under 42 CFR § 489.55 during the temporary manager's duty period, and CMS determines that extraordinary action is necessary to protect the residents until relocation efforts are successful, CMP funds may be used to pay the manager's salary and other items noted in the Emergencies section above.)

While §489.55 permits Medicare and Medicaid payments to a facility to continue for up to 30 days after the effective date of a facility's termination or possibly longer (or shorter) if a facility has submitted a notification of closure under §483.70(l) in order to promote the orderly and safe relocation of residents, if the continued Medicare and Medicaid payments are not being used to pay for facility operations during the relocation period, then residents may be placed at increased risk.

Furthermore, there may be situations where CMS concludes that it is otherwise infeasible to ensure timely payment for a temporary manager by the facility and CMS determines that extraordinary action is necessary in order to protect the residents until relocation efforts are successful. For this

reason, and because CMS places a priority on resident protection and protection of the Trust Fund, CMS would allow the use of CMP funds to pay for a temporary or State-appointed manager salary for a limited time, as long as CMS also intends to stop payments to the facility under §489.55 or redirect the flow of Medicare/Medicaid payments to accounts accessible to the receiver or temporary manager. If access to these funds is not available, States should work with CMS to take actions that would stop the improper flow of Medicare/Medicaid funds directly to the facility and to redirect to accessible accounts.

2) Non-allowable uses of CMP funds

The non-allowable uses of CMP funds include, but not limited to, the following categories listed below. States should review these items to ensure they are not incorporated into applications prior to forwarding to the CMPRP team.

a) ***Conflict of Interest Prohibitions:*** *CMS will not approve projects for which a conflict of interest exists or the appearance of a conflict of interest. Generally, projects greater than three years may not be approved. However, the CMS CMPRP team will review projects on an as needed basis. By obliging the State to fund a long and large multi-year expense, we consider such projects to raise the appearance of a conflict of interest for the purpose of levying future CMPs, rather serving the statutory and regulatory purpose to impose remedies on a nursing home for failure to meet the federal requirements.*

b) ***Duplication:*** *States may not use CMP funds to pay entities to perform functions for which they are already paid by State or Federal sources. CMP funds, for example, may not be used to enlarge an existing appropriation or statutory purpose that is substantially the same as the CMP project. Also, CMP funds may not be used to fund State legislative directives for which no or inadequate state funds have been appropriated.*

c) ***Capital Improvements:*** *CMP funds may not be used to pay for capital improvements (a durable upgrade, adaptation, or enhancement of a property that increases its value, often involving a structural change or restoration to a nursing home, or building a nursing home, as the value of such capital improvement accrues to a private party (the owner). Federal and State payments also already acknowledge the expense of capital costs, so the use of CMP funds for such a purpose is prohibited. Capital improvements include replacing a boiler, redesigning a nursing home, landscaping, parking lot or sidewalk construction, adding a concrete patio, etc.*

d) ***Nursing Home Services or Supplies:*** *CMP funds may not be used to pay for nursing home services or supplies that are already the responsibility of the nursing home, such as laundry, linen, food, heat, staffing costs, medical equipment, resident transportation, resident beds, etc. would duplicate an*

existing responsibility of the nursing home. Please consult the State Operations Manual (SOM) Appendix PP.

e) ***Supplementary Funding of Federally Required Services:*** *CMP funds may not be used, for example, to provide Long-Term Care Ombudsman certification training for staff or volunteers or investigate and work to resolve complaints as these are among the responsibilities of Long-Term Care Ombudsman programs under the federal Older Americans Act (OAA), regardless of whether funding is adequate to the purpose. On the other hand, there is no prohibition to an Ombudsman program receiving CMP funds to conduct or participate in approved projects, or to carry out other quality improvement projects that are not within the Ombudsman program's existing set of responsibilities under the OAA. Nor is there any prohibition to Ombudsman program staff or volunteers to participate in training that is paid by CMP funds but open to a broad audience, such as nursing home staff, surveyors, consumers, or others.*

f) ***Complex Technology:*** *CMP funds cannot be used to purchase high-dollar, complex, or sophisticated technologies, such as telemedicine, alert systems, virtual reality, artificial intelligence, etc. Please review the list of non-allowed technology at:* ***https://www.cms.gov/files/zip/allowable-and-non-allowable-uses-cmp-funds.zip***

