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Senate
State of Minnesota

S.F. No. 127 - Ramsey County Nursing Home Rate Increase

Author: Senator Charles Wiger

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 4, 2005

S.F. No. 127 provides a per diem rate increase of $4.98 for a 180-bed nursing facility in Ramsey County, effective July 1, 2005.

DG:rdr

Senator Wiger introduced--

S.F. No. 127: Referred to the Committee on Health and Family Security.

A bill for an act

relating to counties; providing for a rate increase determination for the Ramsey County nursing facility; amending Minnesota Statutes 2004, section 256B.431, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 256B.431, is amended by adding a subdivision to read:

Subd. 28a. [RAMSEY COUNTY NURSING FACILITY RATE DETERMINATION.] Following the determination under subdivision 28 of the payment rate for the rate year beginning July 1, 2005, for a facility in Ramsey County licensed for 180 beds, the facility's operating cost per diem shall be increased by $4.98.

Sec. 2. [EFFECTIVE DATE.]

Section 1 is effective the day following final enactment.

Senator ..... moves to amend S.F. No. 127 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 256B.434, is amended by adding a subdivision to read:

Subd. 4f. [RATE INCREASE EFFECTIVE JULY 1, 2005.] For the rate year beginning July 1, 2005, a facility in Ramsey County licensed for 180 beds shall have its operating payment rate as determined under this section and in effect on June 30, 2005, increased by $4.98. The increase under this subdivision shall be included in the facility's total payment rates for the purposes of determining future rates under this section or any other section.

Sec. 2. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2005, for the purposes of section 1."

Delete the title and insert:

"A bill for an act relating to counties; providing for a rate increase determination for the Ramsey County nursing facility; amending Minnesota Statutes 2004, section 256B.434, by adding a subdivision."

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MAJA WEIDMANN

Senate
State of Minnesota

S.F. No. 284 - Zero-Depth Swimming Pools

Author: Senator David Gaither

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: February 7, 2005

Minnesota Rules, part 4717.1850, requires pools with a zero-depth area to have a lifeguard present at the zero-depth area at all times the pool is in use. **S.F. No. 284** would exempt a pool with a zero-depth area from this rule requirement when the pool's use is limited to individuals who are 18 years of age or older.

KC:ph

Senators Gaither, Rest and Olson introduced--

S.F. No. 284: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; authorizing the limited use of zero-depth public swimming pools without a lifeguard; amending Minnesota Statutes 2004, section 144.1222, by adding a subdivision.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.1222, is amended by adding a subdivision to read:

Subd. 2c. [POOLS USED FOR ADULT-ONLY RECREATION.] Notwithstanding Minnesota Rules, part 4717.1850, a pool with a zero-depth area may be used without the presence of a lifeguard if access to the pool area is limited to individuals who are 18 years of age or older during the time a lifeguard is not present.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Senator ..... moves to amend S.F. No. 284 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 144.1222, is amended by adding a subdivision to read:

Subd. 2c. [POOLS USED FOR ADULT-ONLY RECREATION.] Notwithstanding Minnesota Rules, part 4717.1850, a pool with a zero-depth area may be used without a lifeguard present if access to the pool area is prohibited to individuals under the age of 18 years during the time a lifeguard is not present.

[EFFECTIVE DATE.] This section is effective the day following final enactment."

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Senate
State of Minnesota

S.F. No. 109 - Federally Qualified Health Centers (FQHC) and Rural Heath Clinics (RHC)

Author: Senator Linda Berglin

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: February 7, 2005

S.F. No. 109 requires the Commissioner of Human Services to provide grants to FQHCs and RHCs that equal the percentage of the provider tax imposed on these clinics in the previous calendar year for medical assistance and MinnesotaCare recipients eligible for federal matching funds. This is related to the change made in 2003 that removed the provider tax exemption for medical assistance and MinnesotaCare revenues. To counteract the financial impact of removing this exemption, the rates to providers were increased accordingly. However, the rates for FQHC and RHC are set federally and could not be raised putting these clinics at a financial disadvantage.

KC:ph

Senator Berglin introduced--

S.F. No. 109: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying the provider tax paid by federally qualified health centers and rural health clinics; appropriating money.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. [FEDERALLY QUALIFIED HEALTH CENTER AND RURAL HEALTH CLINICS GRANTS.]

The commissioner of human services shall provide grants to federally qualified health centers and rural health clinics equal to the percentage of the provider tax imposed under Minnesota Statutes, section 295.50 to 295.59, for the previous calendar year multiplied by the payments made to each health clinic in the previous calendar year for medical assistance and MinnesotaCare recipients who are eligible for federal matching funds. The grants shall be distributed by April 15 of each year beginning April 15, 2005.

Sec. 2. [APPROPRIATION.]

$..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2005, for the purposes of section 1.

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Minnesota Association of Community Health Centers
Testimony to Health & Family Security Committee

S.F. 109

Madame Chair, committee members, my name is Rhonda Degelau. I am the Executive Director of the Minnesota Association of Community Health Centers. I'm here today to testify in support of S.F. 109. My organization represents the Federally Qualified Health Centers, or FQHCs, in Minnesota. An FQHC is a federally designated clinic that must meet three basic criteria. First, it must be located in a Medically Underserved Area. Second, it must provide comprehensive primary care services including dental and mental health care services. And finally, it must agree to serve all patients, regardless of their ability to pay.

In 2004, Minnesota's Federally Qualified Health Centers (FQHCs) served approximately 129,000 patients at 54 clinic sites throughout Minnesota. The FQHC patient population is quite different from that of most other private clinics. Thirty-nine percent (39%) of our patients are low-income uninsured, and an additional 37% are enrolled in public health care programs such as Medicaid or MinnesotaCare. While federal grants help offset the cost of care for uninsured patients, the grants cover only a portion of those expenses. Many low-income uninsured patients also contribute to the cost of their care, as they are able, based on family size and income.

Minnesota's FQHCs also serve a much more diverse population than most other private clinics. Only 36% of our patients are white, while 27% are Latino, 22% African-American, 9% Asian, and 6% Native American. This patient population suffers from much higher rates of diabetes, cardiovascular disease, and other preventable, chronic illnesses than patient populations at other private clinics. In order to reduce these health disparities, Minnesota's FQHCs participate in a national initiative to prevent and manage chronic disease. The 2004 study of quality care data from Minnesota Community Measurement demonstrated that Minnesota's FQHCs provide care that is comparable to or, in some cases, better than that provided at other private clinics.

Minnesota's FQHCs play a critical role in caring for much of the state's low-income, uninsured population. They do so with limited financial resources, and with virtually no ability to cost-shift financial shortfalls.

Senate File 109, introduced by Senator Berglin, corrects what the Department of Human Services has called an "unforeseen consequence" of changes made to the provider tax in 2003. As you know, on January 1, 2004, health care providers in Minnesota were required to pay a two percent tax on revenues collected from the Medical Assistance (MA), General Assistance Medical Care (GAMC) and MinnesotaCare programs. Prior to the change, revenues from these programs were exempt from the provider tax.

In enacting this change in 2003, the legislature also approved a Medicaid rate increase for providers that would roughly cover the amount of additional taxes to be paid. The intent, as I understand it, was to maximize federal match drawdown while minimizing the financial impact to providers. The Medicaid rate increase was intended to "hold harmless" the providers paying the additional tax.

Because FQHCs are paid under a prospective payment system governed by federal law, the state was unable to extend this "hold harmless" offset to FQHCs. The federal prospective payment system establishes rates and adjustment methodology that cannot be adjusted outside of the federal requirements. Therefore, the provider tax offset cannot be extended to FQHCs through a rate increase.

Based on our own internal estimates, FQHCs will pay an additional tax of approximately $1.1 million during the 2006-07 biennium with no corresponding offset to our Medicaid rate. It is important to note here that Minnesota's certified Rural Health Clinics (RHCs) are in the same situation as the FQHCs. They also are paid on the federal prospective payment system, and are therefore paying additional provider tax with no corresponding offset. While our Association does not officially represent the Rural Health Clinics, we estimate that collectively those clinics will pay an additional $360,000 in provider taxes over the biennium.

The legislation before you today would establish a non-competitive grant program that would reimburse each FQHC and RHC an amount equal to the additional provider tax paid. In other words, FQHCs and RHCs would also receive an offset, although through a different vehicle than our Medicaid payment rates.

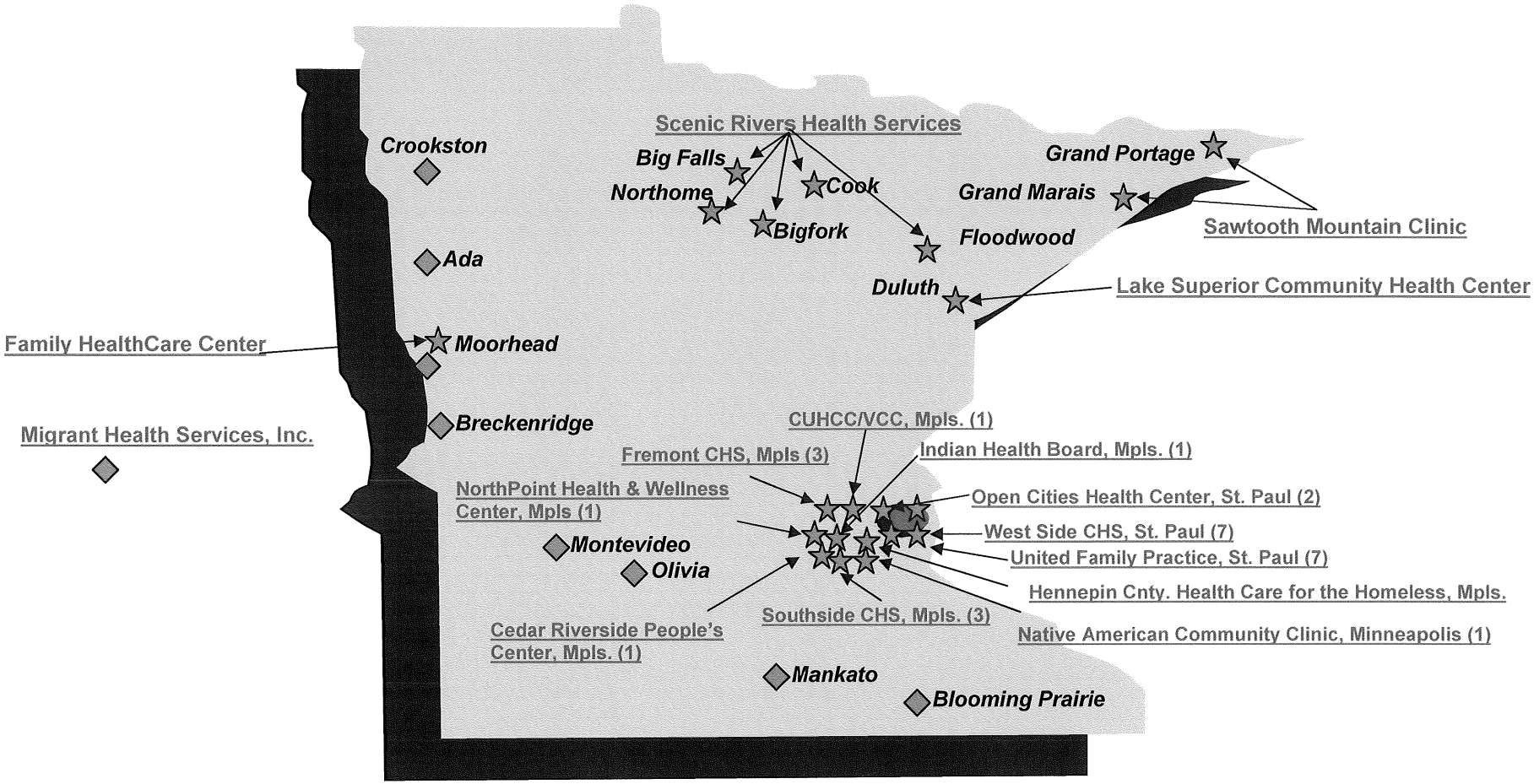
The impact of S.F. 109 is two-fold: First the bill would permit the Department of Human Services to treat FQHCs and RHCs as they treat other providers affected by the provider tax. The policy would then be consistent across all providers. Secondly, and more importantly, the bill would allow FQHCs and RHCs to maintain their commitment to the patients that they serve. With the additional tax burden, FQHCs may need to scale-back the level of services they currently provide. For illustrative purposes, the $1.1 million in additional taxes would otherwise provide care to nearly 1,400 patients on an annual basis.

In summary, I urge you to support S.F. 109. We believe that this bill will help FQHCs maintain their commitment to the communities they serve throughout the state - especially at a time when proposed budget cuts to MinnesotaCare threaten to significantly increase the numbers of uninsured seeking care at these clinics.

Thank you for your time and I'd be happy to answer any questions.

Minnesota Association of
COMMUNITY HEALTH CENTERS

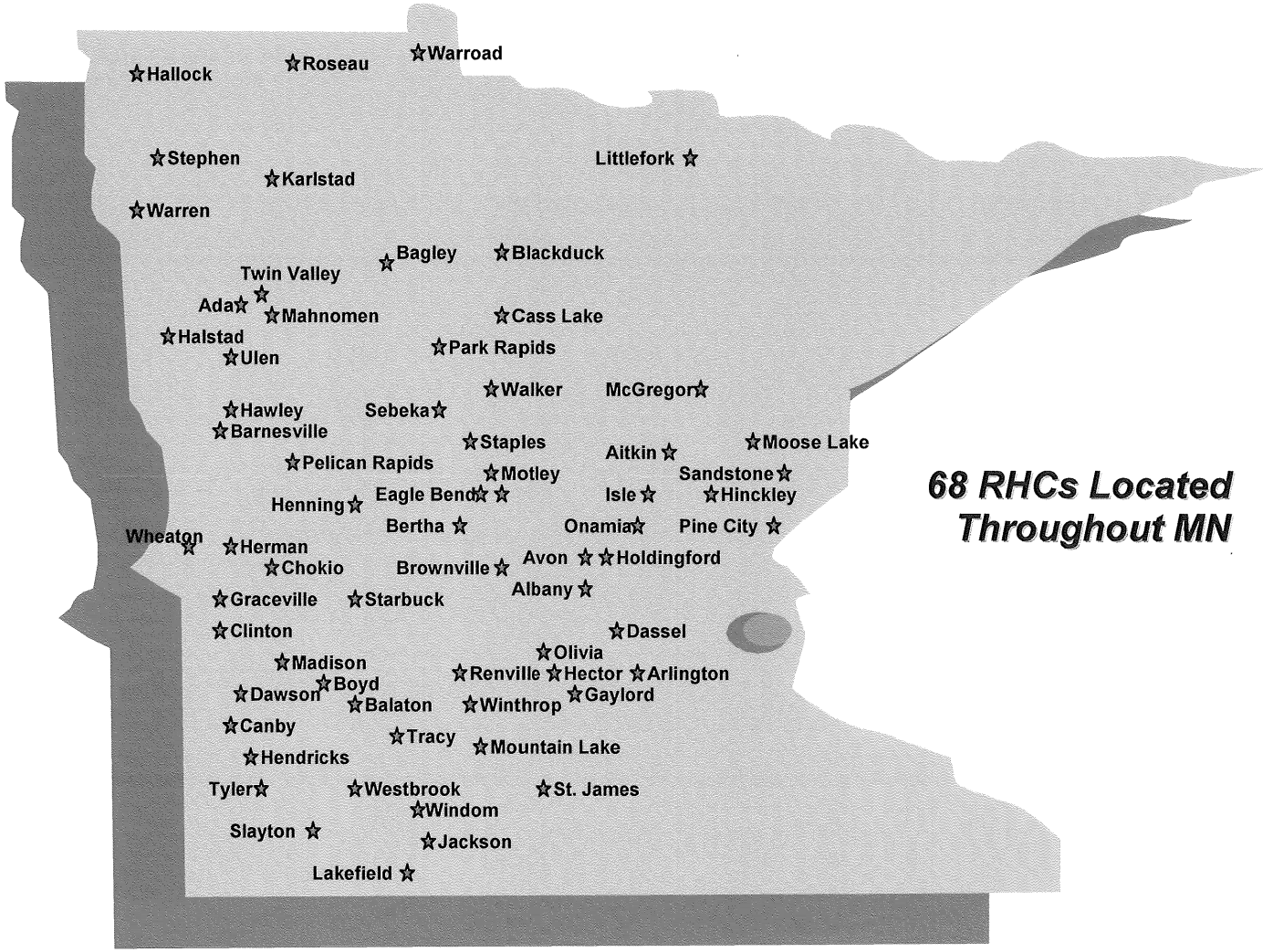
Minnesota's Federally Qualified Health Centers



"Working Together for Affordable Health Care"

Minnesota Association of
COMMUNITY HEALTH CENTERS

Minnesota's Rural Health Clinics



68 RHCs Located Throughout MN

"Working Together for Affordable Health Care"

WORKING TOGETHER FOR AFFORDABLE HEALTH CARE

Minnesota Association of
COMMUNITY HEALTH CENTERS

The Minnesota Association of Community Health Centers (MNACHC) is a non-profit association o Federally Qualified Health Centers (FQHCs) and other providers that offer comprehensiv preventive and primary health care services to all individuals, regardless of their ability to pay. Ou member clinics provide medical, dental and mental health care to patients in urban, rural and tribal areas throughout the state. The majority of patients served by these clinics are low-incom and uninsured.

HOW DO COMMUNITY HEALTH CENTERS BENEFIT MINNESOTA?

FQHCs help prevent illness and disease by supplying preventive and primary care for low-income individuals and families who might otherwise delay seeking medical attention. Not only do FQHCs reduce expensive emergency room visits, but FQHCs cost-effectively save both lives and dollars for Minnesota.

HOW ARE FQHCs FUNDED?

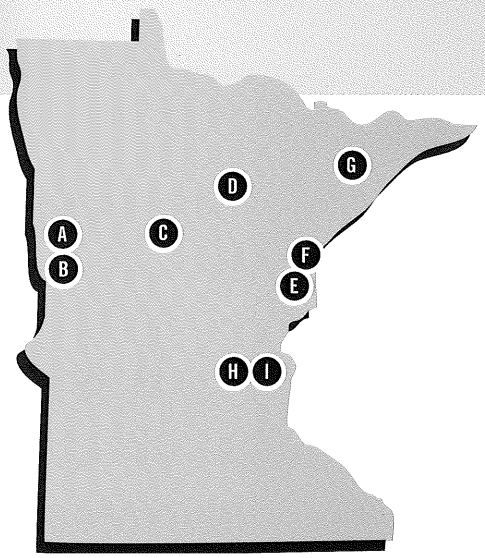
FQHCs are unique among health care providers in the fact that nearly 40 percent of their patients are uninsured. Uninsured and low-income patients contribute, as they are able, to their cost of care. Less than one-third of FQHC revenue can be attributed to federal funding sources.

WHY SUPPORT FQHCs?

The number of uninsured in Minnesota is on the rise. FQHCs provide a safety net for these individuals with sliding-scale fees, culturally competent care, translation and transportation services, and geographically convenient locations.

CLINICS OF THE MINNESOTA ASSOCIATION OF COMMUNITY HEALTH CENTERS

18 member organizations serving
129,000 patients annually at 54 sites.



A Migrant Health Services, Inc.
- Grafton
- Moorhead
- Seasonal locations

B Family Health Care Center
- Moorhead

C Leech Lake Tribal Health Services
- Ball Club
- Bemidji
- Cass Lake
- Inger

D Scenic Rivers Health Services
- Big Falls
- Bigfork
- Cook
- Floodwood
- Northome

E Fond du Lac Tribal Health Services
- Cloquet

F Lake Superior Health Center
- Duluth

G Sawtooth Mountain Clinic, Inc.
- Grand Marais

H MINNEAPOLIS
- Cedar Riverside People's Center
- Community University Health Care Center (CUHCC)
- Fremont Community Health Services, Inc.
- Hennepin County Health Care for the Homeless
- Indian Health Board of Minneapolis
- Native American Community Clinic
- NorthPoint Health and Wellness Center
- Southside Community Health Services, Inc.

I ST. PAUL
- Open Cities Health Center
- United Family Practice
- West Side Community Health Services, Inc.

Minnesota Association of
COMMUNITY HEALTH CENTERS

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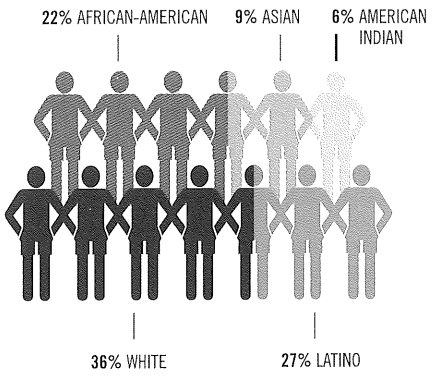
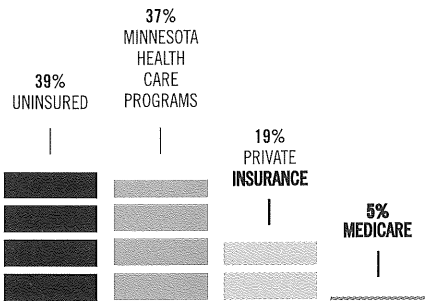
MINNESOTA'S COMMUNITY HEALTH CENTER PATIENT POPULATION

SERVING A RACIALLY DIVERSE POPULATION

COMMUNITY HEALTH CLINIC PATIENTS IN MINNESOTA



PATIENT INSURANCE STATUS AT MINNESOTA'S FQHCs

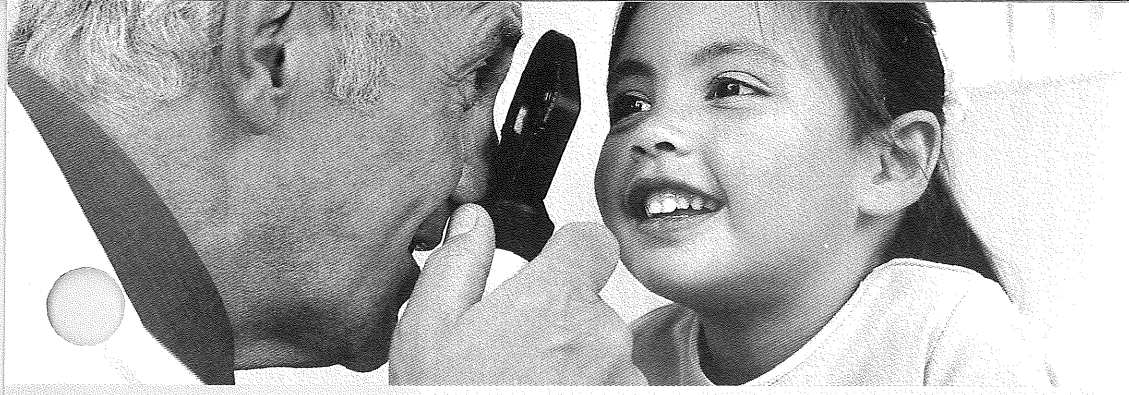


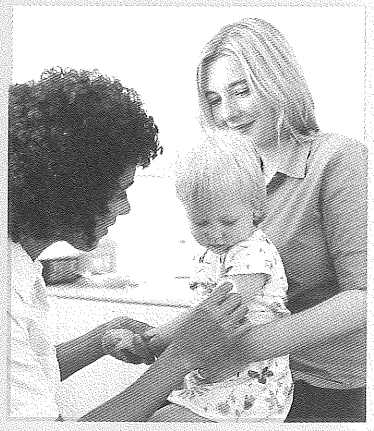
Visit www.mnachc.org for comprehensive data analysis.

TREATING UNINSURED, LOW-INCOME PATIENTS

- Minnesota's community health clinic patients are **FIVE TIMES MORE LIKELY TO BE BELOW 100% OF POVERTY** than the state's general population. (2003 Federal guidelines set poverty at annual income up to $18,400 for a family of four.)

- Compared to the state population, community health clinic patients are **EIGHT TIMES MORE LIKELY TO BE UNINSURED.** With a high percentage of uninsured patients, community health centers rely heavily on state, federal and private funds to remain in operation.





MNACHC SERVICES

A VOICE FOR COMMUNITY HEALTH CENTERS

MNACHC provides state and federal public policy analysis, educational programs and advocacy for member clinics. We advocate for policies that will maintain and increase access to community health care services for low-income and uninsured persons.

LEVERAGING FUNDS

At the state and federal levels, MNACHC fosters public and private partnerships to support health center infrastructure and opportunities for growth.

DATA CLEARINGHOUSE

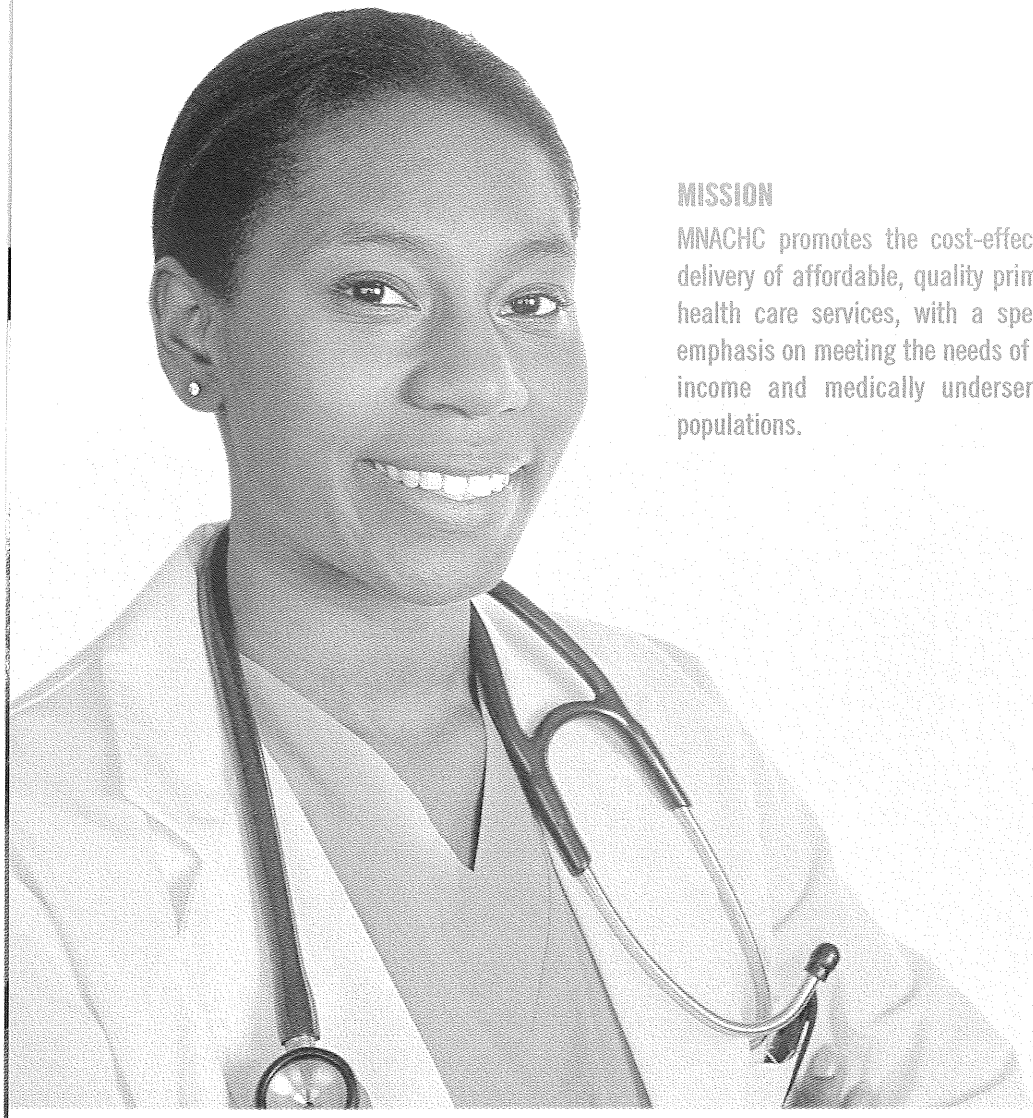
MNACHC compiles data on patient demographics, clinic revenue and market trends. Our Web site—www.mnachc.org—provides timely data and analysis for member clinics, government officials and the public at large.

