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Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature

Minnesota Department of Health

Federal Fiscal Year 2010
Released September 2011

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As requested by Minnesota Statute 3.197: This report cost approximately $4,255 to prepare, including staff time, printing and mailing expenses.

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Executive Summary

Minnesota Statutes, section 144A.10, subdivision 17 requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report with an analysis of several items. MDH is also to identify inconsistencies, patterns, and areas for quality improvement in the report.

Since the law was enacted in 2004, many changes have been enacted in the survey process itself, as well as quality improvement items. Among those is the implementation of the Quality Indicator Survey (QIS) process, a new federal survey process for nursing homes. As of March 2010 all survey staff was trained in QIS and all annual surveys were being conducted using this new process. With the implementation of QIS, the release of new and revised federal guidance, as well as other quality improvement initiatives, MDH has seen a decrease in the average number of health tag deficiencies issued over the past three consecutive years.

For Life Safety Code (LSC) Surveys, MDH contracts with the State Fire Marshal's Office. Minnesota has been issuing the fewest number of LSC deficiencies in the Centers for Medicare and Medicaid Services (CMS) Region V for the past several years. However, Minnesota has also received several disparate tags when CMS conducts its federal monitoring survey. MDH is working closely with the State Fire Marshal's Office to make sure that they are issuing deficiencies as warranted.

Providers who disagree with deficiencies issued can challenge them through one of two of Minnesota's informal dispute resolution processes; Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR). Data over the last few years has shown that approximately 20% of the tags disputed are changed through these two processes and it can be quite costly for providers who often times have legal counsel present. With the passage of the federal Patient Protection and Affordable Care Act, MDH will be examining its IDR and IIDR processes to determine if the current state processes are sufficient or if they need to be modified in order to comply with the new federal health reform law.

The Minnesota law also requires the Department to identify areas for quality improvement or special focus. Below is a summary of the progress made on special focus areas for FFY10.

- Continue Statewide Implementation of the Quality Indicator Survey Process -- As of March 2010 all survey staff were trained and all annual surveys were conducted using QIS. MDH shifted its focus from training and implementation of QIS, to examining the data that the various QIS reports generate.

- Implementation of Minimum Data Set (MDS) 3.0 -- Federal regulations require all certified nursing and boarding care homes to use a standardized assessment instrument when completing comprehensive assessments of residents' needs. This instrument, MDS 2.0, was replaced by MDS 3.0 in October of 2010. MDH's Licensing and Certification (L&C) Program worked with providers, Department of Human Services (DHS) and Case

Mix Review Program in order to provide as seamless a transition to MDS 3.0 as possible. Training was offered to providers, surveyors and Case Mix staff using a multi-modal approach including the use of WebEx presentations, face to face training sessions, conference calls, website with links to educational materials and resources, and clinical and technical assistance phone lines. The department received many kudos for the training and educational materials made available to the providers. MDS 3.0 is now being utilized by all Medicare/Medicaid facilities in the state.

- Additional Provider and Surveyor Training -- Besides the QIS, MDS 3.0, and the usual implementation of revised federal guideline training to providers and survey staff, MDH also provided training on Care Assessments under MDS 3.0, Root Cause Analysis, and Self-Reported Incidents. These were areas identified as complex and needing additional instruction to help providers with compliance.

- Greater Coordination with Public and Private Sector Organizations and Programs on Emergency Preparedness Planning and Response -- MDH developed a web-based survey tool to collect information from long-term care providers about available beds and resources. When there is an emergency event, and residents need to be relocated, information is shared with the evacuating facility which is responsible for contacting an alternative facility and making arrangements for their residents/patients.

  The Department also purchased a number of "fit" testing kits that regional healthcare emergency preparedness coordinators could use to provide train-the-trainer sessions to nursing home staff on how to do fit-testing for N95 masks. This will help to assure that there is staff in the nursing homes capable of fitting N95masks in the event they need to be used.

In addition to these quality initiatives, the Department also completed its evaluation of the revised Nursing Home Post Certification Revisit (PCR) Process that was implemented in November of 2006. MDH revised its PCR process as a means of looking at ways to expand its compliance verification within a constrained budget. After three years of collecting and analyzing data to determine the effectiveness of the revised process, the Department has concluded that the revised process, which allows random, non-mandatory, revisits to be completed offsite via an administrative paper review process, is just as effective in achieving compliance as conducting an onsite revisit. Therefore the Department will continue using its revised PCR process going forward.

In FFY 2011 the Department intends to focus its attention on the following quality improvement areas:

- Implementation of the New Federal Software for QIS -- CMS recently upgraded its federal software, Aspen Survey Explorer, to include QIS. Survey staff will need to learn how to use this new software and understand the data and reports generated from it.

- Training Surveyors on the Use of Data and Information Generated from the Federal Quality Indicator Survey (QIS) Reports -- There are several reports that provide useful

data to survey staff under the new QIS process. Survey staff will be focusing on learning how to interpret the data generated from these reports and use the data to its fullest extent (e.g. identify variations and areas for quality improvement).

- Developing and Implementing a Falls Prevention Program -- Falls in nursing homes are a major concern, and preventing them is a big focus for many facilities. Licensing and Certification staff will collaborate with other partners to adapt successful programming that has been done in community settings (assisted living, senior centers, single family dwellings, etc.) in falls prevention, exercise, chronic disease self-management and nutrition, to long-term care settings. The goal of the project is to develop, train and assist long-term care (LTC) staff and volunteers to use the programs in their facility to prevent falls using a comprehensive approach that includes screening for falls risk for individuals and facilities and the addition of programs to decrease individual risk.

- Collaborating More with the Office of Health Facility Complaints -- For the past two years, CMS has had an increased focus on complaint investigations. MDH's Licensing and Certification Program and the Office of Health Facility Complaints (OHFC) will be examining their investigative practices to identify and resolve any inconsistencies between the two programs. L&C and OHFC will also explore opportunities to provide more joint training to providers and surveyors on topics relevant to both programs.

- Planning for the Future of Long-term Care -- With a rapidly increasing number of people over 65 years of age who prefer to receive health care services in the home or in a community based setting, and changes occurring at the federal and state level around payment for Medicare and Medicaid services, MDH will be monitoring these changes closely and having ongoing discussions with the Minnesota Department of Human Services and other stakeholders regarding how these changes will affect nursing homes, assisted living, home care and the other long term care providers and services it regulates. MDH has already participated in numerous discussions related to this issue in 2010, and anticipates that there will be even more changes and ongoing discussions as they continue to prepare for the future.

More information on these and other quality improvement initiatives are described further in the report.

The Department is proud of the progress it has made in improving relationships with its providers and in assuring a quality survey program since the establishment of the law which required this report. MDH looks forward to making even more improvements in the coming year.

Introduction

Minnesota Statutes, section 144A.10, subdivision 17 (2004) requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report with an analysis of several items including:

(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.

MDH is also to identify inconsistencies, patterns, and areas for quality improvement in the report.

This report is the seventh annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year 2010 (FFY10), which ran from October 1, 2009 through September 30, 2010.

The report is organized into three parts. Part I provides the data and other information required to be included in the annual report. Part II includes a summary of some of the quality improvement activities conducted in FFY10. Part III identifies areas that MDH plans to focus on in the future.

