

## Health Care Financing Administration, HHS

## § 488.1

488.28 Providers or suppliers, other than SNFs and NFs, with deficiencies.

### Subpart B—Special Requirements

488.52 [Reserved]

488.54 Temporary waivers applicable to hospitals.

488.56 Temporary waivers applicable to skilled nursing facilities.

488.60 Special procedures for approving end stage renal disease facilities.

488.64 Remote facility variances for utilization review requirements.

488.68 State Agency responsibilities for OASIS collection and data base requirements.

### Subpart C—Survey Forms and Procedures

488.100 Long term care survey forms, Part A.

488.105 Long term care survey forms, Part B.

488.110 Procedural guidelines.

488.115 Care guidelines.

### Subpart D—Reconsideration of Adverse Determinations—Deeming Authority for Accreditation Organizations and CLIA Exemption of Laboratories Under State Programs

488.201 Reconsideration.

488.203 Withdrawal of request for reconsideration.

488.205 Right to informal hearing.

488.207 Informal hearing procedures.

488.209 Hearing officer's findings.

488.211 Final reconsideration determination.

### Subpart E—Survey and Certification of Long-Term Care Facilities

488.300 Statutory basis.

488.301 Definitions.

488.303 State plan requirement.

488.305 Standard surveys.

488.307 Unannounced surveys.

488.308 Survey frequency.

488.310 Extended survey.

488.312 Consistency of survey results.

488.314 Survey teams.

488.318 Inadequate survey performance.

488.320 Sanctions for inadequate survey performance.

488.325 Disclosure of results of surveys and activities.

488.330 Certification of compliance or non-compliance.

488.331 Informal dispute resolution.

488.332 Investigation of complaints of violations and monitoring of compliance.

488.334 Educational programs.

488.335 Action on complaints of resident neglect and abuse, and misappropriation of resident property.

### Subpart F—Enforcement of Compliance For Long-Term Care Facilities with Deficiencies

488.400 Statutory basis.

488.401 Definitions.

488.402 General provisions.

488.404 Factors to be considered in selecting remedies.

488.406 Available remedies.

488.408 Selection of remedies.

488.410 Action when there is immediate jeopardy.

488.412 Action when there is no immediate jeopardy.

488.414 Action when there is repeated substandard quality of care.

488.415 Temporary management.

488.417 Denial of payment for all new admissions.

488.418 Secretarial authority to deny all payments.

488.422 State monitoring.

488.424 Directed plan of correction.

488.425 Directed inservice training.

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

488.430 Civil money penalties: Basis for imposing penalty.

488.432 Civil money penalties: When a penalty is collected.

488.434 Civil money penalties: Notice of penalty.

488.436 Civil money penalties: Waiver of hearing, reduction of penalty amount.

488.438 Civil money penalties: Amount of penalty.

488.440 Civil money penalties: Effective date and duration of penalty.

488.442 Civil money penalties: Due date for payment of penalty.

488.444 Civil money penalties: Settlement of penalties.

488.450 Continuation of payments to a facility with deficiencies.

488.452 State and Federal disagreements involving findings not in agreement in non-State operated NFs and dually participating facilities when there is no immediate jeopardy.

488.454 Duration of remedies.

488.456 Termination of provider agreement.

AUTHORITY: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395(hh)).

SOURCE: 53 FR 22859, June 17, 1988, unless otherwise noted.

### Subpart A—General Provisions

#### § 488.1 Definitions.

As used in this part—

*Accredited provider or supplier* means a provider or supplier that has voluntarily applied for and has been accredited by a national accreditation program meeting the requirements of and approved by HCFA in accordance with § 488.5 or § 488.6.

*Act* means the Social Security Act.

*AOA* stands for the American Osteopathic Association.

*Certification* is a recommendation made by the State survey agency on the compliance of providers and suppliers with the conditions of participation, requirements (for SNFs and NFs), and conditions of coverage.

*Conditions for coverage* means the requirements suppliers must meet to participate in the Medicare program.

*Conditions of participation* means the requirements providers other than skilled nursing facilities must meet to participate in the Medicare program and includes conditions of certification for rural health clinics.

*Full review* means a survey of a hospital for compliance with all conditions of participation for hospitals.

*JCAHO* stands for the Joint Commission on Accreditation of Healthcare Organizations.

*Medicare condition* means any condition of participation or for coverage, including any long term care requirements.

*Provider of services* or *provider* means a hospital, critical access hospital, skilled nursing facility, nursing facility, home health agency, hospice, comprehensive outpatient rehabilitation facility, or provider of outpatient physical therapy or speech pathology services.

*Rate of disparity* means the percentage of all sample validation surveys for which a State survey agency finds non-compliance with one or more Medicare conditions and no comparable condition level deficiency was cited by the accreditation organization, where it is reasonable to conclude that the deficiencies were present at the time of the accreditation organization's most recent surveys of providers or suppliers of the same type.

*Example:* Assume that during a validation review period State survey agencies perform validation surveys at 200 facilities of the same type (for ex-

ample, ambulatory surgical centers, home health agencies) accredited by the same accreditation organization. The State survey agencies find 60 of the facilities out of compliance with one or more Medicare conditions, and it is reasonable to conclude that these deficiencies were present at the time of the most recent survey by an accreditation organization. The accreditation organization, however, has found deficiencies comparable to the condition level deficiencies at only 22 of the 60 facilities. These validation results would yield  $((60-22)/200)$  a rate of disparity of 19 percent.

*Reasonable assurance* means that an accreditation organization has demonstrated to HCFA's satisfaction that its requirements, taken as a whole, are at least as stringent as those established by HCFA, taken as a whole.

*State* includes the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, and American Samoa.

*State survey agency* means the State health agency or other appropriate State or local agency used by HCFA to perform survey and review functions for Medicare.

*Substantial allegation of noncompliance* means a complaint from any of a variety of sources (including complaints submitted in person, by telephone, through written correspondence, or in newspaper or magazine articles) that, if substantiated, would affect the health and safety of patients and raises doubts as to a provider's or supplier's noncompliance with any Medicare condition.

*Supplier* means any of the following: Independent laboratory; portable X-ray services physical therapist in independent practice; ESRD facility; rural health clinic; Federally qualified health center; or chiropractor.

*Validation review period* means the one year period during which HCFA conducts a review of the validation surveys and evaluates the results of the most recent surveys performed by the accreditation organization.

[53 FR 22859, June 17, 1988, as amended at 54 FR 5373, Feb. 2, 1989; 56 FR 48879, Sept. 26, 1991; 57 FR 24982, June 12, 1992; 58 FR 30676, May 26, 1993; 58 FR 61838, Nov. 23, 1993; 62 FR 46037, Aug. 29, 1997]