COMMUNITY DEVELOPMENT

MNACHC identifies Minnesota communities that could benefit from FQHC presence and then assists these communities through the FQHC designation process. We also work to support the expansion of existing FQHCs throughout Minnesota.

TRAINING AND TECHNICAL ASSISTANCE

MNACHC equips community health centers with the administrative, financial and clinical tools necessary to sustain high-quality operations.



MISSION

MNACHC promotes the cost-effective delivery of affordable, quality primary health care services, with a special emphasis on meeting the needs of low income and medically underserved populations.

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Minnesota Association of
COMMUNITY HEALTH CENTERS

Minnesota Association of
COMMUNITY HEALTH CENTERS

MNACHC Fact Sheet

Fact Sheet 01, January 2005

An Introduction to Federally Qualified Health Centers

Federally Qualified Health Centers -- FQHCs, or simply "community health centers" -- are private, non-profit or public organizations that provide primary and preventive health care services to medically underserved populations.

Unlike other models of health care delivery, FQHCs focus not only on improving the health of individual patients, but improving the health status of the entire community.

There are several requirements that community health centers must meet before they qualify as an FQHC. Among these, community health centers must:

- ☑ Be located in a medically underserved area (MUA) or medically underserved population (MUP).
- ☑ Be incorporated as a non-profit entity or public organization
- ☑ Be governed by users of the health center - 51% of the Board of Directors are also patients at the health center
- ☑ Offer comprehensive preventive and primary health care for all age groups and life cycles including:
  - Health Services related to family medicine, internal medicine, pediatrics, obstetrics and gynecology;
  - Diagnostic Laboratory and Radiology Services;
  - Dental Services
  - Mental Health / Substance Abuse Services; and
  - Enabling Services such as transportation, outreach and language translation services.
- ☑ Accept all patients regardless of their ability to pay by offering a sliding fee scale to those at or below 200% of federal poverty guidelines.

A majority of Minnesota's FQHCs also participate in disease management collaboratives. The collaboratives focus on reducing health disparities for FQHC patients in the areas of cardiovascular health, diabetes and asthma.

Member Clinics

Cedar Riverside People's Center
Minneapolis

Community University Health Care Center,
Minneapolis

Family Health Care Center
Moorhead

Fond du Lac Tribal Health
Services, Cloquet

Fremont Community Health
Services, Minneapolis

Hennepin County Health Care for the
Homeless, Minneapolis

Indian Health Board of
Minneapolis

Leech Lake Tribal Health Services
Cass Lake

Lake Superior Community Health Center,
Duluth

Migrant Health Services, Inc.
Moorhead

Native American Community Clinic
Minneapolis

NorthPoint Health & Wellness Center
Minneapolis

Open Cities Health Center
Saint Paul

Sawtooth Mountain Clinic
Grand Marais

Scenic Rivers Health Services
Cook

Southside Community Health Services,
Minneapolis

United Family Practice
Saint Paul

West Side Community Health Services,
Saint Paul

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Madame Chair, committee members, my name is Mavis Brehm, Executive Director at West Side Community Health Services, located in St. Paul. West Side Community Health Services is one of 16 Federally Qualified Health Centers, or FQHCs, in Minnesota. Incorporated in 1972, La Clinica, as it's commonly known, provides comprehensive primary care for low-income residents at 21 sites throughout St. Paul and one in south Minneapolis. In 2004, my organization provided health care services for nearly 31,000 people.

West Side Community Health Services' medical and dental clinics are located in some of the poorest communities in the State. Over 86% of patients served have household incomes less than 200% of poverty. We serve a large number of immigrants, refugees, and non-English speaking patients - over 50% with no source of health insurance. Barriers to care for our patients include language barriers, cultural barriers and lack of transportation in addition to income and insurance limitations. We systemically breakdown these barriers by focusing on early access to care, convenient locations, affordability, prevention and health education – all reducing the need for more expensive hospital and specialty care. This saves taxpayers money. Unquestionably, West Side Community Health Services- like all FQHCs in Minnesota- are vital safety net health care providers for the medically underserved in the State.

I am here today to testify in support of S.F. 109. In essence, this bill would correct what the Department of Human Services has referred to as an "unforeseen consequence" of the recent changes in the MinnesotaCare provider tax. As you already know, clinic revenues from Medicaid, GAMC and MNCare are no longer exempt from the two percent MinnesotaCare provider tax. While other health care providers have seen an increase to their Medicaid rates to offset the additional tax payments, this simply is not the case with West Side Community Health Services and other FQHCs in the State.

Given our clinic locations and patient population, the Minnesota public insurance programs, such as Medicaid, MinnesotaCare and GAMC, are vital revenue streams for our organization. 34 percent of our patients are enrolled in one of these programs. Furthermore, these programs contribute nearly $5 million in annual revenues or 36 percent of our overall revenue.

Based on our own internal estimates, West Side Community Health Services will pay approximately $80,000 in provider taxes in 2004 – an increase of $60,000 annually. While this may seem a small amount compared to the other budget items discussed here, this amount is significant to a non-profit organization such as West Side Community Health Services. To put $60,000 into perspective, this amount could provide funds for:

- 400 dental visits
- 440 medical visits
- prenatal care and delivery for 50 women

Talking with other directors of FQHCs in the state, the amount of additional tax varies from $2,000 per year to over $100,000 per year. Collectively, the 16 FQHCs will pay $1.1 million in additional taxes over the 2006-2007 biennium that will not be offset in any fashion if S.F. 109 is not enacted into law. Again, to put the collective total in perspective, $1.1 million would otherwise provide care for 1,400 patients.

As important as the financial ramification and resultant impact on patients needing care is the issue of equality. While other health care providers receive an increase in Medicaid rates to offset the additional provider tax payments, this is not the case for West Side Community Health Services and other FQHCs. Unfortunately, our Medicaid payments are set by federal law and cannot be adjusted to provide FQHCs with any "offset" like other providers in Minnesota currently receive. Based on our discussions with the Department of Human Services, they cannot simply increase our Medicaid rate to offset the increased tax payments. Nor can the Department maintain the tax exemption just for FQHCs for public programs. Consequently, much like last session, we worked with Senator Berglin to craft S.F. 109. If S.F. 109 were to become law, FQHCs would be placed on "equal footing" with other health care providers.

In summary, West Side Community Health Services, like all the FQHCs and other health care providers in the state, are operating under budget constraints and reductions to public insurance programs. We are adjusting to the increasing numbers of uninsured as a result of these reductions through a variety of means. Paying an additional tax without any mechanism to offset the impact places an extreme financial burden on the very clinics that a growing number of uninsured will look to for care.

I strongly urge you to approve S.F. 109. By approving S.F. 109 today, our part of the health care safety net in Minnesota will be placed on common ground with our health care colleagues as we face the challenges ahead in Minnesota's health care market. Thank you very much for your time and consideration of this critical issue today. I am happy to answer any questions you may have.

Senate Counsel & Research

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JO ANNE ZOFF SELLNER
DIRECTOR

Senate
State of Minnesota

S.F. No. 490 - Elimination of Alcoholic Beverages Sales Tax Repeal

Author: Senator John Marty

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: February 7, 2005

Section 1 requires that 27.77 percent of the revenues derived from the liquor and beer sales tax be deposited in the general fund and credited to the counties' chemical dependency costs account. The Commissioner of Finance is responsible for distribution to the counties on a per capita basis. At least 50 percent of the amount appropriated to each county must be used to fund chemical dependency treatment programs. The remaining amount must be used by the county to fund expenses related to problems caused by excessive consumption of alcohol or other drugs, which include, but are not limited to, law enforcement, courts, and corrections.

Section 2 strikes the December 31, 2005, repealer of the liquor and beer sales tax. This section is effective the day following final enactment.

JW:rdr

Senators Marty, Lourey and Berglin introduced—

S. F. No. 490 Referred to the Committee on Health & Family Security

A bill for an act

relating to taxation; eliminating the repeal of a portion of sales tax on alcoholic beverages; appropriating money; amending Minnesota Statutes 2004, section 297A.94; Laws 2001, First Special Session chapter 5, article 12, section 95.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 297A.94, is amended to read:

297A.94 [DEPOSIT OF REVENUES.]

(a) Except as provided in this section, the commissioner shall deposit the revenues, including interest and penalties, derived from the taxes imposed by this chapter in the state treasury and credit them to the general fund.

(b) The commissioner shall deposit taxes in the Minnesota agricultural and economic account in the special revenue fund if:

(1) the taxes are derived from sales and use of property and services purchased for the construction and operation of an agricultural resource project; and

(2) the purchase was made on or after the date on which a conditional commitment was made for a loan guaranty for the project under section 41A.04, subdivision 3.

The commissioner of finance shall certify to the commissioner the date on which the project received the conditional commitment. The amount deposited in the loan guaranty account must be reduced by any refunds and by the costs incurred by the

Department of Revenue to administer and enforce the assessment and collection of the taxes.

(c) The commissioner shall deposit the revenues, including interest and penalties, derived from the taxes imposed on sales and purchases included in section 297A.61, subdivision 3, paragraph (g), clauses (1) and (4), in the state treasury, and credit them as follows:

(1) first to the general obligation special tax bond debt service account in each fiscal year the amount required by section 16A.661, subdivision 3, paragraph (b); and

(2) after the requirements of clause (1) have been met, the balance to the general fund.

(d) The commissioner shall deposit the revenues, including interest and penalties, collected under section 297A.64, subdivision 5, in the state treasury and credit them to the general fund. By July 15 of each year the commissioner shall transfer to the highway user tax distribution fund an amount equal to the excess fees collected under section 297A.64, subdivision 5, for the previous calendar year.

(e) For fiscal year 2001, 97 percent; for fiscal years 2002 and 2003, 87 percent; and for fiscal year 2004 and thereafter, 72.43 percent of the revenues, including interest and penalties, transmitted to the commissioner under section 297A.65, must be deposited by the commissioner in the state treasury as follows:

(1) 50 percent of the receipts must be deposited in the heritage enhancement account in the game and fish fund, and may be spent only on activities that improve, enhance, or protect fish and wildlife resources, including conservation, restoration, and enhancement of land, water, and other natural resources of the state;

(2) 22.5 percent of the receipts must be deposited in the natural resources fund, and may be spent only for state parks and trails;

(3) 22.5 percent of the receipts must be deposited in the natural resources fund, and may be spent only on metropolitan park and trail grants;

(4) three percent of the receipts must be deposited in the natural resources fund, and may be spent only on local trail grants; and

(5) two percent of the receipts must be deposited in the natural resources fund, and may be spent only for the Minnesota Zoological Garden, the Como Park Zoo and Conservatory, and the Duluth Zoo.

(f) The revenue dedicated under paragraph (e) may not be used as a substitute for traditional sources of funding for the purposes specified, but the dedicated revenue shall supplement traditional sources of funding for those purposes. Land acquired with money deposited in the game and fish fund under paragraph (e) must be open to public hunting and fishing during the open season, except that in aquatic management areas or on lands where angling easements have been acquired, fishing may be prohibited during certain times of the year and hunting may be prohibited. At least 87 percent of the money deposited in the game and fish fund for improvement, enhancement, or protection of fish and wildlife resources under paragraph (e) must be allocated for field operations.

(g) 27.77 percent of the revenues, including penalties and interest, derived from the tax imposed by section 297A.62, subdivision 2, must be deposited in the general fund and credited to the counties' chemical dependency costs account. Amounts credited to the account under this paragraph are appropriated to the commissioner of finance for distribution to the counties of this state on a per capita basis. At least 50 percent of the amount appropriated to each county must be used by the county to fund chemical dependency treatment programs. The remaining balance of the appropriation must be used by the county to fund expenses related to problems caused by excessive consumption of alcohol or other drugs, including, but not limited to, law enforcement, courts, and corrections.

[EFFECTIVE DATE.] This section is effective for sales made after December 31, 2005.

Sec. 2. Laws 2001, First Special Session chapter 5,

article 12, section 95, is amended to read:

Sec. 95. [REPEALER.]

(a) Minnesota Statutes 2000, sections 297A.61, subdivision 16; 297A.68, subdivision 21; and 297A.71, subdivisions 2 and 16, are repealed effective for sales and purchases occurring after June 30, 2001, except that the repeal of section 297A.61, subdivision 16, paragraph (d), is effective for sales and purchases occurring after July 31, 2001.

(b) Minnesota Statutes 2000, ~~sections 297A.62, subdivision 2, and~~ section 297A.64, subdivision 1, ~~are~~ is repealed effective for sales and purchases made after December 31, 2005.

(c) Minnesota Statutes 2000, section 297A.71, subdivision 15, is repealed effective for sales and purchases made after June 30, 2002.

(d) Minnesota Statutes 2000, section 289A.60, subdivision 15, is repealed effective for liabilities after January 1, 2003.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Office of Justice Programs

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Costs of a Gross Misdemeanor DWI Case

By Gail Carlson

Case Scenario

The case scenario created for this exercise is a second offense DWI Gross Misdemeanor in Ramsey County. Since it is a gross misdemeanor offense, it will be handled by the St. Paul City Attorney's Office. The operating assumptions for the case are as follows:

- No children were in the car.
- Offender agreed to take the BAC screening.
- Blood alcohol level was under.20.
- Offender was held in jail over night and released on bail the next day.
- Offender plead guilty at the omnibus hearing and was sentenced at the same hearing.
- Offender is placed under three months of remote electronic alcohol monitoring (REAM) pre-sentencing, sentenced to 5-50 days in jail, chemical dependency treatment and two years probation. While on probation, the offender is under electronic monitoring for 30 days each year.
- Offender is marginally employed and eligible for public defender services.

Factor that would increase the costs of this case;

- Offender refused to take the evidentiary breath test.
- Offender appealed his license revocation (the Attorney General's Office would represent the Dept of Public Safety in defending against the appeal).
- Inpatient versus outpatient chemical dependency treatment was indicated.
- The case went to trial; court, public defender and prosecutor costs would escalate.
- Remote electronic alcohol monitoring (REAM) is ordered and the offender lacks the resources to pay for it.
- Offender gets the maximum jail sentence. However, the offenders pay part of their room and board.

58% - meth - to complete long Treatment
64% - other primary drugs - completion of treatment

Costs to the Public Based on Case Progression

Law enforcement. We are assuming that the arrest was made by the State Patrol rather than a local law enforcement agency.

- State trooper time - seven hours @$69.25/hour. This includes identification, arrest and transport, testing and booking, completion of reports, license revocation, plate impoundment and court time if necessary. Total **$484.75** [1]

- DWI Testing Costs.

    - Urine test (including lab analysis, court testimony and training to administer tests) at the BCA are $150.
    - Evidentiary breath test, done at the local police department are $30/sample.
    - Blood testing kits (done at a hospital or the BCA) are $6.00 each and a urine testing kit costs $4.00.[2]
    - Total costs: **$190.**

- Jail. The offender is held at the Ramsey County Jail for 12 hours.
    - The booking fee is $140 (the offender pays an additional $10).
    - Jail costs $80/day.
    - Total jail costs: **$220.**[3]

Total law enforcement, alcohol testing and jail time costs are **$894.75.**

Assessment and Supervision. We are assuming that the county will pay half the cost of Remote electronic alcohol monitoring (REAM).

- **Project Remand.** Pre-trial supervision costs about $140 total per case and averages about three months.

- **Remote electronic alcohol monitoring (REAM)** – pre-trial and post-trial.

    - The offender is put on remote electronic alcohol monitoring for 40-90 days until sentencing, at a cost of $12-14/day for a total of $520-1,170. Half of this cost, or $260-585, is paid by the county.

    - The offender is also put on 30 days of REAM post sentencing each year for two years for a total cost of $780. Half, or $390, is paid by the county.[4]

    - Total cost to the county for assessment and supervision: **$890-1,215.**

Prosecution.

- The prosecution would take about 1 ½ hours for preparation of probable cause statement, complaint, open file etc.
- Prosecutor time at arraignment would total about ½ hour. Attorney time preparing for dispositional hearing and omnibus hearing total ½ hour.
- Total prosecutor's time 2 ½ hours @$100/hour (includes attorney, paralegals and clerical support) =**$250**.[5]

Public Defender.

- Public defender time for court, travel and preparation amounts to two hours. Additional costs for dispositional advisors, investigators and clerical support staff bring the costs to **$285**.[6]

Court costs.

- Judge costs are $56.58/hour.
- Judge's law clerk is $19.02/hour.
- Court reporter is $27.30/hour.
- Ramsey County law clerk costs $17.87/hour.
- Bailiff is $23.59/hour.
- Total cost for ½ hour: **$72.18**.[7]

Sentence. A second DWI gross misdemeanor offender can receive a year at the Ramsey County Workhouse and a $3,000 fine. However a more likely sentence in Ramsey County in this case would be:

- Two years probation, 5-50 days in jail, a fine of $300 to $500, and chemical dependency treatment etc. [8]

Ramsey County Workhouse.

- Costs $77/day, but the offender is billed about $12/day for room and board. 5-50 days @ $77/day costs **$325-3,250**.[9]

Chemical dependency treatment. We are assuming that the offender is low income and has no private insurance, therefore the county is responsible for the cost of treatment. We are assuming that the offender will have outpatient treatment.

- Averages $2,600 in Ramsey County, but varies depending upon whether the treatment is outpatient or inpatient. Outpatient treatment costs would be **$1,700**.[10]

Probation.

- Probation costs $2.00/day. Total cost for a two year sentence is **$1,460.** [11]

Driver's License Re-issue.

- Administrative costs of license revocation, plate impoundment, re-issue of driver's license and vehicle license plates total **$25.76.**[12]

Total public costs range from **$5,902.69-9,152.69.**

Costs paid by the offender.

- Booking fee-$10
- REAM-pre sentencing- 40-90 days- $260-585; post sentencing - 30 days for two years $390 [13]
- Attorney fees
- Room and board at the Ramsey County Workhouse ($12/day)-5-50 days-$60-600.[14]
- Fine-$300-500
- Surcharge-$60[15]
- County law library fee-$10
- Probation case fee of $130.
- Re-instate the driver's license is currently $680, plus $18.50 for re-taking the driver's test.

---

[1] Brian Erickson Minnesota State Patrol
[2] Dave Petersen BCA
[3] Dori Martinez, Ramsey County Jail
[4] Judge James Dehn
[5] Therese Skarda, St Paul City Attorneys Office
[6] Jim Hankes, Ramsey County Public Defenders Office
[7] Dan Lundstrum, Ramsey County Court Administrator.
[8] Judge Joanne Smith
[9] Al Carlson, Ramsey County Workhouse
[10] Kurt Koehler, Ramsey County Social Services
[11] Kevin McConnor Ramsey County Corrections
[12] Lois Walton, Driver and Vehicle Services.
[13] Judge James Dehn
[14] Al Carlson Ramsey County Workhouse
[15] Gary Karger House Research

For further information contact:
Deputy Commissioner Mary Ellison at 651-282-6556
Gail Carlson at 651-297-3824

Cost of a Gross Misdemeanor DWI in Ramsey County						
Source		Description	Total Cost	Other Fixed Costs	Source	
Law Enforcement					Brian Erickson,	
	State Patrol	7 hours@$69.25/hour	$484.75		Minnesota State Patrol	
	Includes:					
		2 hours for identification, arrest and transport				
		1 hour for chemical testing and booking				
		4 hours for completion of reports,				
		license revocation, plate impoundment				
		and court time				
	Testing: BCA Lab					
		DWI Urine test: includes lab analysis,	$150	Intoxilizer 5000 - $5000	Dave Petersen,	
		court testimony & training to administer tests			BCA	
		Evidentiary Breath Test-usually done at local police	$30			
		dept-includes record keeping, training				
		Blood testing kits-done at hospital	$6.00			
		Urine testing kits-done at police depts	$4.00			
	Jail					
		Initial arrest				
		12 hours in Ramsey County Jail	$80		Dori Martinez,	
		Booking Fee-offender is charged an additional $10	$140		Ramsey County Jail	
	Total Law enforcement, testing and jail		**$894.75**			
Assessment and Supervision					Mary Maher,	
	Project Remand				Project Remand	
		Alcohol Assessment	$100			
		Pre-Trial Supervision	$140			
		Ream (Remote electronic alcohol monitoring)			Judge James Dehn	
		pre-sentencing for 40-90 days	$260-585			
		post sentence 30 days for 2 years	$390			
	Total assessment and supervision county costs (offender pays half)		**$890-1,215**			
Prosecution						
	Screen case, type probable cause statement, prepare complaint				Therese Skarda	
	open file, get complaint signed and filed -1 1/2 hours				St. Paul Attorneys Office	
	Attorney Preparation time for omnibus hearing - 1/2 hour					
	Arraignment- 1/2 hour					
	Total 2 1/2 hours @$100/hour (includes attorney, paralegals & clerical sta		**$250**			

Public Defender							
	Court, travel, preparation, dispositional advisors, investigators					Jim Hankes,	
	and clerical support staff -2 hours			**$285**		MN Public Defender's Office	
Court							
	1/2 hour court time for bail motion, omnibus/dispositional hearings						
		Judge-$56.58/hour				Dan Lundstrom,	
		Judge's law clerk-$19.02/hr				Ramsey County Court	
		Court Reporter-$27.30/hour				Administrator	
		Ramsey Co Law Clerk-$17.87					
		Bailiff-$23.59/hour					
	Total court costs		$144.36/hour for 1/2 hour	**$72.18**			
Chemical Dependency Treatment						Kurt Koehler,	
	Outpatient average in Ramsey County			**$1,700**		Ramsey County Social Services	
Jail							
	Sentence-Ramsey County Workhouse					Al Carlson,	
		5-50 days in jail @$77/day minus$12/day				Ramsey County Workhouse	
		that the offender pays for room and board		**$325-3,250**			
Probation						Kevin McConnor,	
	*$2.00/day for 2 years			**$1,460**		Ramsey County Corrections	
Driver Re-evaluation						Lois Walton,	
	Administrative fees involved with license revocation,					Driver and Vehicle Services	
	impounding license plates, re-issuance of license plates						
	and driver evaluation			**$25.76**			
Total costs to the county				**$5,902.69-9,152.69**			
Individual costs paid by the offender							
Driver license re-instatement fee				$18.50		Vicki Albu, Driver & Vehicle Services	
Surcharge				$60		Gary Karger, House Research	
Driver license re-evaluation fee				$680		Kathy Swanson, Office of Traffic Safety	
Booking fee				$10		Dori Martinez, Ramsey County Jail	
Fine				$300-500		Judge Joanne Smith	
County law library fee				$10		Gary Karger, House Research	
Probation fee				$130		Kevin McConnon, Ramsey County DWI Unit	
Room & Board at		$12/day		$60-600		Al Carlson Ramsey County Workhouse	
Ramsey County Workhouse							
Ream	*Pre-sentence	$13/day for 3 months 1/2 grant		$260-585		Judge James Dehm	
	*Post sentence 30 days each year for 2 years			$390			
				$1,238.50-	**$2,983.50**		

Background Information

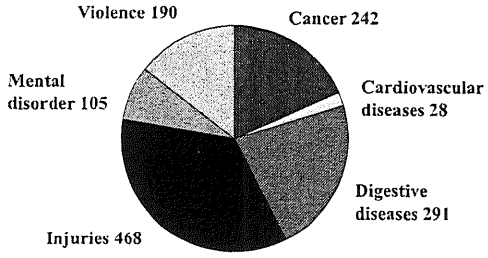
Minnesota Department of Health January 2004

The Human and Economic Cost of Alcohol Use in Minnesota

Highlights

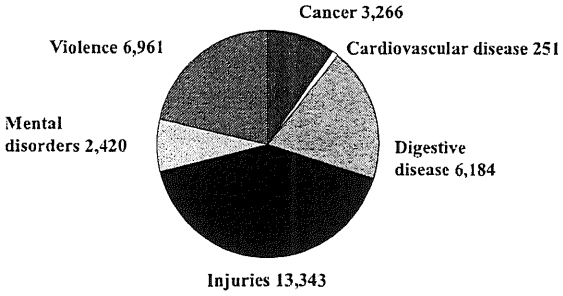
* **The economic costs associated with alcohol use in Minnesota in 2001 amounted to an estimated $4.5 billion.**
* **This amounts to over $900 for every person in the state.**
* **These costs are 19 times greater than the $234 million in tax revenues collected from alcohol sales.**

Figure 1 - Alcohol attributable deaths by cause, Minnesota, 2001



Alcohol attributable deaths by cause were calculated using 2001 Minnesota mortality data research files and alcohol attributable fractions available from "Alcohol use in Minnesota: Extent and cost" from the Minnesota Department of Health (1995) and "New Mexico Alcohol-Related Hospitalization Charges for 1998" from the New Mexico Department of Health (December 27, 2000) and consultation with the CDC for the crosswalk of ICD-9 to ICD-10 codes.

Figure 2 - Alcohol attributable years of potential life lost (YPLL), by cause of death, Minnesota



Alcohol attributable years of potential life lost by cause were calculated using 2001 Minnesota mortality data research files, gender specific life expectancy tables available from "Deaths: Preliminary Data for 2001" V 51, number 5, National Vital Statistics Reports, CDC, and alcohol attributable fractions available from "Alcohol use in Minnesota: Extent and cost" Minnesota Department of Health (1995) and "New Mexico Alcohol-Related Hospitalization Charges for 1998" from the New Mexico Department of Health (December 27, 2000) and consultation with the CDC for the crosswalk of ICD-9 to ICD-10 codes.