Oversight of Nursing Home Inspection Process

The Nursing Home Reform Act (NHRA) of 1987 was designed to ensure that nursing home residents are provided quality of care. To monitor whether nursing homes meet the NHRA requirements this law (42 CFR Part 483, Subpart B) established a certification process for nursing homes accepting payment from Medicare or Medicaid residents. State survey agencies, under contract with the Center for Medicare and Medicaid Services (CMS), are required to conduct unannounced on-site surveys at least once every 15 months and conduct complaint investigations in response to allegations of quality problems. The nursing home survey process provides oversight regarding a nursing home’s delivery of resident care. The survey process holds the nursing home accountable for maintaining an environment that promotes quality care; providing services to attain or maintain the highest practicable physical, mental and psychosocial well-being; and, protecting and promoting the rights of each resident.

Survey Deficiency Citations[1]

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 is then required to correct the practice to come into compliance with regulatory requirements. A written Plan of Correction (PoC) may be required and state surveyors may conduct a revisit survey to ensure that the homes implemented their plans and made the corrections.

The Statement of Deficiencies, which includes all findings of noncompliance, is written on Federal Form Number CMS 2567 (2567). The 2567 statement identifies each area of noncompliance by referencing a specific deficiency ("tag") number. Health tags have the prefix F (e.g., F-309). The tag numbers are contained in the nursing home regulations issued by CMS. The 2567 restates the regulatory language and specifies the survey findings that support the facility not being in compliance. 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 Matrix is attached as Appendix A. The grid identifies 12 levels of deficiencies, labeled A through L, based on a combination of scope and severity scores for a deficient practice.

Variability and Inconsistency in the Survey Process and CMS' Development of the Quality Indicator Survey Process

Variability and inconsistency in the nursing home survey process has been a long-standing concern for policy makers, providers, consumers and nursing home resident advocacy groups. CMS has been reviewing this issue, funding studies, and issuing revised guidance on problematic deficiency tags for the past several years.

In 2005 CMS piloted a new nursing home survey process called the Quality Indicator Survey (QIS). QIS uses new technology to improve the accuracy, consistency and efficiency of the survey process. QIS originally started out as a pilot project with five states. In 2007 Minnesota was chosen by CMS to be the first state to implement QIS statewide beyond the demonstration states. Currently only seven states in the nation, including Minnesota, have completed their training of all survey staff. Fourteen states are in the process, and CMS expects to have training of all surveyors nationwide completed by 2018. Minnesota's training was completed in March of 2010; all annual surveys in Minnesota from that date forward were being conducted using the QIS survey process.

For more information about the nursing home inspection process, deficiency citations, and QIS process please see Appendix B and C for links to various federal and state resources.

[1] 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.

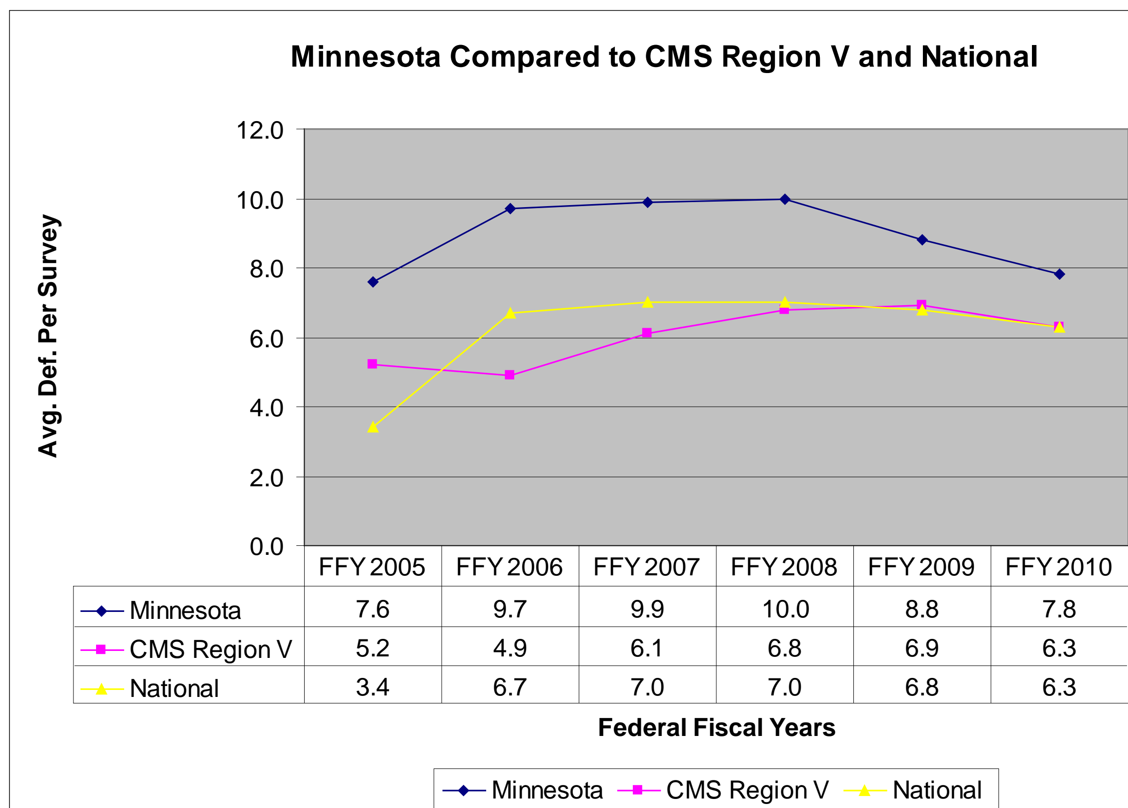
I. Report Data and Information Requirements

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

Health Deficiency Citations Issued in FFY10

For FFY10, Minnesota issued an average of 7.8 deficiencies per survey. This is down from last year's average of 8.8. This is the third consecutive year that Minnesota has shown a decrease in number of deficiencies issued per survey, from 10.0 in FFY08, to 8.8 in FFY09 to 7.8 in FFY10. The implementation of QIS as well as CMS' issuance of revised guidance on specific deficiency tags may have played a role in the decrease of average number of deficiencies issued.
While Minnesota's average number of deficiencies continues to decrease, Minnesota still issues the most deficiencies in CMS Region V (Appendix D, Table 1). The average number of deficiencies in these states range from a high of 7.8 in Minnesota to a low of 5.3 in Ohio. Minnesota and Ohio are the only states within CMS Region V that have completed QIS training. Nationally, the average number of deficiencies per health survey for FFY10 was 6.3, and Minnesota ranked 18 in the nation (Appendix D, Table 3). Graph I, A-1 below shows the average number of deficiencies per health survey for Minnesota, CMS Region V, and nationally, from FFY05-FFY10.

Graph 1, A-1: Minnesota Compared to CMS Region V and National in Average Number of Deficiencies



	FFY 2005	FFY 2006	FFY 2007	FFY 2008	FFY 2009	FFY 2010
Minnesota	7.6	9.7	9.9	10.0	8.8	7.8
CMS Region V	5.2	4.9	6.1	6.8	6.9	6.3
National	3.4	6.7	7.0	7.0	6.8	6.3

Source: Federal Casper Data System

Regarding scope and severity of the deficiencies issued, Minnesota continues to issue most deficiencies in the D scope and severity category, with 2,186 out of the 3,020 or 72% of the deficiencies issued in FFY10 in this category. Issuing the majority of deficiencies in the D scope and severity level is consistent with other states in CMS Region V and has been the trend for several years now.

