Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature, including updates on other legislatively directed activities

Minnesota Department of Health

December 15, 2005

MINNESOTA MDH DEPARTMENT OF HEALTH

Commissioner's Office
625 Robert St. N., Suite 500
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-5000
www.health.state.mn.us

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For more information, contact:
Division of Compliance Monitoring
Minnesota Department of Health
85 East Seventh Place, Suite 300
P.O. Box 64900
St. Paul, MN, 55164-0900

Phone: (651) 215-8701
Fax: (651) 215-8710
TDD: (651) 201-5797

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Executive Summary

The Minnesota Department of Health (MDH) Division of Compliance Monitoring, Licensing and Certification Program licenses and inspects hospitals, nursing homes and other health care providers. MDH also certifies health care facilities and other providers who take part in the federal Medicare and Medicaid programs, as part of a federally funded process known as "survey and certification." MDH employs surveyors who perform annual certification inspections known as "surveys" to evaluate the degree to which nursing homes that are Medicare and/or Medicaid certified are in compliance with a detailed set of federal regulations known as the "Conditions of Participation." These regulations also require nursing homes to comply with applicable state and local laws. When surveyors find a nursing home practice that is out of compliance with a federal regulatory requirement, the survey team issues a "deficiency" and the nursing home then is required to correct the practice to come into compliance with regulatory requirements. Minnesota has 10 district survey teams in the various geographic regions of the state.

In 2003, Commissioner of Health Dianne Mandernach initiated several activities aimed at improving the consistency and accuracy of the survey process across districts throughout the State. The Commissioner invited a broad group of stakeholders to participate in the Long Term Care Issues Ad Hoc Committee to provide a forum for discussion and to advise the Commissioner on issues relating to improving the nursing home survey process. In response to concerns raised there and in other forums, as well as a review done by the Office of the Legislative Auditor, MDH undertook a number of activities aimed at improving and ensuring the consistency and accuracy of the survey process, and improving communication with providers, consumers, and consumer advocates. MDH reported on activities undertaken during 2004 in a December 15, 2004 Report to the Legislature. This report discusses activities during the past year, focusing on the Federal Fiscal Year (FFY) 2005, which ran from 10-1-04 through 9-30-05.

As noted in last year's report, MDH's areas of special focus for making improvements in the nursing home survey process during FFY 2005 were:

> (1) Improving Consistency Across Survey Teams. MDH made progress in narrowing the variation in the number of deficiencies issued per survey across districts. MDH strengthened supervisory and internal communication processes to promote consistent administration and application of the survey process throughout the state.
>
> (2) Improving Communication and an Understanding of the Survey Process. MDH continued meeting with the Long Term Care Issues Ad Hoc Committee, and met regularly with provider associations, professional associations, and consumer advocates. MDH worked with this group on preparation of an educational video that will be distributed to all nursing homes and consumer advocate groups to promote understanding of the survey process and communication expectations for all parties involved in the survey process. MDH initiated and provided support to a regional stakeholders group in the Northeast region of the state. This group met monthly and created a series of

educational presentations and materials based on an observational survey experience by provider Directors of Nursing. The educational sessions and materials have been shared in the Northeast Region and with provider, professional, and surveyor statewide meetings.

(3) Collaborating on Provider Quality Improvement Projects. MDH participated in planning and providing joint training for surveyors, nursing home employees, consumer advocates, residents and families on revised clinical guidance and investigative protocols for Pressure Ulcers and Urinary Incontinence. MDH worked with Stratis Health, providers, and advocates, to share information and resources and devise strategies for improving the quality of care and quality of life for residents of nursing homes. MDH is participating in a culture change task force of a broad group of stakeholders, aimed at fostering and promoting resident-centered care in nursing homes.

This report also contains information on: compliance with time lines for delivering statements of deficiencies and for completing revisits after a nursing home has implemented corrective actions; independent dispute resolution; involvement of family members and family councils in the survey process; status of a process to address defensive documentation, and the final report of a Nursing Home Providers Work Group that made recommendations on State nursing home rule changes.

During the current year, MDH will be giving special attention to the following areas:
A. **Allocation of Survey Hours to Achieve Maximum Resident Benefit.** MDH will examine options for the reallocation of a portion of onsite revisit survey hours to the conduct of more frequent recertification or special monitoring surveys in facilities experiencing difficulty in achieving compliance with federal certification requirements and/or state licensing standards.
B. **Pilot of a model of supervision that involves collaboration between two supervisors for supervising two teams.** The pilot project involves having one "field" supervisor and one supervisor who will provide documentation review and processing oversight to both teams. Goals of the project include improving and maintaining accuracy and consistency of the survey process, and improving and maintaining communication and positive relationships with providers.
C. **Statewide and regional efforts to improve communication.** MDH will evaluate the impact of the northeast regional stakeholders group and training sessions, and will work with stakeholders to assess the potential benefit of additional regional groups. MDH will evaluate the impact of the communication training video. Results of these evaluations will be used to plan future projects and initiatives.
D. **Collaborating on provider quality improvement initiatives.** MDH will seek opportunities to promote an evidence-based approach to implementation of joint training and collaborative quality improvement work, and will work with providers, consumer advocates, quality and research experts, and internal staff to evaluate the impact of joint training and quality initiatives.
E. **Continuing efforts to improve consistency across survey teams.** MDH will continue to use regular internal analysis and communication to administer a consistent statewide program, and will continue regular review of data to identify opportunities to improve the accuracy and consistency of the survey process.

Introduction

This report fulfills the legislative requirement for providing an annual nursing home survey and certification quality improvement report and progress reports on other legislatively directed activities. A copy of Minnesota Session Laws 2004, Chapter 247 is attached as Appendix A.

The nursing home survey and certification program is a federal regulatory program funded by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. CMS contracts with each state to administer the survey and certification program. This report is based on analysis of data representing status of the program during Federal Fiscal Year (FFY) 2005, which ran from October 1, 2004 through September 30, 2005.[1]

The report is organized into four parts. Part I provides the data and other information required to be included in the annual report. Part II describes MDH's progress on the other legislatively directed activities. Part III includes a summary of some of the activities implemented to improve the nursing home survey process. Part IV identifies areas that MDH intends to focus on in the future.

[1] As noted, in a few instances, the report contains data outside of this reporting period.

I. Annual Survey and Certification Quality Improvement Report

Minnesota Statutes, section 144A.10, subdivision 17 (2004) requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report. The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;
(2) cross-referencing of citations by region within the state and between states within the CMS region in which Minnesota is located;
(3) the number and outcomes of independent dispute resolutions;
(4) the number and outcomes of appeals;
(5) compliance with timelines for survey revisits and complaint investigations;
(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;
(7) compliance with timelines for providing facilities with completed statements of deficiencies; and
(8) other survey statistics relevant to improving the survey process.

The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

A. Number, Scope, and Severity of Citations by Region within the State

Data Source

The data provided in this report has been extracted from the Centers for Medicare and Medicaid Services (CMS) Online Survey Certification and Reporting System (OSCAR), a federal database of federal survey data, and Paradise, a state database of state and federal survey data. Tables identify data from the most recent nursing home survey in the database.[2]

Background

Federal law requires that each nursing home be surveyed annually during each federal fiscal year. Surveys can be conducted up to 15 months from the last survey; however, states are required to maintain a 12 month statewide average among all nursing homes. Surveys evaluate the nursing homes' compliance with federal regulations, which are contained in 42 Code of

[2] Data from each survey is entered into the OSCAR database following completion of the survey. The time required for data entry creates a time lag between completion of the survey and data entering the OSCAR database of approximately 45 days.

Federal Regulations (CFR) 483.1 to 483.75. A nursing home is issued a Statement of Deficiencies for findings of noncompliance. The Statement of Deficiencies is written on Federal Form Number CMS 2567 (2567). The 2567 statement identifies each area of noncompliance by referencing a specific tag number.

Health tags have the prefix F, e.g., F-309. The tag numbers are contained in interpretive guidelines for the nursing home regulations issued by CMS. The 2567contains the regulatory language and specifies the survey findings that support the findings of noncompliance.

The federal health regulations cover 15 major areas including resident rights, quality of life, quality of care, and physical environment. The 2567 also identifies the scope and severity of the deficient practice. CMS has developed a scope and severity grid which allows for the classification of deficiencies based on the extensiveness of the deficient practice and the degree of harm presented to residents. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from finding there is a potential for minimal harm if the deficient practice is not corrected, to findings of immediate jeopardy to resident health or safety. The CMS Scope and Severity Grid is attached as Appendix B. The grid identifies 12 levels, labeled A through L, of deficiencies based on a combination of scope and severity score for a deficient practice.

MDH is required to follow the survey process and survey protocols issued by CMS.[3] These provisions are detailed and address specific procedures that must be completed during each survey, including: entrance interview, tour of the facility, selection of resident sample for review, interviews with residents, facility staff, and family members, observations of care received by residents, observation of medication passes and kitchen sanitation, observation of staff interaction with residents, review of individualized resident assessment, individualized care plan, care plan implementation, ongoing assessment and revision of care plan based on ongoing assessment, review of policies and procedures, etc. The CMS survey protocols contain specific criteria for determining circumstances requiring additional sampling of residents for review/observation and for extending survey observation and investigation. CMS Interpretive Guidelines provide information which surveyors are required to review and consider during the decision making process of the survey.

Once the survey is complete, MDH staff provide a draft 2567 to the nursing home at the time of the exit conference, then prepare and send a final 2567 after the supervisory review is complete.

Deficiency Citations[4]

Variation between the states has been identified in the past and has been the subject of reports from the Government Accountability Office and the Office of the Inspector General of the federal Department of Health and Human Services. CMS has been reviewing this issue and has identified 12 tags that had significant variation among states. CMS has been working on revising

[3] Survey protocols are in Appendix PP of the CMS State Operations Manual. See Appendix C of this report for links to Federal regulations, manuals, and program transmittals.
[4] This analysis and discussion is based only on health survey tags. An additional set of regulations, the Life Safety Code, is discussed later in the report.

clinical guidance, investigative protocols and guidance for surveyors for these tags. Revised investigative protocols and guidance for surveyors were issued for Pressure Ulcers in November 2004, for Urinary Incontinence in June 2005, and Medical Director in November 2005. In addition the CMS regional office holds monthly conference calls for State Agency program managers and MDH staff participate. MDH staff also attend regional and national CMS meetings.

Minnesota Compared to National Data and Region V

Table A-1: Average Deficiencies Per Health Survey, CMS Region V Current Survey,[5] Federal Oscar Data System, 10/31/05

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	823	3,717	4.5	4.0
Indiana	512	2,849	5.6	5.0
Michigan	429	3,115	7.3	6.0
Minnesota	409	3,096	7.6	6.0
Ohio	981	4,317	4.4	4.0
Wisconsin	402	1,366	3.4	3.0
Total	**3556**	**18,460**	**5.2**	**4.0**

For the current survey cycle on 10/31/05, Minnesota's average deficiencies per health survey was 7.6. The average deficiencies per health survey for all states in Region V was 5.2, and Minnesota ranked first. The national average deficiencies per health survey was 6.3, and Minnesota ranked twentieth. A table of average number of health deficiencies per survey for the U.S. is attached as Appendix D. MDH continues to monitor the average deficiencies issued per health survey by MDH in comparison with other states. Further exploration and analysis are required to uncover factors that may contribute to Minnesota's average deficiencies per health survey being higher than for the other states in Region V. MDH is working with Stratis Health,[6] an outside researcher, and internal research staff to explore and analyze factors that may contribute to variation in survey results.

Table A-2: Number of tags issued in each scope and severity, CMS Region V Current Survey, Federal OSCAR Data System, 11/1/05

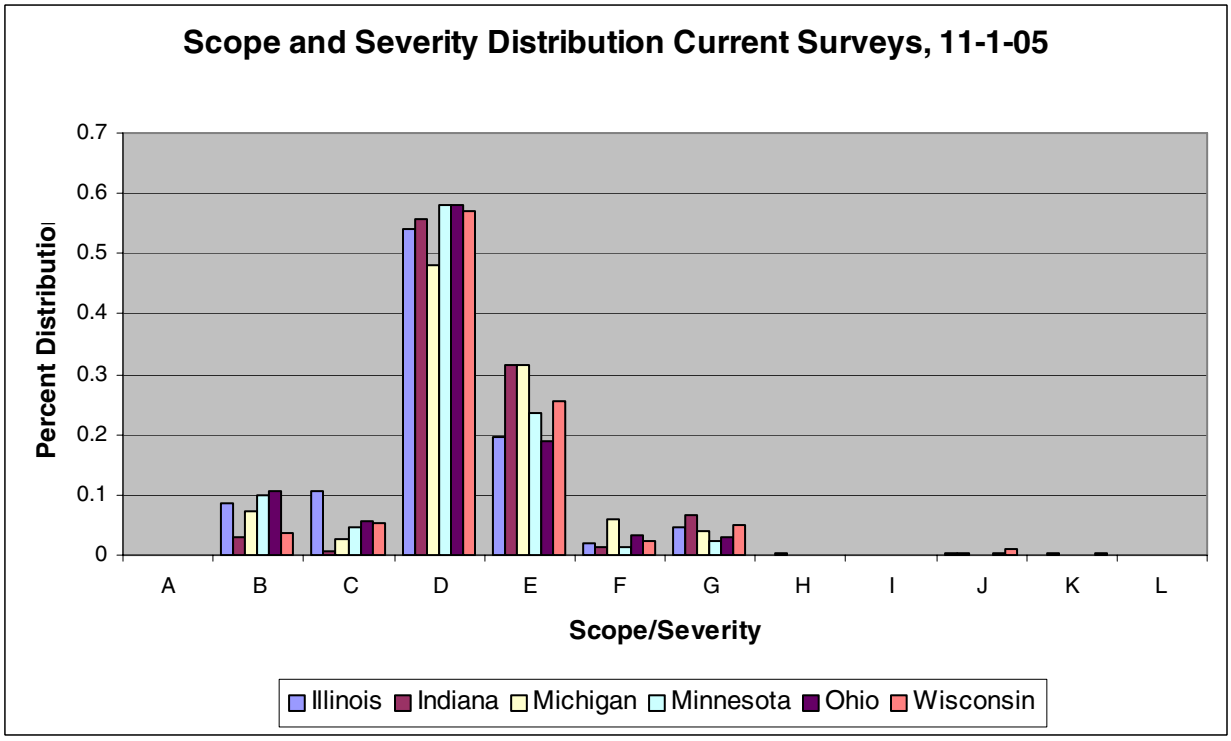
State	A	B	C	D	E	F	G	H	I	J	K	L	Total
Illinois	0	321	392	2,007	723	79	170	4	0	14	4	3	3,717
Indiana	0	88	20	1,572	888	33	190	11	0	5	8	0	2,815
Michigan	0	230	85	1,505	981	183	126	4	0	5	2	3	3,124
Minnesota	0	308	140	1,799	726	43	74	1	0	3	2	0	3,096
Ohio	0	465	251	2,537	824	147	134	2	0	8	1	2	4,371
Wisconsin	0	48	70	757	337	29	65	0	0	13	4	0	1,323
Total	0	1,460	958	10,177	4,479	514	759	22	0	48	21	8	18,446

[5] "Current survey" means the most recent survey performed for each provider.
[6] Stratis Health is the CMS Quality Improvement Organization for Minnesota. CMS funds Stratis Health to perform quality improvement consulting to health care providers within the state. See Appendix C.

Table A-3: Percent of tags issued in each scope and severity, CMS Region V Current Survey, Federal OSCAR Data System, 11/1/05

State	A	B	C	D	E	F	G	H	I	J	K	L	Total
Illinois	0.0%	8.6%	10.5%	54.0%	19.5%	2.1%	4.6%	0.1%	0.0%	0.4%	0.1%	0.1%	100.0%
Indiana	0.0%	3.1%	0.7%	55.8%	31.5%	1.2%	6.7%	0.4%	0.0%	0.2%	0.3%	0.0%	100.0%
Michigan	0.0%	7.4%	2.7%	48.2%	31.4%	5.9%	4.0%	0.1%	0.0%	0.2%	0.1%	0.1%	100.0%
Minnesota	0.0%	9.9%	4.5%	58.1%	23.4%	1.4%	2.4%	0.0%	0.0%	0.1%	0.1%	0.0%	100.0%
Ohio	0.0%	10.6%	5.7%	58.0%	18.9%	3.4%	3.1%	0.0%	0.0%	0.2%	0.0%	0.0%	100.0%
Wisconsin	0.0%	3.6%	5.3%	57.2%	25.5%	2.2%	4.9%	0.0%	0.0%	1.0%	0.3%	0.0%	100.0%
Total	0.0%	7.9%	5.2%	55.2%	24.3%	2.8%	4.1%	0.1%	0.0%	0.3%	0.1%	0.0%	100.0%

Graph 1



In Minnesota the greatest number and percent of tags were issued at scope and severity levels D and E, comparable to other states in Region V. Minnesota had fewer tags written at scope and severity G and above, compared to other states in Region V. Overall, the numbers of tags written at the most serious levels are small compared to lower level tags in all states in Region V. MDH is working to better understand the significance of these patterns.