Consequences of alcohol use

- Alcohol use and misuse is the third leading cause of preventable death in the U.S. according to the last national study in 1993.[1]
- There were 1,324 alcohol attributable deaths in Minnesota in 2001 (see Figure 1) and 32,425 years of potential life lost (see Figure 2).
- Alcohol contributes to injuries resulting from motor-vehicle crashes, fires, falls, and drowning. Alcohol also contributes to violence such as child abuse, homicide, suicide and personal assault.[2]
- Many chronic conditions are attributable to alcohol use, including digestive diseases, certain cancers, mental disorders, and certain cardiovascular diseases.[2]

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The Human and Economic Cost of Alcohol Use in Minnesota – page 2

Drinking patterns in Minnesota

Adults

- In 2002, 21 percent of Minnesota adults reported binge drinking, consuming five or more drinks on an occasion in the last month.[3]
- Binge drinking in Minnesota is higher than the national median of all states and territories, which is 16.1 percent.[3]
- Nearly 6 percent of Minnesota adults report being chronic drinkers in 2002, consuming an average of more than 2 drinks a day for men and more than 1 drink per day for women in the past 30 days.[3]
- In 2000, almost 4 percent of Minnesotan adults reported that they have driven after drinking too much at least once in the past month.[4]
- Men are more likely than women to report binge drinking and heavy drinking.[3]
- Individuals between the ages of 18 and 24 are more likely to report engaging in binge drinking and heavy drinking than any other age group.[5]

Youth

- In 2001, 30 percent of 9th graders and 52 percent of 12th graders in Minnesota reported consuming alcoholic beverages on at least one occasion in the past 30 days.[6]
- Minnesota 12th graders are drinking at a slightly higher rate than 12th graders nationally (52 percent vs. 50 percent).[7]
- In 2001, 16 percent of 9th graders and 32 percent of the 12th graders in Minnesota reported binge drinking, consuming 5 or more drinks in a row, in the past 2 weeks.[8]
- In 2001, 33 percent of 12th graders in Minnesota reported driving a motor vehicle after using alcohol or drugs.[6]
- Among 9th graders in Minnesota, more American Indian and Hispanics report drinking in the past 30 days (41 percent and 38 percent respectively) than Asian, African American or White 9th graders (21 percent, 26 percent and 31 percent respectively).[9]

Cost of alcohol use in Minnesota

- The human and economic costs associated with alcohol use in 2001 amounted to an estimated $4.5 billion. This amounts to over $900 per person in Minnesota. (See Table 1)[10,11]
- A breakdown of economic cost of alcohol abuse from Table 1 shows[10,11]:
    - The vast majority, 65 percent, of the costs associated with alcohol use was attributed to lost productivity ($2.9 billion). Most of these lost productivity costs were due to alcohol-related illnesses and premature death due to alcohol use.
    - Healthcare expenditures for medical consequences of alcohol use and the treatment, prevention, and support for alcohol use disorders amounted to nearly $650 million.
    - Nearly one billion dollars of the costs of alcohol use were attributed to other impacts on society, such as property and administrative costs of alcohol-related motor vehicle crashes, social welfare administration, fire destruction, and various criminal justice system costs of alcohol-related crime.
- For fiscal year 2002, Minnesota collected $234,000,000 in excise and sales tax revenue from alcohol sales.[12] This revenue is miniscule when compared to the economic cost of alcohol use during that same year -- $4.5 billion-- which is 19 times greater than the tax revenue.

- A national study, based on 1992 data, found that much of the economic burden of alcohol abuse is borne by segments of the population other than the alcohol abusers themselves. About 45 percent of the estimated total costs were borne by alcohol abusers and their families, almost all of which was due to lost or reduced earnings. About 20 percent was absorbed by the Federal government and 18 percent by State and local government. About 10 percent was absorbed by private insurance and 6 percent by victims of alcohol-related crimes and by non-drinking victims of alcohol-related motor vehicle crashes.[13]

Table 1: Estimated economic costs of alcohol abuse in Minnesota, 2001*

Economic Cost	2001
Health Care Expenditures	
Alcohol use disorders: treatment, prevention, and support	180,000,000
Medical consequences of alcohol consumption	469,000,000
Total	**$649,000,000**
Productivity Impacts	
Lost productivity due to alcohol-related illness	2,002,000,000
Lost future earnings due to premature deaths**	885,000.000
Lost productivity due to alcohol-related crime	62,000,000
Total	**$2,949,000,000**
Other impacts on society	
Motor vehicle crashes	424,000,000
Crime	94,000,000
Fire destruction	155,000,000
Social welfare administration	290,000,000
Total	**$963,000,000**
Total Costs* **	**$4,561,000,000**

* MDH estimated the economic costs of alcohol abuse for 2001 based upon national estimates for other years, adjusting for inflation, population change, and other factors. Other data sources were used to disaggregate national level data to the state level or calculate a specific state costs when available.
** Present discounted value of future earnings calculated using a 3-percent discount rate.
***The cost per person in Minnesota is over $900.

How to calculate the economic cost of alcohol for your community

To estimate the economic cost of alcohol in your community, multiply the cost of alcohol per person in Minnesota ($900) by the 2001 population estimate for your community.

Upcoming report

A full report on the human and economic cost of alcohol use in Minnesota is forthcoming.

Endnotes

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11. Lost productivity due to premature death in Minnesota was calculated using 2001 Minnesota mortality data research files, gender specific life expectancy tables available from Arias, E, Smith, B. Deaths: Preliminary Data for 2001. National Vital Statistics Reports, CDC 51(5). Alcohol attributable fractions were available from Minnesota Department of Health. Alcohol use in Minnesota: Extent and cost. Minnesota Department of Health 1995, and New Mexico Department of Health. New Mexico Alcohol-Related Hospitalization Charges for 1998. New Mexico Department of Health (December 27, 2000). The crosswalk of ICD-9 to ICD-10 codes was provided through personal communication with Bob Brewer at the CDC. Present value of future earnings was estimated using 1990 amounts from Haddix, A., Teutsch, S. and Corso, P, "Prevention Effectiveness". New York: Oxford University Press, 2003 and adjusting for the Economic Cost Index available in Bureau of Labor Statistics, Office of Compensation Levels and Trends. Employment Cost Index, July 31, 2003.
12. Minnesota Department of Revenue, 2003.
13. National Institute on Alcohol Abuse and Alcoholism. 10th Special Report to the U.S. Congress on Alcohol and Health. U.S. Department of Health and Human Services 2000.

Reuters: Alcohol, Tobacco Pose Equal Burden on Global Health

Thu Feb 3,10:04 PM ET
By Patricia Reaney
LONDON (Reuters) - When it comes to causing death and disability, alcoholic drinks are as bad as tobacco and high blood pressure.

> Alcohol is linked to more than 60 different medical conditions, including oral, liver and breast cancers, heart disease, stroke and cirrhosis. It also increases the risk of car accidents, drowning, falls and homicides.

> "Overall, 4 percent of the global burden of disease is attributable to alcohol, which accounts for about as much death and disability globally as tobacco and hypertension," said Professor Robin Room of Stockholm University in Sweden.

> By comparison, tobacco accounts for 4.1 percent and high blood pressure 4.4 percent.

> "Alcohol is a substantial health problem in the world. It is a particular problem in the developing countries that are well off and in the developed world," he added in an interview with Reuters.

> In a review of alcohol and public health published in The Lancet medical journal, Room and his colleagues in Canada and the United States assessed the problems caused by alcohol and ways of controlling alcohol abuse.

> They said alcohol poses problems not only to drinkers but also to people around them by increasing the risk of violence and injury. How much is consumed and the patterns of drinking have an impact on alcohol-related illnesses and deaths.

> Tobacco may cause more deaths, but they are generally in older people compared with deaths from alcohol. But Room said when the two are compared on the basis of years of life lost, they are about equivalent.

> Evidence has shown that increasing the price of alcohol and limiting its availability would lower consumption and risks to health.

> The researchers estimated that a 10 percent rise in British alcohol prices could reduce deaths from alcohol dependence and poisoning by 28.8 percent in men and 37.4 percent in women.

> Room and his colleagues also suggested there should be an international agreement on alcohol marketing, similar to the Framework Convention on Tobacco Control.

> "The trade is global and the solutions cannot be only local," he said. "In order to facilitate solutions that reach beyond the national level you must think about an international agreement."

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Senate
State of Minnesota

S.F. No. 271 - Access to Certified Death Records

Author: Senator Linda Berglin

Prepared by: David Giel, Senate Research (651/296-7178)

Date: February 4, 2005

S.F. No. 271 expands the list of persons who are entitled to a certified death record to include a sibling of the deceased person. Siblings are added to the list of persons considered to have a tangible interest in a death record. The records must be provided by the local registrar of vital statistics or the Office of the State Registrar in the Minnesota Department of Health.

DG:rdr

Senator Berglin introduced--

S.F. No. 271: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying access to certified death records; amending Minnesota Statutes 2004, section 144.225, subdivision 7.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2004, section 144.225, subdivision 7, is amended to read:

Subd. 7. [CERTIFIED BIRTH OR DEATH RECORD.] (a) The state or local registrar shall issue a certified birth or death record or a statement of no vital record found to an individual upon the individual's proper completion of an attestation provided by the commissioner:

(1) to a person who has a tangible interest in the requested vital record. A person who has a tangible interest is:

(i) the subject of the vital record;

(ii) a child of the subject;

(iii) the spouse of the subject;

(iv) a parent of the subject;

(v) the grandparent or grandchild of the subject;

(vi) if the requested record is a death record, a sibling of the subject;

~~(vi)~~ (vii) the party responsible for filing the vital record;

~~(vii)~~ (viii) the legal custodian or guardian or conservator of the subject;

~~(viii)~~ (ix) a personal representative, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(ix)~~ (x) a successor of the subject, as defined in section 524.1-201, if the subject is deceased, by sworn affidavit of the fact that the certified copy is required for administration of the estate;

~~(x)~~ (xi) if the requested record is a death record, a trustee of a trust by sworn affidavit of the fact that the certified copy is needed for the proper administration of the trust;

~~(xi)~~ (xii) a person or entity who demonstrates that a certified vital record is necessary for the determination or protection of a personal or property right, pursuant to rules adopted by the commissioner; or

~~(xii)~~ (xiii) adoption agencies in order to complete confidential postadoption searches as required by section 259.83;

(2) to any local, state, or federal governmental agency upon request if the certified vital record is necessary for the governmental agency to perform its authorized duties. An authorized governmental agency includes the Department of Human Services, the Department of Revenue, and the United States Immigration and Naturalization Service;

(3) to an attorney upon evidence of the attorney's license;

(4) pursuant to a court order issued by a court of competent jurisdiction. For purposes of this section, a subpoena does not constitute a court order; or

(5) to a representative authorized by a person under clauses (1) to (4).

(b) The state or local registrar shall also issue a certified death record to an individual described in paragraph (a), clause (1), items (ii) to (vii), if, on behalf of the individual, a mortician designated to receive death records under section 144.214, subdivision 4, furnishes the registrar with a properly completed attestation in the form provided by

the commissioner within 180 days of the time of death of the subject of the death record. This paragraph is not subject to the requirements specified in Minnesota Rules, part 4601.2600, subpart 5, item B.

OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

Notice of Report Release
Minnesota Board of Podiatric Medicine

Financial Audit Division Report 05-10 Released February 10, 2005

Conclusions:

- The board needs to strengthen mitigating internal controls to ensure the propriety of its receipts and disbursements and needs to further restrict access to its business systems.
- The board complied with legal provisions for the items tested.

The report contained one finding relating to internal control. The office resolved the one finding included in our prior audit report concerning controls over license receipts.

Audit Scope:

Audit Period: July 1, 2000, through June 30, 2003

Programs Audited:
- Licensing and Fee Receipts
- Payroll Expenditures
- Administrative Expenditures

Agency Background:

The Board of Podiatric Medicine regulates the licensing of podiatrists practicing in the state of Minnesota. In fiscal year 2003, the board collected approximately $85,000 and incurred $78,000 in both direct and indirect costs. During that time, the board renewed about 90 licenses.

For a copy of this report call (651) 296-1235, or visit our website at "www.auditor.leg.state.mn.us".

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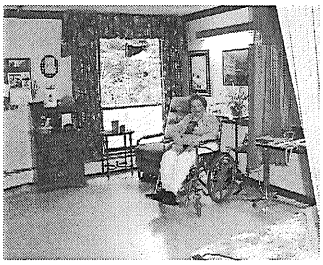
Nursing Home Inspections

OLA Office of the Legislative Auditor
State of Minnesota



Nursing Home Inspections

February 10, 2005

1

Inspection Flexibility

- Federally controlled program
  - At least once every 15 months
  - "Full" inspection
  - Complex and prescriptive regulations

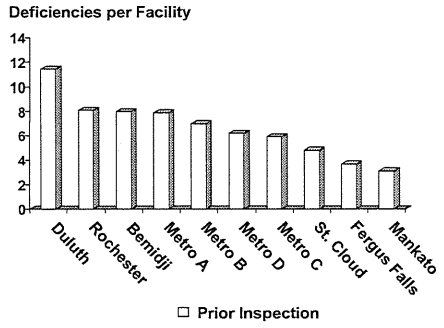
2

Federal Nursing Home Standards

- Difficult to apply consistently
  - Over 270 standards
  - Sometimes unclear, contradictory, or duplicative
  - Few guidelines from MDH

3

Deficiencies by District



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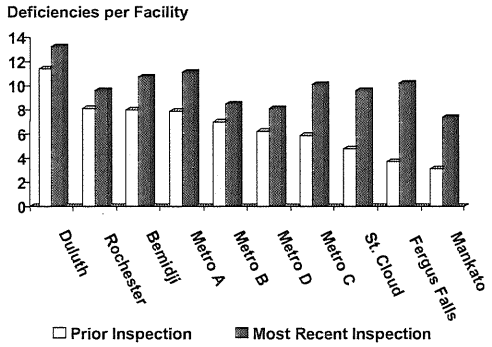
Deficiencies by District



5

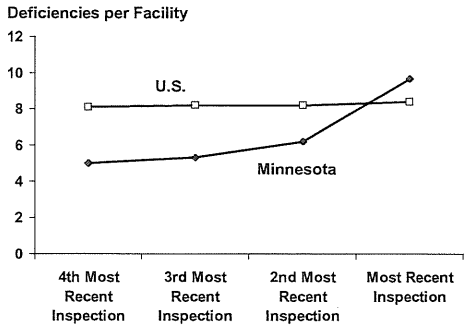
Number of Deficiencies Issued

	Prior Inspection	Most Recent Inspection
Average Deficiencies Per Facility	6.2	9.7
Facilities With No Deficiencies	11%	3%
Facilities With > 10 Deficiencies	19%	40%

6

Nursing Home Inspections

Deficiency Trends



7

Most Common Deficiencies

- Not following resident care plans
- Unsanitary food conditions
- Unsanitary/unsafe/uncomfortable environment
- Not helping residents reach their highest practicable well being

8

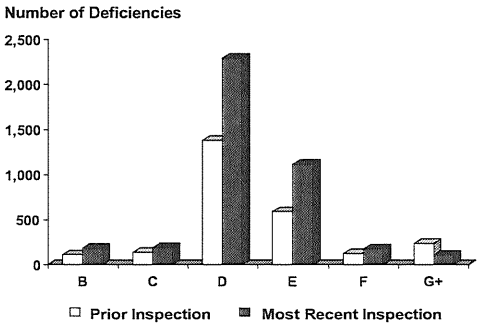
Seriousness of Deficiencies

Severity	Isolated	Pattern	Widespread
Immediate Jeopardy	J	K	L
Actual Harm	G	H	I
Actual Discomfort or Potential for Harm	D	E	F
Potential for Discomfort	A	B	C

Scope

9

Deficiency Scope and Severity



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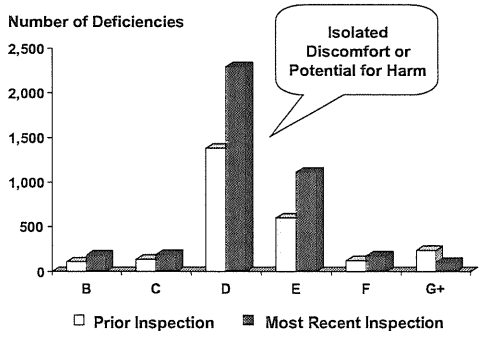
Deficiency Scope and Severity



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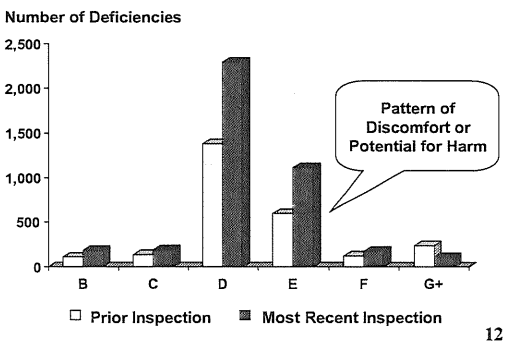
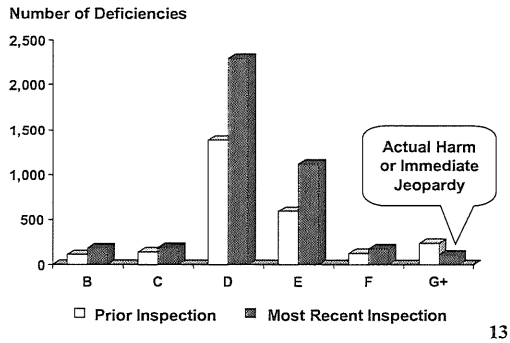
Deficiency Scope and Severity



12

Nursing Home Inspections

Deficiency Scope and Severity



13

Consistency: Classifying Deficiencies

- We questioned 9 percent of the nearly 1,000 deficiencies that we examined
- Problems were generally minor
- Most often understated the seriousness of deficiencies, generally regarding their scope

14

Overall Conclusions

- MDH responding to consistency issues
- Some minor inconsistencies remain
- More can be done

15

Recommendations for MDH

- Quality assurance program
- More timely assistance
- User-friendly summaries

16

Nursing Home Inspections

is available at:

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17

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Nursing Home Inspections

FEBRUARY 2005 **Report No. 05-05**

PROGRAM EVALUATION DIVISION
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658 Cedar Street - St. Paul, MN 55155
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Program Evaluation Division

The Minnesota Office of the Legislative Auditor (OLA) was established in 1973, replacing the Public Examiner's Office. OLA's role is to audit and evaluate public programs and ensure accountability for the expenditure of public funds. In 1975, the Legislature created the Program Evaluation Division within the auditor's office. The division's mission, as set forth in law, is to determine the degree to which activities and programs entered into or funded by the state are accomplishing their goals and objectives and utilizing resources efficiently.

Topics for evaluation are approved by the Legislative Audit Commission (LAC), a 16-member joint, bipartisan commission. The division's reports, however, are solely the responsibility of OLA. Findings, conclusions, and recommendations do not necessarily reflect the views of the LAC or any of its members.

A list of recent evaluations is on the last page of this report. A more complete list is available at OLA's website (www.auditor.leg.state.mn.us), as are copies of evaluation reports.

The Office of the Legislative Auditor also includes a Financial Audit Division, which annually conducts a statewide audit of the 25 largest agencies, an audit of federal funds, and approximately 40 financial and compliance audits of individual state agencies. The division also investigates allegations of improper actions by state employees.

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OLA
OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

February 2005

Members
Legislative Audit Commission

At your request, the Office of the Legislative Auditor (OLA) evaluated the nursing home inspection process in Minnesota. Legislators and other stakeholders were concerned about the focus and consistency of inspections, as well as the amount of flexibility the state has in conducting inspections.

Our report confirms that although inspections are conducted by state employees, the inspection process is essentially controlled by federal requirements. Nevertheless, we think the Minnesota Department of Health can take additional steps to ensure that inspections are fair, consistent, and useful. Specifically, we recommend that the department: (a) implement an on-going, centralized quality assurance program; (b) provide more timely assistance to nursing home inspectors; and (c) develop a user-friendly way to report inspection results.

Our evaluation was conducted by Jo Vos (project manager) and David Chein. Commissioner Mandernach and her staff at the Minnesota Department of Health cooperated fully with us, as did many nursing home administrators and others concerned about the nursing home inspection process. We thank them all for their assistance.

Sincerely,

/s/ James Nobles

James Nobles
Legislative Auditor

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Table of Contents

List of Tables and Figures

Summary

Most of the inspection problems we found are relatively minor. However, the state should do more to improve the consistency and usefulness of nursing home inspections.

Major Findings:

- The federal government determines the overall structure and content of the nursing home inspection program and does not allow states to implement alternative programs (p. 5).
- Minnesota Department of Health (MDH) inspection teams have varied considerably in the average number of deficiencies issued. In the previous round of inspections, teams in one part of the state issued more than three times as many deficiencies as teams in another part of the state (pp. 32-33).
- In 2003, MDH strongly "reminded" inspection teams to cite nursing homes for all deficient practices that they observed, including isolated practices that did not have a negative effect on residents (pp. 33-34).
- As a result, by May 2004, the variation among inspection teams had decreased significantly. At the same time, however, the average number of deficiencies issued statewide increased from 6.2 to 9.7, putting Minnesota above the national average of 8.4 deficiencies per nursing home (pp. 14, 32-33).
- The department has undertaken additional activities over the last year or two to address concerns about inspection practices. We found that some inconsistencies remain, but mostly on minor issues that do not threaten the overall integrity of the nursing home inspection program (pp. 38, 42-44).

Recommendations:

- The Minnesota Department of Health should implement an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from across the state (p. 49).
- The department should provide more timely assistance to inspectors in interpreting federal regulations and guidelines, especially in the area of isolated events that do not involve resident harm (p. 51).
- The department should develop a user-friendly way to summarize and report on the seriousness of the deficiencies that individual nursing homes receive (p. 52).

Report Summary

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care for their residents. The Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services oversees the inspection program for nursing homes that participate in the federal Medicare and Medicaid programs. It sets nursing home standards; provides official interpretations of federal regulations, guidelines, and policies; and establishes and monitors inspection procedures. The federal government contracts with the Minnesota Department of Health (MDH) to conduct nursing home inspections in Minnesota. In addition, MDH licenses all nursing homes operating in the state and certifies that those participating in the federal Medicare and Medicaid programs meet certain standards of care.

Nursing home inspection requirements are dictated by the federal government and are sometimes unclear, contradictory, and/or duplicative.

The Federal Government Does Not Permit States to Significantly Change the Nursing Home Inspection Program

Federal law and regulations outline both the general parameters of the inspection process and the specifics of how each inspection much be conducted. They dictate: (1) how frequently the state must inspect nursing homes, (2) the steps it must go through in conducting the inspections, and (3) the standards that it must apply. Although MDH and other states have asked CMS for more flexibility in conducting inspections, federal law does not allow states to obtain waivers to significantly change or implement an alternative inspection program for homes that participate in the Medicare program.

To comply with federal requirements, MDH inspection teams, usually three to five registered nurses, conduct unannounced inspections of each of the state's 420 nursing homes no later than once every 15 months. The average time between inspections statewide is 12 months. Each annual inspection is a "full" inspection consisting of seven federally mandated steps. During the inspection, team members observe the care and services that residents receive; meet with residents, family, administrators, and staff; examine the physical condition of the facility; and review individual resident and facility records. Team members apply a set of complex and prescriptive federal regulations that facilities must adhere to at all times. Though detailed, the regulations are sometimes unclear, contradictory, and/or duplicative, and therefore difficult to apply consistently. CMS has been slow in responding to inspectors' need for greater clarification, and MDH generally has not provided written, definitive guidance for inspectors. Consequently, inspection teams must often rely on their professional judgment to make many compliance-related determinations.

The Recent Increase in Deficiencies is Largely Due to Inspectors Issuing More Deficiencies for "Less Serious" Violations

As of May 2004, state inspectors issued an average of 9.7 deficiencies per nursing home—57 percent more than they issued in the prior round of inspections (6.2 deficiencies) and nearly double the 5.1 deficiencies that they issued three inspections previously. In contrast, deficiencies per facility nationwide increased only 3 percent over the four inspection periods, from 8.1 to 8.4 deficiencies.

Deficiencies found in inspections can range widely in scope and severity.

Inspectors assign each deficiency a letter code (A through L) to designate its scope and severity. Scope refers to the number of residents or staff affected or involved (isolated, pattern, or widespread) and severity refers to the amount of potential or actual discomfort or harm involved for residents (potential for minimal discomfort; actual discomfort or the potential for harm; actual harm; or immediate jeopardy). Level "A" deficiencies are the least serious.

In facilities' most recent round of inspections, inspectors issued 66 percent more level "D" deficiencies (isolated events that resulted in minimal resident discomfort or have the potential for harm) and 89 percent more level "E" deficiencies (a pattern of such violations) than in their previous inspections. In contrast, only 2.6 percent of the deficiencies issued most recently were for practices that harmed residents or placed them in immediate jeopardy—levels "G" and above, 55 percent fewer than in the previous inspections.

The recent increase in deficiencies is due largely to a change in inspection practices. In 2003, MDH reiterated to inspection teams that they must issue deficiencies for all deficient practices that they observe, including isolated events that do not have negative consequences for residents. Previously, some teams did not issue a deficiency if, in their professional judgment, a deficient incident did not represent an overriding problem but was simply an isolated occurrence with no negative outcome.

Variation in Inspection Practices Throughout the State Has Decreased

In facilities' most recent round of inspections, teams in the Duluth district issued the most deficiencies per facility (13.2) while inspection teams in the Mankato district issued the fewest (7.4), a difference of 78 percent. However, the difference was not as great as it was for the previous inspections. Nursing homes in the Duluth district received, on average, 11.4 deficiencies compared with an average of 3.1 deficiencies in the Mankato district, a difference of 268 percent.

During the same time period, there was a 359 percent increase in level "D" deficiencies in the Fergus Falls district and a 174 percent increase in the Mankato district. Level "E" deficiencies in these two districts increased 143 and 157 percent, respectively. Inspection teams in these two areas of the state have traditionally issued the fewest deficiencies while teams in the Duluth area have issued the most. The average number of deficiencies issued at levels "D" and "E" in the Duluth area increased 47 and 45 percent, respectively.

As part of our study, we reviewed a sample of 100 nursing home inspection reports. We found that inspectors were generally consistent in classifying the seriousness of the deficiencies that they identified. Although there were some differences among teams from different parts of the state, the problems were generally minor and did not threaten the overall integrity of the inspection program. Inspection teams tended to understate the seriousness of deficiencies more often than they overstated it—generally in respect to the number of residents or staff affected by a deficiency. We found only a few instances where we thought that teams understated resident harm (where we thought a deficiency should have been issued at level "G" or higher), and no instances where teams overstated resident harm (where we thought a level "G" or higher deficiency should have been issued at a lower level).

Over the last year or two, the Minnesota Department of Health (MDH) has focused on making inspections more consistent statewide.

MDH Needs to Develop a Better Ongoing Quality Assurance Program for Reviewing Inspection Reports

The department engages in a variety of activities, both ongoing and one-time projects, to help ensure that inspection teams apply regulations consistently throughout the state. For the most part though, MDH relies on district supervisors to review the inspection reports issued by their staff. Although central office managers and district supervisors routinely review the more serious deficiencies (levels "G" and above) before inspection teams are permitted to cite them, there is no similar check on lower-level deficiencies (which comprise the vast majority of deficiencies and are among the fastest growing) other than what might be performed by district supervisors. However, most district supervisors told us they do not have enough time to routinely review all deficiencies before inspection reports are finalized. Furthermore, their review does not help identify differences that may exist among teams in different parts of the state.

To supplement its ongoing activities, MDH has engaged in various one-time projects. These activities include having district supervisors accompany inspectors from other districts on inspections to mentor and coach them and a central office review of physical environment deficiencies. While these actions have yielded some useful information, they were undertaken largely in reaction to criticism from providers and legislators. In our opinion, this approach does not permit MDH to be proactive in monitoring its own activities nor does it allow the department to respond to criticism in a timely manner.

MDH Should Provide More Information About the Seriousness of Nursing Home Deficiencies to Consumers

In March 2004, MDH made nursing home inspection reports and facilities' plans of correction available on-line. However, the department failed to provide any summary information about each report to help put the overall number of deficiencies in perspective. The total number of deficiencies that a facility receives may be less important to consumers and policy makers than the seriousness of the deficiencies. Not all states publish inspection reports on-line, but many provide more summary information to help consumers distinguish among the seriousness of deficiencies and to rate facilities relative to the statewide average or to others in their geographic region. For example, some states compute overall inspection scores based on the number, scope, and severity of facilities' deficiencies.

The department is already moving forward on some of the initiatives that we recommend as a result of studies that it undertook in early 2004. For example, the department has created a quality assurance position that it hopes to fill in early 2005 and is working to create a nursing home "report card" that will include, among other items, information on inspection results. It has also retained a temporary long term care committee that it created in 2003 to continue to work on communication problems among MDH, providers, and others.