g) ***Research:*** *Conducting descriptive, analytical, experimental, or integrative research studies on nursing home residents/staff, often consists of projects where the benefit to nursing home residents is unknown or concentrated on the research entity, or a large portion of the budget does not directly benefit nursing home residents. Additionally, research often uses a large portion of the project budget for the development and testing of an intervention or activity, rather than the implementation of the project.*

h) ***Quality Innovation Network-Quality Improvement Organization (QIN/QIO) Approved Projects:*** *CMP funds cannot be used to fund activities for which QIN-QIOs are already receiving federal funding to complete. Check with the State or CMS Location regarding active QIN/QIO projects and activities.*

i) ***Nursing Home Employee Salary:*** *CMP funds cannot be used for salaries (all or part) of nursing home staff.*

j) ***Palliative Care Services:*** *CMP funds cannot be used for palliative care services. Palliative care services are billable medical services consistent with general medical care; therefore, all services are potentially billable to Medicare, Medicaid, private insurance, and private payer systems.*

k) ***Dental, Vision, and Hearing Services:*** *CMP funds are not intended to bridge the gap in coverage for services Medicare does not currently provide.*

Note: Some dental projects may be allowable, such as training, or based on the extent of the state's current dental coverage.

l) ***Incentives:*** *CMP funds cannot be used for monetary and non-monetary gifts to motivate or encourage individuals to do something, including but not*

limited to providing monetary incentives for attending trainings or for completing surveys.

m) ***Overlap with State Functions:*** *CMP funds cannot be used to pay for state salaries and for functions that states are required to perform. This category also includes funding for survey and certification operations. The exception is the administrative use of CMP funds by the State Agency necessary to administer, monitor, or evaluate the effectiveness of CMP projects.*

n) ***Previously Denied CMPRP Projects:*** *CMP funds cannot be used to reactivate denied projects.*

o) ***Telemedicine Services and Equipment:*** *Telemedicine services and telemedicine equipment are not an appropriate use of CMP funds, as States may not use CMP funds to pay entities to perform functions for which they are already paid by State or Federal sources.*

p) ***Prohibited Budget Items:*** *CMP funds should not be used to include items or services that are not related to directly improving the quality of life and/or care of nursing home residents. Budget items should not contain excessive costs, items already considered a nursing home responsibility, or services/items being paid for by a state or federal agency. Also, infection control supplies, purchasing food and drinks are prohibited. Please review the complete list located on the Nonallowable Uses of CMP Funds document accessible here: https://www.cms.gov/files/zip/allowable-and-non-allowable-uses-cmp-funds.zip*

7535.2 – State Civil Money Penalty Reinvestment Plans

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1. *As specified at 42 CFR 488.433(e), States must maintain an acceptable plan, approved by CMS, for the effective use of CMP funds.. Plans must be submitted to the CMS CMPRP team no later than October 31st of each year, unless otherwise specified by CMS. Plans will be reviewed by CMS for compliance with §488.433(e) and allowable uses of CMPs (§7535.1). If there are issues with the plan, States will be contacted for possible revisions. As part of plan requirements, an annual CMP project tracking sheet must be submitted by each State. An optional CMP Reinvestment State Plan Template and CMP Project Tracking Sheet are available for States' use on the CMS CMP Reinvestment Resource Website at https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/LTC-CMP-Reinvestment.html.*

2. *Acceptable plans should include:*

a) ***Plan Timeline:*** *The start date and end date for the plan (i.e., month and year). This should follow the upcoming calendar year (CY) (e.g., January 1, 20XX – December 31, 20XX).*

b) ***Contacts:*** *Name of the State contact person(s) responsible for the plan and their contact information.*

c) ***Current CMP Balance:*** *The projected CMP balance in the State's Federal CMP reinvestment account as of January 1 for the CY covered by the plan.*

d) ***CMPs Returned to the State:*** *The projected or actual Federal CMPs returned to the State during the CY prior to the covered plan period.*

e) ***Emergency Reserve Fund Plans:*** *The amount of CMP funds that a State will hold in reserve for emergencies during the CY. States must indicate the intended use for the funds, such as the relocation of residents pursuant to an involuntary termination from Medicare and Medicaid. This amount should be sufficient to indicate that a State is prepared to respond to emergencies while at the same time is not maintaining a large unused amount of CMP funds. Details should be sufficient to understand how this amount was reached. The State should take an all-hazards approach to emergencies, including natural disasters that are likely to occur in their area and corresponding expenses. The State should provide adequate detail and justification for the amount they are requesting to include emergency use history, and other applicable details such as number of certified beds and applicable expenses (e.g., relocation expenses). CMP funds cannot be used for facilities to meet emergency preparedness requirements.*