Variation within Survey Districts in Minnesota

Table A-4: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts
Current Survey, MDH Paradise Data System, 12-9-04

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	45	408	9.1	8.0
Duluth	36	467	13.0	12.5
Fergus Falls	42	372	8.9	6.5
Mankato	65	425	6.5	6.0
Metro A	34	406	11.9	11.5
Metro B	35	219	6.3	5.0
Metro C	38	345	9.1	8.0
Metro D	36	197	5.5	4.0
Rochester	47	412	8.8	8.0
St Cloud	37	310	8.4	8.0
Total	**415**	**3,561**	**8.6**	**8.0**

Table A-5: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts, 10-1-04 through 9-30-05, MDH Paradise Data System, 10/1/05

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	43	300	7.0	6.0
Duluth	28	393	14.0	13.5
Fergus Falls	41	249	6.1	5.0
Mankato	61	361	5.9	5.0
Metro A	29	229	7.9	8.0
Metro B	30	228	7.6	8.0
Metro C	32	264	8.3	7.0
Metro D	32	215	6.7	5.0
Rochester	39	386	9.9	9.0
St Cloud	33	220	6.7	7.0
Mix/Max	27	321	11.9	12.0
Total	**395**	**3,166**	**8.0**	**7.0**

During FFY 2004, MDH undertook a number of initiatives to address variation in deficiency citations between survey districts that were described in a December 15, 2004, Report to the Legislature. See Appendix E for a link to the 12/15/04 Report. Continuation of these activities and development of additional initiatives to address the issue of consistency of the survey process are discussed later in this report.

Minnesota's survey teams work out of seven district offices, with four metro teams housed in one of them. MDH has looked at the average number of deficiencies issued by survey district on a monthly basis during FFY 2005.

In December 2004, MDH added analysis of the median number of deficiencies by survey district on a monthly basis. Monthly reports also compare the average and median numbers of deficiencies issued by "Mix/Max" teams.[7]

For FFY 2005, MDH survey program management identified as a quality improvement target goal:

> "The median number of tags issued per survey by team will vary no more than +/- 2 tags from the statewide median."

The purpose of expressing a target was to have a meaningful reference measurement for purposes of comparison and analysis, not to set a quota. For data extracted 12/9/04, reflecting the current survey cycle near the beginning of FFY 2005, four districts were outside this range: two were below the range and two were above. For the survey cycle ending at the end of FFY 2005, one district was outside (above) the target range.

MDH is encouraged that efforts to narrow the variation in deficiencies between districts are resulting in measurable decrease. MDH is continuing to address this area with several continued initiatives and new measures that have recently been put into place, that maintain and enhance the integrity of the survey process, discussed below. Additional steps will be undertaken; the L & C program is currently analyzing the effectiveness of efforts taken to date, developing measurable criteria and working to identify appropriate objectives for the current federal fiscal year (2006).

Table A-6: Minnesota Survey Districts,
Number of Tags Issued In Each Scope and Severity
Current survey cycle, Federal OSCAR Data System, 11-1-05

District	A	B	C	D	E	F	G	H	I	J	K	L	Total
Bemidji	0	19	5	186	126	1	13	0	0	0	0	0	350
Duluth	0	31	7	302	100	8	13	0	0	2	0	0	463
Fergus Falls	0	39	21	138	40	12	3	1	0	1	0	0	255
Mankato	0	50	27	205	84	1	8	0	0	0	0	0	375
Metro A	0	22	13	182	65	0	1	0	0	0	0	0	283
Metro B	0	22	10	119	32	2	7	0	0	0	0	0	192
Metro C	0	18	25	180	67	1	6	0	0	0	0	0	297
Metro D	0	30	11	122	41	5	1	0	0	0	0	0	210
Rochester	0	46	9	197	131	11	19	0	0	0	2	0	415
St Cloud	0	31	12	168	40	2	3	0	0	0	0	0	256
Total	0	308	140	1,799	726	43	74	1	0	3	2	0	3,096

[7] "Mix/Max" or mixed teams are teams that have approximately half the survey team from each of two survey teams. The Mix/Max teams were used during FFY 2004 as a quality improvement initiative. During FFY 2005, MDH scheduled two Mix/Max surveys per month in each district.

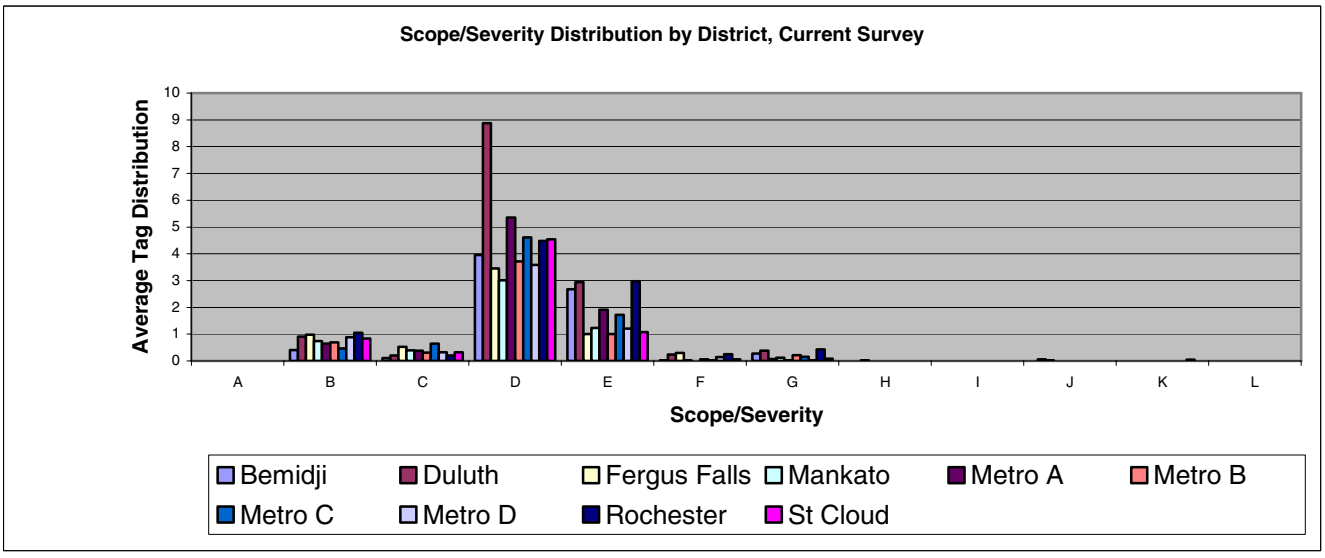
Table A-7: Minnesota Survey Districts, Percent of Tags Issued in Each Scope and Severity
Current survey, Federal OSCAR Data System, 11/1/05

District	A	B	C	D	E	F	G	H	I	J	K	L	Total
Bemidji	0.0%	5.4%	1.4%	53.1%	36.0%	0.3%	3.7%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Duluth	0.0%	6.7%	1.5%	65.2%	21.6%	1.7%	2.8%	0.0%	0.0%	0.4%	0.0%	0.0%	100.0%
Fergus Falls	0.0%	15.3%	8.2%	54.1%	15.7%	4.7%	1.2%	0.4%	0.0%	0.4%	0.0%	0.0%	100.0%
Mankato	0.0%	13.3%	7.2%	54.7%	22.4%	0.3%	2.1%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro A	0.0%	7.8%	4.6%	64.3%	23.0%	0.0%	0.4%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro B	0.0%	11.5%	5.2%	62.0%	16.7%	1.0%	3.6%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro C	0.0%	6.1%	8.4%	60.6%	22.6%	0.3%	2.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Metro D	0.0%	14.3%	5.2%	58.1%	19.5%	2.4%	0.5%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Rochester	0.0%	11.1%	2.2%	47.5%	31.6%	2.7%	4.6%	0.0%	0.0%	0.0%	0.5%	0.0%	100.0%
St Cloud	0.0%	12.1%	4.7%	65.6%	15.6%	0.8%	1.2%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%
Total	0.0%	9.9%	4.5%	58.1%	23.4%	1.4%	2.4%	0.0%	0.0%	0.1%	0.1%	0.0%	100.0%

Table A-8: Minnesota Survey Districts, Average Tags per Survey in Each Scope and Severity
Current survey, Federal OSCAR Data System, 11/1/05

District	Surveys	A	B	C	D	E	F	G	H	I	J	K	L	Total
Bemidji	47	0.0	0.4	0.1	4.0	2.7	0.0	0.3	0.0	0.0	0.0	0.0	0.0	7.4
Duluth	34	0.0	0.9	0.2	8.9	2.9	0.2	0.4	0.0	0.0	0.1	0.0	0.0	13.6
Fergus Falls	40	0.0	1.0	0.5	3.5	1.0	0.3	0.1	0.0	0.0	0.0	0.0	0.0	6.4
Mankato	68	0.0	0.7	0.4	3.0	1.2	0.0	0.1	0.0	0.0	0.0	0.0	0.0	5.5
Metro A	34	0.0	0.6	0.4	5.4	1.9	0.0	0.0	0.0	0.0	0.0	0.0	0.0	8.3
Metro B	32	0.0	0.7	0.3	3.7	1.0	0.1	0.2	0.0	0.0	0.0	0.0	0.0	6.0
Metro C	39	0.0	0.5	0.6	4.6	1.7	0.0	0.2	0.0	0.0	0.0	0.0	0.0	7.6
Metro D	34	0.0	0.9	0.3	3.6	1.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	6.2
Rochester	44	0.0	1.0	0.2	4.5	3.0	0.3	0.4	0.0	0.0	0.0	0.0	0.0	9.4
St Cloud	37	0.0	0.8	0.3	4.5	1.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	6.9
Total	409	0.0	0.8	0.3	4.4	1.8	0.1	0.2	0.0	0.0	0.0	0.0	0.0	7.6

Graph 2, Federal OSCAR Data System, 11/1/05



During the coming year, MDH will continue working towards understanding root causes of variability in survey deficiencies across districts. MDH will continue working with internal research staff, external researchers, and Stratis Health to analyze the relationships between resident, facility, surveyor, survey team, and supervision/management related factors, and deficiency variance.

Life Safety Code Enforcement

The federal government has adopted National Fire Protection Association Standard 101 (Life Safety Code, 2000 edition) as the minimum standard for fire and life safety in all certified health care facilities. Life Safety Code (LSC) surveys are conducted by the Department of Public Safety, State Fire Marshal (SFM) Division, under contract with MDH. LSC deficiencies are data tag K. All states experienced an increase in Federal Monitoring Surveys (FMS) in FFY 2005. These monitoring surveys resulted in a significant number of LSC deficiencies. A review of the monitoring surveys indicated that the approach to surveys used by SFM staff and CMS staff is somewhat different. SFM and MDH staff have adjusted their approach to more closely follow the approach used by CMS. This adjustment has also resulted in a significant increase in the number of LSC deficiencies issued to facilities, particularly long-term care facilities. SFM and MDH staff have communicated these changes to the provider community.

The average number of deficiencies per LSC survey nationally during FFY 2005 was 3.4 and the average in Minnesota was 2.2; Minnesota ranked thirty-third. Within CMS Region V, the average number of deficiencies per LSC survey was 3.2, and Minnesota ranked fourth. A table of average number of LSC deficiencies per survey for the U.S. is attached as Appendix F.

Table A-9: Average Deficiencies per LSC Survey, CMS Region V, OSCAR 10/31/05

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	823	4,197	5.1	4.0
Indiana	512	614	1.2	N/A
Michigan	429	2,445	5.7	5.0
Minnesota	409	900	2.2	1.0
Ohio	981	3,237	3.3	3.0
Wisconsin	402	683	1.7	1.0
Total	**3556**	**12,076**	**3.4**	**4.0**

B. Cross-Referencing of Citations by Region Within the State and Between States within CMS Region V.

During FFY 2004, the Survey Findings Review Subcommittee of the Long Term Care (LTC) Issues Ad Hoc Committee[8] evaluated data suggesting that issuing multiple citations for a single

[8] In 2003, Commissioner of Health, Dianne Mandernach began an initiative to address concerns surrounding long-term care regulations, the survey process and other issues affecting the industry. The Commissioner invited representatives from the provider associations, nursing home administrators, directors of nursing, employees, the

problem, or "cross-referencing," occurred more frequently in Minnesota than other states in Region V and the nation. (See Appendix E for a link to the Survey Findings/Review Subcommittee Report.) Federal survey investigative protocols in the State Operations Manual direct surveyors finding a deficient practice related to a resident outcome, such as an avoidable pressure ulcer, to investigate whether the nursing home also failed to comply with a regulatory requirement in the area of resident assessment, care planning, or care provided matching the care plan. The Commissioner issued a policy in June 2004 that was communicated to providers, surveyors and consumer advocates in MDH Information Bulletin 04-09, NH-100. The policy stated:

> "The Minnesota Department of Health will identify deficient findings under assessment, care planning and outcome tags. If a related deficient practice is found under an assessment and/or care planning tag(s) AND an outcome tag, MDH will cite the finding under the appropriate outcome tag and will NOT include that finding in an assessment and/or care planning deficiency. MDH will continue to issue assessment and/or care planning tags for findings where an outcome tag is not issued."

In February 2005, MDH evaluated the effects of the policy change on deficiency patterns in the state. Patsy Riley of Stratis Health and Dr. Robert Kane, a researcher from the University of Minnesota, provided long term care research, statistical, and analytical expertise. MDH staff included a statistician researcher. The group met three times and evaluated rates of deficiency citations of specific outcome tags[9] and assessment tags[10] that were identified as meaningful in contributing to an understanding of the effects of this policy change. It was determined that the percent of surveys with the identified assessment tags fell in Minnesota from 70.7% before 6/21/04, to 23.6% after the policy change.

Less than one year after Minnesota's policy on not citing both associated outcome and process tags went into effect, CMS issued a directive to all State Survey Agencies affirming its expectation that when noncompliance with a federal requirement has been identified, the facility or provider will receive a deficiency associated with the noncompliance, and that surveyors will follow investigative protocols and cite "independent but associated" citations. This directive was communicated to State Survey Agency Directors in Survey & Certification letter S&C 05-20 which is reproduced in Appendix G.

As a consequence, MDH rescinded the policy stated in Information Bulletin 04-9 NH-100 effective May 2, 2005. See Information Bulletin 05-1, included in Appendix G. MDH communicated with the Region V office and conveyed its expectation that CMS would work to see that the practice of issuing independent but associated citations results in an increase of independent but associated citations in other states in Region V and nationally. Minnesota has seen an increase in deficiencies in the latter half of 2005 since the policy of not issuing

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Minnesota Directors of Nursing Association (MN-DONA), MMDA, Stratis Health, the Ombudsman for Older Minnesotans, a family member of a nursing home resident, and consumer advocacy groups – ElderCare Rights Alliance and the American Association of Retired Persons (AARP), to participate in a long-term care "kitchen cabinet." This group meets quarterly to discuss issues and provide advice to the Commissioner on LTC issues and the nursing home survey process. See Appendix D for a link to additional information.

[9](F309, F312, F314, F316)

[10] (F280, F282, F272, F276)

independent but associated tags was withdrawn. MDH will continue to monitor the rates of citing associated tags within Minnesota and by other states, and will continue to communicate with CMS on this issue.

C. Number and Outcomes of Informal Dispute Resolutions

Federal regulations require CMS and each state to develop an Informal Dispute Resolution process. (42 CFR 488.331). In Minnesota there are two types of dispute resolution: Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR). The State statutory provisions for these two processes are found under Minnesota Statutes, Section 144A.10, subdivisions 15 and 16. See Appendix H. IDR and IIDR decisions made by MDH are subject to CMS oversight.[11]

IDR

The IDR is performed by an MDH employee who has not previously been involved in the survey. For surveys with exit dates during FFY 2005, 19 IDRs were requested, and as of 11/23/05, 18 of those were complete. One IDR request was withdrawn, and one was not yet complete. Two of the requested IDRs initially started as IIDRs and were switched. A total of 59 tags were disputed. Of the disputed tags, the reviewer's decision was to change the scope and severity for two tags, and to delete ten tags, for a total of 12 tags (20%) changed or deleted. Although CMS has the option of reviewing these decisions, in practice the MDH decision has remained in place, and MDH issues a revised 2567 as soon as its decision process is complete.

IIDR

IIDR involves a recommendation by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). The ALJ's recommendation is advisory to the Commissioner, who reviews the case and can accept or modify the ALJ's recommendation. At the current time, CMS is still continuing its practice to review all of the Commissioner's IIDR decisions.

Since the inception of the process in 2003, 61 IIDR requests have been made. Of these, 21 were withdrawn before the review with an ALJ. Four IIDRs were switched to an IDR process; three of these were at the request of the nursing home; one was at the request of MDH, which the facility agreed to. MDH rescinded tags in two IIDRs, and one nursing home has maintained its IIDR request on an indefinite hold. Nursing homes had representation by an attorney in 43, and were represented by the administrator in 18 of the IIDRs. MDH has representation by a survey unit supervisor and does not involve an attorney.

As of 11/23/05, there have been 23 IIDR reviews[12] conducted before an ALJ and the Commissioner has reviewed and made a decision in all 23.

[11] State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR. See Appendix C for a link to the State Operations Manual.
[12] One of these had initially started out as two IIDR requests from one facility, that the facility chose to combine.

Table C-1: Summary of IIDR results, July 2004 – 11/23/05

Number of tags in dispute: 59

ALJ recommended action:	Number of tags:
Uphold tags as written	22
Uphold scope and severity, but delete some findings	5
Total tags upheld	**27**
Dismiss	13
Adjust scope and severity	19
Total tags adjusted or dismissed	**32**

Commissioner's decision:	Number of tags:
Uphold tags as written	26
Uphold scope and severity, but delete some findings	4
Total tags upheld	**30**
Dismiss tags	11
Adjust scope and severity	17
Adjust scope	1
Total number of tags adjusted or dismissed	**29**

The CMS has reviewed 9 of the 23 IIDR reviews and has overruled the Commissioner's decision in all situations where she has recommended a change in the 2567, and determined that Form 2567 will remain as it was originally issued. Until CMS completes its review, MDH cannot issue a revised 2567.