In last year's Legislative Report, MDH indicated that it would be able to once again identify citations by region within the state now that all teams are using the QIS process. However, it has only been since March of 2010 that all surveys were being conducted using this new federal survey process. Data for FFY10 is a mixture of both the traditional and the QIS survey process and MDH does not identify the data by teams. In next year's report, MDH will report the data by "teams" to the best of its ability, beginning with FFY11. However, the Department anticipates that there will be many more surveys falling into the mix-max category, in which only two surveyors are from the "home" team, and the additional surveyors are from one or more teams. The use of mix-max surveys has proven to be an effective quality assurance tool.

Life Safety Code Deficiency Citations Issued in FFY10

MDH contracts the responsibility of conducting Life Safety Code (LSC) surveys to the Department of Public Safety's State Fire Marshal (SFM) Division. LSC deficiencies are designated as "K" tags (e.g. K-76).

The average number of deficiencies per LSC survey nationally during FFY10 was 3.9 and the average in Minnesota was 2.2; Minnesota ranked 35th in the nation. A table of national average number of LSC deficiencies per survey is attached as Appendix D, Table 4.

Within CMS Region V, the average number of deficiencies per LSC survey was 4.8 (Appendix D, Table 2). Minnesota has issued the fewest number of LSC deficiencies in the region for the past several years. However, Minnesota has also received several disparate tags when CMS conducts its federal monitoring survey. MDH has found that survey time can vary as some LSC surveyors are able to survey the facility very quickly, either because of their own skill level, because they have been surveying that facility for a number of years, or other reasons. MDH is committed to addressing those disparate tags in which it agrees with the federal government that the State Fire Marshal's Office should have found the deficient practice.

Survey Complaint Data and Information

The law also requires the Department to submit an annual report on survey complaints. The Department has issued five reports on complaint activity which can be found at http://www.health.state.mn.us/divs/fpc/legislativerpts.html. However, since Minnesota Statutes, section 626.557, subdivision 12b, (Vulnerable Adults Act) also requires an annual report of the complaint process, MDH will be working with stakeholders to determine how to simplify the reporting of this data, because presenting the data in two separate reports may not provide the most comprehensive look at the quality of care in Minnesota's long-term care facilities.

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

Cross Referencing, or the issuance of independent but associated deficiency citations (outcome and process tags), is another item that was originally included in the list of data that is to be included in the annual report. In 2005 CMS directed states to issue independent but associated deficiency citations. Since the statewide implementation of QIS, it has become nearly impossible for the Department to identify cross referencing, other than that specifically directed and incorporated in the QIS process. After QIS has been implemented nationwide, MDH will monitor deficiencies to see if the variation in number of deficiencies and certain tags issued between states decreases and whether continued monitoring of "cross referencing rates" is still necessary.

C. Number and Outcomes of Informal Dispute Resolutions

In Minnesota, there are two options that are available to a facility that disagrees with deficiencies issued by MDH:

1) Informal Dispute Resolution (IDR) -- performed by an MDH supervisor who has not previously been involved in the survey.

2) Independent Informal Dispute Resolution (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.

Approximately 20% or fewer of the deficiencies issued are changed through these two dispute resolution processes (Appendix E). MDH has started seeing more IDRs and fewer IIDRs, perhaps because of IIDR costs which generally involves the use of legal counsel for facilities. Additionally, the federal health reform initiatives (Patient Protection and Affordable Care Act) require IIDR as an option. MDH's IIDR process is a state mandate. The Department hopes to be able to modify its current IIDR process slightly, if needed, so that it only provides one IIDR process to comply with both state and federal law.

Related to the IIDR process is the Freedom of Information Act (FOIA) issue. Much of the information and many of the documents routinely used in the IIDR process requires submission of a Freedom of Information Act (FOIA) request to CMS in order for MDH to release private data that is obtained while conducting a federal survey. There have been a number of FOIA requests by nursing homes that have delayed scheduling IIDRs while MDH awaits CMS responses to those requests. MDH has raised this issue with CMS, but many of the Department's requests for release of data are still awaiting action by CMS. MDH will continue to pursue this issue with CMS in an effort to clarify and simplify the process for obtaining private data from survey records.

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. According to CMS, they received no appeals at the federal level from nursing homes in Minnesota during FFY10.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations When Federal Category 2 and 3 Remedies are in Place

If a survey team finds deficiencies at a B through L level, the nursing facility is required to submit a plan of correction (PoC) to MDH, and facilities may have federal category 2 and 3 remedies imposed by CMS. If necessary, a post certification revisit (PCR) is conducted to determine whether the deficiency has been corrected. Minnesota Statutes, Section 144A.101, subdivision 5, requires the Commissioner to conduct revisits within 15-calendar days of the date by which corrections will be completed, in cases where federal 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. B and C level deficiencies do not require revisits.

For facilities surveyed during FFY10, there were 47 facilities with surveys where CMS imposed and put in place federal category 2 or 3 remedies. These category 2 and 3 remedies were Mandatory Denial of Payment for New Admissions (MDPNA) and Civil Money Penalty (CMP) remedies.

The federal enforcement process allows MDH to recommend to CMS category 2 and 3 remedies; MDH does not have the authority to impose federal category 2 and 3 remedies. CMS imposes all federal category 2 and 3 remedies.

MDH conducted 110 revisits at 47 facilities and of these 47 had MDPNA imposed and 43 had CMPs imposed by CMS. All of these revisits (100%) were conducted before MDPNA and CMPs were in place, which was within the 15 calendar day requirement.

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

MDH uses a variety of techniques for training and evaluating their surveyors to assure that they are issuing deficiencies accurately and consistently. These include, but are not limited to the following:

- New employee training on survey process and regulations. Within 6 months of a new surveyor's probationary period, the new surveyor must be able to demonstrate the ability to survey a facility using the QIS investigative techniques and computerized software tools.
- Supervisors and Assistant Program Managers going onsite with staff to review survey technique, especially as it relates to investigations.

- Quarterly video conferences with all staff to discuss progress and issues with the implementation of QIS and new/revised federal guidelines.
- Annual all staff (L&C and OHFC) training in October of 2010 on MDS 3.0; managing residents on dialysis and hospice; overview of HealthCare Homes; and, understanding the roles of the ombudsmen for long-term care, mental health and developmental disabilities.

Information on other surveyor techniques and quality improvement activities can be found in MDH's Licensing and Certification Section's 2010-11 Quality Improvement Plan (Appendix F), as well as in previous Legislative Reports which are available at: http://www.health.state.mn.us/divs/fpc/legislativerpts.html. In addition to these techniques, the QIS data from CMS' Central and Regional Office help to assure accuracy and consistency of the survey process. These reports are discussed in Section II of this report.

Besides training staff, MDH continues to communicate and offer regular training opportunities to providers and other stakeholders. In FFY10 these opportunities included:

- Meetings with provider association representatives and stakeholders on a quarterly basis to discuss a variety of survey and LTC related issues.
- Training on revised federal guidelines; Root Cause Analysis; Reporting of Suspected Incidents of Vulnerable Adult Mistreatment; and Strategic Approaches for Improving the Care Delivery Process.
- Quarterly conference calls for providers and surveyors on implementation of the following: QIS, MDS 3.0, proper infection control procedures, paid feeding assistance regulations, etc.

