

Enforcement begins before the healthcare surveyors enter the facility—in pre-survey activities. Surveyors must be aware of previous deficiencies, if any, and the facility’s current enforcement cycle status. They must also know if the facility will be afforded an Opportunity to Correct (OTC) or a No Opportunity to Correct (NOTC), which depends on the Scope and Severity of deficiencies cited on previous surveys.

Enforcement continues when the surveyors enter the facility and proceed with their investigation, which includes observations, interviews, and record reviews. When the survey is complete, the facility is notified, within ten (10) working days of any deficiencies identified, in a Statement of Deficiencies (the CMS 2567L- SOD). The facility then must respond within ten (10) calendar days with their Plan of Correction (the P OC).

Once an investigation has been completed, the facility is notified of the deficiencies and the facility’s Plan of Correction is submitted. The State Agency must receive documented evidence (the POC) of the facility’s actions of how the facility has corrected the deficient practice.

Enforcement actions can include the following:

- An Approved PoC is required whenever there is non-compliance;
- Remedies can be imposed anytime for any level of compliance;
- Onsite revisits can be conducted anytime for any level of non-compliance.

Aligned with the facility’s POC are other possible enforcement activities—depending upon the circumstances of the deficiencies identified. Some of the remedies include: directed in-service training; state monitoring; termination of a provider agreement; denial of participation; denial of payment for new Medicare and Medicaid residents (DPNA); denial of all payments for resident care; civil monetary penalties; temporary management, transfer of residents; transfer of residents and closure of the facility; or other CMS approved alternative State remedies such as the Special Focus Facility Initiative.

CMS may terminate an agreement with a provider of services if it is determined that the provider:

- Is not complying substantially with the terms of the agreement, the provisions of title XVIII of the Social Security Act, or regulations promulgated thereunder;
- Has failed to supply information necessary to determine whether payments are or were due and the amounts of such payments;
- Refuses to permit examination of fiscal and other records (including medical records) necessary for the verification of information furnished as a basis for claiming payment under the Medicare program; or
- Refuses to permit photocopying of any records or other information necessary to determine or verify compliance with participation requirements.

See [Chapter 7 of the State Operations Manual](#) for more information related to Enforcement pertaining to SNFs and NFs.