In June 2005, MDH, provider associations, counsel representing some nursing homes, and other stakeholders, participated in a conference call with CMS Region V staff to discuss Minnesota's IIDR process. CMS staff offered to provide training to the Minnesota ALJs for the purpose of educating the ALJs on CMS's approach to the rationale for accepting a tag modification or deletion. At this time Minnesota is awaiting availability of CMS staff for ALJ training.

MDH reimburses OAH for costs associated with review of IIDR cases. Facilities reimburse MDH for the proportion of costs that are attributable to disputed tags on which MDH prevails. Costs from the beginning of the IIDR process through August 31, 2005, are presented in Table C-2.

Table C-2: OAH Costs Paid by Nursing Homes and MDH through August, 2005 (21 IIDR reviews)

OAH Cost Apportionment	Number of Nursing Homes	Number of Tags	Cost Amount
Nursing Home paid 100% of costs	3	3	$3,794
Nursing Home split costs with MDH:	9	37	$27,552
Costs split – portion paid by NH		21	$15,692
Costs split – portion paid by MDH		16	$11,859
MDH Paid 100% of costs	9	15	$15,826

MDH uses a survey team supervisor to review submitted materials and present MDH's position at the IIDRs. The IIDR process has required a considerable investment of staff time. Table C-3 presents a summary of supervisor and surveyor time spent on IIDRs compared to IDRs during FFY 2005.

Table C-3: Staff time in hours spent on IDR and IIDR

Process	Number of Reviews	Total Supervisor & Surveyor Time	Average Supervisor & Surveyor Time per Review
IIDR	27	1212.5	44.9
IDR	24	287.5	12.0

MDH has used the information gained from the IIDR process to improve the survey process with respect to both identifying and documenting deficient practices, through information sharing with program management and a statewide videoconference presentation to surveyors, investigators and supervisors. MDH shares a status log of IIDRs with the two nursing home trade associations on a monthly basis, and with the LTC Issues Ad Hoc Committee at its quarterly meetings.

D. Number and Outcomes of Appeals

The appeals process is a federal process. Nursing homes communicate directly with the CMS Region V Office in Chicago.

MDH is aware of two nursing homes that initiated appeals at the federal level during FFY 2005.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations

If a survey team finds deficiencies at the B through L level, the nursing home is required to submit a plan of correction (PoC) to MDH. If necessary, a post correction revisit (PCR) is conducted to determine whether the deficiency has been corrected. Minnesota Statutes, Section 144A.101, subdivision 5, (see Appendix A) requires the Commissioner to conduct revisits within 15 calendar days of the date by which corrections will be completed, in cases when category 2 or 3 remedies are in place. The statute allows MDH to conduct revisits by phone or written communication, if the highest scope and severity score does not exceed level E. MDH performs an onsite revisit for levels D and E in situations where the determination of whether a deficient practice has been corrected is based on observation. (See Section IV.A.) B and C level deficiencies do not require a revisit.

For facilities surveyed during FFY 2005, there were 28 facilities with surveys or revisits with category 2 or 3 remedies imposed. 39 revisits were completed subsequent to the facility being notified of a category 2 or 3 remedy. Of these:

- 32 revisits (82%) were completed within the 15 calendar days after the facility's identified date of correction.[13]

- Seven revisits (18%) were not completed within the 15 calendar days after the facility's identified date of correction.
  Of these seven revisits not completed within the 15 calendar days after the facility's identified date of correction:
  - Four facilities did not suffer financial loss due to the time of the visits.
  - Three of the facilities did suffer financial loss, but the timing of the visits was due to facility delay in providing an acceptable plan of correction, which impeded MDH's ability to conduct a revisit within 15 days of the facility's identified correction date.

A summary of these seven is as follows:

- Two facilities submitted a PoC with an identified date of correction that predated the acceptable plan of correction by more than 15 days and the PCR was completed within five days of receiving an acceptable PoC.
  A) The timing of the revisit for one of these facilities did not result in the facility having more penalties actually imposed than if the revisit was completed timely.
  B) The other facility did accrue additional remedies, because the facility was found not to have come into compliance.

- Three facilities submitted a PoC with an identified date of correction that predated the acceptable plan of correction by more than ten days and the PCR was completed within 14 days of receiving an acceptable PoC.

[13] When a facility returns a PoC, the facility must identify a date by which corrections will be completed.

A) The timing of the revisit for one of these facilities did not result in the facility having more penalties actually imposed than if the revisit was completed timely.
B) The other two facilities did achieve compliance back to the facility's identified date of compliance based on the MDH PCR, but would have remained under the notice of denial of payment for new Medicare and Medicaid admissions until the completion of the PCR.

- One facility submitted a PoC with an identified date of correction that predated the acceptable PoC by two days and the PCR was completed 28 days after receiving the acceptable PoC. The timing of this revisit did not result in the facility having more penalties actually imposed than if the revisits were completed timely.

- One facility had a PCR completed 16 days after the date of correction identified in the PoC, and was found to not have come into compliance. The facility's remedies continued to accrue.

F. Techniques of Surveyors in Investigations, Communication, and Documentation to Identify and Support Citations

A detailed description of activities taken by MDH and CMS during FFY 2004 to ensure the accuracy, integrity and consistency of the survey process can be found in Appendix D of the December 15, 2004, Annual Quality Improvement Report on the Nursing Home Survey Process. See Appendix E of this report for a link to the 12/15/04 Report. That document summarizes federal oversight activities of CMS, as well as activities carried out by MDH.

During FFY 2005, the following activities took place; some are continuing from measures taken during FFY 2004, and some were new or modified initiatives:

- Federal and state training was provided to new surveyors. Federal and state in-service training was provided to all surveyors. Some existing surveyors participated in federal cross-training.[14]
- Supervisors provided mentoring and coaching to new staff, and continued onsite survey mentoring and coaching with existing staff. Onsite mentoring and coaching activities were discussed in a Report to the LTC Ad Hoc Committee, dated January 20, 2005. See Appendix D for a link to the report.
- Supervisors reviewed all deficiencies before final 2567s were issued.
- Assistant Program Managers reviewed all deficiencies at level G and above before final 2567s were issued.
- Monthly statewide L&C management team meetings including all supervisors, program management and division management, were enhanced. The meetings were used to discuss and reach consensus on clarification of survey procedures. The monthly minutes are distributed shortly after the monthly L&C management team meetings and are used as a written communication tool with all survey staff.

[14] Surveyors must complete specific federal training for each type of federally certified provider before participating in federal certification surveys on that provider type (for example, SNF, NF, home care, hospice, critical access hospital).

- Monthly team meetings involving the supervisor and all surveyors were enhanced as a forum for supervision, clarification, and communication.
- Weekly statewide scheduling conference calls were continued.
- Quarterly statewide surveyor, supervisor and management videoconferences were used as a communication and training forum.
- In February 2005, a two-day L&C management team meeting plus a follow-up session was held to identify, clarify, and prioritize program goals and issues.
- All district teams have participated in Mix/Max surveys on a monthly basis. At the monthly L&C management team meetings, information collected from Mix/Max surveys is reviewed and discussed to identify issues, clarify and then communicate back to each team in the written minutes, which are discussed at monthly team meetings.
- All district teams have had participation of Statewide team members on a rotating basis. Statewide team members are multidisciplinary health professionals[15] who work out of the St. Cloud office and participate on surveys throughout the state. Information from statewide team members is collected, analyzed by the L&C management team on a monthly basis and shared statewide at the monthly district team meetings.
- The L & C Management Team developed tools to help ensure consistent application of the survey process.
    - Specific guidance on investigative protocols was developed and field-tested for four tags that had the greatest variability between districts. The tag guidance tools will be discussed later in this report.
    - A "Quick Tag Review Guide," that assists survey teams conduct their decision making process in a consistent manner, was developed and field tested. This tool has enhanced survey team communication during the survey, to ensure that thorough investigation has been conducted and that deficiency determinations are based upon objective information collected through observation, interview, and review of documentation, according to the State Operations Manual (SOM).
    - A Post Certification Revisit Protocol was developed to promote consistency in conducting revisits across districts.

- Communication between surveyors, district office supervisors, and facility staff has been one of the areas of special focus for quality improvement during 2005. In 2004 a policy was clarified statewide about the process of the exchange of information about concerns surveyors have identified during observation and investigation at a meeting known as "Verify/Clarify." Facility staff are informed of the areas of concern and have an opportunity to bring additional information to the survey team that may in some cases enable the team to determine that the facility satisfied regulatory requirements. Based on informal feedback from providers, provider associations, and professional associations, and Provider Survey feedback forms, the Verify/Clarify meetings have been valuable in facilitating the exchange of information between facility staff and survey teams.
- At each survey exit conference, the team leader gives the facility administrator a "Provider Survey" feedback form to be mailed to the district office with the provider's comments and responses to questions about the survey process, including communication

[15] Statewide team positions include social workers, OT, PT, and registered dietician. A pharmacist position is under development.

between facility staff and survey team. Return of the form is optional, and may be anonymous. The forms are returned to the district office then forwarded to the central office. A web-based form is also available. Survey teams and residents/families also complete feedback forms. Any concerns are followed up by management immediately and are discussed at the monthly L&C management team meetings.

Additional activities in the area of communication about the survey process are discussed later in this report.

G. Compliance with Timelines for Providing Facilities with Completed Statements of Deficiencies

Minnesota Statutes, section 144A.101, subdivision 2 requires the Commissioner to provide facilities with draft statements of deficiencies at the time of the survey exit and with completed statements of deficiencies (the 2567) within 15 working days of the exit conference. See Appendix 1.

Delivery of a draft statement of deficiencies at the time of the survey exit has been implemented, and has occurred in the vast majority of instances. In a handful of situations, extenuating circumstances prevented delivery of a draft 2567 at the time of exit. In these few cases, the draft statement of deficiencies was faxed from the district office within a short period of time (at most a few working days) thereafter. Examples of situations where this occurred included extreme weather conditions, surveyor illness, and extended survey requiring additional documentation time. In a few of these situations, the exit conference was conducted by phone conference. MDH has not specifically tracked data on delivery of draft statements of deficiencies. Beginning in January 2006, MDH will collect this information and will review it on a monthly basis.

A federal enforcement tracking system, AEM, was put in place during FFY 2004. The system was enhanced during FFY 2005. The system tracked 406 surveys that were exited during FFY 2005. Of the 406 surveys tracked, only 12 exceeded the 15 day requirement for delivering final 2567s. Five of these instances related to staff training of a singular nature, which has been addressed. Four instances were due to human error related to computer use. Three were related to surveys which required extra review due to complexity of deficiencies issued or additional information submitted by the facility.

Summary, Compliance with timeframe for delivery of 2567, FFY 2005:

Number of surveys exited:	406
Number of final 2567s delivered over 15 working days after survey exit date:	12
Percentage 15 working days or less:	97.05%
Percentage over 15 working days:	2.95%

H. Other Survey Statistics Relevant to Improving the Survey Process.

Family Council Interviews.

Minnesota Statutes, section 144A.101, subdivision 6, requires family councils to be interviewed as part of the survey process and invited to participate in the exit conference. This requirement went into effect in 2004. For surveys completed during FFY 2005, there were 230 nursing homes in Minnesota that reported having a family council in place.

Interviews with family members have always been part of the survey process; however, prior to this statute there was not a specific requirement to formally meet with a facility's family council. MDH convened a work group composed of representatives from the Minnesota Health and Housing Alliance, Care Providers of Minnesota, Ombudsman for Older Minnesotans, Association for Retired Persons (AARP), and ElderCare Rights Alliance to provide input to MDH. The group assisted MDH in development of Information Bulletin 04-14 NH-105 regarding this legislative requirement. The group also assisted MDH in development of a survey tool used by surveyors to interview family council representatives, if one is available. Surveyors use the tool to interview family members who are not participants in a family council but want to give information to surveyors.

The group met on January 28, 2005, to review implementation of activities associated with the legislative requirement. ElderCare Rights Alliance conducted telephone interviews with the facilities that identified themselves as having a family council and found that there is significant variation among facilities in the level of family council activity and the degree to which facilities foster the establishment and function of these groups. ElderCare Rights Alliance provides training and support to family council members and to facilities. ElderCare Rights Alliance also provided training on this topic to new surveyors that were hired in the spring of 2005.

As a result of input from the family council stakeholders group, MDH implemented two changes in survey procedures during FFY 2005 to promote family council participation in the survey process. (1) Survey teams now ask for contact with family council representatives on the first day of each survey, to ensure that family council members can be contacted and time scheduled for an interview during the survey process, as well as invited to the exit conference. (2) A MDH district office phone number was added to the sign posted in the facility throughout the survey, to ensure that family members and visitors who visit the facility but may not be present during the hours when surveyors are on site, or who do not feel comfortable approaching or talking to surveyors at the facility, have a phone number they can call to reach the survey team to ask questions or give information.

MDH will continue to consult with the ElderCare Rights Alliance, staff from the Ombudsman for Older Minnesotans, AARP, provider and professional associations, residents, family members, and facility employees, on the issue of family council involvement in the survey process and will work to promote the effective involvement of family councils in regulatory compliance and quality improvement initiatives.

II. Progress Reports on Other Legislatively Directed Activities.

The Laws of Minnesota 2004, Chapter 247, section 5 required the Commissioner to include in the December 15, 2004 Report to the Legislature a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;
(2) the nursing home providers work group established under Laws 2003, First Special Session, Chapter 14, article 13c, section 3.
(3) progress in implementing the independent informal dispute resolution process.

These activities required significant involvement of stakeholder participation and at the time of the December 15, 2004, Report to the Legislature, the first two activities listed above were not complete, but an interim report was made. Implementation of the independent informal dispute resolution process was discussed in the December 15, 2004, Report to the Legislature; status during FFY 2005 was discussed above.

A. Analysis of the Frequency of and Plan to Minimize Defensive Documentation

MDH deferred action on the issue of "defensive documentation" pending a report from the Minnesota Health and Housing Alliance Clinical Advisory Council. That group has not completed its recommendations and is scheduled to meet again in December 2005; MDH has been invited and will participate.

MDH works with providers and advocates to clarify requirements, streamline documentation and to ensure that time spent documenting is contributing to quality care for residents. MDH trainers provide training and ongoing support to facilities in their completion of MDS assessments and Resident Assessment Protocols (RAPs). MDH supports efforts to minimize situations where facilities are under a burden of providing the same information in different formats for different purposes. MDH is working with provider associations and other stakeholders to ensure that documentation supports quality of care for residents and efficient delivery of care, and communication between all health professionals and health workers involved in resident care. Documentation was one of the topics covered in collaborative joint training, discussed later in this report.

In a related initiative, MDH convened an e-Health Advisory Council that includes representatives from the long term care industry. This group will make recommendations to promote best practices concerning the adoption of electronic health records.[16]

[16] See Appendix E for links to the Minnesota e-Health Initiative and Advisory committee.

B. Report of the Nursing Home Providers Work Group

A work group was formed in the fall of 2004 consisting of: nursing home and boarding care home providers from both Care Providers and MHHA, representatives of nursing home residents and their families, nursing home employee unions, and representatives from the Minnesota Board of Nursing, Minnesota Department of Human Services and Minnesota Department of Health. The complete Report of the Nursing Home Providers Work Group, including a list of members, is attached as Appendix I.

The work group was charged with reviewing current licensure provisions and evaluating the continued appropriateness of those provisions in instances where there are differences between state and federal regulations. Of the topics reviewed, the work group came to consensus and made the following five recommendations for rule changes:

- Transfer the requirements in **Minnesota Rules 4658.0060, Responsibilities of administrators**, to the Board of Examiners for Nursing Home Administrators (BENHA), and put a reference to the national Domains of Practice in the nursing home rules.
- Amend **Minnesota Rules 4658.0130, Employees' Personnel Record**, by striking the word "personnel" from this provision. The contents of the records should remain the same.
- Amend **Minnesota Rules Part 4658.0455, Telephone and Electronic Orders,** to provide for authenticated electronic signatures for authorized prescribing health care practitioners.
- Amend **Minnesota Rules 4658.0710, Subpart 3** regarding frequency of physician evaluations, to conform to federal rule as it relates to use of advanced practice nurses.
- Change **Minnesota Rules 4658.0730, Subpart 2, Written agreement** and **Minnesota Rules 4655.4800 Subpart 2 Agreement with dentists for emergency care**, to language which requires a nursing home to provide for access to routine and emergency dental care, consultation on oral health policies and procedures, and oral health training for staff.

MDH and Work Group members agreed that these amendments are minor and will require non-controversial rulemaking changes. Given the resources required in the rulemaking process, MDH does not intend to initiate a separate rulemaking proceeding for these changes, but will look for opportunities to add these recommended changes to a future rulemaking activity.

III. Summary of Improvements Made to Date on the Nursing Home Survey Process: Areas of Special Focus for 2005

MDH's Quality Improvement Plan for the Nursing Home Survey Process for 2005 highlighted three areas of special focus that were identified in the December 15, 2004 Annual Quality Improvement Report on the Nursing Home Survey Process. The three areas were: A. Improving consistency across survey teams; B. Improving communication and an understanding of the survey process; and C. Collaborating on provider quality improvement projects. A copy of the

December 15, 2004 Annual Quality Improvement Report on the Nursing Home Survey Process is available on the MDH web site at http://www.health.state.mn.us/divs/fpc/fpc.html. A copy of the 2005 Quality Improvement Plan for the Nursing Home Survey Process is attached as Appendix J.

A. Improving Consistency Across Survey Teams.

As discussed above, MDH has undertaken a number of activities to understand the variations in deficiency citations between districts within the state, and to improve the accuracy and consistency of the survey process. The degree to which these activities have had an impact on reducing variation among the ten district survey teams is discussed in section I.A. of this report.