These communications and trainings have helped to assure that providers understand and comply with state and federal requirements.

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 fifteen (15) working days of the exit conference.

Of the 390 surveys exited during FFY10, approximately 99% met the 15-day requirement for delivering final 2567 forms. Only two surveys exceeded the 15-day requirement. Both surveys had delays related to review time due to the complexity of deficiencies issued. Since MDH consistently meets this requirement, the reporting of this requirement may no longer be necessary in future Legislative Reports.

H. Other Survey Statistics Relevant to Improving the Survey Process

Government Performance and Results Act (GPRA) Goals

Since 2002, CMS has been establishing annual quality improvement goals or Government Performance Results Act (GPRA) goals for nursing facilities. In Calendar Year 2010 CMS set a target goal of achieving a nationwide pressure ulcer rate of 8.1% or below and a physical restraint rate of 3.8% or below. Data from CMS shows that Minnesota out-performed the national and regional target goals with 5.3% rate for pressure ulcers and 1.3% rate for physical restraints (data from CMS 3rd quarter CY2010). The two graphs in Appendix G shows Minnesota's progress in meeting these goals compared to CMS Region V and nationally. MDH will continue to monitor progress and work with its providers and stakeholders in achieving these goals during 2011.

Evaluation of Revised Nursing Home Post Certification Revisit Process

Since November of 2006 MDH has been working under a revised post-certification revisit (PCR) process. PCR follow-up surveys are conducted to assure providers have corrected deficiencies found during an annual survey. The Department revised its process while looking at ways to expand compliance verification within a constrained budget. The revised process allows MDH to accomplish survey revisit tasks offsite, and determine compliance by reviewing the plan of care, requesting additional information, discussing information via telephone, etc. without physically being onsite, except for those identified circumstances which are outlined in the revised PCR process in Appendix H.

The Department has been collecting data and monitoring this change since the policy went into effect. Appendix H includes data to evaluate the efficiency and effectiveness of the revised policy.

After three years of evaluating the revised PCR process the Department has concluded that the revised process which allows for offsite, non-mandatory, PCR reviews is effective in achieving compliance. This determination is based on the data that shows the following:

- correction patterns between onsite and offsite non-mandatory PCRs are not changing or getting worse;
- complaint substantiation patterns did not show a significant difference between providers selected for onsite, non-mandatory, PCRs and those selected for offsite, non-mandatory follow-up reviews; and,
- there were no significant difference in repeat deficiencies between these two PCR follow-up methods that would warrant changing the policy.

Therefore, the Department will continue to use the revised PCR policy going forward.

II. Areas of Special Focus in FFY10

A. Statewide Implementation of the Quality Indicator Survey (QIS) Process

As mentioned earlier in the report, QIS was fully implemented in Minnesota in March of 2010. All annual surveys from that time forward were conducted using the new federal survey process. Strengths of QIS include larger and more diverse resident sample size, more in-depth interviews and investigations, improved documentation and organization of survey findings through automation, and the ability of the state to focus limited survey resources on those nursing homes with the greatest quality of care concerns.

Feedback on QIS from Providers and Surveyors

The status of QIS implementation, including issues surrounding QIS and the sharing of deficiency data, was discussed at each statewide provider surveyor conference call that was held in February, April and June of FFY10. Additionally updates on QIS were given at each quarterly meeting of the Long-term Care Issues Committee as well as other meetings with provider associations. Through these meetings, MDH learned about some of the successes and challenges of implementing QIS.

Anecdotal information from providers continues to indicate that they have more confidence in QIS than the traditional survey process. While providers would like to know if QIS has accomplished what it was intended to do (e.g. improve accuracy and consistency in the survey process) they understand that more time to evaluate QIS is needed before MDH or CMS is able to answer that question.

From a surveyor's perspective, surveyors still prefer QIS over the traditional survey process. QIS has been very helpful in assuring that all survey tasks are completed in the right order and it provides greater quality of life reviews (e.g. resident interviews). The area where QIS appears to be weakest is in observations of residents and staff because of all the other tasks that need to be completed.

MDH will continue to seek feedback on QIS from providers, surveyors and other stakeholders and work to resolve issues that arise from the change in survey processes.

QIS Survey Deficiency Data

As mentioned in last year's Legislative Report, MDH has been tracking and reporting deficiencies issued under QIS and comparing them to those that were issued under the traditional process. For FFY10, 363 surveys out of 389 total surveys, or approximately 93% of surveys, were conducted using the QIS process. This is in comparison to last year's Legislative Report, where Minnesota was approximately 62% QIS implemented and in the FFY08 Report, only 25% QIS implemented. Since 93% of the surveys in FFY10 were conducted using the QIS process, there is no longer a need to compare deficiencies issued under QIS vs. the traditional system. Average number of deficiencies for FFY10 is discussed in Section 1 of this report.

In terms of the types of deficiency tags cited under QIS, Table II, A-1 lists the top10 deficiencies cited in FFY10.

Table II, A-1: Top 10 Deficiencies -- Traditional Survey Deficiencies Compared to QIS Survey Deficiencies, FFY10

QIS Process (362 Surveys w/Deficiencies)	Number Cited
F329 Unnecessary Medications	160
F371 Food Handling & Sanitation	159
F323 Accidents/Supervision	158
F272 Comprehensive Assessment	152
F309 Quality of Care	121
F282 Prov. Care According to Care Plan	119
F428 Drug Regimen Review	116
F279 Comprehensive Care Plan	110
F441 Infection Control	110
F280 Care Plan Revision	104

Source: Paradise Data System

Besides the Department's data, the University of Colorado, under contract with CMS, has been providing states implementing QIS with Desk Audit Reports (DAR-SA) for state agencies. These reports identify outliers and variances by areas and individual surveyors. Although MDH has received training from Nursing Home Quality on the interpretation and use of this data and MDH has done its best to analyze and share data reports with survey staff, MDH continues to find the data reports to be very difficult to read and time consuming to analyze and understand. MDH has expressed these concerns to CMS and Nursing Home Quality. In response to these concerns, and as part of the QIS evaluation process, CMS established a national QIS technical advisory work group. This work group, in which MDH is a participant, discusses the technical aspects of QIS and works on making improvements to the system, including making the reports more user-friendly.

The University of Colorado also provides CMS' regional offices with QIS data reports (DAR-RO) which are then shared with state agencies implementing QIS in specific CMS regions (e.g. CMS Region V for Minnesota). MDH has found the DAR-RO reports to be easier to understand and more user-friendly than the DAR-SA Reports. MDH analyzes these reports and shares the information with survey staff. The DAR-RO reports will be used by CMS Regional Office V during the federal onsite reviews of QIS (FOQIS) surveys. These surveys are due to begin in FFY11. MDH will continue to analyze data generated from the various QIS reports to identify survey process variations and opportunities for quality improvement during FFY11.

