

care on the last three consecutive standard surveys.

(c) *Resumption of payments: Repeated instances of substandard quality of care.* When a facility has repeated instances of substandard quality of care, payments to the facility or, under Medicaid, CMS payments to the State on behalf of the facility, resume on the date that—

(1) The facility achieves substantial compliance as indicated by a revisit or written credible evidence acceptable to CMS (for all facilities except non-State operated NFs against which CMS is imposing no remedies) or the State (for non-State operated NFs against which CMS is imposing no remedies); and

(2) CMS (for all facilities except non-State operated NFs against which CMS is imposing no remedies) or the State (for non-State operated NFs against which CMS is imposing no remedies) believes that the facility is capable of remaining in substantial compliance.

(d) *Resumption of payments: No repeated instances of substandard quality of care.* When a facility does not have repeated instances of substandard quality of care, payments to the facility or, under Medicaid, CMS payments to the State on behalf of the facility, resume prospectively on the date that the facility achieves substantial compliance, as indicated by a revisit or written credible evidence acceptable to CMS (under Medicare) or the State (under Medicaid).

(e) *Restriction.* No payments to a facility or, under Medicaid, CMS payments to the State on behalf of the facility, are made for the period between the date that the—

(1) Denial of payment remedy is imposed; and

(2) Facility achieves substantial compliance, as determined by CMS or the State.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

**§ 488.418 Secretarial authority to deny all payments.**

(a) *CMS option to deny all payment.* If a facility has not met a requirement, in addition to the authority to deny payment for all new admissions as specified in § 488.417, CMS may deny any further payment for all Medicare

residents in the facility and to the State for all Medicaid residents in the facility.

(b) *Prospective resumption of payment.* Except as provided in paragraphs (d) and (e) of this section, if the facility achieves substantial compliance, CMS resumes payment prospectively from the date that it verifies as the date that the facility achieved substantial compliance.

(c) *Restriction on payment after denial of payment is imposed.* If payment to the facility or to the State resumes after denial of payment for all residents, no payment is made for the period between the date that—

(1) Denial of payment was imposed; and

(2) CMS verifies as the date that the facility achieved substantial compliance.

(d) *Retroactive resumption of payment.* Except when a facility has repeated instances of substandard quality of care, as specified in paragraph (e) of this section, when CMS or the State finds that the facility was in substantial compliance before the date of the revisit, or before CMS or the survey agency received credible evidence of such compliance, payment is resumed on the date that substantial compliance was achieved, as determined by CMS.

(e) *Resumption of payment—repeated instances of substandard care.* When CMS denies payment for all Medicare residents for repeated instances of substandard quality of care, payment is resumed when—

(1) The facility achieved substantial compliance, as indicated by a revisit or written credible evidence acceptable to CMS; and

(2) CMS believes that the facility will remain in substantial compliance.

**§ 488.422 State monitoring.**

(a) A State monitor—

(1) Oversees the correction of deficiencies specified by CMS or the State survey agency at the facility site and protects the facility's residents from harm;

(2) Is an employee or a contractor of the survey agency;

(3) Is identified by the State as an appropriate professional to monitor cited deficiencies;

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(4) Is not an employee of the facility;  
(5) Does not function as a consultant to the facility; and

(6) Does not have an immediate family member who is a resident of the facility to be monitored.

(b) A State monitor must be used when a survey agency has cited a facility with substandard quality of care deficiencies on the last 3 consecutive standard surveys.

(c) State monitoring is discontinued when—

(1) The facility has demonstrated that it is in substantial compliance with the requirements, and, if imposed for repeated instances of substandard quality of care, will remain in compliance for a period of time specified by CMS or the State; or

(2) Termination procedures are completed.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

**§ 488.424 Directed plan of correction.**

CMS, the State survey agency, or the temporary manager (with CMS or State approval) may develop a plan of correction and CMS, the State, or the temporary manager require a facility to take action within specified timeframes.

**§ 488.425 Directed inservice training.**

(a) *Required training.* CMS or the State agency may require the staff of a facility to attend an inservice training program if—

(1) The facility has a pattern of deficiencies that indicate noncompliance; and

(2) Education is likely to correct the deficiencies.

(b) *Action following training.* After the staff has received inservice training, if the facility has not achieved substantial compliance, CMS or the State may impose one or more other remedies specified in § 488.406.

(c) *Payment.* The facility pays for directed inservice training.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

**42 CFR Ch. IV (10–1–06 Edition)**

**§ 488.426 Transfer of residents, or closure of the facility and transfer of residents.**

(a) *Transfer of residents, or closure of the facility and transfer of residents in an emergency.* In an emergency, the State has the authority to—

(1) Transfer Medicaid and Medicare residents to another facility; or

(2) Close the facility and transfer the Medicaid and Medicare residents to another facility.

(b) *Required transfer when a facility's provider agreement is terminated.* When the State or CMS terminates a facility's provider agreement, the State arranges for the safe and orderly transfer of all Medicare and Medicaid residents to another facility.

[59 FR 56243, Nov. 10, 1994; 60 FR 50119, Sept. 28, 1995]

**§ 488.430 Civil money penalties: Basis for imposing penalty.**

(a) CMS or the State may impose a civil money penalty for either the number of days a facility is not in substantial compliance with one or more participation requirements or for each instance that a facility is not in substantial compliance, regardless of whether or not the deficiencies constitute immediate jeopardy.

(b) CMS or the State may impose a civil money penalty for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.

[59 FR 56243, Nov. 10, 1994, as amended at 64 FR 13360, Mar. 18, 1999]

**§ 488.432 Civil money penalties: When a penalty is collected.**

(a) *When facility requests a hearing.* (1) A facility must request a hearing on the determination of the noncompliance that is the basis for imposition of the civil money penalty within the time specified in one of the following sections:

(i) Section 498.40 of this chapter for a  
(A) SNF;

(B) Dually participating facility;

(C) State-operated NF; or

(D) Non-State operated NF against which CMS is imposing remedies.

(ii) Section 431.153 of this chapter for a non-State operated NF that is not