1. Regular review and analysis of data

MDH has used data strategically to prioritize focus areas for quality improvement.
During FFY 2005, MDH incorporated regular monthly review of survey data as a tool to understand deficiency patterns and improve integrity of the survey process. In addition to the monthly reports of overall deficiencies by district discussed above, on a semi-annual basis MDH reviews all deficiencies issued by F-Tag by each survey team.

MDH obtained funding for FFY 2005 for an internal research position, and has received advice and assistance from Dr. Robert Kane of the University of Minnesota, and Patsy Riley of Stratis Health. The focus of this work is to understand the interaction of factors in the following three areas:

- Provider/facility characteristics
- Surveyor/survey team characteristics
- Resident characteristics

Factors in each of these three domains influence the rate of deficiencies. Some of the relationships have been researched but more work needs to be done.

2. Tag guidance

In December, 2004, MDH identified twenty-two tags out of a possible total 371 tags that had greatest variation between districts. Ten of the twenty-two were prioritized by CMS for survey guidance, therefore MDH chose not to focus on these at this time. Of the remaining twelve, MDH prioritized four resident outcome tag areas that were issued more frequently. These related to activities of daily living, range of motion, and dignity. The L&C management team developed tag guidance for these four tags to assist surveyors in implementing the survey process in a consistent manner. Tag guidance was shared statewide and field tested by survey teams. One tag guidance was finalized related to F-241, Dignity, and communicated statewide to surveyors. The remaining three tag guidance tools are currently undergoing additional field testing. The tag guidance tools will be made available to providers on the MDH internet once they are finalized.

B. Improving Communication and an Understanding of the Survey Process

During FFY 2005, MDH continued work that was initiated in 2003 when the Commissioner invited a broad stakeholder group to participate in the LTC Issues Ad Hoc Committee. The LTC Issues Ad Hoc Committee identified communication and the need to promote understanding of the survey process as focus areas for improvement. MDH has engaged in several initiatives and activities toward these goals:

1. Participation in regional and statewide meetings and training sessions

During FFY 2005, MDH met regularly with provider associations (Care Providers of Minnesota and the Minnesota Health and Housing Alliance), Minnesota Directors of Nursing Association (MN-DONA), Stratis Health, staff from the Office of the Ombudsman for Older Minnesotans, ElderCare Rights Alliance, AARP, and Minnesota Medical Directors Association (MMDA). MDH participated in monthly or quarterly meetings, regional meetings, and annual meetings of some of these groups; all of the groups are represented on the LTC Issues Ad Hoc Committee.

2. Development of a Communications Video

The statewide Communications for Survey Improvement or "CSI-MN" Subcommittee of the Long Term Care Issues Ad Hoc Committee met April 27, 2005, and decided on a major project of development of a video about two-way communication during the survey process. The goal for the video is to demystify the survey process and help all parties (surveyors, facility staff, residents, families, advocates) understand their role in the survey process and expectations for respectful, two-way communication throughout the survey. The group met again in November 2005 for further planning and development of key messages for the video. The video is expected to be completed in the spring of 2006 and copies will be distributed to all nursing homes in the state, as well as to the provider associations and advocacy organizations.

3. Regional Stakeholders Group Pilot

A regional stakeholders group was formed in the northeast district of the state in January, 2005. The group has representatives from the MDH Duluth district and central offices, nursing homes, nursing home employees, staff from the office of the Ombudsman for Older Minnesotans, and AARP. Please see Appendix K for a list of members and additional information about the group. The group chose the name Communications for Survey Improvement, Duluth, or "CSI-Duluth." CSI-Duluth met monthly during 2005. The purpose of the group was to establish productive and respectful relationships among regulated facilities, residents and their families, and the department; better involve family members and staff in the survey process; and clarify roles and responsibilities of MDH and provider staff in putting the group's recommendations into action.

The group developed an observational survey experience as a learning tool from which education/training for providers, advocacy groups and surveyors could be developed. After protections for resident confidentiality and privacy, and the integrity of the survey process, were put in place, four directors of nursing (DONs) from facilities in the region, who are all members of CSI-Duluth, each accompanied a survey team on a full survey. The CSI-Duluth Education

Subcommittee developed training sessions based on these observational experiences that have been presented to regional groups and statewide groups. Key points from the learning experience are posted on the CSI-Duluth web page, http://www.health.state.mn.us/ltc/csiduluth/index.html, and are included in Appendix K.

The group plans to continue meeting in 2006 and is working on developing quarterly regional joint training sessions for providers and surveyors.

MDH is in the process of evaluating the results of the CSI-Duluth group process and training sessions. A summary of training session evaluations and informal feedback on the group process and training sessions will be presented to the LTC Issues Ad Hoc Committee at its January 19, 2006, meeting. After evaluating the results of the initiative and receiving input from the LTC Issues Ad Hoc Committee, MDH will address the question of forming additional regional groups in other parts of the state.

4. Internal Communication Improvement Initiatives

Internally MDH incorporated statewide quarterly surveyor videoconferences, monthly written clarifications related to regulations, and an annual surveyor face to face meeting. These have received favorable feedback for administering a statewide program consistently and enhancing communication.

C. Collaborating on Provider Quality Improvement Projects

Minnesota Statutes, section 144A.10, subdivision 1a, requires the Commissioner to establish a process for training and educating providers that includes joint training of surveyors and provider staff on new regulations, regulatory guidelines, interpretations, etc. See Appendix A. CMS has identified 12 tags that had significant variation between states and also have importance to quality of care and quality of life for residents of nursing homes. CMS convened groups of experts including providers and surveyors to produce revised clinical guidelines, survey protocols and interpretive guidelines for surveyors for each of the 12 tags. The revised guidelines are being rolled out over two or more years. See Appendix C for links to CMS quality and regulatory information. CMS promotes collaboration between the state regulatory agency and quality improvement organization in each state towards the goal of ensuring and improving quality of care and quality of life for nursing home residents. The role of MDH as the State Agency under contract with CMS for regulatory compliance and enforcement is to ensure that care provided in Medicare/Medicaid participating nursing homes meets federal regulatory requirements, as well as state licensing requirements.[17] The role of Stratis Health as the Quality Improvement Organization under contract with CMS is to promote and support provider quality improvement initiatives.

[17] A few nursing homes in the state are not federally certified. These nursing homes receive a biannual licensing survey. For federally certified facilities, CMS regulations require facilities to comply with all state and local laws and rules, as well as the federal regulations. One of the goals of MDH's educational efforts, including development and distribution of Information Bulletins, is to help providers understand and develop policies, procedures and practices that comply with federal and state requirements.

Collaborative Joint Training

During FFY 2005, MDH worked with Stratis Health, provider associations and quality organizations, MN-DONA, MMDA, staff from the Office of the Ombudsman for Older Minnesotans, and ElderCare Rights Alliance and others to plan, implement, and evaluate collaborative training for surveyors and facility staff, as well as residents, families, and advocates, on new survey protocols, clinical guidelines, and interpretive guidelines issued by CMS in the areas of prevention and treatment of pressure ulcers and urinary incontinence and catheter care.

Pressure Ulcer Training

CMS issued revised Long Term Care for Surveyor Guidelines for pressure ulcers and non-pressure ulcers in November 2004. The collaborative joint training group developed statewide training sessions on the new CMS guidance and survey protocols on the prevention and treatment of pressure ulcers. A clinical pressure ulcer expert was hired under contract to provide current and updated information. Training materials were jointly compiled and included a clinical tool kit, funded by Stratis Health. Twelve regional sessions were presented during the spring of 2005. More than 350 facilities sent staff to one of the training sessions. Evaluation forms of training participants, and informal feedback, were very positive. The training sessions had a component for residents and family members that surveyors also attended. The sessions for family and residents received positive evaluations by those who attended, although attendance was low. MDH issued Information Bulletin 05-02 NH-110 and began surveying on the revised tag F314 on May 31, 2005, which is attached as Appendix L. The Pressure Ulcer Tool Kit is posted on the Stratis Health web site; see Appendix C.

Urinary Incontinence Training

CMS issued revised surveyor guidelines for urinary incontinence and catheter care ("UI") in June of 2005. MDH participated with the other members of the collaborative joint training group to develop joint training. The collaborative training group decided to bring in a national clinical expert for the clinical portion of the training sessions, and decided to use videoconferencing technology for a statewide session and in-person train-the-trainer focused training for a follow-up session. The first session took place September 12, 2005. "Phase One" was a live half-day videoconference presented and open to all providers[18] and surveyors throughout the state, as well as representatives of advocacy organizations, at 31 videoconference sites throughout the state. The second session, which was repeated four times, took place October 24 – 27. "Phase Two" was a live in-person full-day conference repeated in four locations in the north, metro, and south. More than 590 individuals from facilities, MDH, and advocacy organizations participated. The sixth session was a presentation at the annual MMDA meeting. Training materials provided to participants were jointly compiled and were funded by MDH. These included a clinical tool kit and a brochure for educating family members and residents. MDH issued Information Bulletin

[18] Registration was open to all providers, however, the number of staff per facility was limited in some locations by the seats available at regional videoconference sites.

05-5 NH-111 and began surveying on the revised tag F-315 on November 7, 2005. See Appendix M.

Plan-Do-Study-Act Model of Continuous Quality Improvement

Each facility that attended either the Pressure Ulcer or Urinary Incontinence training received a tool kit of clinical quality improvement resources. One of the resources included in both tool kits was the "PDSA Roadmap." The roadmap outlines a model of continuous quality improvement. PDSA stands for Plan – Do – Study- Act. This model guides organizations through the steps of information gathering and analysis to identify opportunities for improvement; planning an improvement; doing the improvement; studying the results with additional and ongoing data collection and analysis; acting on the results of the additional data collection to maintain, modify, or change the improvement. See Appendix C for a link to the roadmap. This model echoes on an organizational level, the individualized approach embodied in the new clinical guidelines for pressure ulcers and urinary incontinence, which call for individualized resident assessment, care planning, implementation of individualized measures for residents identified as likely to benefit, re-evaluation to see if the care plan measures in place are working for that resident, and if necessary, modification of the resident's individualized care plan. Interdisciplinary teamwork is important to implementation of the revised CMS clinical guidelines for both Pressure Ulcer and UI.

The continuous quality improvement cycle has been used as well in developing the process and plan for collaborative joint training efforts. The collaborative joint planning group met over a period of months to identify the needs of the various target audiences, set goals and objectives, plan the training, and evaluate the results. The evaluation is ongoing and a meeting of the planning group took place in November 2005 with a facilitator. This evaluation will be folded into future planning for joint training.

Evaluation of Joint Training Activities

MDH is working with Stratis Health and Dr. Robert Kane to develop measures and analysis to evaluate the effectiveness of the joint training efforts. MDH has been monitoring deficiencies related to the pressure ulcer tag and has provided a summary of information on survey deficiencies related to pressure ulcer to the provider associations, MN-DONA, and Stratis Health. MDH posted a "Q&A" document prepared by Stratis Health on the Clinical Web Window of the MDH web site. MDH will continue to work with these groups to identify and plan additional activities towards improvements in the area of pressure ulcers and urinary incontinence.

Life Safety Code Training

The Department believes that education is a key component in reducing the number of LSC deficiencies. To that end, MDH sponsored five 4-hour LSC training seminars in FFY 2005. Two seminars were conducted in June, 2005, and three seminars were conducted in August 2005. These training seminars were funded by Civil Money Penalty funds; there was no charge for

health care providers to participate. MDH contracted with a nationally renowned fire safety expert to teach the seminars. Over 400 persons attended these seminars.

Government Performance and Results Act (GPRA) Goals

CMS is examining the relationship between nursing home quality measures[19] and deficiencies issued by State Survey Agencies. In a September, 2005, conference call, the CMS regional office informed the states in Region V that in an initiative under the Government Performance and Results Act of 1993 (GPRA),[20] CMS is looking at the relationship between deficiencies on survey and quality measure data in the areas of prevalence of physical restraints and prevalence of pressure ulcers in nursing homes. Minnesota has requested additional information on the quality measure data prepared by CMS, which identified the percentage of facilities in each state that had higher than 15% prevalence of either physical restraints or pressure ulcers.

Culture Change Initiative

MDH is participating in a collaborative group led by Stratis Health on culture change in the nursing home industry. The focus of the group is to identify ways that nursing homes can enhance quality of care and quality of life for residents by focusing attention at all levels on resident-centered care. MDH supports resident-centered care and will continue to work collaboratively with stakeholders towards the shared vision of a long term care system that ensures quality of care and quality of life for every resident.

Continuing Collaboration with Stakeholders

MDH is working with Stratis Health to assist nursing homes by sharing data and resources and will work together during FFY 2006 to reinforce training on CMS quality initiative topics. Based on recent resident assessment data and deficient practices observed during surveys in some facilities, Stratis Health and MDH are working together and will work with the provider associations, professional associations, and consumer advocates to consider additional work in the area of physical restraints, a topic that was the subject of training initiative in FFY 2003. MDH is working with the provider associations, MN-DONA, staff of Office of the Ombudsman for Older Minnesotans and advocacy organizations to identify and act on opportunities where information sharing and collaborative activities can result in improved quality of care for residents of nursing homes.

[19] See Appendix C for a link to information on CMS quality initiatives and description of CMS quality measures.
[20] GPRA requires CMS and other federal programs to identify annual quality improvement goals.

IV. Areas of Special Focus for 2006

The following areas will be given special attention during FFY 2006:

A. Allocation of Survey Hours to Achieve Maximum Resident Benefit

As described in Section I.E. of this report, MDH performs an onsite revisit for deficiency scope and severity levels D and E in situations where surveyor observation is used to determine if the practice has been corrected. Inasmuch as most D and E level deficiencies fall into this category, an onsite revisit(s) is conducted in most facilities each year, consuming a total of approximately 7127 survey hours.[21] A facility's history of regulatory compliance has not been a factor in determining whether an onsite revisit is warranted.

Because MDH survey hours are a finite resource, allocation decisions need to take into consideration the most effective ways to achieve statewide regulatory compliance. Facilities can vary significantly from one another in their regulatory compliance experience. Those with the greatest or repeat problems should receive the greatest attention from MDH. MDH will assess options for the reallocation of a portion of the onsite revisit survey hours to allow for more frequent or extended recertification surveys, or special monitoring surveys in facilities that have demonstrated difficulty in achieving compliance with federal certification requirements and/or state licensing standards. MDH will evaluate the efficiency and effectiveness of verifying compliance when not making an onsite revisit.

B. Rochester/Mankato Survey Pilot

In October, 2005 MDH initiated a pilot project involving two survey districts in the southern region of the state. The pilot project consists of having one "field" supervisor who will provide onsite coaching and mentoring supervisory support to both teams, and a second supervisor who will provide document review and processing oversight to both teams. Goals of the project are to improve and maintain accuracy, consistency and integrity of the survey process, to ensure accuracy, consistency, and timely completion and delivery of documentation, and to develop and maintain positive provider relationships. MDH will evaluate the effectiveness of this pilot project and may continue the model if it is successful.

C. Statewide and Regional Efforts to Improve Communications

MDH is in the process of evaluating the impact of the CSI-Duluth initiative described above. MDH will work with the LTC Ad Hoc Committee, regional providers, consumers and advocates, and district office survey staff, to make decisions about what steps would make sense in additional regions of the state.

[21] This number represents revisits conducted during FFY 2005 to verify implementation of PoCs where the highest scope and severity deficiency being corrected was at level D or E. These revisits required 4.5 FTEs of surveyor time, and comprised 55.6% of the total survey hours devoted to revisits (12,812.5 hours). This time includes preparation, onsite, travel and documentation time.

MDH is working on the Nursing Home Report card that will be made available to the public on the MDH web site. The projected date the Report Card will be available to the public is the end of December 2005. This has been a collaborative project of the Minnesota Department of Human Services (DHS) and MDH. The report card gives consumers the opportunity to obtain quality information for each nursing home in the state of Minnesota. Licensing and Certification survey performance is included as one of the information items that consumers can choose to create an individualized quality profile for each nursing home.

MDH will continue to meet with the LTC Ad Hoc Committee, provider associations, staff from the Office of the Ombudsman for Older Minnesotans, AARP, ElderCare Rights Alliance, professional associations, and other stakeholders in the coming year to continue the process of identifying opportunities for improvement, creating and implementing action plans to improve the nursing home survey process. MDH will work with stakeholders to evaluate the effect of these activities. In particular, MDH will utilize internal staff with guidance from external experts to evaluate the impact of the CSI-MN Survey Communications Video and CSI-Duluth initiative, described earlier in this report.

D. Collaborating on Provider Quality Improvement Initiatives

MDH will continue working with the collaborative training group of stakeholders to evaluate the success and make improvements in future joint training programs. MDH will work towards: identification of evidence-based approaches to training and implementation of clinical practice changes; development of meaningful measurement strategies and tools; reinforcement of past topics; integration of clinically oriented information with quality improvement principles and tools; and identifying and promoting mechanisms for facilities to share information on shared practices to implement and sustain quality care. MDH will continue to participate in the Culture Change initiative with Stratis Health and the stakeholders and will seek opportunities to integrate resident-centered focus in the joint training activities. MDH will seek opportunities to communicate with providers, advocates, residents and families about strategies to ensure that adoption of resident-centered practices in nursing homes also meet regulatory requirements.