In addition to data from the University of Colorado, CMS has contracted with RTI and its subcontractor Long-term Care Institute to assess potential inconsistencies in the QIS process. This is being done as part of evaluating and refining the QIS process. The assessment involves several components including soliciting input from CMS' Technical Expert Panel or the people responsible for developing revised guidance for CMS, and from the QIS development/ implementation contractor and training contractor (Nursing Home Quality). The evaluation also includes performing onsite QIS nursing home survey observations, obtaining feedback from telephone interviews with state survey agencies using QIS, and observing QIS training. MDH

will share information and results from this evaluation with surveyors and providers as it becomes available.

B. Implementation of MDS 3.0

Federal regulations require all certified nursing and boarding care homes to use a standardized assessment instrument when completing comprehensive assessments of residents' needs. The same instrument, the Minimum Data Set (MDS), is used by the federal and state government for payment purposes and for quality indicators. The old version, MDS 2.0, was replaced by MDS 3.0 on October 1, 2010.

MDH's Licensing and Certification Program worked with providers, DHS, and its Case Mix Review Program in order to provide as seamless a transition to MDS 3.0 as possible.

The department's training was conducted via a multi-modal approach providing the necessary education for providers, surveyors, and Case Mix staff. The department received many kudos for the training and educational materials made available to the providers. The training included.

- Twenty-six (26) WebEx presentations that were archived and continue to be accessible online, free-of-charge, to interested parties.
- Eight (8) one day face-to-face training sessions throughout the state to follow-up the WebEx training.
- Multiple telephone conference calls to address questions submitted by providers.
- A website was developed and continues to be maintained with links to educational material, CMS manuals, etc. http://www.health.state.mn.us/divs/fpc/MinnesotaMDS3_0.html
- MDH responded to individual questions through a clinical phone line, a technical phone line, a case mix phone line, and via e-mail throughout the transition. MDH continues to provide this support.

MDS 3.0 is now being utilized by all Medicare/Medicaid facilities in the state and they transmit their data successfully to the federal database. Providers, with the assistance of MDH staff, have successfully negotiated the hurdles created by the voluminous and frequently-changing information disseminated by CMS during the transition; the new software programs that did not always work as planned; and the necessary changes to MN Case Mix as a result of the changes in the federal system.

MDH will continue to provide support and education to providers and consumers throughout the next year.

C. Additional Provider and Surveyor Training

Care Area Assessments under MDS 3.0

In May of 2010, MDH provided training on Strategic Approaches to Improving the Care Delivery Process. The training supplemented the training that was provided on new/revised

federal guidelines over the last four years. It included information on topics such as unnecessary medications, pressure ulcer prevention, activity programming, and pain management; all areas where there have been immediate jeopardy or actual harm deficiencies issued, hospitalizations incurred, common errors made, etc. The training was designed to assist nursing homes with improving their care delivery processes, beginning with assessments and ending with outcomes, and is consistent with the new MDS 3.0 requirements. Providers were able to work through real life case studies, ask questions, and explore answers together on these various care issues and challenges. The training was held at 5 locations in Minnesota and was well attended. Materials from the training were posted on MDH's Clinical Web Window at http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html for providers to access at any time.

Root Cause Analysis Training and Follow-up

At the request of providers, MDH used civil money penalty funds to expand the training that was provided in the Northeast Region of the state (pilot project) and to the Metro Region of the state. MDH's Licensing and Certification Program worked with the Department's Adverse Health Events Program and with Stratis Health (Minnesota's Quality Improvement Organization) to conduct training and follow-up activities in these two regions of the state. Materials from the trainings were posted on MDH's Clinical Web Window at http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html.
The trainings were such a success that providers from other regions of the state traveled to the cities to attend, and many providers had to be turned away because attendance had reached full capacity. Providers have requested that MDH continue to offer training in other regions of the state so all providers can take advantage of the information. MDH will consider the possibility of providing additional training in FFY11, and will explore the use of technology such as WebEx and Webinars for training that can be accessed at any time by providers.

Self Reported Incident Training

In July of 2010, MDH in conjunction with the Minnesota Department of Human Services (DHS), nursing home provider associations and the Office of Ombudsman for Long-Term Care, offered providers a half day video-conference session on the reporting of suspected incidents of vulnerable mistreatment. The training, which included actual case scenarios, was designed to assist providers with identifying, investigating and submitting timely and appropriate self reports and decrease over-reporting to MDH's web-based system. The presentation is available for viewing on MDH's Clinical Web Window at:
http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html.

D. Greater Coordination with Public and Private Sector Organizations and Programs on Emergency Preparedness Planning and Response

MDH continued to work closely with its public and private partners in preparing for and responding to emergency situations. In FFY10 MDH did the following:

- Developed a web-based survey tool to collect information from providers about available beds and resources. This information is useful to MDH providers when an emergency

situation occurs where a provider needs to evacuate residents and requires such assistance. Data is made available to the regional emergency planners, local agencies, or facilities requesting such information. The evacuating facility would review the information and contact facilities directly to make arrangements for their residents/patients. In FFY11, MDH plans to expand its provider base to include Housing with Services providers, supervised living facilities, and residential hospices.

- Established a large supply of N95 masks that were cached throughout the state for use by LTC providers in the event of a pandemic. In addition to the supply of masks, MDH also purchased a number of "fit" testing kits that regional healthcare emergency preparedness coordinators could use to provide train-the-trainer sessions to nursing home staff on how to do fit-testing for N95 masks. This will help to assure that there is staff in the nursing homes capable of fitting N95masks in the event they need to be used.

MDH will continue to work with long term care providers on emergency preparedness activities in FFY11, including providing incident command training, evacuation and shelter-in-place planning, and conducting various emergency response exercises with providers.

III. Areas of Special Focus for 2011

A. Implementation of the New Federal Software for QIS

Some of the problems with the QIS process are software related because the software developers inherited the original QIS software from a third party and had to force it to work with the existing Aspen Survey Explorer (ASE) software. To help fix this problem, CMS upgraded its software to ASE-Q. ASE-Q combines ASE and QIS into one software application and one database. Training for survey staff on the upgraded software was conducted in October 2010, and the new and improved software is currently in use statewide. The first data report produced by the new ASE-Q software is due to be released in FFY11. Survey staff will need to continue learning how to use the new software and how to read and understand the new data reports generated by ASE-Q during FFY11.

B. Training Surveyors on the Use of Data and Information Generated from the Federal Quality Indicator Survey (QIS) Reports

One of the benefits of QIS is the data that can be produced from the new survey process. This includes data and information generated from the DAR-SA, DAR-RO, ASE-Q, Federal Oversight QIS (FO-QIS), and mix-max surveys. This data can help survey staff identify variances and opportunities for quality improvement, and take corrective action when appropriate. However there is a learning curve that is involved before survey staff can use that data to its fullest extent. During FFY11, MDH will be focusing its attention on orienting survey staff to these new data reports, and helping them to read, understand, and use the data that is generated from the reports. MDH will be working with CMS and Nursing Home Quality on this orientation.

C. Developing and Implementing a Falls Prevention Program

Minnesota's falls death rate among older adults is more than twice the national average. Falls among the elderly are driving up health care costs and significantly impacting quality of life for older adults. Falls in nursing homes are a major concern, and preventing them is a big focus for many facilities. Deficiencies related to accidents and falls are a concern, as is the morbidity and mortality associated with falls.

MDH's Licensing and Certification Program in conjunction with MDH's Arthritis and Aging Unit, Injury and Violence Prevention Unit and the MN Falls Prevention Initiative, will work together to adapt successful evidence based programming[2] that has been done in community settings (assisted living, senior centers, single family dwellings, etc) in falls prevention, exercise, chronic disease self-management and nutrition to long-term care settings.