f) ***Annual Administrative Use****: If using CMP funds for administration and management of grant awards (tracking, monitoring, and evaluating approved projects), list the amount of CMP funds that will be used during the CY covered by the plan. These funds must be of a reasonable amount. States should provide a description of how these funds will be used that includes a position description(s) and corresponding costs (e.g., salary and benefits for one full-time staff (1 FTE) to oversee the evaluation of approximately 60 submitted CMP applications as well as the administration and monitoring of approximately 20 CMP awards). States must avoid potentially prohibited or problematic costs (e.g., administrative expenses beyond those necessary to administer, monitor, evaluate, or report on the effectiveness of projects utilizing CMP funds).*

g) ***Obligated Funds Plan:*** *A list of continuing and/or new projects planned for the CY. List each project title, amount obligated for approved CY projects, start and*

end dates of the project, and recipient of funds. Provide the total amount of obligated funds for all continuing and/or new projects planned for the CY.

h) ***Available Funds:*** *Provide the State's available funds for new CMP projects for the CY. This does not include the amount of funds for emergency use, administrative use, or for obligated projects.*

A reasonable amount of available funds must be awarded each year for projects that benefit nursing home residents and are consistent with the Act and CMS regulations. CMS considers it a reasonable goal to award at least 50% of CMP funds beyond those held in emergency reserve to projects benefiting nursing home residents.

i) ***Public Information:*** *States must make standard information about CMP-funded projects publicly available. Project information should be updated annually. Provide the specific web address for the publicly available website where the State will post this information. If a State prefers not to maintain its own website, and instead rely on the CMS CMP Reinvestment Resource Website, the State should include information on its website to direct stakeholders to the CMS site where the state CMP fund use is available. The information posted should include:*

- *Project title,*
- *Duration of the project,*
- *Dollar amount awarded for each approved project,*
- *Project summary (i.e., purpose/goals and objectives),*
- *Awardee name,*
- *Results of projects (i.e. the outcome of completed projects), and*
- *Other key information, such as whether improvements have been institutionalized as a result of the project.*

CMS will obtain this information from the State through the CMP Project Tracking Sheet and post it to the CMS CMP Reinvestment Resource Website. States are encouraged to also include this information on their own website for use by potential CMP reinvestment applicants.

j) ***Solicitation Methods:*** *A description of the method that will be used to solicit projects utilizing CMP funds (e.g., websites, notices to the Ombudsman's office, presentations to the nursing home provider community). Provide relevant details for each solicitation method (i.e., who is responsible, when, where, and who the*

target audience is). If applicable, provide information on the types of projects intended to be solicited (e.g., dementia care, music therapy).

k) ***Review Methods:*** *A description of the method that will be used to review and evaluate incoming applications to determine if the proposal meets the criteria for acceptable uses of CMP funds. Include relevant details (i.e., personnel reviewing applications, criteria the State will use to evaluate applications, expected review timeframe, and process for submitting applications to CMS).*

l) ***Monitoring and Tracking Methods:*** *A description of the methods that will be used to monitor and track projects utilizing CMPs including any funds used for administrative use. Provide information on how the State will assure monies paid out for CMP projects were spent on the items identified by the CMP fund recipient in their application (e.g., site visit, invoices, timecards, receipts for supplies and travel). Describe how the State will track project results (e.g., periodic or standard reporting deadlines, deliverables, final report, tracking of metrics).*

m) ***CMP Project Tracking Sheet:*** *At the end of the CY, States should complete and submit to the CMS CMPRP team by February 1 of the subsequent year (e.g., On February 1, 2023, States should submit tracking sheets with information on projects that took place during CY 2022). The information submitted should include:*

- *CMP funds balance (obligated and available) as of the beginning of the calendar year (CY) (e.g., January 1, 20XX);*
- *CMP funds expended for administrative uses during the CY (e.g., CY 20XX);*
- *CMP funds expended for emergency uses during the CY;*
- *CMP funds spent on CMP projects during the CY;*
- *CMP funds added during the CY;*
- *CMP funds balance at the end of the CY (e.g., December 31, 20XX); and*
- *Information on each project implemented during the CY, including:*
    - *Project start date,*
    - *Project end date,*
    - *Total amount of CMP funds approved for the project,*
    - *Project title,*
    - *Project summary [i.e., specific purpose of the project, description of what the project will achieve, explanation of how the project will benefit nursing home residents, and target audience beyond nursing home residents, if applicable],*
    - *Funded entity(ies),*