Minnesota's cabinet departments were asked to identify priority goals and performance measures. In the area of long term care, MDH identified departmental performance measures for nursing home licensing and certification activities of reducing the Urinary Incontinence deficiency to 12% of facilities across the state, and reducing deficiencies related to evaluation of resident health conditions to 25% of facilities across the state, by 2007, through survey program quality assurance/quality improvement activities, joint training and collaborative activities with stakeholders. For further information about the State Department Results initiative, see the Minnesota Department Results web site at:
http://departmentresults.state.mn.us/health/DeptDetail.htm#Minnesota_is_a_healthy_place_to_live

E. Continuing Efforts to Improve Consistency Across Survey Teams

In addition to the Mankato/Rochester pilot project described above, MDH will be focusing on evaluation of surveyor and survey team performance across the state. Supervisors will be providing onsite mentoring and coaching to all surveyors on a regular basis. MDH will be

collecting and analyzing information from survey teams following all surveys and using the information to identify variations in the application of survey processes. This information, along with deficiency data, will be used by the L&C management team to identify, analyze and provide guidance that will be shared with surveyors statewide. The information will also be used to identify inservice training needs of surveyors. In addition, MDH will continue activities initiated during FFY 2005 focused on recruitment and retention of qualified survey staff.

V. Appendices

APPENDIX A

Minnesota Session Laws 2004 - Chapter 247

Key: (1)~~Language to be deleted~~ (2)New language

Legislative history and Authors

CHAPTER 247-H.F.No. 2246

An act relating to health; modifying the nursing facility survey process; establishing a quality improvement program; requiring annual quality improvement reports; requiring the commissioner of health to seek federal waivers and approvals; amending Minnesota Statutes 2002, sections 144A.10, subdivision 1a, by adding a subdivision; 256.01, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 144A.

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

Section 1. Minnesota Statutes 2002, section 144A.10, subdivision 1a, is amended to read:

Subd. 1a. [TRAINING AND EDUCATION FOR NURSING FACILITY PROVIDERS.] The commissioner of health must establish and implement a prescribed process and program for providing training and education to providers licensed by the Department of Health, ~~either by itself or~~ in conjunction with the industry trade associations, before using any new regulatory guideline, regulation, interpretation, program letter or memorandum, or any other materials used in surveyor training to survey licensed providers. The process should include, but is not limited to, the following key components:

(1) facilitate the implementation of immediate revisions to any course curriculum for nursing assistants which reflect any new standard of care practice that has been adopted or referenced by the Health Department concerning the issue in question;

(2) conduct training of long-term care providers and health department survey inspectors ~~either~~ jointly ~~or during the same time frame~~ on the department's new expectations; and

(3) ~~within available resources~~ the commissioner shall ~~cooperate in the development of clinical standards, work with vendors of supplies and services regarding hazards, and identify research of interest to the long-term care community~~ consult with experts in the field to develop or make available training resources on current standards of practice and the use of technology.

Sec. 2. Minnesota Statutes 2002, section 144A.10, is amended by adding a subdivision to read:

Subd. 17. [AGENCY QUALITY IMPROVEMENT PROGRAM; ANNUAL REPORT ON SURVEY PROCESS.] (a) The commissioner shall establish a quality improvement program for the nursing facility survey and complaint processes. The commissioner must regularly consult with consumers, consumer advocates, and representatives of the nursing home industry and representatives of nursing home employees in implementing the program. The commissioner, through the quality improvement program, shall submit to the

legislature an annual survey and certification quality improvement report, beginning December 15, 2004, and each December 15 thereafter.

(b) The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;

(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;

(3) the number and outcomes of independent dispute resolutions;

(4) the number and outcomes of appeals;

(5) compliance with timelines for survey revisits and complaint investigations;

(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;

(7) compliance with timelines for providing facilities with completed statements of deficiencies; and

(8) other survey statistics relevant to improving the survey process.

(c) The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

Sec. 3. [144A.101] [PROCEDURES FOR FEDERALLY REQUIRED SURVEY PROCESS.]

Subdivision 1. [APPLICABILITY.] This section applies to survey certification and enforcement activities by the commissioner related to regular, expanded, or extended surveys under Code of Federal Regulations, title 42, part 488.

Subd. 2. [STATEMENT OF DEFICIENCIES.] The commissioner shall provide nursing facilities with draft statements of deficiencies at the time of the survey exit process and shall provide facilities with completed statements of deficiencies within 15 working days of the exit process.

Subd. 3. [SURVEYOR NOTES.] The commissioner, upon the request of a nursing facility, shall provide the facility with copies of formal surveyor notes taken during the survey, with the exception of interview forms, at the time of the exit conference or at the time the completed statement of deficiency is provided to the facility. The survey notes shall be redacted to protect the confidentiality of individuals providing information to the surveyors. A facility requesting formal surveyor notes must agree to pay the commissioner for the cost of copying and redacting.

Subd. 4. [POSTING OF STATEMENTS OF DEFICIENCIES.] The commissioner, when posting statements of a nursing facility's deficiencies on the agency Web site, must include in the posting the facility's response to the citations. The Web site must also include the dates upon which deficiencies are corrected and the date upon which a facility is considered to be in compliance with survey requirements. If deficiencies are under dispute,

the commissioner must note this on the Web site using a method that clearly identifies for consumers which citations are under dispute.

Subd. 5. [SURVEY REVISITS.] The commissioner shall conduct survey revisits within 15 calendar days of the date by which corrections will be completed, as specified by the provider in its plan of correction, in cases where category 2 or category 3 remedies are in place. The commissioner may conduct survey revisits by telephone or written communications for facilities at which the highest scope and severity score for a violation was level E or lower.

Subd. 6. [FAMILY COUNCILS.] Nursing facility family councils shall be interviewed as part of the survey process and invited to participate in the exit conference.

Sec. 4. Minnesota Statutes 2002, section 256.01, is amended by adding a subdivision to read:

Subd. 21. [INTERAGENCY AGREEMENT WITH DEPARTMENT OF HEALTH.] The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

Sec. 5. [PROGRESS REPORT.]

The commissioner of health shall include in the December 15, 2004, quality improvement report required under section 2 a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;

(2) the nursing home providers workgroup established under Laws 2003, First Special Session chapter 14, article 13c, section 3; and

(3) progress in implementing the independent informal dispute resolution process required under Minnesota Statutes, section 144A.10, subdivision 16.

Sec. 6. [RESUBMITTAL OF REQUESTS FOR FEDERAL WAIVERS AND APPROVALS.]

(a) The commissioner of health shall seek federal waivers, approvals, and law changes necessary to implement the alternative nursing home survey process established under Minnesota Statutes, section 144A.37.

(b) The commissioner of health shall seek changes in the federal policy that mandates the imposition of federal sanctions without providing an opportunity for a nursing facility to correct deficiencies, solely as the result of previous deficiencies issued to the nursing facility.

Presented to the governor May 18, 2004

Signed by the governor May 26, 2004, 9:00 p.m.

Appendix B

Table 1: Deficiency and CMS Remedy Table

Scope of the Deficiency				
Severity of the Deficiency		**Isolated**	**Pattern**	**Widespread**
	Immediate jeopardy to resident health or safety	J PoC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	K poC Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2	L PoC Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1
	Actual harm that is not immediate	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1	I PoC Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F PoC Required* Cat. 2 Optional: Cat. 1
	No actual harm with potential for minimal harm	A No PoC No remedies Commitment to Correct	B PoC	C PoC

Source: State Operations Manual. February 25, 2004.
http://www.cms.hhs.gov/manuals/pub07pdf/pub07pdf.asp

Table Notes: *Required only when a decision is made to impose alternate remedies instead of or in addition to termination. Deficiencies in F, H, I, J, K and L categories are considered substandard quality of care (**darker shade**). Deficiencies in A, B and C are considered substantial compliance (**lighter shade**). PoC refers to a plan of correction (a plan by the facility for correcting the deficiency).

There are three remedy categories referred to on the table (Cat. 1, Cat. 2, Cat. 3). These categories as associated with the following penalties:

Category 1 (Cat.1)	**Category 2 (Cat.2)**	**Category 3 (Cat.3)**
Directed Plan of Correction State Monitor; and/or Directed In-Service Training	Denial of Payment for New Admissions Denial of Payment for All Individuals Imposed by CMS; and/or Civil Money Penalties: Up to $3,000 per day $1,000 - $10,000 per instance	Temp. Mgmt. Termination **Optional**: Civil Money Penalties 3,050-$10,000 per day $1,000 - $10,000 per instance

Denial of payment for new admissions must be imposed when a facility is not in substantial compliance within 3 months after being found out of compliance.

Denial of payment and State monitoring must be imposed when a facility has been found to have provided substandard quality of care on three consecutive standard surveys.

NOTE: Termination may be imposed by the State or CMS at any time.

APPENDIX C

How to Access CMS Regulations, Manuals, Updates, and Quality Initiative Information

Federal regulations are available at the CMS Laws and Related Regulations web page,
http://www.cms.hhs.gov/regulations/
This is a federal web page and MDH does not control its content.

The State Operations Manual, which contains survey protocols and interpretive guidelines for surveyors, is available from the CMS manuals web page,
http://www.cms.hhs.gov/manuals/
The same page contains a links to the Program Transmittals, which transmit updates to the manuals.

CMS Nursing Home Quality Initiative information is available from this CMS web page,
http://www.cms.hhs.gov/quality/nhqi/

Stratis Health, Quality Improvement Organization web site
http://www.stratishealth.org/index.html

Pressure Ulcer Quality Resources Kit and PDSA (Plan-Do-Study-Act) Roadmap
http://www.stratishealth.org/Tools_Kit_pressure_ulcer.html

CMS Survey & Certification Online Training website
http://www.cms.internetstreaming.com/
CMS webcast training sessions are available on this website for one year from the date of original broadcast.

Links to the CMS web site are also provided from MDH's Facilities Compliance Monitoring web page. (See Appendix E). Nursing homes are encouraged to check both the MDH Facilities Compliance Monitoring web page and the CMS web site weekly for updated information.

APPENDIX D Average Health Deficiencies per Nursing Home Survey, by State OSCAR data system 10/31/05

State	Surveys	Average Number of Health Deficiencies
Puerto Rico (PR)	6	20.3
District of Columbia (DC)	20	13.1
Nevada (NV)	47	10.0
California (CA)	1,311	9.3
Arkansas (AZ)	246	9.1
Colorado (CO)	215	9.0
Hawaii (HI)	43	9.0
West Virginia (WV)	133	8.7
Idaho (ID)	80	8.7
Kansas (KS)	364	8.6
Oklahoma (OK)	371	8.5
Wyoming (WY)	39	8.3
Louisiana (LA)	308	8.2
Maine (ME)	116	8.2
South Carolina (SC)	176	8.2
Arizona (AZ)	133	8.1
Delaware (DE)	42	8.0
Connecticut (CT)	230	7.9
Maryland (MD)	228	7.8
Minnesota (MN)	409	7.6
New Mexico (NM)	75	7.6
Florida (FL)	689	7.3
Alabama (AL)	229	7.3
Michigan (MI)	429	7.3
Georgia (GA)	373	7.0
Tennessee (TN)	334	6.9
Washington (WA)	250	6.8
Montana (MT)	99	6.5
Missouri (MO)	525	6.5
Texas (TX)	1,162	6.3
Vermont (VT)	41	6.3
Guam (GU)	1	6.0
Indiana (IN)	512	5.6
Massachusetts (MA)	465	5.4
Alaska (AK)	14	5.4
New Hampshire (NH)	82	5.0
North Carolina (NC)	421	5.0
Rhode Island (RI)	92	4.8
Pennsylvania (PA)	726	4.8
Virginia (VA)	278	4.7
Illinois (IL)	823	4.5
North Dakota (ND)	83	4.5
Oregon (OR)	138	4.4
Ohio (OH)	981	4.4
Kentucky (KY)	297	4.4
Iowa (IA)	460	4.4
Nebraska (NE)	229	4.4
New Jersey (NJ)	364	4.3
Utah (UT)	93	4.1
New York (NY)	661	4.1
Mississippi (MS)	209	3.9
South Dakota (SD)	112	3.7
Wisconsin (WI)	402	3.4

APPENDIX E **How to Access MDH Facilities Compliance Monitoring Information**

Annual Quality Improvement Report on the Nursing Home Survey Process
and Progress Reports on Other Legislatively Directed Activities, December 15, 2004
http://www.health.state.mn.us/divs/fpc/AQIRrpt.html

Long Term Care Issues Ad Hoc Committee home page
http://www.health.state.mn.us/ltc/

Survey Findings/Review Subcommittee Final Report, July 2004
http://www.health.state.mn.us/ltc/Findings%20Final%20Report.pdf

Minnesota Health Care Facilities Home
http://www.health.state.mn.us/divs/fpc/fpc.html

Onsite Licensing and Certification Supervisor Quality Improvement Initiative,
Report to the LTC Ad Hoc Committee, January 20, 2005
http://www.health.state.mn.us/ltc/update1-05.pdf

Compliance Monitoring Division Resident and Provider Information
http://www.health.state.mn.us/divs/fpc/consinfo.html

Compliance Monitoring Division Bulletins, Reports, Manuals, Forms
Includes link to Information Bulletins
http://www.health.state.mn.us/divs/fpc/consinfo.html
Providers are encouraged to sign up for e-mail notification of MDH Information Bulletins and CMS Program Transmittals.

Compliance Monitoring Division Federal OBRA Survey Activity Report
http://www.health.state.mn.us/divs/fpc/profinfo/progressreport.htm

Nursing and Boarding Care Home Inspections:
Information for Residents, Families and Visitors
http://www.health.state.mn.us/divs/fpc/nursingpamplet.htm

Nursing and Boarding Care Home Survey Inspection Findings
http://www.health.state.mn.us/divs/fpc/directory/surveyfindings.htm

Communications for Survey Improvement Minnesota (CSI-MN) Report, June 30, 2004
http://www.health.state.mn.us/ltc/CSI-MN%20final%20report.pdf

Communications for Survey Improvement Duluth (CSI-Duluth)
http://www.health.state.mn.us/ltc/csiduluth/index.html

MDH e-Health Initiative
http://www.health.state.mn.us/e-health/

APPENDIX F Average LSC Deficiencies per Nursing Home Survey, by State, OSCAR data system 10/31/05

State	Surveys	Average Number of Life Safety Code Deficiencies
Montana (MT)	99	8.8
Nevada (NV)	47	8.1
Kansas (KS)	364	7.8
Colorado (CO)	215	6.9
Pennsylvania (PA)	726	6.5
California (CA)	1,311	6.0
Wyoming (WY)	39	5.8
Utah (UT)	93	5.8
Michigan (MI)	429	5.7
Illinois (IL)	823	5.1
New Mexico (NM)	75	5.1
Delaware (DE)	42	4.9
North Dakota (ND)	83	4.8
Alaska (AK)	14	4.4
Texas (TX)	1,162	4.3
Puerto Rico (PR)	6	4.0
Arizona (AZ)	133	3.9
Alabama (AL)	229	3.6
Iowa (IA)	460	3.5
South Dakota (SD)	112	3.5
Virginia (VA)	278	3.4
Ohio (OH)	981	3.3
Washington (WA)	250	3.2
Oregon (OR)	138	3.1
Tennessee (TN)	334	3.1
Georgia (GA)	373	3.0
North Carolina (NC)	421	2.7
District of Columbia (DC)	20	2.6
Oklahoma (OK)	371	2.5
Massachusetts (MA)	465	2.4
Louisiana (LA)	308	2.4
Missouri (MO)	525	2.4
Minnesota (MN)	409	2.2
West Virginia (WV)	133	2.1
New York (NY)	661	1.9
Wisconsin (WI)	402	1.7
Florida (FL)	689	1.6
Nebraska (NE)	229	1.5
Connecticut (CT)	230	1.4
Maine (ME)	116	1.4
Arkansas (AZ)	246	1.4
Maryland (MD)	228	1.3
Indiana (IN)	512	1.2
Kentucky (KY)	297	1.2
New Jersey (NJ)	364	1.1
Hawaii (HI)	43	1.1
Vermont (VT)	41	1.0
Mississippi (MS)	209	1.0
South Carolina (SC)	176	1.0
Rhode Island (RI)	92	0.8
Idaho (ID)	80	0.6
New Hampshire (NH)	82	0.5
Guam (GU)	1	0.0

APPENDIX G

Minnesota Department of Health

April 2005

Information Bulletin 05-1
All Providers

CMS Survey & Certification Letter S&C 05-20: "Independent, but Associated Deficiency Citations" Implementation Date: May 2, 2005

MDH Information Bulletin 04-9 NH-100: "Federal SNF/NF Deficiencies Related to Outcome, Assessment and/or Care Planning Findings Effective Date" is rescinded effective May 2, 2005.

Policy:

The Centers for Medicare and Medicaid Services (CMS) issued Survey and Certification Letter 05-20 "Independent, but Associated Deficiency Citations" dated March 10, 2005.

With the issuance of CMS S&C 05-20, Minnesota Department of Health Information Bulletin 04-9 is rescinded effective May 2, 2005. This CMS Letter applies to ALL Provider types. MDH strongly urges that the CMS S&C 05-20 be read in detail and can be found at: http://www.cms.hhs.gov/medicaid/survey-cert/sc0520.pdf

Background:

Prior to the issuance of S&C 05-20 Letter, Minnesota identified that different state survey agencies issued different patterns of nursing home citations with some issuing only the outcome tag and others issuing outcome, assessment and/or care planning tags when the findings were related.

The issuance of CMS S&C 05-20 addresses this and therefore MDH Information Bulletin 04-9 is no longer appropriate. MDH will issue deficiencies consistent with S&C 05-20 effective May 2, 2005 for all certified providers during surveys and complaint investigations.

For example, this means that effective May 2, 2005 for nursing home surveys/complaint investigations, consistent with CMS S&C 05-20, if a related deficient practice is found under an

assessment and/or care planning tag(s) AND an outcome tag, MDH will cite the finding under the appropriate outcome tag and will also include associated findings under the assessment and/or care planning deficiency if appropriate.