The goal of the project is to develop, train and assist long-term care (LTC) staff and volunteers to use the programs in their facility to prevent falls using a comprehensive approach that includes screening for falls risk for individuals and facilities and the addition of programs to decrease individual risk. Information, including strategy description and implementation and results, will be summarized and distributed for wide spread use in any LTC setting. Training and monitoring protocols will be developed and used to support an expanded training infrastructure for LTC that will support the sustainability of these efforts. Information and materials will be placed on MDH's website for all providers to access.

MDH will use civil money penalty funds to help fund this initiative. Civil money penalties are monies paid by nursing homes for non-compliance. This money is then used to fund programs and activities that improve nursing home residents' quality of care and quality of life.

D. Collaborating More with Office of Health Facility Complaints

CMS has been reviewing complaint procedures in Minnesota and other states. With CMS' enhanced focus on complaint investigations, MDH's Licensing and Certification Program and the Office of Health Facility Complaints will be examining their investigative practices to identify and resolve any inconsistencies between the two programs. L&C and OHFC will also explore opportunities to provide more joint training to providers and surveyors on topics relevant to both programs, such as the Root Cause Analysis Training that was conducted in FFY10.

E. Planning for the Future of Long-Term Care

With a rapidly increasing number of people over 65 years of age who prefer to receive health care services in the home or in a community based setting, and changes occurring at the federal and state level around payment for Medicare and Medicaid services, MDH will need to monitor

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[2] An "evidence based program" has been demonstrated to be effective in basic research that involved the same target audience in a rigorous experimental design and then has been demonstrated to be effective in dissemination in the "real world," using the professionals and peer leaders and participants in a community population. These programs use clear protocols for training and conduct so that programs can maintain fidelity and reliably ensure successful outcomes.

these changes closely and have ongoing discussions with the Minnesota Department of Human Services and other stakeholders regarding how these changes will affect nursing homes, assisted living, home care and the other long term care providers and services it regulates. MDH will need to assess how these changes fit with current federal and state regulations and discuss such things as how they will have an impact on the quality of care and services provided; whether there is sufficient and capable workforce to serve future long-term care populations; how technological advances will play a role in providing services; and, how to assure that we have viable nursing homes in the future to serve some of the most needy and vulnerable adults who cannot remain in the home or in a community based setting. In 2010 MDH's Licensing and Certification managers participated in numerous discussions related to the future of long term care and MDH anticipates that there will be even more changes and ongoing discussions in 2011 as they continue to prepare for the future.

IV. Appendices

APPENDIX A: Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

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

APPENDIX C: How to Access MDH's Compliance Monitoring Division Information

APPENDIX D: Health and Life Safety Code Survey Deficiency Data

APPENDIX E: IDR and IIDR Data and Information

APPENDIX F: 2010-11 Quality Improvement Plan for Survey Agency

APPENDIX G: Government Performance Results Act (GPRA) Goals

APPENDIX H: Nursing Home Post Certification Revisit Process

APPENDIX A

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX

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. 1 Optional: Cat. 2
Actual harm that is not immediate jeopardy	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 Not on HCFA-2567	B PoC	C PoC
	Isolated	**Pattern**	**Widespread**

Substandard quality of care in any deficiency in 42 CFR 483.13 Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care that constitutes immediate jeopardy to resident health or safety; or, a pattern of or widespread actual harm that is not immediate jeopardy; or, a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

REMEDY CATEGORIES

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; $50 - $3,000 per day $1,000 - $10,000/instance	Temp. Mgmt. Termination Optional: Civil money penalties: $3,050 - $10,000 per day $1,000 - $10,000/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.

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APPENDIX B

HOW TO ACCESS CMS REULATIONS, MANUALS, UPDATES QUALITY INDICATOR SURVEY PROCESS INFORMATION AND OTHER QUALITY INITIATIVE MATERIALS.

Federal regulations are available at the CMS Laws and Related Regulations web page,
http://www.cms.hhs.gov/home/regsguidance.asp
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.
https://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=-99&sortByDID=1&sortOrder=ascending&itemID=CMS1201984&intNumPerPage=10

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

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

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

Nursing Home Quality Indicator Survey (QIS) Process Resources

CMS' Updated Brochure Describing the QIS Survey Process
http://www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter08-21.pdf

QIS Forms, Resource Manual, and Q&As
http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/hcpr/qis/Pages/default.aspx

Nursing Home Quality Web Site -- This is the organization that CMS contracted with for Quality Indicator Survey Process (QIS) Training for State Survey Agencies.
http://nursinghomequality.com/

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

APPENDIX C

HOW TO ACCESS MDH FACILITIES COMPLIANCE MONITORING DIVISION INFORMATION

Annual Quality Improvement Report on the Nursing Home Survey Process and Progress Reports on Other Legislatively Directed Activities, FFY 2004, 2005, 2006 and 2007
http://www.health.state.mn.us/divs/fpc/legislativerpts.html

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

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

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

Compliance Monitoring Division Clinical Web Window
http://www.health.state.mn.us/divs/fpc/cww/cwwindex.html

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

Complaint Investigations of Minnesota Health Care Facilities Legislative Report, 2005, 2006, 2007, 2008, and 2009 and 2010
http://www.health.state.mn.us/divs/fpc/legislativerpts.html

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

APPENDIX D

HEALTH AND LIFE SAFETY CODE DEFICIENCY DATA AND INFORMATION FOR FFY10

Minnesota Compared to CMS Region V and Nationally in Health Deficiency Citations

For FFY10, Minnesota's average deficiencies per health survey was 7.8, which is down from last year's 8.8. The average number of deficiencies per health survey for all states in Region V was 6.3. The range of deficiencies was from a high of 7.8 in Minnesota to a low of 5.3 in Ohio. Table 1 below shows the six states in CMS Region V with their respective average deficiency rates. In July of 2010, CMS established a new workgroup to review deficiencies across Region V states and work on consistency. MDH serves on that workgroup.

Table 1: Average Deficiencies per Health Survey for CMS Region V, FFY10

State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	755	4,417	5.9
Indiana	516	3,668	7.1
Michigan	459	3,337	7.3
Minnesota	389	3,016	7.8
Ohio	893	4,748	5.3
Wisconsin	329	1,870	5.7
Total	3,341	21,056	6.3

Source: Federal CASPER Data System, FFY10

The national average number of deficiencies per health survey for FFY10 was 6.3, and Minnesota ranked 18th in the nation (Table 3 below). In FFY09 Minnesota ranked 14th in the nation.

Life Safety Code Deficiencies

The average number of deficiencies per LSC survey nationally during FFY10 was 3.9 and the average in Minnesota was 2.2, Minnesota ranked 35th in the nation (Table 4 below). Regionally, Minnesota continues to issue the least number of LSC deficiencies compared to other states in the CMS Region V (Table 2 below).