Introduction

The Minnesota Department of Health (MDH) licenses all nursing homes operating in the state and certifies that those participating in the federal Medicare and Medicaid programs meet certain standards for care.[1] Using a team of inspectors usually consisting of three to five registered nurses, the department conducts an unannounced inspection of each of the state's approximately 420 nursing homes no later than once every 15 months.[2]

Nursing home providers think inspection reports often present an unfair picture of their facilities.

Over the last few years, legislators, nursing home providers, and other stakeholders have expressed various concerns about the inspection process. They note that inspection results have varied significantly by area of the state, with nursing homes in northeastern Minnesota traditionally receiving more "deficiencies," on average, than homes in other parts of the state.[3] Also, the number of deficiencies issued statewide by inspectors has increased significantly in the last year. While providers view many of the deficiencies that they receive as "picky," unreasonable, or duplicative, they say that the increase has caused low morale among their staff and presents an "unfair" picture of nursing home quality to the public.

In February 2004, the Health and Human Services Policy Committee of the Minnesota House of Representatives held a day-long hearing largely devoted to listening to providers' concerns about inspections.[4] Later that year, the Legislature required the Commissioner of Health to establish a quality improvement program for the nursing home inspection and complaint processes.[5] Under the new legislation, the Commissioner must report annually, beginning December 15, 2004, on a variety of items, including (1) the number and type of deficiencies issued by inspectors in different parts of the state with an explanation of any variations; (2) the techniques used by inspectors to investigate, communicate, and document deficiencies; and (3) the number and outcome of independent dispute resolutions and appeals. Also, the legislation requires the Commissioner to seek federal approval to implement an alternative nursing home inspection process.[6]

---

1 For the most part, state laws and rules for nursing home licensure mirror federal requirements for participation in the Medicare and Medicaid programs. Nearly all nursing homes in Minnesota participate in the federal programs.

2 State and federal agencies refer to inspections as "surveys" and staff who conduct inspections as "surveyors." We use the words "inspections" and "inspectors" because we believe they more accurately reflect the tasks performed.

3 If a nursing home does not meet a federal requirement, the inspection team issues a "deficiency."

4 Minnesota House of Representatives, House Health and Human Services Policy Committee, February 25, 2004.

5 *Laws of Minnesota* (2004), ch. 247, sec. 2.

6 *Ibid.,* sec. 6.

At the same time, MDH stepped up its oversight of the inspection process and contracted with the Management Analysis Division of the Department of Administration to (1) facilitate a series of meetings among MDH staff, nursing home providers, and other stakeholders to examine communication problems, and (2) conduct an independent review of the department's regulatory activities. The department also created a task force to examine trends in nursing home deficiencies. These activities resulted in a number of reports issued in Summer 2004 that called for, among other things, improved communication between MDH and nursing home providers and a more targeted quality assurance program for nursing home inspections within the department.[7]

In April 2004 the Legislative Audit Commission directed our office to also examine the inspection program for nursing homes. We were asked to focus on the following research questions:

- **How have the number, type, and distribution of nursing home deficiencies cited by MDH inspectors changed over time and why?**

- **What has the department done to ensure consistent application of standards during nursing home inspections and how well have such activities worked?**

- **How much flexibility does MDH have in conducting inspections and has it used that flexibility effectively?**

To answer these questions, we examined state and federal laws, rules, regulations, guidelines, and reports related to conducting inspections and monitoring the inspection process. We obtained data on nursing home deficiencies maintained by the U.S. Department of Health and Human Services for every facility participating in the Medicare and Medicaid programs nationwide over the last several years. In addition, we examined in detail the most recent inspection report for a sample of 100 Minnesota nursing homes as well as the most recent inspection report for the 11 Minnesota facilities cited for deficiencies involving substandard care or immediate jeopardy to residents.[8] We supplemented these data by interviewing at least one-half of the nursing home inspectors in each district of the state, all district supervisors, MDH program administrators, and 20 nursing home administrators from throughout the state. Finally, we talked with federal representatives, officials in other states, and representatives from various advocacy and provider groups.

This report is divided into three chapters. Chapter 1 discusses the nursing home inspection process and the role of the Minnesota Department of Health. Chapter 2 provides descriptive data on the number, type, and "seriousness" of nursing home deficiencies in Minnesota over time and compares deficiency rates in Minnesota with those of other states. Chapter 3 examines how consistently Minnesota inspection teams identify and classify deficiencies and state efforts to address inspection consistency issues.

---

7 Minnesota Department of Administration, *Communications for Survey Improvement (CSI-MN)* (St. Paul, June 30, 2004); Minnesota Department of Administration, *Nursing Home Licensing and Certification* (St. Paul, June 30, 2004); and Minnesota Department of Health, *Survey Findings/Review Subcommittee Final Report* (St. Paul, July 2004).

8 The most recent inspection reports refer to inspections conducted and entered into the federal government's inspection database by May 24, 2004.

1 The Nursing Home Inspection Process

SUMMARY

Both the Minnesota Department of Health (MDH) and the U.S. Department of Health and Human Services share responsibility for ensuring that Minnesota's nursing homes provide an acceptable level of care for their residents. Because the federal government dictates the overall structure and content of the inspection program, the State of Minnesota has few opportunities to make significant changes in how it conducts nursing home inspections. The federal government mandates how often the state must inspect nursing homes, the steps the state must follow when conducting inspections, and the standards the state must apply. Although MDH and other states have asked the federal government for more flexibility in conducting inspections, the federal government has not issued any waivers that allow states to significantly change or implement an alternative inspection program.

The current nursing home inspection process emerged in the mid-1980s, as Congress responded to reports of resident abuse and inadequate enforcement of nursing home regulations. In a 1986 report on nursing home quality, the Institute of Medicine found "serious, even shocking inadequacies" in the enforcement of regulations.[1] As a result of this report and the efforts of advocacy groups and professional organizations, Congress passed a major reform of nursing home regulation as part of the Omnibus Budget Reconciliation Act of 1987.[2]

Since that time, Congress and the U.S. Department of Health and Human Services have periodically modified inspection requirements in response to studies that have shown continued weak and inconsistent enforcement of nursing home regulations and quality of care problems. Most significantly, the Nursing Home Oversight Improvement Program was implemented in 1998, which, among other things, enhanced federal review of state inspections and required the federal government to terminate funding for states that fail to conduct adequate inspections.

This chapter addresses the following question about how the Minnesota Department of Health (MDH) inspects nursing homes:

- **What are the respective roles of the Minnesota Department of Health and U.S. Department of Health and Human Services in conducting nursing home inspections?**

---

1 Institute of Medicine, Committee on Nursing Home Regulation, *Improving the Quality of Care in Nursing Homes* (Washington DC: National Academy Press, 1986), 146.

2 *Pub. L.* 100-203, Dec. 22, 1987.

To answer this question, we examined state and federal laws, rules, regulations, and guidelines related to nursing homes inspections, as well as a wide variety of research reports by state and federal agencies. We also interviewed state policymakers, nursing home inspectors and their supervisors, and a sample of nursing home administrators from throughout the state.

FEDERAL REGULATION OF INSPECTIONS

State and federal laws define a nursing home as a facility (or that part of a facility) that provides health evaluation and treatment services to five or more residents who do not need an acute care facility (such as a hospital) but who require nursing supervision or rehabilitation services on an inpatient basis.[3] In lay terms, this means a facility that provides a room, meals, recreational opportunities, and help with daily living activities such as dressing, eating, bathing, walking, and using the bathroom. Residents generally have health problems that keep them from living on their own and may require daily medical attention.

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care to residents.

The federal government and states share responsibility for ensuring that nursing homes provide an acceptable level of care to residents. The Centers for Medicare and Medicaid Services (CMS) in the U. S. Department of Health and Human Services oversees the inspection program for nursing homes that participate in the federal Medicare and Medicaid programs.[4] The agency sets nursing home standards; interprets federal regulations, guidelines, and polices; and establishes and monitors inspection procedures. It contracts with MDH to conduct nursing home inspections in Minnesota.[5] In addition to conducting inspections, MDH licenses nursing homes for state purposes and certifies their eligibility for participation in the Medicare and Medicaid programs. Finally, the department is

Nursing home residents generally need help with many activities of daily living.

3 *Minn. Stat.* (2004), §144A.01, subd. 5-6; and *42 U.S. Code*, §1396r, (a) (2000).

4 CMS was formerly called the Health Care Financing Administration.

5 The Minnesota Department of Health contracts with the State Fire Marshall's Office in the Minnesota Department of Public Safety to determine facility compliance with the federal Life Safety Code, which is necessary for participation in the Medicare and Medicaid programs. State Fire Marshall findings are included in the inspection reports issued by MDH.

responsible for explaining program participation requirements to providers to help them comply with federal requirements.[6]

Overall, we found that:

- **The federal government sets forth the overall structure and content of the nursing home inspection program, and Minnesota has very few opportunities to make significant changes in the program.**

Federal regulations outline both the general parameters of the inspection process as well as the specifics of how each inspection must be done. They dictate: (1) how frequently the state must inspect nursing homes, (2) the steps the state must follow when conducting inspections, and (3) the standards that the state must apply. We discuss each of these areas in greater detail below.

Inspection Frequency

The federal government sets forth how often nursing homes must be inspected:

- **Federal law and regulations require that the Minnesota Department of Health inspect nursing homes every 12 months, on average.**

Nursing homes must have at least one "surprise" inspection every 9 to 15 months.

All nursing facilities must be inspected no later than once every 15 months, with an average time statewide between inspections of 12 months. Federal regulations do not allow states to inspect nursing homes with "good" inspection records less frequently than homes with "bad" records. In addition, CMS requires that at least 10 percent of inspections be "staggered" (started outside of normal business hours). To meet this requirement, the state must begin some inspections on weekends or holidays, some in the early morning (before 8:00 AM), and some in the evening (after 6:00 PM). Furthermore, the federal government requires that all nursing home inspections be unannounced.

About 420 Minnesota nursing homes participated in the Medicare and Medicaid programs during federal fiscal year 2003.[7] The department inspected all of these nursing homes within 14.7 months of their prior inspection, with an average time between inspections of 12 months.[8] In addition, 12 percent of the 403 inspections conducted were staggered, with 21 inspections beginning before 8:00 AM, 16 inspections after 6:00 PM, and 10 beginning on a weekend or holiday.[9]

For the most part, nursing home providers, state policymakers, and nursing home inspectors generally agree that requiring annual inspections of all nursing homes

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6 The department has additional responsibilities related to nursing homes, such as investigating complaints, which were outside the scope of our evaluation. Nursing home inspectors also inspect other types of health care facilities, such as hospitals and intermediate care facilities for the mentally retarded. These activities were likewise outside the scope of our evaluation.

7 The federal fiscal year runs from October 1 through September 30.

8 Centers for Medicare and Medicaid Services, *Federal Fiscal Year 2003 State Performance Standard Review Report* (Washington, DC, March 15, 2004), 1.

9 *Ibid.,* 2. Because nursing homes may go up to 15 months between inspections, the number of nursing homes that MDH inspected during federal fiscal year 2003 was less than the total number of nursing homes in the state.

is, at times, an inefficient use of staff resources. The requirement does not permit the state to focus efforts on the nursing homes that need oversight the most. To help increase the efficiency and effectiveness of the inspection process, the Legislature has repeatedly required the Commissioner of Health to seek federal permission to implement an alternative inspection process that would change how often nursing homes must be inspected.[10] In response, the department submitted a proposal to CMS that would have increased the time between "full" inspections up to 30 months for some homes with "good" compliance records. Other states have proposed similar approaches, including ones to conduct abbreviated annual inspections for homes with "good" compliance records.

Because of federal requirements, MDH cannot inspect nursing homes with "good" inspection records less frequently than those with "bad" records.

To date, CMS has not approved an alternative inspection program put forth by any state, including Minnesota. According to CMS, the social security law does not allow states to obtain waivers to implement an alternative inspection program for nursing homes participating in the Medicare program, although states could implement an alternative inspection program for homes that only participate in the Medicaid program. However, because this would involve only a few nursing homes, it is generally not feasible for states to do so.

For the last several years, CMS has been studying the feasibility of an alternative inspection process. Recently, the agency announced that it would be establishing a few pilot sites around the country to implement a "revamped" inspection process. Designed to address concerns about inspection consistency and efficiency, pilot sites will make greater use of computers to make initial determinations of deficiencies rather than relying on the judgment of inspection teams. The alternative process will not result in less frequent inspections for facilities, but may allow inspectors to spend somewhat less time in "good" facilities and more time in "bad" ones.

Inspection Steps

In addition to requiring an inspection no later than once every 15 months:

- **Federal regulations require that each nursing home's annual inspection be a "standard" or full inspection consisting of seven federally mandated steps.**

Federal regulations do not allow states to do shorter or abbreviated inspections of nursing homes with "good" records of compliance or to cut short an inspection when inspectors do not detect any problems in a facility. On the other hand, state inspectors must extend the inspection if they suspect that a facility is providing substandard care to its residents.

As shown in Table 1.1, the standard inspection consists of seven federally mandated steps. First, inspectors prepare off-site by reviewing information about the nursing home and its residents to help identify areas of concern. Immediately upon arriving at the facility, the inspection team meets with the nursing home administrator to explain the inspection process and request specific information;

10 *Laws of Minnesota* (2000), ch. 312, sec. 2, 5; *Laws of Minnesota* (1Sp2001), ch. 9, art. 5, sec. 38; *Laws of Minnesota* (2002), ch. 379, art. 1, sec. 113; and *Laws of Minnesota* (2004), ch. 247, sec. 6.

Table 1.1: The Federal Nursing Home Inspection Process

Step 1:	Off-site preparation
Step 2:	Entry conference and on-site preparation
Step 3:	Initial nursing home tour
Step 4:	Resident sample selection
Step 5:	Information gathering
	A. General observation of the facility
	B. Kitchen/food service observation
	C. Resident review
	D. Quality of life assessment
	E. Medication pass
	F. Quality assessment and assurance review
	G. Abuse prevention review
Step 6:	Deficiency determination
	A. Determination of substandard quality of care
Step 7:	Exit conference

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), ch. 7, sec 7200.

Likewise, MDH cannot do abbreviated inspections in nursing homes with "good" records.

this is followed by a facility tour. Using the information provided by the facility and what inspectors learned during the tour, the team then selects a sample of residents to focus on during the information-gathering portion of the inspection. During this phase, the team meets on a daily basis to compare notes, discuss new areas of concern, and make adjustments to the inspection as deemed necessary. Inspectors observe the care and services that facility staff provide to residents, such as preparing and serving meals, administering medications, and helping, as necessary, with activities such as bathing, toileting, walking, and grooming. Inspection team members also interview residents and staff and review resident records. Once the team is satisfied that they have gathered enough information, it meets to determine whether the facility has failed to meet any regulatory requirements. The team prepares a draft inspection report that discusses each violation of federal regulations (commonly referred to as a deficiency) that the team has identified, and then meets with nursing home personnel and interested residents and family members to present its preliminary list of deficiencies.

Inspectors spend much of their time observing and talking with residents and staff.

After the inspection team leaves the facility, it finalizes the "Statement of Deficiencies" and submits it to the team's district supervisor who is responsible for reviewing the document and submitting a final copy to the facility and CMS. The facility must submit a "Plan of Correction" within ten days that indicates how and when it will correct each of the deficiencies that it has received.[11] Inspectors normally conduct an unannounced revisit to verify that the plan of correction has been implemented and that the deficiencies no longer exist. For the most part, MDH generally gives a facility 40 days from the end of the inspection to correct deficiencies before MDH imposes any sanctions on the facility.

11 Facilities may also dispute a deficiency and request a hearing before MDH or an administrative law judge within this ten-day period. Chapter 2 discusses how often this happens and the outcome of such hearings.

While the state is unable to make significant changes in how inspections are done:

- **Minnesota has expanded the federal nursing home inspection process in several ways.**

The state goes beyond federal inspection requirements by adding other tasks, including requirements to: (1) interview family council members; (2) expand the number of evening observations nursing home inspectors must make each month; (3) conduct a "verify and clarify" session with the provider to discuss possible areas of concern prior to the exit conference; and (4) leave a draft inspection report with nursing homes after the inspection, with the final report due within 15 days. Some of these activities were added to make the inspection process more "user friendly" for providers. Others, such as expanding the inspection to include final interviews with family council members, were at the urging of advocacy groups.

State law requires inspectors to leave a draft inspection report with facilities when they leave.

For the year ending September 30, 2004, MDH inspectors, working in teams of three to five registered nurses, spent an average of about 150 hours per facility to complete the state and federally mandated inspection tasks.[12] As would be expected, it took longer to inspect larger nursing homes than smaller ones. For example, a facility with 40 or fewer beds averaged about 72 hours per inspection while a facility with 116 to 160 beds averaged 176 hours.[13]

Nursing home inspectors must meet with each facility's resident council.

Inspection Standards

The federal *State Operations Manual* (*SOM*) sets forth the federal standards that inspectors must apply during an inspection as well as guidelines to help them apply those standards.[14] As currently written:

12 Minnesota Department of Health analysis of data from the Online Survey and Certification Reporting System, December 2, 2004. State inspectors spent an additional 54 hours per facility, on average, conducting follow-up inspections to ensure that facilities corrected deficiencies.

13 Minnesota Department of Health, *Federal Fiscal Year 2005 Initial Budget Request* (St. Paul, July 15, 2004), unnumbered.

14 Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004).

- **The federal standards and guidelines that state inspection teams must use to inspect nursing homes are prescriptive and complex.**

The *SOM* covers hundreds of pages and contains 274 regulatory standards that nursing homes must meet at all times. The standards cover 16 different categories of operation, including administration, dietary services, infection control, life safety, physical environment, quality of care, quality of life, resident assessment, and resident rights. Some requirements must be met for each resident and any violation of these requirements, even for one resident, is a deficiency. For example, each resident must have a comprehensive care plan. Other requirements focus on facility systems and are evaluated comprehensively rather than in terms of a single incident. For example, a facility must have a medication error rate below 5 percent.[15]

Inspectors grade the seriousness of each deficiency by assigning it a letter code.

For each deficiency, inspectors must use professional judgment to assess how many residents or staff are affected by or involved in the deficient practice (scope) and the amount of actual or potential discomfort or harm involved for residents (severity). As shown in Table 1.2, these two determinations result in the inspection team assigning a letter code (A through L) to each deficiency, with level "A" deficiencies being the least serious.

Table 1.2: Deficiency Scope and Severity Grid

Severity	Scope		
	Isolated	Pattern	Widespread
Level 4: A situation that has caused or is likely to cause serious resident injury, harm, impairment, or death.	J	K	L
Level 3: A situation that has caused resident harm.	G	H	I
Level 2: A situation that has caused minimal discomfort to a resident OR has the potential to cause resident harm.	D	E	F
Level 1: A situation that has the potential of causing no more than minimal discomfort to a resident.	A	B	C

NOTE: Harm is defined as a situation that compromises a resident's ability to maintain or reach his or her highest practicable physical, mental, or psychosocial well being, as defined by an accurate and comprehensive assessment, care plan, and provision of services. A nursing home with one or more quality of life, quality of care, or resident behavior and facility practices deficiencies issued at level "F" or "H" or above (the shaded area of the grid) is considered to be providing "substandard" care to its residents.

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), Appendix P, V, B-C.

To determine a deficiency's scope, inspectors must classify each deficiency in one of three ways: isolated, pattern, or widespread. Federal guidelines say that a deficiency is isolated when one or a very limited number of residents or staff are affected or the situation has occurred only occasionally or in a very limited number of locations in the facility. For example, if 60 of 70 residents in a facility are incontinent and the facility failed to provide adequate care or services to restore or improve bladder function for 2 of these residents, the deficiency should be classified as isolated. A deficiency represents a pattern when it affects more

15 However, a single medication error that is considered severe enough may result in a deficiency.

than a very limited number of residents or staff, occurs in several locations, or the same resident has been affected by repeated occurrences of the same deficient practice. If the above facility did not provide adequate care or services to 10 of its 60 incontinent residents, the resulting deficiency should be issued as a pattern. A deficiency is identified as widespread when it refers to the entire facility or when a system failure has affected or has the potential to affect a large number of residents. For example, a facility failing to provide adequate care or services to improve or restore bladder function to 30 of its 60 incontinent residents should be issued a deficiency classified as widespread.

Inspectors must also determine the severity of a deficiency on a scale from one to four. Level one refers to deficiencies that have the potential for causing no more than a minor negative impact on, or minimal physical, mental, or psychosocial discomfort to, a resident. For example, a facility should receive a level one deficiency if it failed to post its inspection results or only made them available upon request. Level two deficiencies are those that have resulted in resident discomfort or have the potential to harm residents. Federal regulations define harmful situations as those that compromise residents' ability to maintain or reach their highest practicable physical, mental, and psychosocial well being, excluding situations that are of a "limited consequence" to residents. For example, a nursing home should receive a level two deficiency if inspectors observed staff failing to wash their hands properly between caring for residents but no one became seriously ill as a result. Level three deficiencies are those that have actually resulted in resident harm. The hand-washing example should be a level three deficiency if there was evidence that a resident caught a contagious disease as a result of staff failing to wash their hands properly after providing resident care. Level four represents immediate jeopardy situations whereby the facility must undertake immediate corrective action to address problems that have resulted in or are likely to cause serious injury, harm, impairment, or death to a resident. For example, if a resident with dementia was found outside during an inspection heading toward a busy highway and the nursing home did not have a working system in place to monitor residents with dementia, the facility should be issued a level four deficiency.

A deficiency's letter code helps determine what sanctions MDH could impose on the facility.

The "seriousness" of a facility's deficiencies (their scope and severity) helps determine the sanctions for nursing homes that fail to correct deficiencies within an allowable time frame. As shown in Table 1.3, there are three categories of required sanctions. Generally, nursing homes do not face sanctions for deficiencies issued at levels "A" through "C."[16] Category 1 sanctions are reserved for deficiencies issued at levels "D" and "E" and require that facilities implement a plan of correction developed by the state, have their staff attend a specific training program, or be subject to state monitoring. Conversely, category 3 sanctions are reserved for the most serious deficiencies and include the state assuming management of the facility, terminating the facility's participation in the Medicare and Medicaid programs, or closing the facility. Except in instances of immediate jeopardy to residents (a deficiency issued at level "J" or above) or when facilities receive level "G" or higher deficiencies in two consecutive inspections, facilities are generally given an opportunity to correct deficiencies before any sanctions are imposed—usually 40 days. MDH must deny Medicare

16 Although the federal government does not require that sanctions be imposed on facilities for low-level deficiencies (levels "B" and "C"), the state may choose to impose sanctions from category 1 when facilities fail to correct their deficiencies.

Table 1.3: Required Sanctions for Noncompliance

Category 1: Deficiencies issued at levels "D" and "E"

Directed plan of correction;
State monitoring; and/or
Directed in-service training.

Category 2: Deficiencies issued at levels "F" through "I"

Denial of payment for new Medicare and Medicaid admissions[a];
Denial of payment for all Medicare and Medicaid residents;
Civil money penalties of $50-$3,000 per day of noncompliance; and/or
Civil money penalties of $1,000-$10,000 per incident of noncompliance.

Category 3: Deficiencies issued at levels "J" and above

Temporary management;
Termination from the Medicare/Medicaid programs; and/or[b]
Facility closure.

NOTE: The Minnesota Department of Health may impose a category 2 sanction to supplement a category 1 sanction for deficiencies issued at levels "D" and "E." In general, a category 1 or 2 sanction can also be imposed whenever a category 3 sanction is required, and a category 1 sanction may also be imposed when a category 2 sanction is required. Civil penalties increase to $3,050-$10,000 per day when they are imposed in addition to a category 3 sanction. The state may also assume temporary management (a category 3 sanction) when a facility has been issued a level "I" deficiency. Also, a facility cited for providing substandard care cannot operate a nurse aide training and competency evaluation program for two years.

[a]The state must deny Medicare and Medicaid payments for new admissions when a facility is not in substantial compliance within three months of the inspection and when a facility has been cited for substandard care on three consecutive annual inspections. In the latter situation, state monitoring must also be imposed.

[b]The state must recommend termination from the Medicare and Medicaid programs when a facility is not in substantial compliance within six months of the inspection.

SOURCE: Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), ch. 7, sec. 7210G and 7400.

and Medicaid reimbursements for new admissions when facilities have not corrected their deficiencies within three months of the department's inspection. Facilities must be terminated from the program if deficiencies are not corrected within 6 months.

FUNDING

In keeping with the high degree of federal involvement in the nursing home inspection program:

- **State funds cover less than 10 percent of the total cost of nursing home inspections and complaint investigations.**

The federal government is the major source of funding for the inspection program, with the state contributing less than 10 percent of the total cost for nursing homes. In fiscal year 2004, MDH spent about $12 million from state and

federal sources on activities related to nursing home inspections, including costs related to investigating complaints against nursing homes.[17] The state's share (about $1.1 million) is the result of state negotiations with CMS and has historically been low when compared with that of other states. According to a 2000 analysis of costs by the Health Care Financing Administration, Minnesota was the only state in the Chicago region that paid less than 10 percent of total inspection costs.[18] Other states paid at least 16 percent, with one state paying almost 25 percent of total costs.

17 Cecelia Jackson, "Re: FFY 2004 Nursing Home Expenditures" (December 23, 2004), electronic mail to jo.vos@state.mn.us.

18 Health Care Financing Administration, "Nursing Home Survey, State Licensure Cost Shares" (Chicago, May 2000). Minnesota is part of the Chicago region, which also includes Illinois, Indiana, Michigan, Ohio, and Wisconsin.

2 Inspection Results

SUMMARY

Over the last inspection year, there has been a significant increase in the average number of deficiencies issued to nursing homes in Minnesota. In the most recent round of inspections, Minnesota Department of Health (MDH) inspectors issued an average of 9.7 deficiencies per nursing home, 57 percent more than in their prior inspections. Minnesota's rate of deficiencies exceeded the national average of 8.4 for the first time in recent years. Despite the increase, however, the number of deficiencies that resulted in resident harm or placed residents in immediate jeopardy decreased in Minnesota. Furthermore, few nursing homes appealed inspection results, and the majority of the deficiencies that were appealed were upheld. Federal regulations set forth for a range of sanctions for nursing homes that do not correct their deficiencies, and MDH generally gives them 40 days to do so before imposing sanctions. In federal fiscal years 2002 and 2003 combined, MDH denied Medicare and Medicaid payments for new admissions to 4 percent of Minnesota nursing homes with deficiencies and issued civil monetary penalties to 2 percent of them.

As discussed in Chapter 1, nursing home inspectors issue deficiencies for violations of federal regulations. Each deficiency's seriousness is defined by its scope (how many residents or staff are affected by or involved in the deficient practice) and severity (the amount of actual or potential discomfort or harm involved for residents). This chapter addresses the following questions:

- **How have the number, type, and distribution of deficiencies cited by nursing home inspectors changed over time, and how do these changes compare with national averages?**

- **How often have nursing homes in Minnesota been sanctioned for the deficiencies that they receive, and how does this compare with national averages?**

- **To what extent have nursing home providers appealed deficiencies that they have been issued, and what has been the result?**

To answer these questions, we examined state and federal laws, rules, regulations, and guidelines related to nursing home inspections. We obtained data from the Minnesota Department of Health (MDH) on deficiencies for each nursing home participating in the Medicare and Medicaid programs nationwide over the last several years.[1] We examined the national literature and reviewed data on Minnesota nursing home characteristics to determine what factors might explain why some nursing homes receive more deficiencies than others and why states differ in the number of deficiencies they issue. We also analyzed national enforcement data on sanctions against nursing homes in Minnesota and other states, and data from MDH on the extent to which Minnesota nursing homes appeal deficiencies and the outcomes of those appeals.