If you have any questions regarding this Information Bulletin, please contact in writing:

Minnesota Department of Health
Division of Compliance Monitoring
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 215-8701

CM/April 2005

For questions about this page, please contact our Compliance Monitoring Division: fpc-web@health.state.mn.us

http://www.health.state.mn.us/divs/fpc/profinfo/ib05_1.html

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-12-25
Baltimore, Maryland 21244-1850

Center for Medicaid and State Operations/Survey and Certification Group

Ref: S&C-05-20

DATE: **March 10, 2005**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: **All Provider Types - Independent but Associated Deficiency Citations**

Letter Summary

- The purpose of this memorandum is to affirm our expectation that when noncompliance with a federal requirement has been identified, the facility or provider will receive a deficiency associated with the noncompliance.
- This memorandum restates existing CMS policy in Appendix P regarding independent but linked deficiency citations.
- This clarification applies to all provider types.

Attached you will find documents supporting this requirement including:

- Regulatory language that identifies facility compliance requirements; and
- Relevant areas of the State Operations Manual (SOM), Appendix P Task 5C and 6. This guidance addresses the necessity of survey teams to review all requirements in order to determine if there was noncompliance with any of the regulations.

There are instances in which a deficient practice creates noncompliance with more than one regulation. In those situations, noncompliance with each requirement should be cited. This situation may be referred to as "independent but associated" citations. This guidance applies to all provider types.

Some investigative protocols (such as those for pressure ulcers, hydration, and weight loss) include a list of regulations that may or may not be a concern depending upon investigation. The surveyor is expected to conduct further investigation, if concerns are identified, to determine whether non-compliance is present with those additional requirements.

For Example:
If a resident develops avoidable pressure ulcers after admission, the surveyor may make the determination that the facility failed to meet the requirement that a resident entering a facility without a pressure ulcer does not acquire one unless it is unavoidable. In that case, the pressure ulcer (sore) requirement (tag F314) is out of compliance. During the investigation, the surveyor might also find the facility did not conduct a comprehensive assessment of the resident's risk for development of a pressure ulcer. If so, the facility has also failed to comply with the regulatory language at F272. This tag requires a comprehensive assessment and is not specific to just pressure ulcers.

If the facility fails to do a comprehensive assessment of residents in other care areas, these would be combined with the pressure ulcer finding into a citation that describes the facility failure at F272. This example is not simply a matter of referencing non-compliance of one requirement with a second requirement. Rather, it reflects determining two distinct requirements have not been met after conducting a thorough review.

Another facility may have failed to meet the requirement for F314 because the resident developed an avoidable pressure ulcer. During the review the surveyor noted there was not sufficient staff to implement the care plan. In that case, the staffing requirement at F353 would also be out of compliance, since that regulation requires the facility to employ sufficient staff to provide care to the residents based on their care plan. In these two cases only determining non-compliance with F314 does not account for what the facility failed to do. Equally important, it does not inform the facility of the problems they need to fix.

In General:

1. Cite to the regulatory language, summarizing or describing the deficient practice as it relates to the requirement:
    - If the failure led to a negative or potentially negative outcome, cite the appropriate outcome tag; and
    - Cite the specific process and/or structure requirement if specific failures in the areas of process or structure are identified through investigation.
2. While writing the survey finding on Form CMS-2567, it is important to remember that the language for related deficiencies should not merely be repeated. Language should be written at each tag that reflects noncompliance for that specific requirement.

We expect the survey process to be conducted consistent with Federal guidance and the Centers for Medicare & Medicaid Services (CMS) remains committed to monitoring adherence with our program requirements. The expectation that the certification program will be conducted consistent with our guidance is the basis on which the State performance review is conducted.

Concerns:
We have heard from some providers that citation of more than one deficiency for a single type of negative outcome simply represents "piling it on" by states or CMS. The regulations do not support this view. Nor do we agree as a matter of proper management and practice. Often one citation will focus on or manifest cause for a poor outcome, while another citation may focus on a systemic or root cause. It is vital that health care providers address all factors that contribute to negative outcomes.

If you have any further questions or concerns regarding the issues in this letter, please contact Cindy Graunke at (410) 786-6782 or Beverly Cullen at (410) 786-6784.

Effective Date: The information in this memorandum should be shared with survey staff within 30 days of the publication date.

Training: The information contained in this announcement should be shared with all survey staff, their managers and the state/RO training coordinators.

/s/
Thomas E. Hamilton

cc: Survey and Certification Regional Office Management (G-5)

Attachment

ADDENDUM

The survey process requires surveyors to determine a facility's compliance with the applicable requirements. In order to maintain certification in the Medicare/Medicaid program, nursing homes must be in compliance with all of the regulations. This is in regulation at the following:

42 CFR 483.1 (b) - Scope. The provisions of this part contain the requirements that an institution must meet in order to qualify to participate as a Skilled Nursing Facility (SNF) in the Medicare program, and as a Nursing Facility (NF) in the Medicaid program. They serve as the basis for survey activities for the purpose of determining whether a facility meets the requirements for participation in Medicare and Medicaid.

42 CFR 483.75 (b) - Compliance with Federal, State and local laws and professional standards. The facility must operate and provide services in compliance with **all** applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility (emphasis added).

42 CFR 488.301 - Definitions. Deficiency means a SNF's or NF's failure to meet a participation requirement specified in the Act or in part 483, subpart B of this chapter.

Excerpts from Appendix P of the State Operations Manual (SOM) – Survey Protocol for Long Term Care Facilities

The survey process contains specific procedures, which are delineated in the SOM, Appendix P, to provide guidance for a surveyor in how to conduct the standard, extended, revisits and complaint surveys. Within the guidance, in order to promote consistency, investigative protocols have been developed that provide specific processes for the surveyor to utilize in evaluating areas of concern such as the following: Hydration; Unintended Weight Loss; Dining and Food Service; Nursing Services - Sufficient Staffing; Adverse Drug Reactions, and the Abuse Prohibition Protocol. Within each protocol, at the end, is a section titled Task 6, Determination of Compliance. This section provides guidance for the surveyor to investigate regulatory requirements related to the issue that may be out of compliance and to cite deficiencies if negative findings are identified. This section includes a list of several regulatory requirements. An example of the Investigative Protocol – Hydration, is attached for review.

TASK 6 - Information Analysis for Deficiency Determination

A component of the survey process is the decision making by the survey team to determine if the facility is in compliance with **all** the requirements (emphasis added). The surveyors are required to conduct a review of all the requirements as a team to ascertain whether they identified any areas of non-compliance and to delineate the areas of non-compliance that will be cited. For the purpose of this paper, only excerpts of the Task 6, which describe the review of the regulatory requirements, will be attached.

This section also defines a "deficiency as a facility's failure to meet a participation requirement." It should be noted that the guidance states that all regulatory requirements that are deficient may be issued based upon findings. (Please refer to Task 6 in the SOM, Appendix P for the complete version.)

Investigative Protocol
Hydration

Objectives:

- To determine if the facility identified risk factors which lead to dehydration and developed an appropriate preventative care plan; and
- To determine if the facility provided the resident with sufficient fluid intake to maintain proper hydration and health.

Task 5C: Use:

Use this protocol for the following situations:

- A sampled resident who flagged for the sentinel event of dehydration on the Resident Level Summary;
- A sampled resident who has one or more QI conditions identified on the Resident Level Summary, such as:
    - #11 - Fecal impaction;
    - #12 - Urinary tract infections;
    - #13 - Weight loss;
    - #14 - Tube feeding;
    - #17 - Decline in ADLs;
    - #24 - Pressure Ulcer
- A sampled resident who was discovered to have any of the following risk factors: vomiting/diarrhea resulting in fluid loss, elevated temperatures and/or infectious processes, dependence on staff for the provision of fluid intake, use of medications including diuretics, laxatives, and cardiovascular agents, renal disease, dysphagia, a history of refusing fluids, limited fluid intake or lacking the sensation of thirst.

Procedures:

- Observations/interviews conducted as part of this procedure should be recorded on the Forms CMS-805 and/or the Form CMS-807.
- Determine if the resident was assessed to identify risk factors that can lead to dehydration, such as those listed above and also whether there were abnormal laboratory test values which may be an indicator of dehydration.

NOTE: A general guideline for determining baseline daily fluid needs is to multiply the resident's body weight in kilograms (kg) x 30ml (2.2 lbs = 1 kg), except for residents with renal or cardiac distress, or other restrictions based on physician orders. An excess of fluids can be detrimental for these residents.

- Determine if an interdisciplinary care plan was developed utilizing the clinical conditions and risk factors identified, taking into account the amount of fluid that the resident requires. If the resident is receiving enteral nutritional support, determine if the tube feeding orders included a sufficient amount of free water, and whether the water and feeding are being administered in accordance with physician orders?

- Observe the care delivery to determine if the interventions identified in the care plan have been implemented as described.

    - What is the resident's response to the interventions? Does staff provide the necessary fluids as described in the plan? Do the fluids provided contribute to dehydration, e.g., caffeinated beverages, alcohol? Was the correct type of fluid provided with a resident with dysphagia?

    - Is the resident able to reach, pour and drink fluids without assistance? Is the resident consuming sufficient fluids? If not, is staff providing the fluids according to the care plan?

    - Is the resident's room temperature (heating mechanism) contributing to dehydration? If so, how is the facility addressing this issue?

    - If the resident refuses water, are alternative fluids offered that are tolerable to the resident?

    - Are the resident's beverage preferences identified and honored at meals?

    - Does staff encourage the resident to drink? Are they aware of the resident's fluid needs? Is staff providing fluids during and between meals?

    - Determine how the facility monitors to assure that the resident maintains fluid parameters as planned. If the facility is monitoring the intake and output of the resident, review the record to determine if the fluid goals or calculated fluid needs were met consistently.

- Review all related information and documentation to look for evidence of identified causes of the condition or problem. This inquiry should include interviews with appropriate facility staff and health care practitioners, who by level of training and knowledge of the resident, should know of, or be able to provide information about the causes of a resident's condition or problem.

NOTE: If a resident is at an end of life stage and has an advance directive, according to State law, (or a decision has been made by the resident's surrogate or representative, in accordance with State law) or the resident has reached an end of life stage in which minimal amounts of fluids are being consumed or intake has ceased, and all appropriate efforts have been made to encourage and provide intake, then dehydration may be an expected outcome and does not constitute noncompliance with the requirement for hydration. Conduct observations to verify that palliative interventions, as described in the plan of care, are being implemented and revised as necessary, to meet the needs/choices of the resident in order to maintain the resident's comfort and quality of life. If the facility has failed to provide the palliative care, cite noncompliance with 42 CFR 483.25, F309, Quality of Care.

- Determine if the care plan is evaluated and revised based on the response, outcomes, and needs of the resident.

Task 6: Determination of Compliance:

- Compliance with 42 CFR 483.25(j), F327, Hydration:
    - For this resident, the facility is compliant with this requirement to maintain proper hydration if they properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed. If not, cite at F327.
- Compliance with 42 CFR 483.20(b)(1) & (2), F272, Comprehensive Assessments:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they assessed factors that put the resident at risk for dehydration, whether chronic or acute. If not, cite at F272.
- Compliance with 42 CFR 483.20(k)(1), F279, Comprehensive Care Plans:
    - For this resident in the area of hydration, the facility is compliant with this requirement if they developed a care plan that includes measurable objectives and timetables to meet the resident's needs as identified in the resident's assessment. If not, cite at F279.
- Compliance with 42 CFR 483.20(k)(3)(ii), F 282, Provision of care in accordance with the care plan:
    - For this resident in the area of hydration, the facility is compliant with this requirement if qualified persons implemented the resident's care plan. If not, cite at F282.

EXCERPTS FROM SOM APPENDIX P – TASK 6 – Information Analysis for Deficiency Determination
(For complete text refer to SOM Appendix P)

A. General Objectives

The objectives of information analysis for deficiency determination are:

- To review and analyze all information collected and to determine whether or not the facility has failed to meet one or more of the regulatory requirements;

C. Decision-Making Process

Each member of the team should review his/her worksheets to identify concerns and specific evidence relating to requirements that the facility has potentially failed to meet. In order to identify the facility's deficient practices and to enable collating and evaluating the evidence, worksheets should reflect the source of the evidence and should summarize the concerns on relevant data tags.

- In order to ensure that no requirements are missed, proceed through the requirements sequentially as they appear in the interpretive guidelines, preferably section by section. Findings/evidence within each section should be shared by each team member during this discussion. Consider all aspects of the requirements within the tag/section being discussed and evaluate how the information gathered relates to the specifics of the regulatory language and to the facility's performance in each requirement. The team should come to consensus on each requirement for which problems have been raised by any member. If no problems are identified for a particular tag number during the information gathering process, then no deficiency exists for that tag number.

D. Deficiency Criteria

To determine if a deficiency exists, use the following definitions and guidance:

- A "deficiency" is defined as a facility's failure to meet a participation requirement specified in the Social Security Act or in Part 483, Subpart B (i.e., 42 CFR 483.5 - 42 CFR 483.75).

- **To help determine if a deficiency exists, look at the language of the requirement. Some requirements need to be met for each resident. Any violation of these requirements, even for one resident, is a deficiency.**

- Other requirements focus on facility systems.

Certain facility systems requirements must be met in an absolute sense, e.g., a facility must have an RN on duty 7 days a week unless it has received a waiver. Other facility system requirements are best evaluated comprehensively, rather than in terms of a single incident. In evaluating these requirements the team will examine both the individual parts of the system, e.g., the adequacy of the infection control protocol, the adequacy of facility policy on hand washing, as well as the actual implementation of that system.

APPENDIX H

Minnesota Statutes 2005, 144A.10

Subd. 15. **Informal dispute resolution.** The commissioner shall respond in writing to a request from a nursing facility certified under the federal Medicare and Medicaid programs for an informal dispute resolution within 30 days of the exit date of the facility's survey. The commissioner's response shall identify the commissioner's decision regarding the continuation of each deficiency citation challenged by the nursing facility, as well as a statement of any changes in findings, level of severity or scope, and proposed remedies or sanctions for each deficiency citation.

Subd. 16. **Independent informal dispute resolution.** (a) Notwithstanding subdivision 15, a facility certified under the federal Medicare or Medicaid programs may request from the commissioner, in writing, an independent informal dispute resolution process regarding any deficiency citation issued to the facility. The facility must specify in its written request each deficiency citation that it disputes. The commissioner shall provide a hearing under sections 14.57 to 14.62. Upon the written request of the facility, the parties must submit the issues raised to arbitration by an administrative law judge.

(b) Upon receipt of a written request for an arbitration proceeding, the commissioner shall file with the Office of Administrative Hearings a request for the appointment of an arbitrator and simultaneously serve the facility with notice of the request. The arbitrator for the dispute shall be an administrative law judge appointed by the Office of Administrative Hearings. The disclosure provisions of section 572.10 and the notice provisions of section 572.12 apply. The facility and the commissioner have the right to be represented by an attorney.

(c) The commissioner and the facility may present written evidence, depositions, and oral statements and arguments at the arbitration proceeding. Oral statements and arguments may be made by telephone.

(d) Within ten working days of the close of the arbitration proceeding, the administrative law judge shall issue findings regarding each of the deficiencies in dispute. The findings shall be one or more of the following:

(1) Supported in full. The citation is supported in full, with no deletion of findings and no change in the scope or severity assigned to the deficiency citation.

(2) Supported in substance. The citation is supported, but one or more findings are deleted without any change in the scope or severity assigned to the deficiency.

(3) Deficient practice cited under wrong requirement of participation. The citation is amended by moving it to the correct requirement of participation.

(4) Scope not supported. The citation is amended through a change in the scope assigned to the citation.

(5) Severity not supported. The citation is amended through a change in the severity assigned to the citation.

(6) No deficient practice. The citation is deleted because the findings did not support the citation or the negative resident outcome was unavoidable. The findings of the arbitrator are not binding on the commissioner.

(e) The commissioner shall reimburse the Office of Administrative Hearings for the costs incurred by that office for the arbitration proceeding. The facility shall reimburse the commissioner for the proportion of the costs that represent the sum of deficiency citations supported in full under paragraph (d), clause (1), or in substance under paragraph (d), clause (2), divided by the total number of deficiencies disputed. A deficiency citation for which the administrative law judge's sole finding is that the deficient practice was cited under the wrong requirements of participation shall not be counted in the numerator or denominator in the calculation of the proportion of costs.

APPENDIX I

Nursing Home Providers Work Group Report

Introduction

This report is submitted pursuant to the following provision in Minnesota Laws 2003 First Special Session, Chapter 14, Article 13C, Section 3, Subdivision 3:

> **Nursing Providers Work Group.** The commissioner shall establish a working group consisting of nursing home and boarding care home providers, representatives of nursing home residents, and other health care providers to review current licensure provisions and evaluate the continued appropriateness of these provisions. The commissioner shall present recommendations to the legislature by November 1, 2004.

In 2004, the Minnesota Legislature directed the Department of Health to submit an annual quality improvement report relating to the nursing home regulatory process. The legislature also directed that the Department provide a progress report on the Nursing Home Providers Work Group established in 2003. The 2004 Report indicated that the initial meeting of the Work Group was scheduled for December 21, 2004. Prior to that date, Department staff had focused on other nursing home related activities established under legislation enacted in 2003 and 2004.

The following report summarizes the activities and recommendations of the Work Group in 2004 and 2005.