Table 2: Average Deficiencies per LSC Survey, CMS Region V, FFY10

State	Surveys	Tags from Each Group	Average Defs. Per Survey
Illinois	755	4,729	6.3
Indiana	516	1,403	2.7
Michigan	459	2,561	5.6
Minnesota	389	846	2.2
Ohio	893	4,300	4.8
Wisconsin	329	2,037	6.2
Total	3,341	15,876	4.8

Source: Federal CASPER Data System, FFY10

Table 3: Average Health Deficiencies per Nursing Home Survey by State FFY10

State	Surveys	Average Number of Health Deficiencies
District of Columbia	18	20.1
Guam	1	20.0
Puerto Rico	7	14.9
Colorado *	210	11.8
Delaware *	29	10.8
California	1,127	10.7
Kansas *	295	10.5
West Virginia *	72	10.0
Arizona *	112	10.0
Nevada	49	9.8
Wyoming	37	9.6
Idaho	75	9.4
Oklahoma	298	8.9
Minnesota *	389	7.8
Maryland *	196	7.5
Hawaii	35	7.5
Michigan	459	7.3
Louisiana *	277	7.2
Indiana	516	7.1
Washington *	227	7.1
Missouri	536	6.7
Connecticut *	221	6.6
Virginia	279	6.6
Arkansas	235	6.6
Florida *	685	6.5
Alaska	17	6.4
Vermont *	37	6.2
Illinois	755	5.9
Wisconsin	329	5.7
Montana	85	5.6
Maine	107	5.5
South Carolina	171	5.3
Ohio *	893	5.3
Texas	1,162	5.3
Utah	99	5.3
Nebraska *	215	5.2
New Jersey	363	5.1
New Hampshire	76	5.0
New York *	656	5.0
Kentucky	292	5.0

Source: Federal Casper Data System FFY10

State	Surveys	Average Number of Health Deficiencies
Iowa	400	5.0
Mississippi	202	4.8
Pennsylvania	722	4.7
Georgia *	298	4.7
Tennessee	280	4.6
North Dakota	84	4.6
Oregon	129	4.4
Massachusetts	434	3.9
New Mexico *	62	3.8
Alabama	223	3.7
South Dakota	112	3.7
North Carolina *	414	3.4
Rhode Island	85	2.1
Totals	**15,087**	**6.3**
* Denotes QIS states		

Table 4: Average Life Safety Code (LSC) Deficiencies per Nursing Home Survey by State FFY10

State	Surveys	Average Number of Health Deficiencies		State	Surveys	Average Number of Health Deficiencies
Guam	1	9.0		Washington	227	3.1
Montana	85	8.0		Tennessee	280	3.0
Colorado	210	6.7		South Dakota	112	3.0
Oregon	129	6.5		Louisiana	277	2.8
Illinois	755	6.3		Indiana	516	2.7
Wisconsin	329	6.2		New York	656	2.5
Pennsylvania	722	6.1		Idaho	75	2.5
California	1,127	6.1		Georgia	298	2.4
Utah	99	6.0		Delaware	29	2.3
Nebraska	215	5.7		Minnesota	389	2.2
Michigan	459	5.6		Kentucky	292	2.0
Alabama	223	5.5		North Dakota	84	1.9
Iowa	400	5.2		Connecticut	221	1.7
Kansas	295	5.0		New Jersey	363	1.7
Ohio	893	4.8		Arkansas	235	1.7
Wyoming	37	4.8		West Virginia	72	1.4
Texas	1,162	4.4		Florida	685	1.4
New Hampshire	76	4.2		Massachusetts	434	1.3
Maryland	196	4.0		Maine	107	1.3
Puerto Rico	7	3.9		Mississippi	202	1.3
Oklahoma	298	3.8		Nevada	49	1.2
District of Columbia	18	3.7		South Carolina	171	0.8
New Mexico	62	3.7		Rhode Island	85	0.5
Missouri	536	3.6		Vermont	37	0.4
North Carolina	414	3.4		Hawaii	35	0.4
Arizona	112	3.4				
Virginia	279	3.2		**Totals**	**15,087**	**3.9**
Alaska	17	3.2				

Source: Federal Casper Data System FFY10

APPENDIX E

NUMBER AND OUTCOME 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. IDR and IIDR decisions made by MDH are subject to CMS oversight.[3]

IDR

The IDR is performed by an MDH supervisor who has not previously been involved in the survey or complaint investigation. For surveys with exit dates during FFY10, 26 IDRs were requested. A total of 54 tags were disputed. Of the disputed tags, the reviewer's decision was to change the scope and severity for 8 tags, and to delete 15 tags, for a total of 23 tags (43%) 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.

Since the inception of the process in 2003, 137 IIDR requests have been made through FFY10. In FFY10, there were 11 requests involving 24 tags. Of the 11 requests, 6 were withdrawn by the facility prior to the IIDR review, and those 6 included 12 tags; 1 was changed to an IDR at the facilities request, and one has yet to be scheduled. Table I, below, summarizes the tags that went forward with an IIDR in FFY10.

Table 1: Summary of IIDR Results, FFY10

Number of tags in dispute: 3		
ALJ recommended action:		Number of tags:
Uphold tags as written		3
Uphold scope and severity, but delete some findings		0
Total tags upheld	**3**	
Dismiss		0
Adjust scope and severity		0
Total tags adjusted or dismissed	**0**	

[3] 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.

Commissioner's decision:	Number of tags:
Uphold tags as written	3
Uphold scope and severity, but delete some findings	0
Total tags upheld	**3**
Dismiss tags	0
Adjust scope and severity	0
Adjust scope	0
Total number of tags adjusted or dismissed	**0**

Since CMS conducted ALJ training in April of 2006, CMS has not requested to review any files for IIDR decisions rendered by the ALJs and the commissioner. Therefore all decisions made by the commissioner have been "final."

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. The costs for 2010 were approximately $6,858 and nursing homes paid for all of those costs.

MDH uses a trained surveyor to review submitted materials and present MDH's position at the IIDRs. The IIDR process has required a considerable investment of staff time. The IIDR process was contemplated as an "independent" but informal review of the disputed tags. Most nursing homes elect to use legal counsel in preparation of the IIDR materials and for representation at the IIDR review. MDH does not use legal counsel in the IIDR process. The IIDR process has increasingly become less informal over time and in many respects functions as a formal hearing. The amount of staff time devoted to preparation for IIDRs is substantial.

In FFY08 the Centers for Medicare and Medicaid Services (CMS) reminded states of its guidance on the Release of Federal Documents by the State Survey Agencies, Administrative Information Bulletin 07-06, issued January 12, 2007. Per that Administration Memo, much of the information and many of the documents routinely used in the IIDR process require a Freedom of Information Act (FOIA) request. There have been a number of FOIA requests by nursing homes delaying scheduling IIDRs while MDH awaits CMS responses to those requests. To date, MDH has not received an approval for a requested FOIA. One IIDR request from FFY10 is delaying scheduling an IIDR pending notification from CMS on their FOIA request.

MDH continues to use the information gained from the IIDR process, as well as the IDR process, to improve the survey process with respect to both identifying and documenting deficient practices. This information is shared with program management, supervisors and investigators. MDH also shares a status log of IIDRs with the two nursing home trade associations on a monthly basis, and with the LTC Issues Committee at its quarterly meetings.

APPENDIX F

2010-11 Quality Improvement Plan for Survey Agency
Working Document

Mission of Minnesota Department of Health:
Protecting, Maintaining and Improving the Health of Minnesotans

Vision of Licensing and Certification (L&C) Program:
Quality and Individualized 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 statutes, regulations and guidelines;
3. Educating stakeholders via information sharing and training; and,
4. Overseeing the Nursing Assistant Registry (NAR) 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 in accordance with established state and federal requirements to protect health, well-being, safety and comfort; to identify areas for improvement in performance and in systems; and, to make those improvements.