TRENDS IN NURSING HOME DEFICIENCIES

This section looks at the overall number of deficiencies that Minnesota inspectors issued to nursing homes over the last four inspections and compares those figures to national trends. We also examine the types of deficiencies issued and their scope and severity.

Deficiencies per Nursing Home

Inspection teams from MDH issue deficiencies when a nursing home does not meet a federal requirement.[2] Our review of the results of nursing homes' four most recent inspections revealed that:

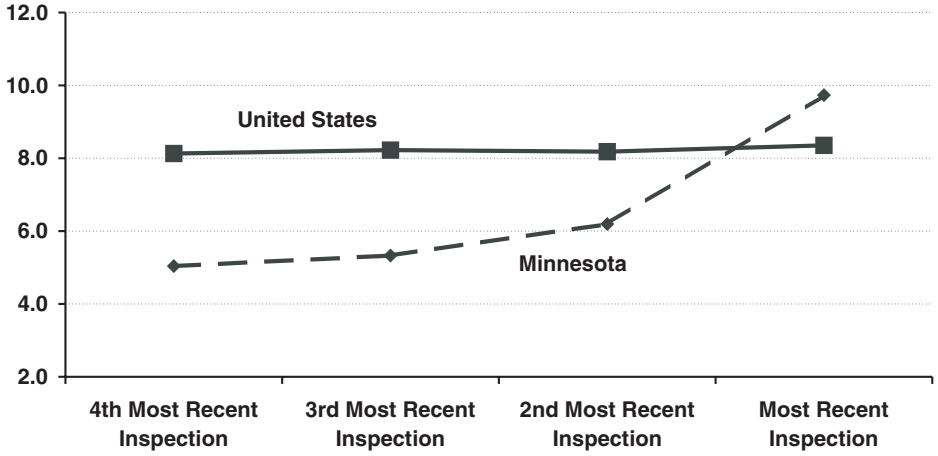
- **MDH inspectors issued significantly more deficiencies per nursing home in their most recent inspections than they issued in the three previous ones, putting Minnesota above the national average for the first time in recent years.**

As shown in Figure 2.1, Minnesota inspectors issued 9.7 deficiencies per nursing home in their most recent inspections—57 percent more than the 6.2 deficiencies they issued in nursing homes' previous inspections and nearly double the average of 5.1 deficiencies per nursing home that MDH inspectors issued in the fourth

1 The department downloaded data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System, which maintains records for the four most recent inspections. When the results from a new inspection are entered, the most recent inspection becomes the prior or second most recent inspection, and the results of the fourth most recent inspection are dropped from the database. As a result, the system is constantly in flux, making analysis specific to the point in time that data were downloaded. The data that we used were downloaded on May 24, 2004, and include inspections from October 1999 through March 2004. Deficiencies issued as a result of Office of Health Facility Complaints investigations are also included in the database.

2 A facility receives a deficiency for each regulation that it violates, regardless of how many times it violates that regulation. For example, a facility where one or two nurse assistants fail to wash their hands after contact with a resident and a facility where ten nurse assistants fail to do so will both receive one deficiency. However, a deficiency's scope will generally increase as the number of times a regulation is violated increases.

Figure 2.1: Average Number of Nursing Home Deficiencies, Four Most Recent Inspections, Minnesota and the United States



SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

In the most recent round of inspections, Minnesota issued 17 percent more deficiencies per facility than were issued nationwide.

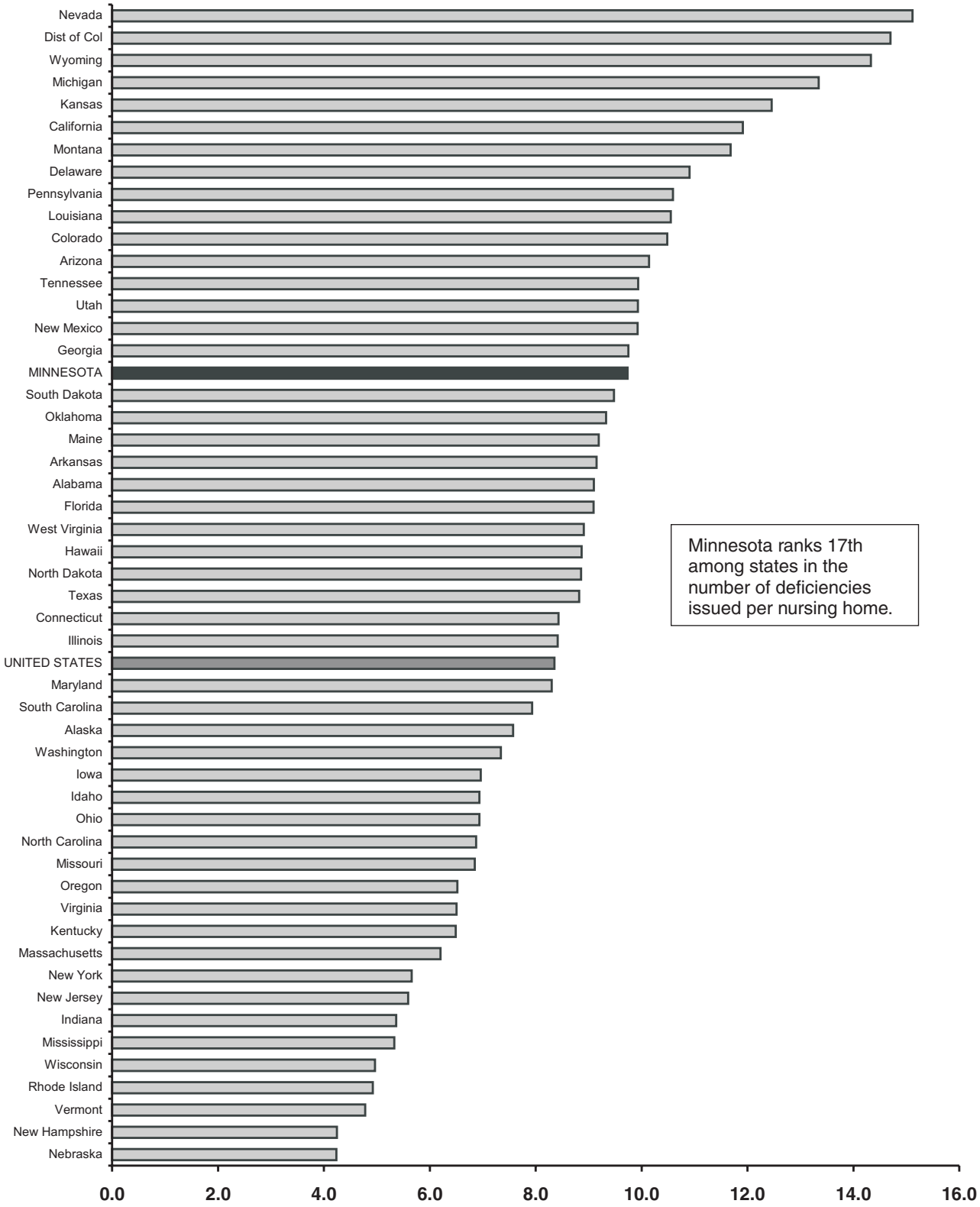
most recent inspections.[3] Furthermore, only 3 percent of Minnesota nursing homes had no deficiencies in their most recent inspections, compared with 11 percent in their prior round of inspections. Inspectors issued more than ten deficiencies to 40 percent of the nursing homes in the most recent inspections, compared with 19 percent in the prior inspections.

In contrast, the average number of deficiencies per facility nationwide increased only 3 percent over the four inspection periods, from 8.1 to 8.4 deficiencies per facility. As a result, Minnesota inspectors issued, on average, 17 percent more deficiencies per facility in the most recent round of inspections than were issued nationwide. In the three previous inspections, Minnesota inspectors issued from 24 to 38 percent fewer deficiencies than the national average.

As shown in Figure 2.2, states vary considerably in the number of deficiencies they issue, ranging from 4.2 deficiencies per nursing home in Nebraska and New Hampshire to 15.1 in Nevada. Minnesota ranked 17th among states in deficiencies issued per facility. Only two states, Maryland and Maine, had greater percentage increases in deficiencies per nursing home than Minnesota over their four most recent inspections.

3 In a recent report that recorded nursing home deficiencies as of December 9, 2004, MDH found that Minnesota nursing homes averaged 8.6 deficiencies per facility. This figure, though, excludes life safety deficiencies. The department contracts with the State Fire Marshall's Office to conduct this portion of the inspection. We found that, as of May 24, 2004, Minnesota averaged 8.8 deficiencies per nursing home, excluding life safety deficiencies. MDH also found that facilities inspected after April 1, 2004 had fewer deficiencies, on average, than those inspected earlier. Minnesota Department of Health, *Annual Quality Improvement Report on the Nursing Home Survey Process and Progress Reports on Other Legislatively Directed Activities* (St. Paul, December 15, 2004), 2-5.

Figure 2.2: Deficiencies per Nursing Home by State, Most Recent Inspection



SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

Minnesota ranked second among the six states in the Chicago region in deficiencies issued per facility.[4] Michigan inspectors issued the most deficiencies per facility (13.3) and Wisconsin the fewest (5.0). On average, the number of deficiencies per facility issued by inspectors in the Chicago region was the same in the most recent round of inspections as it was four inspections ago. Appendix A shows the number of deficiencies issued per facility for all 50 states and the District of Columbia over the four most recent inspections.

Nursing homes must comply with more than 270 standards at all times.

As noted in Chapter 1, facilities can receive deficiencies for failing to meet any of CMS's 274 nursing home standards. In the most recent round of inspections, Minnesota inspectors issued deficiencies to nursing homes for violating 176 of the 274 standards. Table 2.1 lists the ten most frequently issued deficiencies in Minnesota. Together, violations of these ten standards accounted for 38 percent of the deficiencies issued. Appendix B provides a more inclusive list of deficiencies issued to 20 or more nursing homes in their most recent inspections. It organizes deficiencies into categories, which we discuss next.

Table 2.1: Ten Most Frequently Issued Deficiencies to Minnesota Nursing Homes, Most Recent Inspections

Deficiency Description	Number of Deficiencies Issued	Percentage of Facilities With This Deficiency
Services must be provided by competent persons in accordance with the resident's care plan.	231	55%
Facilities must store, prepare, distribute, and serve food under sanitary conditions.	167	40
Facilities must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.	162	39
Each resident must receive care and services necessary to achieve the highest practicable physical, mental, and psychological well-being.	161	38
Care must be provided in a manner and environment that maintains or enhances each resident's dignity.	130	31
Facility must remain as free of accident hazards as is possible.	125	30
Incontinent residents must receive appropriate treatment and services.	121	29
Each resident's drug regimen must be free from unnecessary drugs.	121	29
Each resident must receive adequate supervision and assistance devices to prevent accidents.	120	29
Each resident must have a comprehensive care plan.	118	28

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

4 The federal government divides the United States into ten regions. The Chicago region covers Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin.

Categories of Deficiencies

As noted in Chapter 1, CMS organizes deficiencies into 16 categories. We combined some of the lesser used categories for our analysis, resulting in the 10 categories shown in Table 2.2. We found that:

- **MDH inspectors issue more quality of care deficiencies than any other category of deficiencies.**

Table 2.2: Categories of Deficiencies Issued to Minnesota Nursing Homes, Most Recent Inspections

Type of Deficiency	Total Deficiencies Issued	Percentage of All Deficiencies	Average Number of Deficiencies per Facility	Percentage of Facilities With This Type of Deficiency
Quality of Care	1,163	29%	2.8	82%
Resident Assessment	708	17	1.7	74
Safety	393	10	0.9	37
Resident Rights and Facility Practices	390	10	0.9	55
Quality of Life	372	9	0.9	52
Dietary Services	274	7	0.7	49
Physical Environment	265	6	0.6	47
Medical and Related Services	234	6	0.6	38
Infection Control	178	4	0.4	35
Administration	102	3	0.2	21
Total	4,079	100%	9.7	

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

In recent reports, five out of six nursing homes were cited for not providing appropriate treatment and services to residents.

Twenty-nine percent of the 4,079 deficiencies that MDH inspectors issued to nursing homes in their most recent inspections were for quality of care violations. These violations involve failing to provide appropriate treatment and services to meet residents' needs, such as providing assistance with eating, walking, toileting, exercising, grooming, hygiene, and receiving medication; or failing to keep the nursing home environment free from hazards that could lead to accidents. For example, a resident who sits in a chair or lies in bed all day without being repositioned could develop a pressure sore that, in addition to being painful, could lead to infection. Likewise, failing to provide walking or range of motion exercises could result in a decline in a resident's physical mobility. Preventable accidents and medication errors could also result in resident discomfort or harm. On average, inspectors issued 2.8 quality of care deficiencies per Minnesota nursing home, an increase of 59 percent from their previous inspections. Nearly five out of every six nursing homes received at least one quality of care deficiency in their most recent inspections.

Seventeen percent of deficiencies issued to nursing homes in their most recent inspections were related to requirements to assess residents' needs when they enter the nursing home and periodically thereafter. Included in this category are

violations for failing to develop a care plan for each resident and to provide services in accordance with that care plan. Nearly three-fourths of Minnesota nursing homes received at least one resident assessment deficiency in their most recent inspections.

Life safety code violations and violations of resident rights and facility practices each made up 10 percent of the deficiencies that inspectors issued to nursing homes. As noted in Chapter 1, MDH contracts with the State Fire Marshall's Office to examine facility compliance with life safety regulations. Life safety violations typically involve fire hazards such as fire doors that do not close tightly, exit aisles that are blocked, and smoke barriers not up to code. Resident rights and facility practices include, among other things, the right to personal privacy, the right to obtain information, and the right to be free from abuse.

Physical environment violations accounted for 6 percent of deficiencies.

Quality of life deficiencies, which made up 9 percent of the deficiencies issued to nursing homes in their most recent inspections, are related to the physical comfort and psychological well being of residents. They include violations such as the failure to treat residents with dignity, accommodate reasonable resident preferences, have an ongoing activities program, and provide a safe and comfortable environment.

Nursing homes must provide services to residents in a dignified manner.

Physical environment deficiencies involve conditions such as scrapes and gouges in furniture, doors, and walls; excessive dirt, dust, and debris; and unlocked closets or storerooms that could pose a danger to residents who enter. Many providers have criticized inspectors for issuing deficiencies for scratches on furniture or dust on radiators, conditions they argue are common to many private residences. Regardless of the merits of those criticisms, physical environment deficiencies only accounted for 6 percent of the deficiencies issued in nursing homes' most recent inspections.

Infection control deficiencies, while only 4 percent of deficiencies issued in the most recent inspections, increased 154 percent from the previous inspections and 205 percent over the four-inspection period, the greatest percentage increase of any type of deficiency. The failure of staff to wash their hands after direct contact with residents is the most common deficiency in this category.

Other deficiency categories are dietary services, medical and related services (including physician, nursing, pharmacy, dental, and rehabilitation services), and administration. Appendix C shows the number of deficiencies per Minnesota nursing home for each deficiency category for the four most recent inspection periods.

Seriousness of Deficiencies

Although there has been a dramatic increase in the number of deficiencies issued per nursing home:

- **Most of the deficiencies that MDH inspectors issued were for isolated occurrences that did not involve actual harm or immediate jeopardy to nursing home residents.**

As discussed in Chapter 1, inspection teams assign each deficiency a letter code (A through L) depending on its scope and severity. As shown in Table 2.3, 56 percent of deficiencies issued by MDH inspectors were level "D" deficiencies—isolated occurrences that resulted in no more than minimal discomfort to residents or had the potential for resident harm. Another 27 percent

Table 2.3: Number of Deficiencies in Minnesota Nursing Homes by Scope and Severity, Four Most Recent Inspections

	Fourth Most Recent Inspection		Third Most Recent Inspection		Second Most Recent Inspection		Most Recent Inspection		Percentage
Scope and Severity	Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage	Change[a]
B	94	4.5%	111	5.0%	110	4.2%	184	4.5%	96%
C	160	7.6	161	7.3	140	5.4	193	4.7	21
D	1,020	48.3	1,166	52.6	1,384	53.4	2,296	56.3	125
E	469	22.2	495	22.3	593	22.9	1,119	27.4	139
F	133	6.3	92	4.1	126	4.9	180	4.4	35
G	206	9.8	167	7.5	192	7.4	93	2.3	-55
H	11	0.5	8	0.4	14	0.5	2	0.0	-82
I	0	0.0	0	0.0	0	0.0	0	0.0	0
J	14	0.7	15	0.7	31	1.2	8	0.2	-43
K	2	0.1	2	0.1	2	0.1	3	0.1	50
L	2	0.1	1	0.0	1	0.0	1	0.0	-50
Total	2,111	100.0%	2,218	100.0%	2,593	100.0%	4,079	100.0%	93%
G or Higher	235	11.1	193	8.7	240	9.3	107	2.6	-54
Substandard Care[b]	19	0.9	19	0.9	26	1.0	11	0.3	-42
Immediate Jeopardy[c]	18	0.9	18	0.8	34	1.3	12	0.3	-33

NOTE: Level "A" deficiencies are not entered into the federal government's database. We estimated that they make up a very small percentage of total deficiencies in Minnesota. In our review of a random sample of 100 inspection reports, we found 16 level "A" deficiencies, about 1.6 percent of the deficiencies issued to those facilities.

[a]Percentage change from the fourth most recent inspection to the most recent inspection.

[b]A quality of life, quality of care, or resident behavior and facility practices deficiency issued at level "F" or "H" or higher is considered to be substandard care.

[c]An Immediate jeopardy deficiency has a scope and severity level of "J" or higher.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

were level "E" deficiencies—a pattern (rather than an isolated occurrence) of such violations. Only 2.6 percent of deficiencies involved actual harm or immediate jeopardy to residents (level "G" or higher).

The data in Table 2.3 also show that the total number of deficiencies increased 93 percent over the last four inspection periods. However:

- **The total number of deficiencies increased because of increases in "less serious" deficiencies.**

Over the past four inspections, the number of level "D" deficiencies increased 125 percent and the number of level "E" deficiencies increased 139 percent. In contrast, the number of deficiencies at level "G" or higher (actual harm or immediate jeopardy) declined 54 percent. In the most recent inspection, 15 percent of facilities had at least one deficiency at level "G" or higher compared with 21 percent of facilities in the prior inspections and 23 percent three inspections ago.

Although total deficiencies have increased, inspectors are issuing fewer "serious" deficiencies.

According to CMS, a facility is providing substandard care if it has one or more quality of care, quality of life, or facility practices and resident behavior deficiencies at level "F" or "H" or higher. As shown in Table 2.3, substandard care deficiencies declined 58 percent, from a total of 26 substandard deficiencies in the prior inspections to 11 in the most recent inspections. The total number of immediate jeopardy deficiencies (level "J" or higher) declined 65 percent, from 34 to 12.

Nationwide, inspectors issued level "G" or higher deficiencies to 16 percent of the nursing homes inspected, compared with 15 percent for Minnesota nursing homes. Inspectors issued immediate jeopardy deficiencies to 2.2 percent of the facilities nationwide compared with 2.1 percent of Minnesota facilities; 3.2 percent of facilities nationwide had at least one substandard care deficiency compared with 2.1 percent of Minnesota facilities. For the Chicago region, 16 percent of nursing homes had at least one deficiency at level "G" or higher, 1.9 percent had an immediate jeopardy deficiency, and 2.5 percent had a substandard deficiency. Appendix D presents several indicators of the number and seriousness of nursing home deficiencies for each state and federal region.

Factors Relating to Nursing Home Deficiencies

In theory, the number of deficiencies that inspectors issue to nursing homes might be influenced by: (1) nursing homes characteristics, such as the number of residents living there, the staff to resident ratio, and the amount of care required by residents; (2) management practices, such as employee training and supervision and spending on facility upkeep and maintenance; and (3) inspection practices, such as inspector decisions about issuing deficiencies, state policies, and the number of hours spent observing resident care. In this section, we briefly consider the relationship between nursing home characteristics and the number of deficiencies they receive.

In general, national studies and our own analysis suggest that:

- **Nursing home characteristics, for the most part, do not explain why inspectors issue more deficiencies to some nursing homes than to others.**

Researchers have found statistically significant but weak relationships between nursing home characteristics, such as the number of residents and the proportion of residents receiving Medicaid, and the number of deficiencies that facilities receive. However, these relationships explain only a small portion of the variance in deficiencies.[5]

We examined facility characteristics in three ways: size (average number of residents per day), staffing (number of nursing and total staff per resident), and case mix (residents' need for services). Table 2.4 shows the average number of deficiencies issued to Minnesota nursing homes that are high, medium, and low

Table 2.4: Minnesota Nursing Home Characteristics and Number of Deficiencies, Most Recent Inspections

Nursing Home Characteristic	N	Average Number of Deficiencies	Correlation
Size			
Small	140	7.9	
Medium	141	9.4	r = .22; significant at p = .01.
Large	139	11.9	
RNs and LPNs per Resident			
Low	140	9.5	
Medium	140	9.8	r = -.07; not significant.
High	140	9.9	
Nursing Staff per Resident[a]			
Low	140	9.7	
Medium	140	9.9	r = -.04; not significant.
High	140	9.6	
Total Staff per Resident			
Low	140	10.1	
Medium	140	10.3	r = -.10, significant at p = .05.
High	140	8.8	
Resident Case Mix[b]			
Low	130	9.9	
Medium	130	9.1	r = ,09; not significant.
High	131	10.5	

[a]Includes nurse administrators, registered nurses, licensed practical nurses, certified nurse aides, nurse aides in training, and medication aides.

[b]The higher the case mix score, the more services the residents required. We were only able to obtain case mix data for 391 facilities (93 percent).

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004; and Minnesota Department of Human Services case mix data for federal fiscal year 2003.

5 Harrington, Charlene, Zimmerman, David, Karon, Sarita L, Robinson, James, and Beutel, Patricia, "Nursing Home Staffing and its Relationship to Deficiencies," *Journal of Gerontology* (2000), 55 (5), S278-S287; and Minnesota Department of Health, *Survey Findings Review Subcommittee Final Report* (St. Paul, July 2004), 7.

on each characteristic as well as the correlation between the characteristic and the number of deficiencies issued.

As shown in Table 2.4, we found a positive relationship between the average number of residents in a nursing home and the number of deficiencies that a facility receives. Nursing homes with many residents averaged four more deficiencies in their most recent inspections than nursing homes with few residents. One possible explanation is that larger facilities are more difficult to manage and more things can go wrong. They care for more residents, they need to train and manage more staff, and they maintain more square footage. In addition, MDH allocates more staff hours to larger facilities. It seems plausible that with more observations, more interviews of residents, and more records reviewed, the likelihood of observing errors giving care or doing paperwork might increase.

We did not find a strong relationship between nursing home characteristics and the number of deficiencies they receive.

We did not find a significant relationship between the number of nursing staff per resident and deficiencies.[6] We did find a small relationship between total staff per resident and deficiencies.[7] Facilities in the high staff per resident group had 1.5 fewer deficiencies than nursing homes in the low or medium groups. But when we controlled for facility size, the correlation between total staff per resident and deficiencies was not statistically significant.

Nursing home residents differ in their physical and mental capabilities and some residents need more assistance and care than others. It is possible that homes with a high proportion of "needy" residents find it more difficult to meet all of their residents' needs in a timely manner, thereby incurring more deficiencies. We looked at the relationship between deficiencies and residents' needs using case mix data compiled by the Minnesota Department of Human Services.[8] As shown in Table 2.4, facilities whose residents have the highest need for services received slightly more deficiencies, on average, than other facilities, but facilities whose residents have the least need for services averaged slightly more deficiencies than facilities whose residents had a medium level of need. Overall, we did not find a statistically significant relationship between resident case mix and deficiencies.

The absence of strong relationship between facility characteristics and deficiencies suggests that Minnesota nursing homes' above average rate of deficiencies compared with other states is not due to differences in nursing home

6 Nursing staff includes nurse administrators, registered nurses, licensed practical nurses, certified nurse aides, nurse aides in training, and medication aides.

7 Total staff includes nursing staff and administrators, physicians, dentists, podiatrists, pharmacists, dieticians, food service workers, occupational therapists, physical therapists, recreational therapists, activities staff, speech pathologists, social workers, mental health professionals, housekeeping staff, and others.

8 The term "case mix" refers to the average need for services of a facility's residents. All nursing home residents are periodically assessed on a scale that measures their need for assistance with various activities, including eating, ambulating, and toileting, and whether they suffer from a variety of conditions, such as incontinence, pressure sores, dementia, or depression. Each item is weighted based on the average number of minutes required to provide the needed services. A facility's case mix is calculated by averaging the scores of its residents. The Department of Human Services uses the case mix scores as one component in determining nursing home reimbursement rates for Medicare and Medicaid. We used case mix data for the federal fiscal year ending September 30, 2003. Fifty-nine percent of nursing homes' most recent inspections as of May 24, 2004 occurred during this period. We also looked at the relationship between case mix and deficiencies for the second most recent inspections and found similar results to those reported in Table 2.4.

size, staffing, or resident characteristics. Moreover, even if there were stronger relationships, the characteristics of Minnesota nursing homes would not explain why Minnesota facilities received more deficiencies, on average, than the nation as a whole. Nursing homes in Minnesota were smaller than nursing homes nationwide, averaging 83.4 residents per facility in calendar year 2003 compared with 88.9 for the nation as a whole.[9] Minnesota nursing homes, on average, had the same number of nursing staff (registered nurses, licensed practical nurses, and nurse assistants) per resident as nursing homes nationwide.[10] In addition, Minnesota nursing home residents appear to have slightly less need for services than nursing home residents nationwide. On a measure similar to DHS' case mix score, Minnesota nursing home residents had an average score of 95.7 in calendar year 2003 compared with an average score of 103.7 nationwide, indicating less need for services in Minnesota facilities[11] Finally, nursing home size, staffing, and case mix in Minnesota has not changed appreciably in the last few years. Thus, the sharp increase in deficiencies issued in the most recent round of inspections is most likely due to factors other than nursing home characteristics.

SANCTIONS

As discussed in Chapter 1, federal regulations provide for a range of sanctions that MDH must impose when nursing homes have deficiencies at level "D" or above.[12] Depending on the seriousness of a nursing home's deficiencies, sanctions may be relatively mild, such as state monitoring of facilities, or more severe, such as denial of Medicare and Medicaid payments for new admissions. In addition, MDH may impose civil monetary penalties of up to $10,000 per day or $10,000 per deficiency.[13] Most sanctions, however, do not become effective immediately upon imposition and, depending on the circumstances, facilities are usually able correct deficiencies before sanctions go into effect.

Nursing homes can generally avoid sanctions if they correct deficiencies within 40 days.

For most deficiencies, nursing homes can generally avoid imposition of a sanction if they correct their deficiencies and return to substantial compliance within a time frame specified by MDH, usually 40 days from the completion of the inspection.[14] The department must impose sanctions immediately if inspectors issue an immediate jeopardy deficiency or if a facility receives one or more deficiencies at level "G" or higher in two consecutive inspections.[15] However,

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9 Harrington, Charlene, Carrillo, Helen, and Crawford, Cassandra, *Nursing Facilities, Staffing, Residents, and Facility Deficiencies, 1997 Through 2003* (San Francisco: University of California San Francisco Department of Behavioral Sciences, August 2004), 8, 14.