Background

During the 2003 legislative session HF 471 was introduced that included a number of changes to the regulations regarding nursing homes. One of those changes was to allow "deemed status" for those facilities that met Medicare Certification standards. The intent was to minimize areas of regulatory duplication between the federal certification requirements and the state licensure provisions. However, a number of concerns were identified about this particular provision. The Department noted that such a provision could result in very significant increases in the state licensure fees since the federal government would want the Department to allocate survey costs equally between federal and state activities. Additionally, consumer and advocacy groups raised concerns about a potential decrease in the protections provided to residents under state licensure rules that might not be adequately addressed under the federal provisions.

The House changed the provisions relating to "deemed status" and directed that the Department not conduct state licensure surveys in nursing homes during the biennium and to also establish a work group to review the current licensure provisions. The final version that was enacted during the 2003 Special Session included only the provision relating to the work group.

Work Group Membership, Charge and Meetings

The first meeting of the Work Group was held on December 21, 2004. Work Group membership included the following: representatives from the Minnesota Health and Housing Alliance and Care Providers of Minnesota; nursing home and boarding care
home providers from both professional trade associations, representatives of nursing home residents and their families, the Office of Ombudsman for Older Minnesotans and other advocacy associations, and representatives from a nursing home employee union, the Minnesota Board of Nursing, Minnesota Department of Human Services and Minnesota Department of Health. Please see Page 8 of this report for a complete list of members.

The work group was charged with reviewing current licensure provisions and evaluating the continued appropriateness of those provisions. Specifically, members were asked to identify where there are differences between state and federal regulations, look at whether they conflict in some way, and if they didn't conflict, determine whether the state regulations are additives which go above and beyond the federal requirements. If the state rules were more restrictive than the federal requirements, members were asked to discuss whether those provisions should continue.

Members identified the following 17 licensure provisions to review:

Specialized Care Units
Administration of Medications
Clinical Record Contents
Employees' Personnel Records
Responsibilities of Administrator
Routine and Emergency Oral Health Services
Dental Services Agreement
Activities Program
Infection Control Tuberculosis Programs
Electronic Records
Incontinence Checks
Social Services Provider Qualifications
Positioning
Staffing
Name Tags
Advanced Practice Nurses (Physician Extenders)
Pets in Nursing Homes

After further review and discussion of these 17 provisions, work group members recommended that only five provisions required changes to state regulations. The remaining provisions they determined should remain as written, because they provided more protection for consumers than the federal regulations.

Some Work Group members were surprised that there were not more differences between the state and federal rules. However, in 1991 the Minnesota Legislature authorized a study, commonly known as the "Nursing Home Regulatory Reform Project" which involved a

comprehensive review of all current rules relating to nursing home and boarding care homes. Fifteen different work groups were established to discuss the various regulatory requirements and make sure they conformed to the federal regulations as well as to minimize inconsistencies with the state licensure requirements. Based on those recommendations, the rules were subsequently amended to incorporate the recommended changes. Since then, there have been no substantial changes to state and federal regulations governing nursing homes and boarding care homes.

Recommendations

Recommendation #1:

Transfer the requirements in MN Rules 4658.0060, Responsibilities of administrators, to the Board of Examiners for Nursing Home Administrators (BENHA). MDH should work with BENHA on the transfer of these requirements.

Rationale: MN Rules 4658.0060 includes a detailed list of administrator's responsibilities. These responsibilities date back to 1972 when the original rule was created. Many of those responsibilities are now outdated. There are national Domains of Practice for nursing home administrators that contain similar responsibilities and are much more comprehensive than BENHA's rules or statutes and administrator's responsibilities listed in MN Rules 4658.0060. There are five areas on the national exam for administrators that relate to the Domains of Practice. Although the Domains of Practice are very comprehensive, they do not have the force and effect of law.

In reviewing past deficiencies, MDH found that they seldom issued deficiencies under the responsibilities of administrator provision. MDH interests are to ultimately hold the licensee responsible for the operations of the nursing home, not the administrator. BENHA has also been in the process of reviewing its own rule provisions and staff from MDH and BENHA have met to discuss the most appropriate location for the current provisions. It has been agreed that since these provisions relate to administrator responsibilities that it would be more appropriate to include these provisions under the rules for the administrator's licensure board. This would provide BENHA with specific standards to evaluate an administrator's performance. At the current time, BENHA is reviewing these provisions and updating the requirements. At the time of the BENHA's rule hearing to include these provisions, the MDH will also repeal these provisions from its licensure rules.

There is requirement for a licensed nursing home administrator in the boarding care rules. Boarding care rules require an administrator in charge, but this individual is not required to be licensed. If the person in charge is not a licensed nursing home administrator BENHA has no authority. Therefore work group members recommend keeping the language in MN Rules 4655.1400 for the expectations of the administrator in charge.

Recommendation #2:

Amend MN Rules 4658.0130, Employees' Personnel Record, by striking the word "*personnel*" from this provision. The contents of the records should remain the same.

Rationale: MN Rules 4658.0130 requires specific content in employee records that is not required by federal regulations. There other records that are kept in the nursing home that contain some of the same information (e.g. labor and industry regulations, OSHA regulations). Work group members believed that the content of the information is more important then where it is placed. As long as the nursing home can produce the information or record, it should not matter where that information or record is filed. Similar language is contained in the boarding care rules.

Recommendation #3:
Amend Minnesota Rules Part 4658.0455, Telephone and Electronic Orders, as follows:

B. Orders received by telephone ~~or other electronic means~~, not including facsimile machine, must be immediately recorded or placed in the resident's record by the person authorized by the nursing home and must be countersigned by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, whichever is sooner.

D. Orders received by other electronic means must meet the confidentiality requirements of 4658.0435, Subpart 1 and the security and verification requirements of Subp. 2. A statement from an entity transmitting health care data to the facility electronically that the entity complies with all statutory and regulatory requirements authorizing the electronic submittal meets the verification requirements of Subp. 2. The orders must be immediately recorded or placed in the resident's record by the person authorized by the nursing home, or they must be entered into the nursing home's electronic health information management system and must comply with 4658.0475.

MDH should discuss any proposed rule language with staff working on the Minnesota e-Health Initiative, staff responsible for the Minimum Data Set and the Centers for Medicare and Medicaid Services. In the short term, facilities could request a waiver regarding the current requirements in 4658.0455. However first, MDH would need to obtain clarification from the federal government on how to handle waiver requests.

Rationale: The current rule regarding electronic records requires a countersignature by the ordering health care practitioner authorized to prescribe at the time of the next visit, or within 60 days, which ever is sooner. The countersignature is required for security and verification purposes. Providers have reported difficulty with obtaining the prescriber's signature on electronically submitted orders. Having a provision in rule which requires the entity who submits the electronic order to provide a statement that indicates they have complied with all statutory and regulatory requirements authorizing the electronic submittal would assure that the signature is valid and meets the other security requirements stated in MN Rules 4658.0435 Subpart 2.

There are no provisions in the Boarding Care Rules that address electronic records. Since there are no regulations for receipt and transmission of electronic health records, these types of facilities have the ability to develop their own policies and procedures.

Recommendation #4

Amend MN Rules 4658.0710, Subpart 3 regarding frequency of physician evaluations, to conform to federal rule as it relates to use of advanced practice registered nurses. Under federal rule, required visits in skilled nursing facilities, after the initial visit, may alternate between personal visits by the physician and visits by a physician assistant or an advanced practice registered nurse authorized by state law to practice as physician assistant or an advanced practice registered nurse. Advanced practice registered nurses include clinical nurse specialists, nurse anesthetists, nurse-midwives, and nurse practitioners. The state rule limits alternate visits to performance by a nurse practitioner or physician assistant. Clinical nurse specialists are not included in this provision. The state rule was adopted in 1996 and it wasn't until 1999 that clinical nurse specialists were given additional authority by law. Because the state rule is more restrictive than the current federal rule, the state rule should be changed to conform to federal rules. Boarding care home rules specifically require physicians to conduct annual visits. Therefore, no change in those rules is being recommended.

Rationale: Changing the state nursing home rule to conform to the federal rule, which allows clinical nurse specialists to perform alternate visits, recognizes the qualifications of clinical nurse specialists and conforms to current nursing standards of practice. Federal rules only really conflict with state nursing home rules, as it relates to who can perform alternate visits, because the boarding care home rules only require an annual visit. Therefore, the work group is only proposing changes to the nursing home rules, not the boarding care home rules.

Recommendation #5:

Change MN Rules 4658.0730, Subpart 2, Written agreement and MN Rules 4655.4800 Subpart 2, Agreement with dentists for emergency care, to language which requires a nursing home to provide provisions for access to routine and emergency dental care, consultation on oral health policies and procedures, and oral health training for staff. Currently the rules require nursing homes and boarding care homes to have a written dental provider agreement with at least one state licensed dentist for such services.

Rationale: Providers have reported difficulty with finding dentists who will accept Medical Assistance payment and enter into a written agreement. The deletion of the requirement for a "written agreement" would provide some administrative relief to the providers. However, this would not modify requirements that routine and emergency dental concerns of residents need to be met or that dentists be available for training and consultation.

The concerns that were raised during the discussion focused on the difficulty of obtaining written agreements with dental providers, especially for the provision of emergency care. There didn't seem to be concern about the requirements for nursing homes to provide access to routine and emergency dental care, consultation on oral health policies and procedures, and oral health training for staff. Under federal regulations (42 CFR, 483.55, (a.) (1), nursing facilities must provide or obtain from an outside resource, routine and emergency dental services to meet the needs of each resident. Therefore, the Department will consider amending the rules to delete the language which requires a written agreement, but will maintain the language which outlines the need for meeting the dental needs of residents and the training requirements for nursing home

staff. The Department will review both current state requirements and federal provisions in developing an amendment to this rule.

OTHER DISCUSSIONS

The areas listed below have been identified as having significant differences between state and federal regulations, but areas where work group members could not reach consensus on any one specific recommendation. This could be due to the fact that there are changes occurring at the state and federal level.

MN Rules 4658.0510, Subpart 2, Minimum hour requirement, requires sufficient staffing and states that for nursing homes not certified to participate in the medical assistance program a minimum of two hours of nursing personnel per resident per 24 hours is required. Federal regulations require sufficient staffing and a registered nurse for at least 8 consecutive hours a day, 7 days a week.

Work group members discussed whether a state staffing standard was necessary and questioned what that standard should be. Work group members could not reach consensus on what the staffing standard should be. They thought that MDH should wait to see what happens at the legislature in terms of staffing bills. Some members liked the 2.0 staffing standard, because it was symbolic and easier for providers to respond to than requiring "adequate staffing." Others thought that the 2.0 standard was a minimum standard and that the state should be raising the bar to excellence. However, they acknowledged that funding a higher standard would be an issue.

MN Rules 4658.0520, Subpart 2, B., Criteria for determining adequate and proper care, requires residents who are incontinent to be checked at least every two hours. MS 144A.04, Subd.11 allows for longer intervals if approved by the attending physician. In the federal regulations, incontinent checks are based on the individual's assessment and care plan. The two-hour state standard is inconsistent with the federal regulations. The federal government recently released new guidelines for urinary incontinence and catheter care and training on these protocols is currently in progress.

Work group members determined that they should refrain from making any recommendations regarding incontinence checks until there has been more experience with the implementation of the federal guidelines. MDH will track the impact of the urinary incontinence training.

MN Rules 4658.0525, Subpart 4, Positioning, requires positioning every two hours for residents who are unable to change their position themselves. Federal regulations require individual assessment before setting up a treatment plan. The new federal regulations (language related to pressure ulcers) are much more involved and training on this recently occurred.

Work group members determined that they should refrain from making any recommendations regarding positioning until there has been more experience with the implementation of the federal guidelines. MDH will track the impact of the pressure ulcer training.

PLAN FOR IMPLEMENTING RECOMMENDATIONS

There are five amendments to the rules that are being recommended. MDH and Work Group members agree that these amendments are minor and will require non-controversial rulemaking changes. Given what is required in the rulemaking process, MDH does not intend to initiate a rulemaking proceeding for these minor changes. Rather, MDH will look at opportunities to add these recommended changes to future rulemaking activity.

Nursing Home Providers Work Group Members

Jeff Amann
Courage Residence
jeffa@courage.org

Dale Armitage
Twin City Linnea Home &
First Christian Residence
darmitage@ecumen.org

Kristin Beckmann
SEIU Minnesota State Council
kbeckmann@seiumn.org

Doug Beardsley
Care Providers of Minnesota
dbeardsley@careproviders.org

Carolyn Christensen
Evangelical Lutheran Good Samaritan Society
cchriste@good-sam.com

Iris Freeman
Advocacy Strategy / Alzheimers Assoc.
advocacystrategy@aol.com

Gail Geisenhoff
Beverly Health Care
gail_geisenhoff@beverlycorp.com

Joy Hellen
Lake Ridge Healthcare Center
joy_hellen@beverlycorp.com

John Huhn
Walker Methodist Health Care Center
jhuhn@walkermeth.org

Mary Lundquist
Bywood East Health Care
mlundquist@bywoodeast.com

Jill Marquardt
Consumer
jma@usfamily.net

Maria Michlin
Deputy Ombudsman for
Older Minnesotans
maria.michlin@state.mn.us

Anne Ringquist
Minnesota Board of Nursing
anne.ringquist@state.mn.us

Darrell Shreve
Minnesota Health and Housing Alliance
dshreve@mhha.com

Mark Wandersee
ElderCare Rights Alliance
mwandersee@eldercarerights.org

Keith Weigel
AARP
kweigel@aarp.org

Munna Yasiri
Minnesota Dept. of Human Services
munna.yasiri@state.mn.us

MDH Staff:

David Giese
MDH Compliance Monitoring Division
david.giese@health.state.mn.us

Mike Tripple
MDH Compliance Monitoring Division
mike.triple@health.state.mn.us

Bonnie Wendt
MDH Compliance Monitoring Division
bonnie.wendt@health.state.mn.us

Kay Herzfeld
MDH Compliance Monitoring Division
kay.Herzfeld@health.state.mn.us

APPENDIX J

WORKING DRAFT
2005 Quality Improvement Plan for
Nursing Facility Survey Process

Mission of Minnesota Department of Health:

Keeping All Minnesotans Healthy

Vision of Licensing and Certification (L & C) Program:

Quality and Compassionate Care Every Time

Mission of Licensing and Certification Program:

To protect and improve the health, safety, comfort and well-being of individuals receiving services from federally certified and state licensed health care providers, and to monitor the quality of nursing assistant training programs.

This mission is accomplished through:

1. Issuance and renewal of licenses and certification/recertification activities for providers;
2. Surveying providers and enforcing compliance with federal and state statues, regulations and guidelines;
3. Educating stakeholders via information sharing and training; and
4. Oversight of the nursing assistant registry and nursing assistant training programs.

Purpose of the Ongoing L & C Quality Improvement Plan:

To ensure that activities carried out by L&C staff are performed accurately and consistently over time and by all staff in accordance with established state and federal requirements to protect resident health, well-being, safety and comfort; to identify areas for improvement in performance and in systems; and to make those improvements.

The 2005 Quality Improvement Plan includes 3 focus area goals:

1. Improving consistency and accuracy across survey teams.

2. Improving communication and an understanding of the survey process.

3. Collaborating on stakeholder quality improvement projects.

Goal 1: Improving consistency and accuracy across survey teams.
Data/ measurement: The median number of tags issued per survey by team will vary no more than +/- 2 tags from the statewide median.

Objective 1A. Identify acceptable outcome measures of survey performance, analyze variations and develop methods to reduce variation through routine data collection and analysis.
Actions:

1.A.i. MDH research staff will collect and analyze deficiency data and produce monthly reports for L & C managers, supervisors, and division management. Supervisors will communicate results to surveyors.

1.A.ii. L & C supervisors and managers will review all tags and develop specific guidelines for surveyors for certain tags. Guidelines will be field tested before they are finalized.

1.A.iii. Supervisors will review average and median numbers of deficiencies by team monthly and will share this information with survey staff.

Objective 1.B: To identify and correct known, suspected or potential problems with the survey process and identify opportunities for further improvement.
Actions:

1.B.i. Supervisors will provide on-site mentoring, supervision and performance monitoring to surveyor teams. Supervisors will review all tags before deficiencies are finalized and issued.

1.B.ii. L & C Assistant Program Managers will review all tags at the level of actual harm and above, or substandard quality of care, before deficiencies are finalized and issued.

1.B.iii. Division will meet CMS 2005-2006 Performance Standards.

1.B.iv. Expand statewide survey staff to include other disciplines, including occupational therapy, physical therapy, and pharmacy. Capture observations and insights from statewide team members on survey process variances, communicate information back to supervisors to share with survey teams.

1.B.v. Continue use of “mix/max” teams for surveying and share results with supervisors and survey staff. (The “mix/max” teams are survey teams consisting of surveyors from two or more different teams.)

Objective 1.C: To ensure coordination and integration of all quality improvement activities and communication of findings to all pertinent MDH staff and external stakeholders.

Actions*:*

1.C.i. Surveyors will be informed of standards of care, CMS program changes and regulatory interpretation through quarterly all-staff video teleconferences, monthly statewide supervisor and management team meetings, monthly survey team meetings, and annual statewide staff inservice/staff meeting.

1.C.ii. Providers, provider associations, professional associations, and advocacy groups will be informed of CMS program changes and regulatory interpretations regarding the overall survey process through participation in joint training activities, and advance communications from MDH staff.

Goal 2: Improving communication with stakeholders and stakeholder understanding of the survey process.

Data/measurement: Solicit feedback from participants in Long Term Care Ad Hoc Committee and subcommittees, providers and other stakeholders.

Objective 2.A.: Ensure two-way flow of information between MDH staff, providers, and external stakeholders and build trust to enhance working relationships.

Actions:

2.A.i. MDH L & C management and staff will continue to participate in Long Term Care Ad Hoc Committee with representatives from providers, provider organizations, advocacy organizations, provider employees, and the quality improvement organization.