- *Results/Outcomes of the project, and*
- *Total amount of CMP funds expended during the CY for the project.*

3. *As specified at 42 CFR 488.433(f), if CMS finds that a State does not spend its CMP funds in accordance with 42 CFR 488.433; fails to use its funds to improve the quality of care or quality of life of nursing home residents; or fails to maintain a CMS-approved CMP reinvestment state plan, then CMS may withhold future CMP fund disbursements to the State until an acceptable plan is submitted and approved by CMS. There may be several scenarios where this might occur, for example:*

   - *If CMS has information that a State is using Federal CMP funds for projects or activities that are not in conformance with our law or regulations, which may also include situations where a State is approving projects without obtaining prior CMS approval;*
   - *If a State has a significant fund balance and they have not solicited any requests for proposed projects within the past year, nor have they submitted any project for approval to CMS within the past year; or*
   - *If a State fails to submit an acceptable plan for the use of civil money penalty funds.*

   In these instances, when CMS receives information that a State has misspent CMP funds or fails to make use of funds to benefit the quality of care or life for residents, or fails to maintain an acceptable plan for the use of CMP funds that is approved by CMS, CMS should first contact the State to confirm that this information is accurate. In the case of the State's failure to submit an acceptable plan, the State should be given the opportunity to do so in a timely manner. If CMS determines that the State is not in compliance with 42 CFR 488.433, CMS will notify the CMS Office of Financial Management to withhold Medicaid CMP disbursements until an acceptable CMP reinvestment state plan and/or CMP spending practices are reviewed and approved by CMS.

7536 - Loss of Nurse Aide Training and Competency Evaluation Program or Competency Evaluation Program as a Result of Civil Money Penalty

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Sections *1819(f)(2)(B)* and *1919(f)(2)(B)* of the Act and *42 CFR 483.151(b)* use the term "assessed" to state that the approval of a nurse aide training and competency evaluation program or competency evaluation program is prohibited in a facility which, within the previous 2 years, has been assessed a civil money penalty of not less than $5,000. Section 7809 provides additional information regarding nurse aide training and competency evaluation program and competency evaluation program disapprovals.

7536.2 - Effective Date for Prohibition of Nurse Aide Training and Competency Evaluation Program or Competency Evaluation Program When Civil Money Penalty of $5,000 or More Is Assessed

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

If a civil money penalty of $5,000 (*as adjusted for inflation at 45 CFR 102.3)* or more is assessed on a facility as a result of current or past noncompliance found during a survey, the effective date of the prohibition of the nurse aide training and competency evaluation program or competency evaluation program specified in the notice cannot be before the time frame for requesting a hearing has expired, or after receipt of the written waiver, or later than the date on which a civil money penalty of $5,000 or more (*as adjusted for inflation at 45 CFR 102.3)* is upheld on administrative appeal. In accordance with *42 CFR 483.151,* the State notifies the program in writing, indicating the reason(s) for withdrawal of approval of the program. However, students who have started a training and competency evaluation program for which approval has been withdrawn must be allowed to complete the course.

It is possible for a facility to experience two or more separate disapprovals of its nurse aide training and competency evaluation program or competency evaluation program that could run concurrently for at least part of the same period of time. When two periods of program disapproval overlap, the program will not be restored until the second 2-year disapproval period has been completed. (See §7809.7)

7550.1 - Introduction

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

This remedy is established pursuant to *§1819(h)(2)(A)(I), §1819(h)(B)(iii), §1919(h)(1)(A), §1919(h)(2)(A)(iii), §1919(h)(3)(B)(I), and §1919(h)(3)(C)(iii)* of the Act and *42 CFR 488.415*.

7550.4 - Selection of Temporary Manager

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The State will select the temporary manager when the State Medicaid Agency is imposing the remedy and will recommend a temporary manager to the CMS Location 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, such as through a mutual fund, 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.

The State should investigate eligible candidates' past performance by reviewing any compliance histories in the *iQIES* of facilities managed by the candidates, and by consulting with the long-term care ombudsman, and State Medicaid Agency, if appropriate. The State should reject a candidate who has demonstrated difficulty maintaining compliance in the past.

The State should select or recommend a temporary manager whose work experience and education qualifies the individual to correct the deficiencies in the facility to be managed.