10 *Ibid*., 66.

11 *Ibid*., 36.

12 For some types of deficiencies, such as room size or staffing levels, nursing homes can request a waiver from MDH that allows them to be out of compliance without incurring a sanction. Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), ch. 7, sec. 7014.

13 Penalties must be reduced 35 percent if a facility waives its right to appeal a deficiency. *42 CFR* sec. 488.436 (b).

14 Nursing homes may request a waiver extending the amount of time they have to comply with certain types of deficiencies.

15 CMS, *State Operations Manual*, ch. 7, sec. 7301A and 7304B1.

except for civil monetary penalties, MDH must generally give a nursing home at least 15 days notice before the "imposed" sanction goes into effect; MDH must give 2 days' notice for immediate jeopardy deficiencies.[16] Nursing homes can sometimes correct deficiencies immediately. For example, a home would normally repair a malfunctioning call button system the same day it is brought to the facility's attention or well before the sanction becomes consequential. If a nursing home does not achieve compliance within three months of an inspection, MDH must deny Medicare and Medicaid payments for new admissions to the facility. If a facility fails to comply within six months, it must be terminated from the Medicare and Medicaid programs.[17]

Taken together, the federal regulations result in a system in which:

- **Most deficiencies do not result in sanctions because nursing homes have the opportunity to correct deficiencies before sanctions take effect.**

As shown in Table 2.5, MDH imposed sanctions that became effective on 14 percent of the nursing homes with deficiencies in calendar years 2002 and 2003. In comparison, 15 percent of nursing homes in nearby states (those bordering Minnesota or in the Chicago region) and about 10 percent nationwide experienced sanctions. Most of Minnesota's sanctions involved state monitoring, where a state employee or contractor oversees the nursing home's correction of deficiencies. MDH routinely informs all facilities receiving deficiencies that state

Table 2.5: Sanctions Received by Nursing Homes in Minnesota and Nearby States, CY 2002 and 2003 Combined

State	Inspections Resulting in Deficiencies	Sanctions Put Into Effect		State Monitoring		Denial of Payment for New Admissions		Civil Monetary Penalty	
		Number	Percentage	Number	Percentage	Number	Percentage	Number	Percentage
Minnesota	**795**	**114**	**14%**	**113**	**14%**	**30**	**4%**	**14**	**2%**
Illinois	2,118	444	21	0	0	265	13	364	17
Indiana	1,667	240	14	0	0	141	8	208	12
Iowa	835	40	5	0	0	23	3	32	4
Michigan	1,396	347	25	35	3	129	9	254	18
North Dakota	268	5	2	0	0	0	0	0	0
Ohio	2,422	326	13	0	0	22	1	315	13
South Dakota	216	38	18	14	6	4	2	0	0
Wisconsin	938	75	8	0	0	13	1	73	8
Nearby States	9,860	1,515	15	31	0	583	6	1,243	13
U.S.	34,817	3,498	10	200	1	1,113	3	2,573	7

NOTE: This table excludes sanctions that were imposed but did not go into effect because facilities corrected the deficiencies before the effective date of the sanction.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed April 28, 2004.

16 CMS, *State Operations Manual*, ch. 7, sec. 7305B3.

17 New deficiencies cited in follow-up inspections must also be corrected within the original three and six month deadlines.

monitoring will be imposed if a deficiency is not corrected by a specified date. Other nearby states do not make extensive use of state monitoring as an enforcement tool.[18]

Few nursing homes paid fines or had their Medicare and Medicaid payments withheld due to noncompliance.

Two sanctions have direct monetary consequences for nursing homes: civil monetary penalties and denial of reimbursement for new Medicare and Medicaid residents.[19] For 2002 and 2003 combined, 4 percent of Minnesota nursing homes with deficiencies were denied reimbursement for new Medicare and Medicaid residents and 2 percent paid civil monetary penalties. Amounts collected ranged from $650 to $41,020, with a median penalty of $8,395. Eleven Minnesota facilities paid civil monetary penalties in 2002, but only 3 facilities paid them in 2003.

As shown in Table 2.5, Minnesota was less likely to deny Medicare and Medicaid reimbursements for new admissions and it issued fewer civil monetary penalties than did nearby states. On average, nearby states denied Medicare and Medicaid payments for new residents to 6 percent of their nursing homes with deficiencies and they imposed civil monetary penalty on 13 percent of their facilities.

APPEALS

Federal regulations require that states have an "informal" method for facilities to dispute deficiencies.[20] Except for immediate jeopardy or substandard quality of care deficiencies, facilities may not appeal the scope and severity of a deficiency.[21] In Minnesota, facilities can choose one of two informal methods. Under "informal dispute resolution," an MDH supervisor or manager from a district other than the one that conducted the inspection hears the appeal and makes a recommendation to the Commissioner of Health.[22] Under "independent informal dispute resolution," an administrative law judge from the Office of Administrative Hearings conducts the hearing. Both sides have the right to present evidence and be represented by counsel. The law judge must issue findings on each contested deficiency within ten days of the close of the hearing. MDH reimburses the Office of Administrative Hearings for the cost of hearings, but nursing homes must reimburse the department for the proportion of costs corresponding to the proportion of contested deficiencies that are upheld. The Commissioner of Health may reject or modify the law judge's recommendation.[23] While CMS holds states accountable for decisions made through both informal

Minnesota nursing homes can appeal inspection results through one of two informal mechanisms.

18 Some states impose sanctions that Minnesota does not use. For example, 15 percent of South Dakota facilities with deficiencies and 12 percent of Illinois' facilities were directed to attend in-service training. Michigan imposed directed plans of correction on 4 percent of its facilities with deficiencies.

19 Other sanctions that have significant financial impacts, such as termination from the Medicare and Medicaid programs or facility closure, are rarely imposed by any state.

20 CMS allows facilities to appeal findings of noncompliance that result in sanctions other than state monitoring directly to the U.S. Department of Health and Human Services. CMS, *State Operations Manual*, ch. 7, sec. 7303.

21 CMS, *State Operations Manual*, ch. 7, sec. 7212A, 7212C (2).

22 *Minn. Stat.* (2004), §144A.10, subd. 15.

23 *Minn. Stat.* (2004), §144A.10, subd. 16.

dispute resolution mechanisms, the agency retains the right to reject state decisions and make its own binding determinations.[24]

Despite the significant increase in the number of deficiencies issued:

- **Minnesota nursing homes appealed very few deficiencies in the last two years, and the majority of their appeals were not successful.**

In federal fiscal years 2003 and 2004 combined, 68 nursing homes appealed 141 deficiencies through informal dispute resolution with MDH.[25] This represents about 2 percent of all deficiencies issued. As shown in Table 2.6, MDH rescinded 22 of the 141 deficiencies (16 percent) that were appealed and reduced the scope and severity of 9 others (6 percent).[26] The remaining 110 deficiencies (78 percent) were upheld, although a few of them were slightly modified, such as eliminating or restating one of several findings that supported the deficiency.

Although the 2003 Legislature required that the administrative law judge option become effective on July 1, 2003, MDH did not implement the process until July 2004.[27] As of December 2004, 34 nursing homes had requested administrative hearings regarding 141 deficiencies. Fourteen facilities subsequently withdrew their appeals and MDH rescinded two other facilities' deficiencies before the hearing occurred. Of the remaining appeals, 7 are pending and 12 have been decided. Those 12 originally covered 73 deficiencies but facilities later withdrew 35 deficiencies from their appeals. Table 2.6 shows that,

Table 2.6: Nursing Home Appeals of Deficiencies

	Number	Percentage
Appeals Heard by the Minnesota Department of Health		
Deficiencies rescinded	22	16%
Deficiencies upheld with no change in scope or severity	110	78
Deficiencies upheld but scope and severity reduced	9	6
Total	141	100%
Appeals Heard by an Administrative Law Judge		
Deficiencies rescinded	6	16%
Deficiencies upheld with no change in scope or severity	16	42
Deficiencies upheld but scope and severity reduced	16	42
Total	38	100%

NOTE: This table reflects appeals heard by the Minnesota Department of Health in federal fiscal years 2003 and 2004 and appeals heard by administrative law judges between July 2004 and December 2004.

SOURCE: Minnesota Department of Health, Informal Dispute Resolution Tracking Log, federal fiscal years 2003 and 2004.

24 CMS, *State Operations Manual,* ch. 7, sec. 7212C (3). To date, CMS has not reversed any appeal decisions made by MDH.

25 This excludes three requests that were subsequently withdrawn.

26 Six of the nine were reduced from level "G" to level "D".

27 *Laws of Minnesota* (1Sp2003), ch. 14, art. 2, sec. 10; and MDH, *Annual Quality Improvement Report*, 10.

of the 38 remaining deficiencies, administrative law judges upheld 16 deficiencies (42 percent), reduced the severity and scope of 16 (42 percent), and rescinded 6 (16 percent).

According to some providers, both informal dispute resolution mechanisms are biased against them because the Commissioner of Health, whose agency issued the deficiencies in the first place, makes the final decision. Moreover, some nursing home administrators were concerned that the Commissioner of Health recently overruled a law judge in one appeal in support of the inspectors' decision. In that case, however, the Commissioner modified but did not entirely reject the law judge's decision. So far, the Commissioner has not overturned other administrative law judge decisions.

3 Inspection Consistency and Other Issues

SUMMARY

The Minnesota Department of Health (MDH) has undertaken various activities over the last year to help address concerns about the number and classification of deficiencies. To a great extent, the department's actions have led to a large increase in the number of "low-level" deficiencies that nursing homes receive, further straining the adversarial relationship between the department and nursing home providers. Part of the problem is due to the complex and sometimes unclear federal standards and guidelines that state inspectors must apply. Lack of clear guidance from MDH has, at times, resulted in inspection teams applying regulations differently, which explains some of the variation in deficiencies issued per nursing home across the state. Although we did not find major problems with how inspectors classify deficiencies once identified, the department could do more to ensure that inspection teams apply federal regulations and guidelines in a consistent and meaningful manner by: (a) developing an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from throughout the state; (b) providing more written guidance to inspectors, especially in key areas such as issuing deficiencies for isolated occurrences with no negative outcomes; and (c) providing more meaningful information about inspection results to consumers.

Legislators, nursing home providers, and other stakeholders are concerned about the consistency with which Minnesota Department of Health (MDH) inspectors in different parts of the state apply nursing home regulations and the significant increase in the number of deficiencies issued over the last year. This chapter addresses these concerns by examining two major questions:

- **How consistent are Minnesota Department of Health nursing home inspection teams in applying nursing home regulations across the state?**

- **What has the Minnesota Department of Health done to help ensure that inspectors apply nursing home requirements in a consistent and meaningful manner, and how well have these activities worked?**

To answer these questions, we analyzed data from the Centers for Medicare and Medicaid Services (CMS) on the number and type of deficiencies written by state inspectors in each of the state's ten districts. We reviewed a sample of 100 nursing home inspection reports as well as 11 inspection reports involving

substandard resident care or immediate jeopardy deficiencies. We supplemented these data by interviewing at least one-half of the nursing home inspectors in each district, all district supervisors, and twenty nursing home administrators from throughout the state.[1] We also talked with state and federal officials, including state officials in other states. Finally, we reviewed nursing home laws, regulations, rules, guidelines, interpretations, and other state and federal documents.

CLARITY OF INSPECTION STANDARDS

As noted in Chapter 1, the federal regulations that nursing home inspectors must apply are complex. In examining the regulatory standards and the accompanying guidelines that CMS provides, we concluded that:

- **Federal nursing home regulations and guidelines are sometimes unclear, contradictory, and/or duplicative; as a result, inspection teams must often rely on their professional judgment to make compliance-related decisions.**

Federal nursing home regulations are difficult to apply consistently.

Federal nursing home standards are inherently difficult to apply in a consistent and meaningful manner for several reasons. First, the regulations and guidelines are sometimes unclear and confusing, especially language that defines resident harm. According to CMS' *State Operations Manual (SOM),* deficiencies issued at or above level "G" must either (1) result in actual harm that "has compromised the resident's ability to maintain and/or reach his or her highest practicable physical, mental, and psychosocial well being;" or (2) present a situation of immediate jeopardy whereby "noncompliance has caused or is likely to cause serious injury, harm, impairment, or death."[2] The definition specifically excludes practices that are of "limited consequence" to a resident. For example, repeated falls that result in minor bruises, cuts, or skin tears would likely be cited as a level "D" rather than level "G" deficiency, even if the facility failed to assess the resident for falls or to implement preventive measures. On the other hand, repeated falls that result in bone fractures or breaks would likely be issued at a level "G" or above.

In 2003, the General Accounting Office (currently known as the Government Accountability Office or GAO) noted that nationwide, ". . . the continuing prevalence of and state surveyor [inspector} understatement of actual harm deficiencies is disturbing."[3] GAO attributes part of the problem to the confusing definition of harm used by CMS, which suggests that harmful situations must represent life-altering situations for residents. In response to GAO's concern, CMS indicated that it would delete the reference to "limited consequence" in its

1 In all, we interviewed 52 inspectors and 9 area supervisors (one position was vacant at the time of our study). We selected which nursing home administrators to interview based on the results of their most recent inspections as of May 2004. Using the random sample of inspection reports that we reviewed, we tried to interview one administrator from a facility with an above average number of deficiencies and another from a facility with a below average number of deficiencies in each MDH district, for a total of 20 administrators.

2 Centers for Medicare and Medicaid Services, *State Operations Manual* (Washington, DC, May 21, 2004), Appendix P, Part 1, IV, B.

3 U.S. General Accounting Office, *Nursing Home Quality* (Washington, DC, July 2003), unnumbered.

next revision of the *SOM*.[4] However, when the manual was revised in May 2004, CMS did not clarify its definition of harm.

Second, federal regulations and guidelines sometimes contradict one another. On the one hand, the *SOM* states that some requirements, especially quality of life or certain facility system requirements, are best evaluated comprehensively rather than in terms of a single incident.[5] The *SOM* goes on to state that inspection teams must consider the sum of staff actions or decisions for a resident to determine if a quality of life requirement has been met. On the other hand, the *SOM* says that a single incident that is considered severe enough may result in a deficiency. The *SOM* gives little guidance, however, to help inspectors determine when it is appropriate to cite single violations of quality of life standards as deficiencies, especially for isolated events that have resulted in only minimal discomfort to residents. Also, while the *SOM* defines a faulty practice as one that does not meet regulatory requirements, it also says that a faulty or deficient practice does not necessarily constitute a deficiency.[6] Yet, inspection teams are encouraged to cite all violations, even those that involve a single resident or event that has no adverse outcome.

Third, some deficiencies are, in practice, duplicative. For example, inspectors may cite nursing homes for storing dangerous cleaning products in unlocked cabinets under two different quality of care deficiencies or as a physical environment deficiency. Likewise, inspectors can cite facilities for having stained carpeting and furniture as either a quality of life deficiency or a physical environment deficiency. Nursing homes that do not completely close a resident's privacy or window curtain when providing personal care can receive a resident rights deficiency or a quality of life deficiency. Because quality of care or quality of life deficiencies can lead to findings of substandard care and thus harsher sanctions than most other types of deficiencies, the decision regarding which deficiency to issue may have important consequences for providers.

Finally, regulations often use words such as "timely," "adequate," "prompt," and "appropriate" but do not always provide further explanation or guidance for actually interpreting what is timely, adequate, prompt, or appropriate. For example, standards require that facilities address resident grievances promptly, but little guidance is offered to define prompt. Likewise, facilities must have sufficient staff to provide the services that residents need. However, the *SOM* provides little guidance to help inspectors determine whether residents are not receiving needed services because of insufficient staff or for other reasons, especially when facilities may be staffing at levels required by state laws and rules.

Many inspection teams want more direction from MDH in some key areas.

When we talked with inspection teams about the inspection process, about half of the teams told us that lack of clear direction from MDH and CMS was a major problem for them in applying the federal regulations. Many indicated that they need more direction in a number of areas such as issuing deficiencies for isolated events that do not result in negative outcomes or determining resident harm.

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4 *Ibid.*, 46. As we discuss later, Minnesota inspectors do not issue "G" level deficiencies for violations that do not significantly alter a resident's lifestyle or are of "limited consequence."

5 CMS, *State Operations Manual*, Appendix P, Part 1, II, Task 6, D.

6 *Ibid.*

Furthermore:

- **MDH has issued few guidelines to help inspectors interpret and apply federal standards in a consistent and meaningful manner throughout the state.**

The department issues "information bulletins" via its website to notify state inspectors and nursing home providers about a variety of issues, such as changes in state or federal regulations, inspection activities, and other miscellaneous information.[7] It issued 17 nursing home-related bulletins in 2004, 9 in 2003, and 8 in 2002. However, most of the bulletins issued in 2004 do not provide additional insight into problem areas for inspectors; rather they restate federal or state requirements or notify providers about information sources that might be of interest to them.

CONSISTENCY AMONG DISTRICTS

We examined inspection consistency in Minnesota in two ways. First, we looked at how the number of deficiencies cited by inspection teams in various parts of the state differed and possible reasons why. Second, we looked at how consistently inspection teams assigned scope and severity levels to the deficiencies that they identified.

Issuing Deficiencies

The Minnesota Department of Health uses teams of nursing home inspectors assigned to one of ten districts to conduct inspections. There are four districts in the Twin Cities area and district offices in Bemidji, Duluth, Fergus Falls, Mankato, Rochester, and St. Cloud. Each district has a supervisor and seven to nine inspectors. Inspectors typically work in teams of three or four, with one of them designated as team leader. Each district is responsible for inspecting anywhere from 32 to 64 nursing homes annually.[8]

We found that:

- **Although inspection teams throughout the state differ significantly in the average number of deficiencies issued to nursing homes, the differences have decreased dramatically in the last year.**

As shown in Table 3.1, in the most recent round of inspections, teams in the Duluth district issued the most deficiencies per facility (13.2) while inspection teams in the Mankato district issued the fewest (7.4), a difference of 78 percent. However, the difference was even greater for the previous inspections. Nursing

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7 The federal government has a similar website to notify state staff and providers about changes in its regulations or practices and to provide points of information.

8 State inspectors are also responsible for inspecting other types of health care facilities and programs, including hospitals, home health agencies, and intermediate care facilities for the mentally retarded. Inspectors estimate that they spend about 75 to 80 percent of their time inspecting nursing homes.

Table 3.1: Average Number of Deficiencies Issued to Minnesota Nursing Homes by District

District	Fourth Most Recent Inspection	Third Most Recent Inspection	Second Most Recent Inspection	Most Recent Inspection	Percentage Change[a]
Bemidji	5.6	6.5	8.0	10.7	35%
Duluth	7.1	9.2	11.4	13.2	16
Fergus Falls	3.0	3.1	3.7	10.2	178
Mankato	3.4	3.7	3.1	7.4	142
Metro A	6.7	5.4	7.9	11.1	41
Metro B	6.2	5.9	7.0	8.5	20
Metro C	5.0	5.3	5.9	10.1	71
Metro D	6.4	4.8	6.2	8.1	31
Rochester	4.7	6.8	8.1	9.6	18
St. Cloud	5.5	4.8	4.8	9.6	102
Statewide	5.1	5.3	6.2	9.7	57%

[a]Percentage change refers to the change from the second most recent inspection to the most recent inspection.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

In the last round of inspections, some teams more than doubled the number of deficiencies they issued.

homes in the Duluth district received, on average, 11.4 deficiencies compared with an average of 3.1 deficiencies in the Mankato district, a difference of 268 percent.

The number of deficiencies issued per facility increased in all districts over the previous inspections. However, the increase was greatest in those districts that had been issuing the fewest deficiencies. The two districts that issued the most deficiencies in the previous inspections, Duluth and Bemidji, had increases of 16 and 35 percent, respectively, in the number of deficiencies per facility. In contrast, the two districts with the fewest deficiencies in the previous inspections, Mankato and Fergus Falls, had increases of 142 and 178 percent, respectively.

We talked with state inspection teams and their supervisors about recent changes in the number of deficiencies issued across the state. As we discussed in Chapter 2, there are a number of reasons why deficiency rates might vary, including factors related to nursing home characteristics, facility practices, and inspection practices. We learned that, in at least one respect, state inspection practices have changed considerably over the last year:

- **In 2003, MDH strongly "reminded" inspection teams to cite nursing homes for all deficient practices, including isolated practices that did not have a negative effect on residents.**

Prior to this, inspection teams in some parts of the state used their professional judgment to determine whether a specific violation represented an overriding problem or whether it was simply an isolated event. If the teams determined that a violation was simply an isolated event that did not have any negative consequences, they pointed it out to nursing home staff, but did not generally issue a deficiency. For example, some inspection teams may not have issued a

deficiency if they noticed that loaves of bread were stored too close to the kitchen ceiling, opting instead to just discuss the situation with staff.

In early 2003, however, MDH surveyed all of the state's nursing home administrators to learn more about their concerns regarding the inspection process. When a provider indicated that inspectors in his district did not issue as many deficiencies as they could have in its most recent inspection, the department immediately conducted another inspection of his facility, using program management staff from the central office rather than inspectors from that district. The re-inspection found several deficiencies that were missed in the earlier inspection, including a finding that the nursing home was providing substandard care to its residents. Concerned over the discrepancy between the re-inspection and the one conducted earlier, MDH took immediate corrective action. First, it temporarily reassigned the district supervisor in that area to job duties outside the district and assigned other district supervisors the responsibility of overseeing the work of that district's inspectors. Second, MDH summoned inspectors from that district to the department's main office and, in no uncertain terms, strongly "reminded" staff that they needed to comply with CMS' inspection protocols and requirements. Third, it required district supervisors to accompany those inspectors on all nursing home inspections for the remainder of the summer. Finally, it notified inspectors statewide of the need to adhere to CMS' inspection requirements.

Consequently:

- **Inspection teams, especially those in areas of the state that were issuing the fewest deficiencies, began issuing more deficiencies for "less serious" violations.**

As noted previously, inspectors assign each deficiency a letter code (A through L) to designate its scope (isolated, pattern, or widespread) and severity (potential for minimal discomfort, actual discomfort or the potential for harm, actual harm, or immediate jeopardy). As shown in Table 3.2, over the past two inspections, there was a 66 percent increase statewide in the number of deficiencies with a scope and severity level of "D" (isolated occurrences that resulted in minimal resident discomfort or have the potential for harm) and an 89 percent increase in level "E" deficiencies (a pattern of such violations). During the same time period, there was a 359 percent increase in level "D" deficiencies in the Fergus Falls district and a 174 percent increase in the Mankato district. Level "E" deficiencies in these two districts increased 143 and 157 percent, respectively.

Another state policy that may affect the total number of deficiencies that inspection teams issue involves the practice of "cross-referencing," which refers to issuing multiple deficiencies for a single incident. For example, one of the facilities that we looked at received two deficiencies because a resident repeatedly walked away from the facility (also known as "elopement"). One of the deficiencies was for failing to reassess the resident for his elopement episodes and the other was for not providing proper supervision to prevent the elopements. Providers argue that issuing two or more deficiencies for the same incident is needless duplication because the action they take to correct both deficiencies is the same.

Table 3.2: Number of Deficiencies Issued to Minnesota Nursing Homes by Scope and Severity and by District

District	Most Recent Inspection						
	B	C	D	E	F	G and Above	Total
Bemidji	10	12	233	151	27	17	450
Duluth	12	17	293	129	19	18	488
Fergus Falls	38	22	248	158	14	9	489
Mankato	38	27	266	121	17	7	476
Metro A	11	19	204	107	12	3	356
Metro B	14	21	192	52	29	5	313
Metro C	23	32	245	97	20	16	433
Metro D	19	19	147	73	16	3	277
Rochester	7	5	230	140	12	19	413
St. Cloud	12	19	238	91	1,410	10	384
Statewide	184	193	2,296	1,119	180	107	4,079

District	Second Most Recent Inspection						
	B	C	D	E	F	G and Above	Total
Bemidji	1	3	161	83	20	50	318
Duluth	7	10	199	89	20	50	375
Fergus Falls	23	8	54	65	14	19	183
Mankato	17	22	97	47	10	10	203
Metro A	8	19	128	76	3	18	252
Metro B	16	25	142	24	14	18	239
Metro C	17	22	135	44	8	9	235
Metro D	10	12	126	57	13	6	224
Rochester	8	5	201	78	19	39	350
St. Cloud	3	14	141	30	5	21	214
Statewide	110	140	1,384	593	126	240	2,593

District	Percentage Change						
	B	C	D	E	F	G and Above	Total
Bemidji	900%	300%	45%	82%	35%	-66%	42%
Duluth	71	70	47	45	-5	-64	30
Fergus Falls	65	175	359	143	0	-53	167
Mankato	124	23	174	157	70	-30	134
Metro A	38	0	59	41	300	-83	41
Metro B	-13	-16	35	117	107	-72	31
Metro C	35	45	81	120	150	78	84
Metro D	90	58	17	28	23	-50	24
Rochester	-13	0	14	79	-37	-51	18
St. Cloud	300	36	69	203	180	-52	79
Statewide	67%	38%	66%	89%	43%	-55%	57%

NOTE: The Centers for Medicare and Medicaid Services does not record level "A" deficiencies in its inspection database.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

We examined how often inspection teams cited the same deficient practice to document two or more deficiencies across all 16 categories of standards. We found that:

- **Although inspection teams differed in the extent to which they issue multiple deficiencies based on the same incident, less than 10 percent of the total number of deficiencies issued were completely duplicated in other deficiencies.**

Of the 978 deficiencies that were issued to the 100 nursing homes in our sample, about 8 percent were completely cross-referenced to other deficiencies. To be counted as cross-referenced, all incidents supporting a violation had to be cited in another deficiency or deficiencies.[9] Because inspection teams frequently cite multiple instances of noncompliance in documenting deficiencies, eliminating those that also appeared elsewhere often had little effect on the overall number of deficiencies issued.

In June 2004, MDH stopped issuing multiple deficiencies for some types of violations.

Inspection teams varied in the extent to which they cross-referenced deficiencies. Teams in the Mankato district tended to cross-reference the least (less than 5 percent of deficiencies), while teams in the Metro D and Rochester districts cross-referenced the most (12 to 13 percent).

Concerned about the increase in the number of deficiencies issued statewide and the fact that Minnesota was issuing more deficiencies per facility than the national average, MDH recently directed inspection teams to stop cross-referencing certain types of deficiencies. Effective June 21, 2004, inspection teams discontinued issuing deficiencies related to assessing residents or developing their care plans if the incident supporting the deficiency also resulted in a quality of care or quality of life deficiency.[10] According to MDH, the department will examine the effect of this policy change on the total number of deficiencies in February 2005. Our data suggest that, if inspection practices do not change in other ways, discontinuing cross-referencing should have only a small effect on the number of deficiencies issued statewide. On the other hand, it may decrease inconsistencies in inspection practices throughout the state.

Because data in Chapter 2 showed a weak relationship statewide between the number of residents in a facility and the number of deficiencies it received, we also looked at the average size of the facilities in each district. We found that:

- **Overall, differences in the average size of nursing homes in each of the state's inspection districts do not explain differences in the number of deficiencies issued.**

Table 3.3 shows how districts rank on the average size of their nursing homes and the number of deficiencies issued during the most recent round of inspections. As these data show, the Metro A district ranks first in the size of its nursing homes and second in the average number of deficiencies issued while the Mankato

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9 To calculate the extent of cross-referencing, we did not eliminate quality of care or quality of life deficiencies that were totally cross-referenced to other deficiencies because deficiencies in these two categories may reflect substandard care problems in facilities.