2.A.ii. MDH L & C management and staff will continue to meet regularly with provider associations, MNDONA, Stratis Health, and resident advocates.

2.A.iii. MDH L & C management and staff will participate in Duluth pilot district stakeholder group.

2.A.iv. MDH L & C management and staff will participate in quarterly statewide video conference.

2.A.v. MDH L & C management and supervisors will participate in weekly telephone conferences.

2.A.vi. Supervisors will provide ongoing information to surveyors in monthly survey team meetings.

2.A.vii. Include stakeholder input in supervisor and manager 360 degree

Assessment for Leadership Development process as appropriate**.**

Goal 3: MDH will collaborate on stakeholder quality improvement projects.
Objective 3.A.: To promote and participate in joint stakeholder groups and training to improve outcomes and quality of life for patients/residents/clients and ensure conformance to standards.

Data/measurement: (a) Identify key indicators that are tracked; stakeholder group to monitor and evaluate resident/client outcomes for quality improvement in those indicators using defined measures.
(b) Monitor rates of deficiencies relating to areas covered in compliance training.

Actions:

3.A.i. MDH L & C management and staff will work with stakeholder representatives to jointly plan surveyor and stakeholder training sessions around common clinical areas that meet needs of users.

3.A.ii. MDH L & C management and staff will work with stakeholder representatives to jointly plan and MDH staff will prepare and make available technical assistance around common clinical areas and regulatory change topics.

3.A.iii. MDH L & C management and staff will work with stakeholder representatives to develop relevant, defined outcomes measures for monitoring and evaluating effectiveness of training sessions and outreach/technical assistance.

3.A.iv. MDH L & C management and staff will participate in culture change process led by CMS and Stratis Health.

3.A.v. MDH staff will provide life safety code training for providers.

QI Plan Development: The 2005 Quality Improvement Plan is based on priorities identified in the following reports: Communications for Survey Improvement (CSI-MN) Report, Management Analysis Division, 6/30/04; MDH Survey Findings/Review Subcommittee Final Report, 7/04; Office of the Legislative Auditor Evaluation Report, Nursing Home Inspections, 2/05; Annual Quality Improvement Report on the Nursing Home Survey Process, 12/15/04; and based on the work of the Long Term Care Issues Ad Hoc Committee, the L & C Supervisors Group, and MDH Survey Team meetings.
QI Plan Results: Results of the 2005 Quality Improvement Plan for Survey Process will be communicated in the Annual Quality Improvement Report to the Legislature due in December 2005.

Updated August 26, 2005
http://www.health.state.mn.us/divs/fpc/profinfo/qualitypolicy.pdf

APPENDIX K

Communications for Survey Improvement - Duluth

A regional stakeholders group has been developed in the Northeast district of Minnesota. The regional group was established by the Commissioner of Health, Dianne Mandernach, to identify ways to minimize tensions created by the survey process and the regulatory relationship, and to implement actions designed to:

- establish productive and respectful relationships among regulated facilities, residents and their families, and the department;
- better involve family members and staff in the survey process; and
- clarify roles and responsibilities of MDH and provider staff in putting the group's recommendations into action.

This group began to meet in January 2005, on a monthly basis. Since that first meeting, there has been a lot of work done toward the group charge. The current areas of focus have been related to communication and education. In order to facilitate communication about what the group has been working on and the progress being made, this Web site has been created. This site will contain meeting minutes, a roster of stakeholder members and their contact information, and information related to the progress of the two subcommittees on communication and education. This Web site will be updated following each meeting as the information becomes available.

http://www.health.state.mn.us/ltc/csiduluth/index.html

Communication for Survey Improvement (CSI) Duluth Contact Information

Name of Contact	Telephone/Email	Address
Andrew Selvo Family Representative	(218) 263-3442 or ajselvo@aol.com	426 Mesabi Drive Hibbing, MN 55746
Brenda Marshall Director of Nursing	(218) 625-8408 or brendamarshall@ecumen.org	Lakeshore 4002 London Road Duluth, MN 55804
Brian Carlson President/CEO	(218) 834-7345 or bcarlson@slhduluth.com	Lake View Memorial Hospital and Home 325 11th Avenue Two Harbors, MN 55616

Chris Campbell HFE Unit Supervisor	(218) 723-4637 or Christine.Campbell@state.mn.us	Minnesota Dept. of Health Division of Compliance Monitoring 320 West Second Street, Suite 703 Duluth, MN 55802
Cindy Green Director of Nursing	(218) 748-7810 or cindy.green@bhshealth.org	St. Michael's Health and Rehab Center 1201 8th Street South Virginia, MN 55792
Darcy Miner Assistant Division Director	(651) 282-6363 or darcy.miner@health.state.mn.us	Minnesota Dept. of Health Division of Compliance Monitoring Golden Rule 85 East Seventh Place St. Paul, MN 55101
David Giese Division Director	(651) 282-5611 or David.Giese@health.state.mn.us	Minnesota Dept. of Health Division of Compliance Monitoring Golden Rule 85 East Seventh Place St. Paul, MN 55101
Deb Doughty Administrator	218) 258-8742 or Doughty612@hotmail.com	Cornerstone Villa 1000 Forest Street Buhl, MN 55713
Diane Pearson Administrator	(218) 387-3260 or dpearson@sisunet.org	Cook County North Shore Hospital 515 5th Avenue West Grand Marais, MN 55604
Diane Strongitharm Director of Nursing	(218) 628-2341 or Diane.strongitharm@bhshealth.org	St. Eligius 7700 Grand Avenue Duluth, MN 55807
Gayle Wallin Surveyor	(218) 723-4656 or Gayle.Wallin@state.mn.us	Minnesota Dept. of Health Division of Compliance Monitoring 320 West Second Street, Suite 703 Duluth, MN 55802
AARP Representative (Pending)		
Jeri Cummins Surveyor	(218) 723-4831 or Jeri.Cummins@state.mn.us	Minnesota Dept. of Health Division of Compliance Monitoring 320 West Second Street, Suite 703 Duluth, MN 55802
Kristin Larsen	(218) 724-8423 or	124 E. Arrowhead Road

Family Representative	Larse026@umn.edu	Duluth, MN 55803
Larry Penk Administrator	(218) 384-8411 or lcpenk@infionline.net	Inter-Faith Care Center 811 Third Street Carlton, MN 55718
Michelle Fisk Nursing Assistant Registered	(651) 583-2229 or tawandafisk@yahoo.com	The Margaret Parmley Residence 28210 Ole Towne Road Chisago City, MN 55013
Nikki Boder Director of Nursing	(218) 485-5569 or nboder@sisunet.org	Mercy Hospital and Health Care Center 710 South Kenwood Avenue Moose Lake, MN 55767
Stephanie Williams Nursing Assistant Registered	(320) 532-7917 or stephaniew@millelacshealth.com	Mille Lacs Health System c/o Rita Iverson 200 N. Elm Street Onamia, MN 56369
Virda Hall Ombudsman	(218) 729-1303 or Virda.hall@state.mn.us	P. O. Box 117 Duluth, MN 56504

http://www.health.state.mn.us/ltc/csiduluth/contactinfo.html

CSI Duluth DON Observational Survey Experience Communication Points DRAFT

- The DON Observational Survey Experience processes have been completed.
- The DON Observational Survey Experience processes have been very beneficial. We needed to finish this process in order to have a broad base of information to share without the ability risk of to identifying a specific facility. At the conclusion of all four processes, we will pull together a more comprehensive report. Information presented will be general in nature and not facility specific.
- If the facility is in the "survey window" and the survey team is due to come into the facility, be prepared.
- Have the current State Operations Manual (SOM) and regulations available in the facility and educate staff on where it is and how to use it.
- The survey team asks a lot of questions because they are trying to tie multiple pieces of information together. It's important the survey team explain to facility staff why they are repeating or rephrasing questions they may have already asked.
- Issues at a facility are identified through the survey process, regardless of who is on the survey. Issues are brought to the team by individual surveyors and the team makes the determination if a deficiency should be issued.
- Immediate jeopardies are determined by the entire team – everyone has a voice in making the determination based on a review of Appendix Q. If the team decides it is potentially an IJ, the unit supervisor is called, and eventually the St. Paul office is called. It is not an individual's decision.
- During team meetings, including decision-making, there is a lot of team discussion and healthy debate on issues.
- During tag review, the team discusses concerns to ensure that decisions are consistent with previous deficiencies cited and any updates received.
- If something wasn't identified to the facility as an issue during previous surveys, that doesn't mean it wasn't a deficient practice. The team may not have been led to do an investigation in previous surveys, but was led to investigate the concern in the current survey.
- If there are concerns about the survey team, the concerns need to be brought forward to the team leader or supervisor. For best resolution, it helps to have specifics about the concerns.
- Minnesota Department of Health supervisors are on site to evaluate the team and work with the team, not necessarily because there are problems with the facility. It is part of the MDH quality assurance and quality improvement work.
- Communication is a two way street.
- It continues to be crucial to identify and develop improved communication and educational opportunities. Through this process, we have identified areas in which all stakeholders could benefit.
- Network. Use the provider organizations, peers, consultants, etc. available to you. Talk and share information, ask questions. As questions arrive, talk with the MDH unit supervisor.
- The need for shared practices continues to be recognized for all stakeholders. A mechanism needs to be identified, developed, and implemented to share those practices. http://www.health.state.mn.us/ltc/csiduluth/donsurvey.html

CSI Duluth Educational Update

Multiple training sessions related to the DON Observational Survey experience were presented in October and November, 2005. These training sessions were modified to meet the needs of each audience.

Northeast Regional Training Sessions:

November 1, 2005, 12:30 – 16:30, Proctor.
November 2, 2005, 12:30 – 16:30, Eveleth.

Brian Carlson and Christine Campbell, co-chairs	Introduction/Welcome
David Giese and Darcy Miner	History/Background
Four DON's and 3 MDH surveyors	Education/Training Points
Additional CSI-Duluth members	Additional Background
David Giese, Darcy Miner, all presenters	Question & Answer

Condensed sessions for statewide audiences:

MNDONA Annual Meeting: October 13, 2005 at 08:30 and repeated at 11:15. Brainerd area, 1.25 hours in length.

Surveyor Statewide Staff Meeting: October 26, 2005 at 10:00. Bloomington, 2 hours in length.

Care Providers Convention: November 16, 2005 at 08:30, Minneapolis, 1.25 hours in length.

APPENDIX L

Minnesota Department of Health

May 2005

Information Bulletin 05-02
BC-28
NH-110

CMS Survey & Certification Letter S&C 05-17

Pressure Ulcers, Non-Pressure Ulcers & Regulatory Text Changes in CMS Transmittals 4 & 5

Implementation Date: May 31, 2005

Purpose:

The purpose of this information bulletin is to inform providers that Minnesota Department of Health surveyors and investigators effective May 31, 2005 will implement Survey Guidelines and Regulatory Changes related to Pressure Ulcers, Non-Pressure Ulcers & other Regulatory Text found in CMS Transmittals 4 & 5 and CMS Survey and Certification Letter 05-17.

Background:

The Center for Medicare and Medicaid Services issued revised Long Term Care Surveyor Guidelines for Pressure Ulcers and Non-Pressure ulcers and other regulatory text changes in November of 2004 in Transmittals 4 & 5.

CMS Survey and Certification Letter 05-17 explains in greater detail the background and context of these changes.

In summary: These changes are related to an ongoing CMS project to issue guidance that contains, in addition to interpretive guidelines, an investigative protocol and specific severity guidance for determining the correct level of severity of outcome to residents from deficiencies issued at F 314, Pressure Ulcers. As part of the F314 revision, a minor addition was made to interpretive guidelines at F309.

A second change was made to the SOM, Appendix PP in Transmittal 5 that corrected typographical errors, moved certain regulatory text, changed certain regulatory language due to 2003 changes in regulations and modified Appendix P consistent with new investigative protocol at F314 in Appendix PP.

These guidelines can be accessed via Survey & Certification Letter 05-17 and Transmittals 4 and 5 at the websites below:

http://www.cms.hhs.gov/medicaid/survey-cert/sc0517.pdf
http://www.cms.hhs.gov/manuals/pm_trans/R4SOM.pf
http://www.cms.hhs.gov/manuals/pm_trans/R5SOM.pdf

The content of the transmittals are also updated by CMS on the web version of the State Operations Manual (SOM) and may be accessed in Appendix P and PP of the SOM at the website below. At the time of issuance of this MDH Information Bulletin, CMS had not yet updated their website:

http://www.cms.hhs.gov/manuals/107_som/som107_appendixtoc.asp

Ongoing resources related to pressure ulcers can be found at the websites below:

http://www.stratishealth.org/health-care/nursing-home.html
http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html
http://www.ahrq.gov
http://www.amda.org
http://www.medqic.org
www.healthinaging.org
http://www.wocn.org
http://www.npuap.org

If you have any questions regarding this Information Bulletin, please contact in writing:

Minnesota Department of Health
Division of Compliance Monitoring
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 215-8701

This document can be made available in alternative formats upon request. Call (651) 215-8701 or contact The Direct Connect MN Relay Service (MRS): (651) 297-5353 or (800) 627-3529.

http://www.health.state.mn.us/divs/fpc/profinfo/ib05_2.html

APPENDIX M

Minnesota Department of Health

September 2005

Information Bulletin 05-5
BC-29
NH-111

Urinary Incontinence and Catheters: Federal and State Requirements. Revision of Appendix PP, State Operations Manual (SOP), Surveyor Guidance for Incontinence and Catheters: Implementation Date: November 7, 2005

Purpose:

This bulletin replaces MDH Bulletin 01-12 Urinary Incontinence.

The purpose of this information bulletin is to inform providers that Minnesota Department of Health surveyors and investigators effective November 7, 2005 will implement Survey Guidelines and Regulatory Changes related to Urinary Incontinence (UI) and Catheters (F315) Regulatory Text found in CMS Transmittal 8 and CMS Survey and Certification Letter 05-23.

MDH is consolidating duplicative and out of date information related to this clinical area into this information bulletin. Clinical information about urinary incontinence previously available in MDH Information 01-12 can be accessed in the revised federal guidelines.

Related Minnesota state laws/rules still in effect are included in this bulletin related to UI.

Background Federal Changes:

The Center for Medicare and Medicaid Services issued revised Long Term Care Surveyor Guidelines for Incontinence and Catheters and other regulatory text changes in June of 2005 in Transmittal 8. The CMS Survey and Certification Letter 05-23 explains in greater detail the background and context of these changes.

In summary: These changes are part of an ongoing CMS project to issue guidance relating to the expanded clinical interpretive guidelines, surveyor investigative protocols and specific severity guidance for determining the correct level of severity of outcome to residents from deficiencies issued at tag F 315, Urinary Incontinence and Catheters. These revised guidelines include examples of deficient practices. The CMS revision includes the combining of tags F315 and F316 into one tag i.e.F315. Tag F316 has been deleted. The regulatory texts for both tags are combined, followed by this revised guidance.

These guidelines can be accessed via CMS Survey &Certification Letter 05-23 and CMS Transmittal 8 at the websites below:

http://www.cms.hhs.gov/medicaid/survey-cert/sc0523.pdf
http://www.cms.hhs.gov/manuals/pm_trans/R8SOM.pdf

The content of the transmittals are also updated by CMS on the web version of the State Operations Manual (SOM) and may be accessed in Appendix P and PP of the SOM at the website below:

http://www.cms.hhs.gov/manuals/107_som/som107_appendixtoc.asp

Excerpts from Current Minnesota Requirements

Minnesota Nursing Home Licensure regulations may be accessed at:
http://www.revisor.leg.state.mn.us/arule/4658

Adequate and Proper Nursing Care

For ease in better understanding the current requirements, presented below is the rule language currently in effect. Rule language that is not in effect based on current Minnesota law has not been included.

Minnesota Rule 4658.0520 Adequate and Proper Nursing Care states in part:

Subpart 1. **Care in general.** A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed.

Subpart 2. **Criteria for determining adequate and proper care.** The criteria for determining adequate and proper care include:

A. Evidence of adequate care and kind and considerate treatment at all times. Privacy must be respected and safeguarded.
B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated.

Minnesota (MN) Session Laws 2003:

Section 144A.04 is amended.

Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.

This section is effective July 1, 2003.

Minnesota Rule 4658.0520 further states:

An incontinent resident must receive perineal care following each episode of incontinence. Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with

the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.

Rehabilitation Nursing Care

Minnesota Rule 4658.0525 Rehabilitation Nursing Care states in part:

Subpart 5. **Incontinence.** A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that:

A. A resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and
B. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

Educational Resources:

- The American Medical Directors Association (AMDA) at www.amda.com
- The Quality Improvement Organizations, Medicare Quality Improvement Community Initiatives at www.medqic.org
- CMS Sharing Innovations in Quality website at http://www.cms.hhs.gov/medicaid/survey-cert/siqhome.asp
- Association for Professionals in Infection Control and Epidemiology (APIC) www.apic.org
- Centers for Disease Control www.cdc.gov
- Annals of LTC publications www.mmhc.com
- American Foundation for Urologic Disease, Inc. www.afud.org
- American Geriatrics Society www.americangeriatrics.org

References of non-MDH sources or sites on the internet are provided as a service and do not constitute or imply endorsement of these organizations or their programs by MDH. MDH is not responsible for the content of pages found at these sites.

If you have any questions regarding this Information Bulletin, please contact in writing:

Minnesota Department of Health
Compliance Monitoring Division
Licensing and Certification Program
85 East Seventh Place, Suite 300
PO Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 215-8701.

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CM/10.20.2005

http://www.health.state.mn.us/divs/fpc/profinfo/ib05_5.html