

(c) CMS does and the State must deny payment for new admissions when a facility is not in substantial compliance 3 months after the last day of the survey.

(d) CMS terminates the provider agreement for SNFs and NFs, and stops FFP to a State for a NF for which participation was continued under paragraph (a) of this section, if the facility is not in substantial compliance within 6 months of the last day of the survey.

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§ 488.414 Action when there is repeated substandard quality of care.

(a) *General.* If a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, as defined in § 488.305, regardless of other remedies provided—

(1) CMS imposes denial of payment for all new admissions, as specified in § 488.417, or denial of all payments, as specified in § 488.418;

(2) The State must impose denial of payment for all new admissions, as specified in § 488.417; and

(3) CMS does and the State survey agency must impose State monitoring, as specified in § 488.422, until the facility has demonstrated to the satisfaction of CMS or the State, that it is in substantial compliance with all requirements and will remain in substantial compliance with all requirements.

(b) *Repeated noncompliance.* For purposes of this section, repeated noncompliance is based on the repeated finding of substandard quality of care and not on the basis that the substance of the deficiency or the exact tag number for the deficiency was repeated.

(c) *Standard surveys to which this provision applies.* Standard surveys completed by the State survey agency on or after October 1, 1990, are used to determine whether the threshold of three consecutive standard surveys is met.

(d) *Program participation.* (1) The determination that a certified facility has repeated instances of substandard quality of care is made without regard to any variances in the facility's program participation (that is, any standard survey completed for Medicare,

Medicaid or both programs will be considered).

(2) Termination would allow the count of repeated substandard quality of care surveys to start over.

(3) Change of ownership. (i) A facility may not avoid a remedy on the basis that it underwent a change of ownership.

(ii) In a facility that has undergone a change of ownership, CMS does not and the State may not restart the count of repeated substandard quality of care surveys unless the new owner can demonstrate to the satisfaction of CMS or the State that the poor past performance no longer is a factor due to the change in ownership.

(e) *Facility alleges corrections or achieves compliance after repeated substandard quality of care is identified.* (1) If a penalty is imposed for repeated substandard quality of care, it will continue until the facility has demonstrated to the satisfaction of CMS or the State that it is in substantial compliance with the requirements and that it will remain in substantial compliance with the requirements for a period of time specified by CMS or the State.

(2) A facility will not avoid the imposition of remedies or the obligation to demonstrate that it will remain in compliance when it—

(i) Alleges correction of the deficiencies cited in the most recent standard survey; or

(ii) Achieves compliance before the effective date of the remedies.

§ 488.415 Temporary management.

(a) *Definition.* Temporary management means 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.

(b) *Qualifications.* The temporary manager must—

(1) Be qualified to oversee correction of deficiencies on the basis of experience and education, as determined by the State;

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(2) Not have been found guilty of misconduct by any licensing board or professional society in any State;

(3) Have, or a member of his or her immediate family have, no financial ownership interest in the facility; and

(4) Not currently serve or, within the past 2 years, have served as a member of the staff of the facility.

(c) *Payment of salary.* The temporary manager's salary—

(1) Is paid directly by the facility while the temporary manager is assigned to that facility; and

(2) Must be at least equivalent to the sum of the following—

(i) The prevailing salary paid by providers for positions of this type in what the State considers to be the facility's geographic area;

(ii) Additional costs that would have reasonably been incurred by the provider if such person had been in an employment relationship; and

(iii) Any other costs incurred by such a person in furnishing services under such an arrangement or as otherwise set by the State.

(3) May exceed the amount specified in paragraph (c)(2) of this section if the State is otherwise unable to attract a qualified temporary manager.

(d) *Failure to relinquish authority to temporary management—*(1) *Termination of provider agreement.* If a facility fails to relinquish authority to the temporary manager as described in this section, CMS will or the State must terminate the provider agreement in accordance with § 488.456.

(2) *Failure to pay salary of temporary manager.* A facility's failure to pay the salary of the temporary manager is considered a failure to relinquish authority to temporary management.

(e) *Duration of temporary management.* Temporary management ends when the facility meets any of the conditions specified in § 488.454(c).

§ 488.417 Denial of payment for all new admissions.

(a) *Optional denial of payment.* Except as specified in paragraph (b) of this section, CMS or the State may deny payment for all new admissions when a facility is not in substantial compliance with the requirements, as defined in § 488.401, as follows:

(1) *Medicare facilities.* In the case of Medicare facilities, CMS may deny payment to the facility.

(2) *Medicaid facilities.* In the case of Medicaid facilities—

(i) The State may deny payment to the facility; and

(ii) CMS may deny payment to the State for all new Medicaid admissions to the facility.

(b) *Required denial of payment.* CMS does or the State must deny payment for all new admissions when—

(1) The facility is not in substantial compliance, as defined in § 488.401, 3 months after the last day of the survey identifying the noncompliance; or

(2) The State survey agency has cited a facility with substandard quality of 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).