7556 - Termination Procedures for Skilled Nursing Facilities and Nursing Facilities When Facility Is Not in Substantial Compliance *w*ith Participation Requirements

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

7600.7 - Facility Takes Corrective Action According to its Plan of Correction *b*ut Fails to Achieve Substantial Compliance

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

The Medicare facility would not be required to repay the Federal funding received because it followed its approved plan of correction. However, because the facility failed to achieve substantial compliance, continued Federal funding beyond 6 months would stop, and the CMS Location will terminate the skilled nursing facility's provider agreement.

7700.1- Notification Procedures- Preliminary Determinations

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

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:

1. **Individuals Notified** - The State notifies the following individuals in writing within 10 working days of the investigation:

a. Individual(s) implicated in the investigation; and

b. The current administrator of the facility in which the incident occurred.

2. **Notice Information** - The following information is included in the notice:

a. Nature of the allegation (specific facts);

b. Date and time of the occurrence;

c. 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;

d. Statement that if the individual fails to request a hearing, in writing, within 30 days from the date of the notice, the findings will be reported to the nurse aide registry or the appropriate licensure authority;

e. The intent to report *the* findings *in writing, once the individual has had the opportunity for a hearing,* to the nurse aide registry and/or to the appropriate licensure authority;

f. Consequences of waiving the right to a hearing;

g. Consequences of a finding through the hearing process that the resident abuse or neglect, or misappropriation of property did occur; and

h. Right of the accused individual to be represented by an attorney at the individual's own expense.

7700.3- Reporting Findings

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

1 - 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 findings must be reported in writing within 10 working days to:

1. The individual;

2. Current administrator of the facility in which the incident occurred;

3. The administrator of the facility that currently employs the individual, if it is not the same facility in which the incident occurred;

4. Applicable licensing authorities; and

5. The nurse aide registry for nurse aides as specified in *42 CFR 483.156* and discussed in *Chapter 4* of this manual. *Chapter 4 also* discusses the function of the registry, the information contained in the registry, and responsibility for the registry.

2 - Information Submitted to the Nurse Aide Registry

The following information must be included and remain in the registry permanently, unless the finding was made in error, the individual was found not guilty in a court of law, or the State is notified of the individual's death. See *Chapter 4* of this manual.

a. Documentation of the investigation, including the nature of the allegation and the evidence that led to the conclusion that the allegation was valid;

b. The date of the hearing, if the individual chose to have one, and its outcome; and

c. A statement by the individual disputing the allegation if the individual chose to make one.

3- 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.

7701 - Reporting Abuse to Law Enforcement and the Medicaid Fraud Control Unit

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

When the CMS Location or SA *identifies noncompliance related to* finding*(s)* of abuse, the CMS Location or SA must report the findings to local law enforcement and, if appropriate, the Medicaid Fraud Control Unit.

7809.1 - Introduction

(Rev. 244; Issued: 06-26-26; Effective: 06-26-26; Implementation: 06-26-26)

Sections *1819(f)(2)(B)(iii)* and *1919(f)(2)(B)(iii)* of the Act, as well as *42 CFR 483.151(b)(2)* and *483.151(e)*, require denial or withdrawal of approval of facility-based Nurse Aide Training and Competency Evaluation Programs and

Competency Evaluation Programs offered by or in a facility which, within the previous 2 years:

- Has operated under a *§1819(b)(4)(C)(ii)(II)* or *1919(b)(4)(C)(ii)* waiver (see *Chapter 4* of this manual);

- Has been subject to an extended or partial extended survey under *§1819(g)(2)(B)(i)* or *§1919(g)(2)(B)(i)* of the Act; or

- Has been assessed a civil money penalty described in the Act at *§1819(h)(2)(B)(ii)* or *§1919(h)(2)(A)(ii)* of not less than $5,000 or has been subject to a denial of payment, the appointment of a temporary manager, termination, or, in the case of an emergency, been closed and/or had its residents transferred to other facilities. (See §7536 for additional information regarding civil money penalties.)

The program will not be approved if it is offered by or in a facility unless the State makes the determination, upon an individual's completion of the program in the facility, that the individual is competent to provide nursing and nursing related services in skilled nursing facilities or nursing facilities.

Any reversals of *NATCEP/CEP* denials or withdrawals are limited to the informal dispute resolution *or Independent informal dispute resolution* process*es*.

In accordance with *42 CFR 483.151*, the State notifies the program in writing, indicating the reason(s) for withdrawal of approval of the program. However, students who have started a program for which approval has been withdrawn must be allowed to complete the course.