10 Minnesota Department of Health, *Information Bulletin 04-09* (St. Paul, June 2004).

Table 3.3: Average Size of Minnesota Nursing Homes and Number of Deficiencies Issued by District

District	Average Number of Residents	Rank	Average Number of Deficiencies	Rank
Bemidji	67	9	10.7	3
Duluth	87	5	13.2	1
Fergus Falls	75	7	10.2	4
Mankato	65	10	7.4	10
Metro A	110	1	11.1	2
Metro B	99	4	8.5	8
Metro C	108	2	10.1	5
Metro D	106	3	8.1	9
Rochester	73	8	9.6	6
St. Cloud	79	6	9.6	7
Statewide	87		9.7	

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

district ranks last on both measures. However, the Bemidji district ranks third in the number of deficiencies issued, but ninth in the size of its facilities. Conversely, Metro D ranks third in the size of its facilities, but ninth in the average number of deficiencies issued.

Finally, it is important to note that Minnesota is not the only state that is concerned about the consistency with which its inspection teams issue deficiencies. Recent studies of the inspection process in California, Kansas, Missouri, Montana, and Wisconsin have examined various consistency issues, such as differences in the average number of deficiencies issued by teams in different parts of those states.[11] However, none of the studies have pointed out the definitive reasons for inspection team variation. Likewise, the federal government is not immune to consistency problems. According to various reports by GAO and others, including our own analysis in Chapter 2, federal regions of the country differ significantly in the average number of deficiencies cited per nursing home.[12]

11 California State Auditor, *Oversight of Long-Term Care Programs* (Sacramento, CA, April 2004); Kansas Legislative Division of Post Audit, *Kansas' Nursing Home Inspections: A K-Audit Determining Whether They're Carried Out in a Reasonable Manner* (Topeka, KA, December 2001); Missouri Office of State Auditor, *Review of the Division of Aging's Monitoring of Nursing Homes and Handling of Complaint Investigations* (Jefferson City, MO, March 1, 2000); Montana Legislative Audit Division, *Nursing Home Surveys* (Helena, MT, January 2003); and Wisconsin Legislative Audit Bureau, *Regulation of Nursing Homes and Assisted Living Facilities* (Madison, WI, December 2002).

12 For example, see: GAO, *Nursing Home Quality*; U.S. Department of Health and Human Services, *Nursing Home Deficiency Trends and Survey and Certification Process Consistency* (Washington, DC, March 2003); and Appendix A of this report.

Determining Scope and Severity

We also looked at whether inspection teams were consistent in how they classified the scope and severity of deficiencies once they were identified. We examined the most recent inspection reports for a sample of 100 nursing homes—10 facilities chosen at random in each of the state's 10 geographic districts.[13] These inspections resulted in nursing homes receiving 978 deficiencies (excluding level "A" deficiencies).

Classification Problems

We compared the deficiencies as written in the final inspection report with federal regulations and guidelines, paying special attention to each deficiency's scope and severity rating and the federal regulation under which the deficiency was written. We found that:

- **While there were some inconsistencies among inspection teams in how they classified deficiencies, the problems were generally minor and did not threaten the overall integrity of the inspection process.**

We questioned how inspection teams classified about 9 percent of the deficiencies we examined.

Overall, inspection teams generally did a good job classifying the deficiencies that they identified and most of the deficiencies seemed reasonable. We questioned the scope, severity, or regulation under which deficiencies were written for about 9 percent of the deficiencies that we examined. The percentage that we questioned varied by district and ranged from about 5 percent for the Mankato and Metro B districts to 18 percent for Metro D. In general, inspection reports tended to understate the scope or severity of deficiencies more often than they overstated them.

We most often questioned whether inspection teams correctly classified the scope of a deficiency. For example, in one instance, the inspection team documented that a resident's care plan failed to address the need for a lap buddy or anti-slip pad on the wheelchair. Instead of issuing a level "D" deficiency (isolated) because only one resident was affected, the inspection team issued a level "E" deficiency (pattern), a classification generally reserved for violations that affect three or more residents. In another case, the inspection team documented that a facility did not take action after residents complained about meals being served late in one of six units in the facility. As a result, the team issued two deficiencies: one for not resolving resident grievances and another for not accommodating resident preferences. However, the first deficiency was cited as an "E" (pattern), whereas the second was cited as a "D" (isolated).

We questioned fewer severity ratings that inspection teams assigned deficiencies. In one instance, a facility received a level "C" deficiency for having one of two emergency doors obstructed. Most inspection teams cite similar problems at a higher level because residents could be seriously harmed if they could not escape the facility during an emergency. In another instance, inspectors cited numerous examples of unsanitary kitchen conditions, including dust and dirt, dried food on

13 The inspections were done between December 2002 and March 2004. Our review was limited to examining only those deficiencies that were issued in the final inspection report; we do not know the extent to which inspection teams overlooked a violation.

equipment, and a refrigerator that was kept too warm. Instead of receiving an "F" level deficiency because of the potential for resident harm, the facility received a level "C" deficiency, which reflects the potential for resident discomfort.

To help prevent accidents, nursing homes must keep corridors free from obstructions.

In a few cases, inspection teams cited the wrong regulation in writing the inspection report, used the same incident to issue two mutually-exclusive deficiencies, or made some other error in completing the inspection report. For example, an inspection team cited one facility for placing a wet food processor lid under a plastic cover and for having a number of baking sheets and pans darkened with food debris. Instead of citing the facility for not preparing, distributing, and serving food under sanitary conditions, the facility was cited for failing to obtain food from sources approved or considered satisfactory by state, federal, or local authorities.

As discussed in Chapter 2, CMS does not require that states report "A" level deficiencies to the federal government. Like most other states, MDH does not keep track of them, although inspectors record level "A" deficiencies during inspections and pass them on to nursing homes. We found that:

- **Most inspection teams did not issue level "A" deficiencies, which reflect isolated situations that have the potential for resident discomfort.**

Out of the nearly 1,000 deficiencies issued in our sample, inspection teams issued only 16 level "A" deficiencies. Of the ten districts, Metro C issued eight level "A" deficiencies and five districts (Bemidji, Metro A, Metro D, Rochester, and St. Cloud) did not issue any. Some of the inspectors that we talked with indicated that they could not think of an instance where they would issue one. We noted that most of the incidents cited as level "A" deficiencies were typically cited at the "D" level by other inspection teams. For example, one inspection team issued an "A" level deficiency when it observed staff failing to wash their hands when it was necessary; almost all other inspection teams issue such a finding as a "D" level deficiency. In another instance, a facility received a deficiency at the "A" level when it failed to have two of its residents visited by a physician at least once every 60 days. Other inspection teams cite non-timely physician visits at the "D" level.

"Serious" Deficiencies

To better understand the circumstances surrounding the most serious types of deficiencies, we also reviewed the 11 inspection reports from the most recent inspections that involved substandard care or immediate jeopardy deficiencies. In examining these reports as well as the 100 inspection reports from our sample of nursing homes, we found that:

- **For the most part, state inspection teams were consistent in classifying the most "serious" deficiencies, those at levels "G" and above.**

In our review of inspection reports, we found a few instances where we thought that an inspection team understated the seriousness of a deficiency (that is, where we thought that the deficiency should have been issued at level "G" or above). In one instance, an inspection team issued a "D" level deficiency after a resident who suffered from depression and anxiety lost 45 pounds over a three-month period and the facility failed to address her need for psychological counseling. In another instance, a facility received a "D" level deficiency when a resident failed to receive regular pain medication for five months despite facility records indicating that the resident needed regular treatment to control chronic pain.

We found few problems with how inspectors classified the most "serious" deficiencies.

Some of the instances where we thought that inspectors should have issued a level "G" or higher deficiency involved two or more deficiencies that were at least partially cross-referenced to one another. In these cases, inspection teams typically issued one deficiency at level "G" and the other at level "D." According to the *State Operations Manual (SOM)* though, if the team's findings for a particular requirement include examples at various severity or scope levels, the deficiency should be classified at the highest level of severity, even if most of the evidence corresponds to a lower level of severity.[14] For example, in one facility a newly admitted resident, previously hospitalized for knee surgery, had to wait two hours before receiving pain medication. The nursing staff could not find the medication the resident had been receiving in its emergency kit and staff had to "borrow" medication from another resident. The facility received a "G" level deficiency for not providing services necessary to attain a resident's highest practicable well being and a "D" level deficiency for not providing the necessary pharmacy services to meet the resident's emergency needs.

Inspection teams must observe how nursing home staff administer medication to residents.

14 CMS, *State Operations Manual*, Appendix P, IV, D.

To supplement our random sample of 100 nursing homes, we also looked at the most recent inspection reports for facilities that were cited for providing residents with substandard care or placing them in immediate jeopardy.[15] We did not find any instances where inspection teams overstated resident harm (that is, where we thought that a level "G" or higher deficiency should have been issued at a lower level). The most common reason for issuing a finding of substandard resident care or immediate jeopardy was when a facility failed to provide adequate supervision or assistive devices to prevent accidents. For example, inspectors cited one facility for not supervising or implementing interventions for 5 of 6 cognitively-impaired residents who had repeatedly attempted to leave the facility, often successfully, even though the residents were identified as elopement risks.

As we discussed earlier in Chapter 2, the number of deficiencies issued at level "G" or above decreased 54 percent over the last few rounds of inspections in Minnesota. According to MDH, part of the reason for the decline was in response to CMS' concern that Minnesota was not interpreting resident harm the way that it should be—actual harm has to result in a lifestyle change for a resident or be of more than "limited consequence." By this definition, it is difficult to issue a deficiency at level "G" or above. For example, if a resident fell, but was not seriously hurt, the resulting deficiency would be issued as a "D" rather than "G" level deficiency. As noted earlier, GAO has expressed concern to CMS over the definition of resident harm, indicating that the confusing definition has led to inconsistency problems in identifying level "G" and above deficiencies in a number of states.[16] At that time, CMS indicated that its definition of resident harm was not meant to be as restrictive as some states were interpreting it, but, as noted earlier, CMS has yet to clarify how it defines resident harm.

The federal Government Accountability Office (GAO) found that states vary in how they interpret resident harm.

MDH requires that inspection teams consult with their district supervisors whenever teams think they might have a level "G" or higher deficiency or a finding of immediate jeopardy. District supervisors make the final decision whether inspection teams have collected enough evidence to document a level "G" or higher deficiency. For situations involving immediate jeopardy, the district supervisor consults with program administrators in the central office, who make the final determination.

Proliferation of "D" Level Deficiencies

In keeping with how CMS defines the severity of deficiencies, our review of inspection reports showed that:

- **The seriousness of "D" level deficiencies varies widely, ranging from isolated minor violations with little potential for harm to practices that could lead to serious resident harm if left uncorrected.**

In our opinion, this mixing of seriousness blurs the significance of "D" level deficiencies. For example, we found one facility receiving a level "D" deficiency for not giving a resident who was on a calorie restricted diet a cookie the first time

15 Most often, the same incidents resulted in a finding of substandard care as well as immediate jeopardy. Seven of the nine facilities that inspectors cited for substandard care in their most recent inspection were cited at levels high enough ("J" or above) to likewise trigger a situation of immediate jeopardy.

16 GAO, *Nursing Home Quality,* 19-20, 45-46.

she asked for one. Another facility received a level "D" deficiency for failing to adequately supervise a cognitively impaired resident who was missing from the facility from 6:00 PM to 12:30 AM (when she returned to the facility disheveled and smelling of alcohol). The potential ramifications of both deficiencies differ drastically, yet both were classified at the same level of seriousness.

In a few instances, we thought that citing every instance of noncompliance with a regulation—though perhaps technically correct—was somewhat unreasonable. For example, a facility was cited with a level "D" deficiency because one of three employees interviewed did not know what to do in case of a fire. However, the employee in question had only started work the previous day and had not received orientation yet. The other two employees questioned answered satisfactorily. In another example, a facility received a deficiency because the floor covering in one lounge was dirty and frayed even though the nursing home administrator indicated that the flooring was scheduled to be replaced in an upcoming building project. In both of these instances, it may have been better if the team examined the totality of the facilities' systems to ensure resident safety or the special circumstances of the finding before issuing the deficiency.

Moreover:

- **The large increase in deficiencies, especially isolated, low-level ones, has further strained the relationship between the Minnesota Department of Health and nursing home providers.**

Most nursing home administrators told us that issuing deficiencies for relatively minor violations that have little potential for harm has created staff morale problems for facilities. In addition, administrators were concerned that the public was not receiving enough information about the deficiencies cited (for example, the severity of the violation and the number of residents affected) to put them in proper context. Many of the inspection teams that we talked with agreed. Furthermore, they indicated that, in the last year, the department has taken away their ability to use their professional judgment in determining whether some deficient events are truly deficiencies or isolated lapses.

ACTIVITIES TO ADDRESS INSPECTION CONSISTENCY

It is unreasonable to expect absolute consistency among inspection teams.

Because nursing home inspection teams must use their professional judgment in determining whether residents are receiving appropriate care or how serious an incident may be, it is unrealistic to expect absolute consistency among inspectors. However, it is not unreasonable to expect that state and federal governments establish appropriate policies and procedures to ensure that regulations are applied in as consistent and meaningful manner as possible.

State Oversight

As shown in Table 3.4, MDH has engaged in a variety of on-going activities and special, one-time projects to help promote consistent interpretation and application of nursing home regulations. We concluded, however, that:

- **MDH does not have an effective quality assurance program that routinely examines and measures how inspection teams are applying nursing home standards.**

Among other things, MDH relies on district supervisors to review the inspection reports issued by their staff.[17] As we pointed out earlier, numerous managers and supervisors review all higher-level deficiencies (level "G" and above) before inspection teams are permitted to cite them. In contrast, there is no such check on lower-level deficiencies (which comprise the vast majority of deficiencies and are among the fastest growing) other than that performed by district supervisors. However, most district supervisors told us that they do not have enough time to

Table 3.4: Minnesota Department of Health Activities to Oversee the Inspection Process

Ongoing Activities

- District Supervision: District supervisors are responsible for monitoring, evaluating, and mentoring inspectors and reviewing draft inspection reports.
- Supervisory Review of Higher-Level Deficiencies: Inspection teams must consult with their district supervisor before issuing a deficiency at level "G" or above or when they might have a finding of immediate jeopardy.
- District Supervisor Meetings: Supervisors attend monthly meetings in St. Paul and hold weekly telephone conference calls.
- Inspector Conferences Calls: All inspectors and supervisors participate in a two to three hour statewide telephone conference about four times a year.
- Mixed-Team Inspections: Inspectors periodically inspect nursing homes with inspectors from other districts.
- Statewide Inspectors: Four inspectors with specialized backgrounds accompany each inspection team at least once a year.

Special, One-Time Projects

- On-Site Mentoring and Coaching Surveys: From October 2003 through November 2004, all inspection teams were accompanied on-site by at least five different district supervisors.
- Environmental Deficiency Review: From March through July 2004, MDH management reviewed physical environment deficiencies prior to their issuance.
- Deficiency Review: In October 2003, MDH conducted training on deficiency writing and review.
- Re-Inspection: In early 2003, MDH management re-inspected a nursing home shortly after district inspectors completed their annual inspection.

SOURCES: Minnesota Department of Health, *Actions to Promote Integrity Through Consistent Implementation of the Survey Process* (St. Paul, 2004); and Office of the Legislative Auditor interviews with MDH staff.

17 After their review, district supervisors send the final inspection reports to facilities and CMS. They also review and approve facilities' plans of correction.

routinely review all deficiencies before inspection reports are finalized. Furthermore, their review does not help identify differences that may exist among inspection teams in different parts of the state.

The department holds a variety of routine meetings to help address inspection related problems and concerns. It conducts a two to three hour statewide telephone conference call with all inspectors and supervisors about four times a year to provide clinical updates, interpretive guidance, and inspection process clarifications. The department also holds monthly district supervisor meetings in St. Paul to discuss inspection findings, identify areas that need clarification, review workload, and resolve consistency-related issues. To provide for more frequent communication, the department also conducts "Monday morning" telephone conferences calls with all district supervisors. District supervisors are expected to share whatever they learn at the monthly and weekly conferences with their respective staff.

MDH has used a variety of ongoing activities and special projects to oversee the inspection process.

Most of the inspection teams that we talked with, though, were skeptical about the value of the quarterly conference calls, citing many technical-related problems as well as little follow-up by central management in terms of providing written clarification or guidance about problems discussed. Many district supervisors were likewise skeptical about the value of the monthly meetings that they attended in St. Paul. They noted that, while many important issues were discussed, department management generally failed to follow through by developing a written position on issues of concern in the field. A common refrain that we heard from many district supervisors and inspectors was that "nothing ever happens" as a result of the meetings that they attend.

In the absence of an effective ongoing quality assurance program, MDH has had to undertake various one-time activities to respond to recent legislative and provider concerns about inspection consistency. These one-time activities, which included (1) on-site mentoring and coaching by supervisors, (2) an environmental deficiency review, (3) quality assurance review, and (4) one nursing home re-inspection, have yielded some useful information. For example, in March 2004, MDH began reviewing all deficiencies related to the physical environment of nursing homes prior to issuing them.[18] The department reviewed 195 deficiencies and found that inspectors accurately assigned scope and severity ratings 91 percent of the time. As discussed earlier, the one nursing home re-inspection that the department performed led to a major change in inspection practices. However, these projects have been undertaken sporadically and generally as a reaction to criticism from others—largely because MDH does not have an ongoing, centralized quality assurance program that it can rely on to both anticipate and respond to outside criticism and to help direct its own activities.

MDH staff told us that it was a management decision to forgo more ongoing activities in favor of one-time projects. In light of the seriousness of the issues being raised, the department wanted to better focus its resources. At the same time, department management recognized that some of the projects would decrease the amount of time district supervisors had available to routinely monitor their staff.

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18 Minnesota Department of Health, *Dietary, Sanitation, and Environmental Tags Review Summary* (St. Paul, undated).

Federal Oversight

The federal government engages in three activities to help ensure that inspection teams across the country are implementing the nursing home inspection program consistently. These include: (1) Federal Oversight/Support Surveys (FOSS) where one or more federal inspectors observe and evaluate how well state teams conduct individual inspections; (2) comparative inspections (also called "look-behinds") where federal inspectors essentially replicate an inspection done a few weeks earlier by a state team; and (3) an annual state performance standard report, which measures how well individual states perform on a number of comparative measures. District supervisors routinely receive copies of all FOSS reports and comparative inspections. They distribute the reports that are related to facilities in their district to their staff.

In reviewing available documents over federal fiscal years 2003 and 2004, we found that:

- **The federal government has generally given Minnesota satisfactory or higher marks for how it implements and conducts nursing home inspections statewide—slightly higher ratings than it has given other states in the Chicago region.**

As part of the oversight program, federal staff accompany state inspectors on about 5 percent of inspections.

FOSS reports use a scale from one (much less than satisfactory) to five (extremely effective) to grade state inspection teams in six different categories (identification of inspection concerns, sample selection, general investigation, kitchen/food service investigation, medications investigation, and deficiency determination). State inspection teams rarely received a rating below 3 (satisfactory). During federal fiscal year 2004, federal investigators observed Minnesota inspection teams on 16 nursing home inspections. Minnesota inspectors received an average rating of 4.57; average ratings by category ranged from 4.07 (deficiency determination) to 4.93 (kitchen and food service investigation).[19] Ratings were slightly lower in 2003 when federal investigators observed 20 inspections in Minnesota. Average ratings for federal fiscal year 2003 were 4.45 overall, with individual ratings ranging from 3.95 (general investigation) to 4.80 (sample selection).[20]

For the last two federal fiscal years, CMS has issued a *State Performance Standard Review Report*, which is based partially on the FOSS reports.[21] The performance report measures Minnesota's performance against seven standards: (1) inspections are planned, scheduled, and conducted in a timely fashion; (2) findings are supportable; (3) certifications are fully documented and consistent with applicable law, regulations, and general instructions; (4) adherence to proper procedures when certifying noncompliance; (5) proper expenditures and charges; (6) accurate and timely complaint investigations; and (7) accurate and timely data

19 Office of the Legislative Auditor analysis of 16 FOSS reports for federal fiscal year 2004.

20 Office of the Legislative Auditor analysis of 20 FOSS reports for federal fiscal year 2003.

21 Centers for Medicare and Medicaid Services, *Final FY 2003 State Performance Standard Review Report* (Washington, DC, March 15, 2004) and *Final FY 2002 State Performance Standard Review Report* (Washington, DC, March 14, 2003).

entry. For federal fiscal year 2003, Minnesota fully met five of the performance standards and partially met the remaining two (timely and accurate complaint investigation and data entry).

In Minnesota's 2003 report, CMS also looked at how state inspection teams determined deficiencies for 21 nursing home inspections (18 FOSS inspections and 3 comparative inspections), which represent 5 percent of the inspections done in Minnesota. The federal government rated state teams on 103 measures for the FOSS inspections. Minnesota was rated at or above the satisfactory level on 99 measures (96 percent) and "less than satisfactory" on 4 measures (4 percent). Overall, the states in the Chicago region (Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin) had 95 percent of the measures rated satisfactory or above.

The report also reviewed the scope and severity ratings of the 155 deficiencies that state inspectors initially cited during the 18 FOSS reviews. Federal investigators compared those ratings to what appeared in the final inspection report filed with the federal government. For 19 deficiencies (12.3 percent), federal investigators felt that state inspectors had insufficient evidence to document the discrepancy between what was cited in the draft inspection report and the final report.[22] The discrepancy rate for the Chicago region was also 12.3 percent.

In addition, CMS analyzed the extent to which it agreed with the 153 deficiencies cited in the final inspection reports. For 2003, CMS agreed with the scope and severity ratings MDH inspection teams assigned to 98 percent of the deficiencies issued; the comparable figure for the Chicago region was 93 percent.[23]

OTHER ISSUES

Overall we think that the nursing home inspection process has many strong points: (1) inspections are team-based, (2) inspection teams rely heavily on observation, interviews, and resident outcomes, and (3) inspections are unannounced and occur at diverse times of the day and week. In addition, state inspectors and their supervisors are well trained and experienced. As of July 2004, 73 of the 77 inspectors (95 percent) were registered nurses. There were also two social workers that specialized in facility programs, one nutritionist, and one medical records specialist.[24] About one-third of the inspectors were hired

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22 The federal government defines satisfactory performance as an unjustified discrepancy rate of 20 percent or less.

23 MDH inspectors either did not write a deficiency or changed its scope or severity rating for 10 of the 19 deficiencies that the federal government disagreed with at the time of the inspection. If federal officials had not been at the inspection, it is likely that the deficiencies would have appeared in the final inspection report. Adding the ten deficiencies not cited because of "federal involvement" and the three deficiencies that federal inspectors did not agree with in the final report yields an 8 percent "error" rate for MDH inspectors—comparable to the 9 percent that we found.

24 At the beginning of our study, MDH also employed a sanitation specialist. He died during the course of our study and, to date, has not been replaced. The department has recently hired more inspectors from other disciplines, including occupational therapy and physical therapy, and plans to add staff with other professional backgrounds, such as pharmacy.

within the last two years, and about one-fifth had over ten years experience as an inspector, for an overall median tenure of about six years. Most of the inspectors had prior nursing home experience, and about one-fifth were directors of nursing at some point before becoming an inspector. To supplement their professional background, newly hired inspectors receive extensive state sponsored training in addition to the week-long training program and written exam that the federal government requires.[25]

District supervisors also have extensive long term care backgrounds. On average, they have been with the department for eight years—five of those years as a supervisor. About one-half previously worked as inspectors for the department, and all have had other long term care experience.

The inspection process, though, has a few problems that have contributed to low morale among inspectors and, at times, high turnover.[26] Specifically:

- **Different travel policies, expanded evening observation requirements, and poor communication have contributed to low morale among nursing home inspectors.**

Travel-related concerns are sensitive issues for nursing home inspectors.

First, some travel policies for nursing home inspectors are different from those for other state employees. Several MDH policy statements and Memoranda of Understanding with the Minnesota Nurses Association (the bargaining unit that represents nursing home inspectors, among others) govern how inspectors are reimbursed for travel expenses and how they are compensated for their travel time.[27] Travel-related issues are sensitive issues for inspectors because they spend very little time in their office, especially those based outside the Twin Cities metropolitan area. Most inspection teams that we talked with are "on-the-road" four days a week. Because their jobs entail considerable travel to and from facilities as well as unconventional work hours, inspectors generally leave for work from their home.

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25 Before inspectors attend the mandatory federal training, the department requires that newly hired inspectors complete a two-month training program consisting of classroom instruction. This is followed by a supervised on-site inspection component in which they accompany teams on actual inspections. Most newly hired inspectors spend several more months participating in inspections under the supervision of an experienced inspector. When we talked with inspection teams from around the state, almost all were very satisfied with the inspection-related training that they received to do their jobs. At the same time, many noted that additional computer training would be helpful, including more training specifically related to filling out expense reports, time sheets, and other department reports.

26 The department experienced significant turnover among its licensing and certification staff in 2002 when it adopted new travel and scheduling requirements for inspectors. Turnover (including retirements) was 15 percent in 2002 compared with 7 percent in 2001 and 8 percent in 2003. Cecelia Jackson, Information and Compliance Monitoring Division, Minnesota Department of Health, interview by author, In person, St. Paul, Minnesota, August 1, 2004.

27 Minnesota Department of Health, *Compensated Travel Time Policy* (St. Paul, September 30, 2002); Minnesota Department of Health, *Overnight Stay Policy* (St. Paul, September 30, 2002); Minnesota Department of Health, *Policies and Procedures: Vehicle Use* (St. Paul, May 2004); and *Memorandum of Understanding Between the State of Minnesota and Minnesota Nurses Association Regarding Compensated Travel Time* (St. Paul, September 4, 2002).

Like many other state employees who use their own vehicles to commute directly from home to a temporary worksite, state inspectors are reimbursed for the actual mileage from their home or office, whichever is less. However, inspectors in the four Twin Cities district offices are usually reimbursed at a lower rate than other inspectors (and some other state employees) because MDH generally has state vehicles available that staff could use. Inspectors told us, though, that it is not always convenient or easy to pick up or drop off a state vehicle, especially outside of "normal" office hours. Also, to ensure that inspectors are not being compensated for routine commuting time, nursing home inspectors who travel directly to a facility from home (or vice versa) are compensated only for the time that it takes to drive to a facility in excess of 20 miles from their office. The department calculates compensated travel time at 2 minutes per mile for inspectors in the four Twin Cities districts and 1.5 minutes per mile for inspectors in the six remaining districts. Finally, inspectors are reimbursed for hotel expenses if their compensated travel time one way exceeds one hour and the inspection lasts more than one day.

Second, federal nursing inspection regulations require that inspectors observe resident care and services at different times of the day, including early morning and evening ("off-hours"). The regulations do not, however, specifically quantify how much off-hour time inspectors must spend at a facility. Concerned over the wide variation in the amount of off-hour time inspectors in different parts of the state spent in facilities and the vagueness of the federal regulations, MDH entered into a Memorandum of Understanding with the Minnesota Nurses Association that requires inspection teams to spend at least two hours observing residents between 6:00 PM and 9:00 PM for every 36 hours of inspection time at each facility.[28] In addition, inspection teams must conduct evening observations on more than one day of the inspection in two facilities each month. The memorandum requires that the department determine in advance of the inspection which facilities inspectors will stay "late" in, subject to the approval of the district supervisor. Nursing home inspectors told us that they used to be able to use their professional judgment regarding when to stay late, depending on the conditions they encountered during an inspection. They indicated that there are times when facilities do not need to have additional late observations, but they must stay anyway, resulting in an inefficient use of staff time.

Third, communication between inspectors and central management in MDH could be improved. The majority of the inspectors that we talked with felt "unappreciated" or "betrayed" by central office management. Many inspectors believe that MDH did not "defend" staff at the day-long hearing held by the Health and Human Services Policy Committee of the Minnesota House of Representatives in February 2004 or in the days thereafter.[29] Instead, they said that central management "assumed" that inspectors were not doing their jobs correctly throughout the state. In addition, some felt "betrayed" in the aftermath

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28 *Memorandum of Understanding Between the State of Minnesota and Minnesota Nurses Association Regarding Scheduling of Work* (St. Paul, September 4, 2002), 1.

29 Minnesota House of Representatives, House Health and Human Services Policy Committee, February 25, 2004.

of the department's re-inspection of one nursing home using central office staff rather than district inspectors. Most inspection teams reported that their ability to use their professional discretion was taken away.

Despite low morale, all of the inspection teams that we talked with found much satisfaction in the work they did. They believed their work improved the lives or care of the elderly throughout the state. They enjoyed working as part of a team and looked forward to meeting and talking with nursing home staff and residents.

Minnesota Department of Health management is aware of the problems that inspectors have with their travel and work schedules. At the request of the Minnesota Nurses Association, the department is meeting with association representatives to discuss inspectors' concerns. Until such time as changes are made to the negotiated agreements, however, MDH indicates that it has little recourse but to abide by them.

RECOMMENDATIONS

Our report makes three recommendations that we think will help address some of the concerns that legislators, MDH staff, providers, advocacy groups, and other stakeholders have about the nursing home inspection program. The recommendations also should help improve the adversarial relationship that exists between MDH and providers. We agree with the Commissioner of Health's recent decision to retain the Long Term Care Issues Ad Hoc Committee that she created in 2003 so that the committee can continue to work on communication problems among various stakeholders. The group consists of nursing home providers, representatives from provider, advocacy, and professional organizations, and various state agency and legislative staff. In addition, the department is working on improving communication between state inspectors and providers during the inspection process. It has obtained federal funds to hire a provider liaison that will, among other things, develop consistent standards of behavior that inspection teams and facility staff can use during the inspection process.

MDH is working on improving communication among various nursing home stakeholders.

Quality Assurance

RECOMMENDATION

The Minnesota Department of Health should implement an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from across the state.

Our major concern about MDH's nursing home inspection program has to do with the department's inability to systematically identify inspection-related problems before they become major issues. This makes it difficult to respond to the concerns of providers, legislators, and advocacy groups in a timely manner. The

department should implement an ongoing quality assurance program that routinely examines inspection reports statewide, and should rely less on special one-time projects developed largely to respond to outside criticisms. Currently, MDH does not centrally review inspection reports or the vast majority of deficiencies issued, thereby neglecting the largest and some of the fastest growing categories of deficiencies—those at levels "D" and "E." Such reviews would allow the department to identify and address problems or concerns, such as the growth of "D" level deficiencies, issuing level "A" deficiencies, or discrepancies among districts in issuing certain types of deficiencies.

MDH needs to have a more centralized review process for lower-level deficiencies.

A recent report from the Office of Inspector General in the U.S. Department of Health and Human Services found that 31 states had formal internal quality assurance programs to review draft inspection reports.[30] For example, Indiana has nurses who do nothing but review inspection reports from across the state before they are issued. In addition to meeting monthly to review problems or issues, staff "run the book" once a year, a process whereby they discuss problems or concerns regarding how Indiana inspection teams use each deficiency. Ohio has one program manager that routinely monitors, on a statewide basis, the deficiencies issued by each district, looking for outliers or areas that might need more clarification.

In 2003, GAO recommended that CMS require states to have a quality assurance process that includes, at a minimum, a review of a sample of inspection reports below the level of actual harm to help reduce instances of inspectors understating quality of care problems.[31] In its comments to the GAO, New York stated that it had implemented such a process and was experiencing positive results. New York uses these reviews to provide inspector feedback and expects that instances where deficiencies may be understated will decline. Although we did not detect major problems with state inspection teams understating the seriousness of deficiencies, routinely reviewing all lower-level deficiencies on a statewide basis might help the state deal with the large increase in "D" level deficiencies and the subsequent "blurring" of their significance that we discussed earlier.

It should be noted that MDH has already embarked on an improved quality assurance program as a result of the reports issued by the Department of Administration in mid-2004.[32] For example, the department has created a quality assurance position that it hopes to fill in the near future. This person's responsibilities will include implementing routine monitoring procedures regarding the inspection process.

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30 U.S. Department of Health and Human Services, *Deficiency Trends*, 18.

31 GAO, *Nursing Home Quality*, 42.

32 Minnesota Department of Administration, *Communications for Survey Improvement (CSI-MN)* (St. Paul, June 30, 2004); Minnesota Department of Administration, *Nursing Home Licensing and Certification* (St. Paul, June 30, 2004); and Minnesota Department of Health, *Survey Findings/Review Subcommittee Final Report* (St. Paul, July 2004).

Written Guidance

RECOMMENDATION

The Minnesota Department of Health should provide more timely assistance to inspectors in interpreting federal regulations and guidelines, especially in the area of one-time events with no negative outcomes.

Although nursing home inspections are significantly controlled by federal requirements, MDH needs to assume more ownership over the program in Minnesota.

We also concluded that state inspectors need more written guidance from MDH to help them apply CMS' regulations consistently and meaningfully. In meeting with MDH staff throughout the state, we were struck by how strongly staff emphasized that the nursing home inspection program was a federal rather than a state program. We think that the department must assume more ownership over the inspection program. Until very recently, the department's approach has been to seek clarification from the federal government when regulations and guidelines are not clear, which can be a slow and fruitless approach. In the meantime, state inspection teams work with little state direction in key areas. We think that the department should be providing more guidance to inspectors, especially in areas where the federal regulations are not clear, such as one-time events with no negative outcomes.

We also noted that inspectors are not always informed about the results of appeals regarding deficiencies that they issued or about changes to inspection reports once they submit their draft reports to their supervisor. Inspectors indicated that knowing why a report was changed or why a deficiency did not withstand the appeal process would be a good training exercise. In addition, inspectors in one part of the state told of learning about a significant policy change in how inspections were to be conducted from the facility they were inspecting rather than from their district supervisor.

While an ongoing, centralized quality assurance program should enhance the department's ability to identify issues that need clarification before they become major problems, MDH also needs to respond to issues raised by supervisors and inspectors in a timely manner. District supervisors need to routinely bring district concerns to their monthly meetings where they should be discussed and resolved by the entire group of supervisors. This would help ensure a more consistent interpretation of unclear or confusing nursing home regulations statewide. Resolution of issues should be communicated to inspectors, both verbally and in writing (through the department's website), as well as to nursing home providers.

To some extent, MDH has become more proactive in the last year in terms of clarifying federal regulations that are unclear or problematic. For example, in June 2004, the department directed inspection teams to stop issuing multiple deficiencies for selected types of violations based on the same negative finding. According to the department, this would bring Minnesota inspection practices more in line with those of other states. The department had brought the issue to the attention of federal officials earlier, but CMS had not acted on the problem. Also, the department has aggressively pursued federal interpretations and guidance regarding the life safety standards that State Fire Marshall inspectors apply.

Deficiency-Related Information

RECOMMENDATION

To supplement on-line inspection reports, the Minnesota Department of Health should develop a more user-friendly way to summarize and report on the seriousness of inspection deficiencies.

In March 2004, MDH made nursing home inspection reports and nursing homes' plans of correction available on-line. However, the department failed to provide any summary information that would help consumers put the overall number of deficiencies in perspective. For example, it is difficult for consumers to distinguish between administrative deficiencies and quality of care or quality of life deficiencies. We think that the manner in which the state reports nursing home inspection results places too much emphasis on the number rather than the type or seriousness of deficiencies, which can be misleading to the public. The total number of deficiencies that a facility receives may be less important to consumers and policy makers than the seriousness of the deficiencies.

MDH's on-line reporting of inspection results places too much emphasis on the number of deficiencies rather than their seriousness.

The state could provide summary information about deficiencies resulting in immediate jeopardy situations or findings of substandard care, or group deficiencies into categories of most interest to consumers, such as quality of care, quality of life, or resident rights. Another measure that may be of interest to the public is the extent to which inspectors cite a facility for the same deficiencies over time. Also, MDH could weight deficiencies by their scope and severity to better help consumers understand their seriousness. Not all states publish actual inspection reports on-line, but many states provide more summary information about the results of nursing home inspections. The summary information can help consumers distinguish among the seriousness of various deficiencies and rate one facility relative to the statewide average or to others in its geographic region.

For example, Florida computes an overall inspection score based on the number, scope, and severity of a facility's deficiencies and then assigns the facility anywhere from one to five "stars" based on whether it had fewer or less serious deficiencies relative to other facilities in its geographical region. A "five star" nursing home means that it ranks in the top 20th percentile of facilities in the region; a "one star" star facility ranks in the bottom 20th percentile. The overall score (which includes all possible deficiencies) is also broken down into three categories: administration, quality of care, and quality of life. Facilities are also assigned stars for selected inspection components, including dignity, nutrition and hydration, pressure sores, resident decline, and restraints and abuse. In addition, a panel of state agencies and provider associations in Florida awards "gold seals" to nursing homes with exceptionally high standards in managing care and quality of life for their residents. Performance criteria include: high quality of care ranking relative to other nursing homes in the region; no conditional licenses or nursing home watch list appearances in the previous 30 months; and an excellent record

with the state long-term care ombudsman. Implemented in 2002, the panel recently awarded 13 homes a gold seal for outstanding performance.[33]

In Indiana, each facility is scored against 45 standards related to administration, care and services, dietary, environment, and resident rights that the state believes are most indicative of quality care. Deficiencies in these areas are assigned a point value based on their scope and severity; facilities cited for substandard care or immediate jeopardy get additional points. Facilities receive a weighted score based on their scores from each of their last three inspections, although the most recent inspection is weighted the most heavily. The best score that a facility can receive is zero—which means that the facility did not receive any deficiencies in the 45 requirements used for scoring in its last three inspections, and there were no findings of substandard care or immediate jeopardy. As of November 24, 2004, the average score statewide in Indiana was 110, with 64 percent of the facilities scoring better than average and 36 percent scoring below average.[34]

To some extent, Minnesota is moving toward providing consumers easier access to information about nursing homes. At the direction of the Governor, MDH is developing a nursing home report card that will contain a variety of measures, including one related to inspection results. The department hopes that the report card will be available on-line in 2005.

33 Tampa Bay Business Journal, "Four Bay Area Nursing Homes Receive State Honors" (2004); http://tampabay.bizjournals.com/tampabay/stories/2004/11/229/daily9.html?jst=b_1n_h1; accessed November 30, 2004.

34 Indiana State Department of Health, "Nursing Home Report Cards (2004); http://www.state.in.us/isdh/regsvcs/ltc/repcard/rcgrp.htm; accessed January 11, 2005.

Summary of Recommendations

- The Minnesota Department of Health should implement an ongoing, centralized quality assurance program that, among other things, periodically examines inspection reports from across the state (p. 49).

- The Minnesota Department of Health should provide more timely assistance to inspectors in interpreting federal regulations and guidelines, especially in the area of one-time events with no negative outcomes (p. 51).

- To supplement on-line inspection reports, the Minnesota Department of Health should develop a more user-friendly way to summarize and report on the seriousness of inspection deficiencies (p. 52).

Average Number of Deficiencies per Facility by State, Four Most Recent Inspections

APPENDIX A

State/Region	Fourth Most Recent Inspection	Third Most Recent Inspection	Second Most Recent Inspection	Most Recent Inspection	Percentage Change[a]
Atlanta Region					
Alabama	12.7	10.4	9.7	9.1	-28%
Florida	8.3	9.7	8.7	9.1	9
Georgia	7.6	8.9	10.6	9.8	29
Kentucky	8.2	8.3	7.2	6.5	-21
Mississippi	7.0	6.3	5.3	5.3	-24
North Carolina	8.4	7.8	6.9	6.9	-18
South Carolina	8.2	5.5	6.2	7.9	-3
Tennessee	7.3	9.8	10.1	9.9	35
Regional Average	8.4	8.7	8.3	8.3	-1
Boston Region					
Connecticut	5.3	6.6	5.8	8.4	59%
Maine	4.3	5.8	7.3	9.2	112
Massachusetts	5.7	5.7	5.7	6.2	9
New Hampshire	5.5	4.8	3.4	4.2	-23
Rhode Island	3.4	4.1	4.7	4.9	45
Vermont	4.6	3.8	3.2	4.8	4
Regional Average	5.2	5.6	5.5	6.7	30
Chicago Region					
Illinois	8.2	8.4	7.7	8.4	3%
Indiana	7.9	6.9	6.0	5.4	-32
Michigan	12.6	12.7	13.3	13.3	6
Minnesota	**5.0**	**5.3**	**6.2**	**9.7**	**93**
Ohio	7.6	7.4	8.0	6.9	-8
Wisconsin	6.0	5.3	4.5	5.0	-18
Regional Average	7.9	7.7	7.7	7.9	0
Dallas Region					
Arkansas	8.4	8.5	7.5	9.2	9%
Louisiana	8.1	9.9	11.9	10.6	30
New Mexico	6.2	5.7	6.6	9.9	59
Oklahoma	6.4	6.5	8.1	9.3	46
Texas	10.6	11.1	10.2	8.8	-16
Regional Average	8.4	8.9	9.4	9.4	13
Denver Region					
Colorado	6.8	7.0	8.3	10.5	55%
Montana	12.0	11.3	11.8	11.7	-3
North Dakota	7.1	8.3	8.6	8.9	25
South Dakota	8.7	9.4	9.9	9.5	9
Utah	7.0	7.0	10.2	9.9	41
Wyoming	12.6	16.0	15.9	14.3	14
Regional Average	8.4	8.8	9.9	10.4	25

State/Region	Fourth Most Recent Inspection	Third Most Recent Inspection	Second Most Recent Inspection	Most Recent Inspection	Percentage Change[a]
Kansas City Region					
Iowa	5.1	5.5	6.1	7.0	37%
Kansas	8.5	8.4	10.0	12.5	47
Missouri	6.5	6.6	7.3	6.9	6
Nebraska	4.9	5.2	5.0	4.2	-14
Regional Average	6.3	6.5	7.3	7.8	24
New York City Region					
New York	5.7	6.6	6.7	5.7	0%
New Jersey	5.9	6.3	6.2	5.6	-5
Regional Average	5.8	6.5	6.5	5.6	-2
Philadelphia Region					
Delaware	9.6	5.9	7.8	10.9	13%
District of Columbia	8.5	10.8	10.7	14.7	73
Maryland	3.6	5.0	7.4	8.3	134
Pennsylvania	11.8	10.8	10.8	10.6	-10
Virginia	5.4	5.1	4.5	6.5	21
West Virginia	8.6	8.5	8.0	8.9	4
Regional Average	8.8	8.4	8.7	9.3	6
San Francisco Region					
Arizona	11.8	12.1	9.7	10.1	-14%
California	15.2	14.1	12.0	11.9	-22
Hawaii	7.7	9.0	9.0	8.9	15
Nevada	19.6	18.8	16.7	15.1	-23
Regional Average	14.6	13.8	11.7	11.7	-20
Seattle Region					
Alaska	7.1	7.1	5.2	7.6	6%
Idaho	6.8	7.4	7.7	6.9	1
Oregon	10.1	10.0	9.2	6.5	-36
Washington	10.5	10.0	9.1	7.3	-30
Regional Average	9.7	9.5	8.8	7.0	-27
United States	8.1	8.2	8.2	8.4	3%

[a]Percentage change from the fourth most recent inspection to the most recent inspection.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

Common Deficiencies of Minnesota Nursing Homes, Most Recent Inspections

APPENDIX B

Deficiency Category and Description	Number of Deficiencies
Quality of Care	
Each resident must receive care and services necessary to achieve the highest practicable physical, mental, and psychological well-being,	161
Facility must remain as free of accident hazards as is possible.	125
Incontinent residents must receive appropriate treatment and services.	121
Each resident's drug regimen must be free from unnecessary drugs.	121
Eech resident must receive adequate supervision and assistance devices to prevent accidents.	120
Residents unable to carry out activities of daily living must receive services necessary to receive good nutrition, grooming, and personal and oral hygiene.	97
Residents must be provided with services to assist as needed with walking, transferring, eating, bathing, grooming, using the toilet, and communicating.	83
Residents with limited range of motion must receive services to increase or prevent further decrease in their range of motion.	75
Residents should not develop pressure sores and those entering with pressure sores must receive treatment to promote healing and prevent infection.	61
Facility must have medication error rates below 5 percent.	43
Residents must maintain acceptable parameters of nutritional status, such as body weight and protein levels, if possible.	23
Unless clinically containdicated, facilities must reduce the dosage of antipsychotic drugs for those residents taking them.	23
Other.	110
Subtotal	1,163
Resident Assessment	
Services must be provided by competent persons in accordance with each resident's care plan.	231
Each resident must have a comprehensive care plan.	118
The care plan must be completed within seven days after the assessment is completed and it must be reviewed and revised each time the resident is reassessed.	94
Facilities must make a comprehensive assessment of each resident's needs.	73
Assessments must accurately reflect residents' status.	55
Assessments must be updated at least once every three months.	48
Residents must be reassessed within 14 days of a significant change in their physical or mental condition.	47
Other.	42
Subtotal	708

Deficiency Category and Description	Number of Deficiencies
Life Safety	
Smoke barriers must provide at least a 30-minute fire resistance rating and windows must be protected by fire-rated glazing or by wired glass panels and steel frames.	49
Walls separating corridors from use areas must prevent the passage of smoke and, in unsprinkled buildings, must be able to resist fires for at least 30 minutes.	34
Corridors serving as exit accesses must be at least four feet wide and must be kept clear of obstructions.	28
Corridor doors must be able to close, prevent the passage of smoke, and, in unsprinkled areas, resist fires for at least 20 minutes.	26
Exits must be readily accessible at all times.	20
Other	285
Subtotal	393
Resident Rights and Facility Practices[a]	
Residents have rights to personal privacy and confidentiality of records.	73
Residents have the right to self-administer drugs if deemed safe.	53
Residents have the right to be free from physical restraints if not required for treatment.	52
A facility must inform resident and resident's family about accidents or significant changes in the resident's status.	37
Facilities must not employ individuals with a history of abuse and they must report and investigate all allegations of abuse.	33
Facilities must make prompt efforts to resolve resident grievances.	22
Results of the most recent inspection must be accessible to residents.	20
Facilities must have written policies that prohibit mistreatment, abuse, and neglect of residents.	20
Other	80
Subtotal	390
Quality of Life	
Care must be provided in a manner and environment that maintains or enhances each resident's dignity.	130
Services must be provided with reasonable accommodations of individual needs and preferences.	65
Facilities must provide an ongoing activities program.	39
Facilities must provide medically related social services.	35
Residents have the right to choose activities, schedules, and health care consistent with their interests and care plan.	34
Facilities must provide a safe, comfortable, and homelike environment, allowing residents to use personal belongings to the extent possible.	27
Facilities must provide housekeeping and maintenance services.	26
Other	16
Subtotal	372
Dietary Services	
Facilities must store, prepare, distribute, and serve food under sanitary conditions.	167
Food must be palatable, attractive, served at the proper temperature, and prepared using methods that preserve nutritive value.	36
Each resident must receive three meals per day plus a bedtime snack, with no more than 14 hours between the evening meal and the next day's breakfast.	25

Deficiency Category and Description	Number of Deficiencies
Dietary Services (continued)	
Menus must meet the nutritional needs of residents, be prepared in advance, and be followed.	20
Other	26
Subtotal	274
Physical Environment	
Facilities must provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.	162
Facilities must have adequate outside ventilation.	24
Nurses stations must be equipped to receive calls through a communications system from resident rooms and toilet and bathing areas.	20
Other	59
Subtotal	265
Medical and Related Services[b]	
Pharmacists must report any irregularities to the attending physician and the director of nursing.	50
Facilities must provide pharmaceutical services to meet the needs of each resident.	48
Drugs must be stored in locked compartments under proper temperature controls.	31
Each resident must be seen by a physician at least once every 30 days for the first 90 days and once every 60 days thereafter.	26
Other	79
Subtotal	234
Infection Control	
Staff must wash hands after each resident contact.	100
Facilities must establish and maintain an effective infection control program.	59
Other	19
Subtotal	178
Administration	
Facilities must comply with federal, state, and local laws and professional standards.	41
Facilities must maintain clinical records on each resident that are complete, accurately documented, readily accessible, and systematically organized.	23
Other	38
Subtotal	102
Total	4,079

NOTE: This appendix lists deficiencies issued to at least 20 nursing homes in their most recent inspection, organized into ten deficiency categories. We grouped less frequently cited deficiencies in each deficiency category into "other."

[a]Includes resident rights; admission, transfer, and discharge rights; and resident behavior and facility practices.

[b]Includes pharmacy services, nursing services, physician services, dental services, and rehabilitation services.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

Deficiencies per Minnesota Facility by Category, Four Most Recent Inspections

APPENDIX C

Deficiency Category	Fourth Most Recent Inspection	Third Most Recent Inspection	Second Most Recent Inspection	Most Recent Inspection	Percentage Change[a]
Resident Rights and Facility Practices	0.4	0.5	0.5	0.9	112%
Quality of Life	0.4	0.5	0.6	0.9	114
Resident Assessment	1.2	1.2	1.5	1.7	44
Quality of Care	1.5	1.5	1.7	2.8	84
Diet and Nutrition	0.4	0.4	0.4	0.7	72
Medical Services	0.3	0.3	0.4	0.6	112
Infection Control	0.1	0.1	0.2	0.4	205
Physical Environment	0.3	0.3	0.4	0.6	122
Administration	0.1	0.1	0.2	0.2	160
Safety	0.4	0.3	0.4	0.9	156
Total	5.1	5.3	6.2	9.7	92%

[a]Percentage change from the fourth most recent inspection to the most recent inspection.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

Number and Seriousness of Nursing Home Deficiencies by State, Most Recent Inspections

APPENDIX D

State/Region	Percentage of Nursing Homes With: No Deficiencies	More Than Ten Deficiencies	Level G or Higher Deficiency	Immediate Jeopardy Deficiency[a]	Substandard Deficiency[b]
Atlanta Region					
Alabama	5%	33%	14%	4.4%	4.0%
Florida	3	33	9	0.9	2.2
Georgia	3	35	20	2.5	4.4
Kentucky	9	20	19	2.0	4.7
Mississippi	7	11	20	8.8	9.8
North Carolina	5	19	25	1.9	2.1
South Carolina	3	24	33	8.5	10.2
Tennessee	1	39	24	7.1	8.6
Regional Average	4	28	18	3.5	4.8
Boston Region					
Connecticut	3%	27%	49%	0.4%	2.4%
Maine	3	38	13	1.7	5.8
Massachusetts	17	21	22	0.0	2.3
New Hampshire	27	10	21	2.5	4.9
Rhode Island	14	13	5	0.0	3.2
Vermont	12	12	17	2.4	4.9
Regional Average	12	22	25	0.6	3.1
Chicago Region					
Illinois	4%	30%	17%	2.2%	2.8%
Indiana	13	15	20	1.9	2.9
Michigan	1	57	23	3.9	4.6
Minnesota	**3**	**40**	**15**	**2.1**	**2.1**
Ohio	6	20	14	0.7	1.7
Wisconsin	10	11	11	1.5	1.5
Regional Average	6	27	16	1.9	2.5
Dallas Region					
Arkansas	3%	29%	29%	12.9%	20.4%
Louisiana	4	44	15	7.1	6.7
New Mexico	2	39	23	6.0	10.8
Oklahoma	5	36	20	4.9	4.6
Texas	3	32	14	1.3	1.9
Regional Average	3	34	17	4.2	5.5
Denver Region					
Colorado	2%	47%	24%	1.9%	2.8%
Montana	0	52	16	1.0	3.0
North Dakota	1	33	14	1.2	2.4
South Dakota	0	34	26	0.9	4.4
Utah	2	43	12	2.2	3.4
Wyoming	0	72	21	5.1	5.1
Regional Average	1	44	20	1.7	3.3
Kansas City Region					
Iowa	3%	20%	9%	1.1%	1.5%
Kansas	2	53	29	2.9	5.9
Missouri	12	22	10	0.6	2.3
Nebraska	15	8	12	0.4	0.9
Regional Average	7	27	14	1.3	2.7

State/Region	Percentage of Nursing Homes With: No Deficiencies	More Than Ten Deficiencies	Level G or Higher Deficiency	Immediate Jeopardy Deficiency[a]	Substandard Deficiency[b]
New York City Region					
New York	11%	14%	11%	2.0%	3.4%
New Jersey	7	11	9	0.7	1.5
Regional Average	8	12	10	1.2	2.1
Philadelphia Region					
Delaware	2%	45%	10%	0.0%	0.0%
District of Columbia	0	70	50	0.0	0.0
Maryland	9	33	16	0.0	2.1
Pennsylvania	0	44	16	1.2	2.2
Virginia	6	19	12	4.4	3.3
West Virginia	0	31	10	1.5	0.7
Regional Average	3	37	15	1.6	2.1
San Francisco Region					
Arizona	2%	34%	11%	0.7%	0.7%
California	2	49	5	1.0	0.6
Hawaii	2	36	20	0.0	2.2
Nevada	0	65	7	2.3	4.7
Regional Average	2	48	6	1.0	0.8
Seattle Region					
Alaska	7%	36%	0%	0.0%	0.0%
Idaho	4	20	21	2.5	3.8
Oregon	11	19	21	3.6	2.9
Washington	5	25	21	2.0	3.1
Regional Average	7	23	20	2.5	3.1
United States	5%	30%	16%	2.2%	3.2%

[a]A facility with one or more quality of life, quality of care, or resident behavior and facility practices deficiencies issued at level "F" or "H" or above is considered to be providing substandard care.

[b]A facility's residents are in immediate jeopardy if it has one or more deficiencies with a scope and severity level of "J" or higher.

SOURCE: Office of the Legislative Auditor's analysis of data from the Centers for Medicare and Medicaid Services' Online Survey and Certification Reporting System; accessed May 24, 2004.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, maintaining and improving the health of all Minnesotans

January 21, 2005

James Nobles
Legislative Auditor
Centennial Office Building, Room 140
685 Cedar Street
St. Paul, Minnesota 55155-1603

Dear Mr. Nobles:

We have had an opportunity to review the Nursing Home Inspections report and believe it will be very helpful in answering a number of questions raised by legislators and others concerning the overall integrity of the nursing home inspection program. While we have made significant progress during this past year in addressing certain issues, we still have important work to accomplish and the recommendations in the report will help us focus our attention in the most productive areas. In this regard, we intend to share the report with our Long Term Care Ad Hoc Committee and seek their advice in developing a plan to implement the report's recommendations.

We would like to express our appreciation to Ms. Jo Vos and Mr. David Chein of your staff for the professionalism shown during the process of collecting and analyzing information for this report.

Thank you for providing this opportunity to comment.

Sincerely,

Dianne Mandernach

Dianne M. Mandernach
Commissioner
P.O. Box 64882
St. Paul, MN 55164-0882

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