The 2009 Quality Improvement Plan includes 4 goals:

1. Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.
2. All nursing facilities in Minnesota will meet or exceed the national Government Performance and Results Act* (GPRA) goals related to pressure ulcer and physical restraint reduction.
3. Improve consistency and accuracy across survey teams through implementation of the Federal Nursing Home Quality Indicator Survey (QIS) Process and through understanding and use of the QIS data reports.
4. Maintain positive communication about regulatory programs and promote knowledge of the survey process.

*The Government Performance and Results Act (GPRA) of 1993, is to improve public confidence in the Federal Government by systematically holding Federal agencies accountable for achieving program results made public through annual performance goals, based on strategic goals and linked to budget. Two of CMS goals for FY10 for nursing facilities include achieving nationwide Pressure Ulcers (PU) rate of 8.1% and Physical Restraints: rate of 3.8%. See http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSOPA01302008.pdf.
http://www.cms.hhs.gov/PerformanceBudget/Downloads/CMSOPAFY2011.pdf

Goal: Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.

❖ Culture Change is an ongoing transformation in the physical, organizational, and psycho-social-spiritual environments that is based on person centered values. Culture Change restores control to elders and those who work closest to them.

- Participate in the Minnesota Culture Change Coalition.
- Improve quality of life for long-term care residents by promoting awareness and understanding of culture change with stakeholders.
- Promote surveyor and provider mutual understanding about how regulations support culture change in nursing facilities and vice versa through ongoing dialogue and educational programs.

Goal: All nursing facilities in Minnesota will meet or exceed the national GPRA goals related to pressure ulcer and physical restraint reduction.

- Support ongoing efforts of stakeholders to follow-up with those facilities which exceed GPRA goals.
- Work with stakeholders to track the progress in meeting GPRA goals.
- Support and advance collaboration among MDH, the Quality Improvement Organization, consumers and all provider types to prevent pressure ulcers.

Goal: Improve and maintain consistency and accuracy across survey teams through implementation of the Federal QIS Nursing Home survey process and use QIS Quality Improvement (QI) data.

Objective: Educate surveyor agency staff about Federal QIS Nursing Home survey process, and use of QIS tools for quality improvement.

- Orient current MDH staff to QIS survey process over a three-year period (2008-2011).
- Orient newly hired MDH staff to QIS survey process on an ongoing basis.
- Seek adequate resources from CMS to understand and use QIS data tools, and educate and work individually with MDH staff on how to use QIS survey process QI tools.
- Use mix-max survey teams to capture observations and insights on survey process variances, and communicate information back to surveyors.
- Improve proficiency with writing deficiencies consistent with CMS principles of documentation.

Objective: Analyze variations and develop methods to reduce variation for quality improvement.

- Use information gained from QIS survey process and Federal Oversight Quality Indicator Surveys to identify areas for quality improvement.
- Seek adequate resources from CMS to analyze and fully understand data from DAR-SA reports.
- Expand understanding of survey outcomes by using QIS data reports that analyze survey data for variances.

Objective: Identify and correct known, suspected or potential problems with survey process and identify opportunities for quality improvement.

- Use QIS data to analyze variations and to take corrective action when appropriate.
- Use QIS survey process investigative pathways.
- Use mix-max survey teams, unit supervisors and managers, surveyor trainers and federal oversight surveys to capture observations and insights on survey process variances, and communicate information back to surveyors.
- Review all deficiencies prior to being finalized and issued.
- Communicate areas for improvement through surveyor-training tools, quality tag, survey task guides and QIS available resources.

Objective: Value all members of the Licensing and Certification Program and administrative staff individually. Attract and retain a professional survey and administrative staff workforce. Develop a succession plan for staff as retirements occur.

- Maintain and implement a positive work environment that supports survey agency staff in their positions. Communicate together as a statewide team.
- Attract competent and knowledgeable individuals.
- Use available options to plan for succession of staff.
- Provide effective staff orientation using knowledgeable surveyor trainers.
- Solicit ideas from survey agency staff for quality improvement.

Objective: MDH will meet CMS Performance Standards

Goal: Improving communication and promoting knowledge of the survey process and other issues affecting long term care providers.

Objective: Ensure ongoing flow of information between MDH staff, providers, and external stakeholders.

- Participate in Long Term Care Issues Committee with representatives from providers, advocates, families and the quality improvement organization. Solicit feedback from participants.
- Meet regularly with provider associations, MNDONA, Stratis Health, and resident advocates.
- Work jointly with stakeholders to plan regulatory related educational programs, and technical assistance around common clinical and regulatory change topics.
- Continue to implement transparency in sharing information via MDH and CMS website.
- Improve communication with customers through improved technology for the Nursing Assistant Registry (NAR).
- Participate in statewide emergency preparedness activities.

Objective: Simplify and streamline the process of soliciting feedback on surveys.

- Simplify the questionnaire format.
- Improve the online approach to soliciting survey feedback.

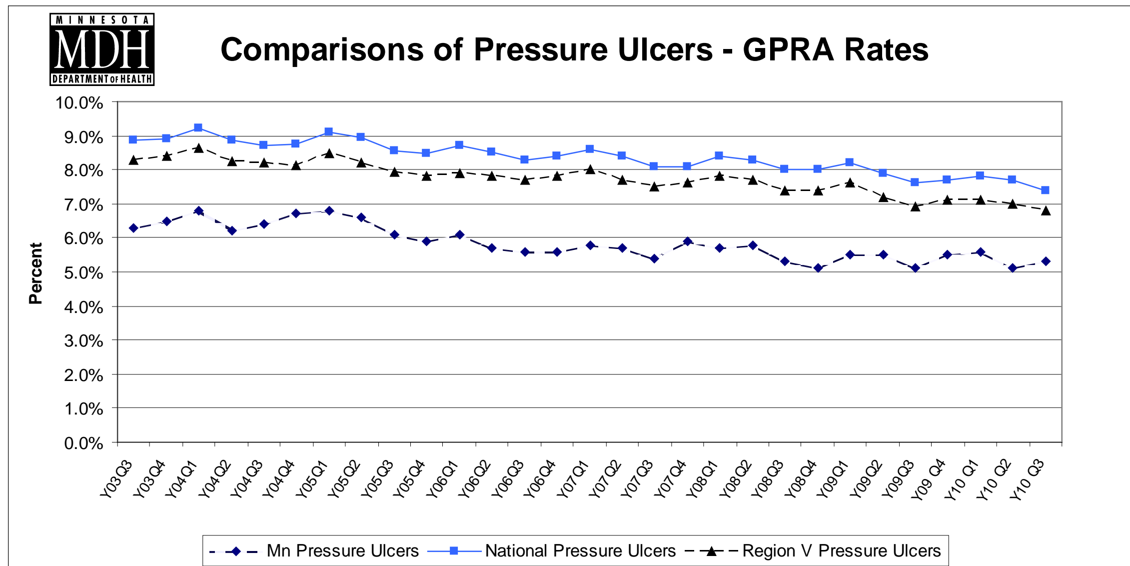
APPENDIX G

Government Performance and Result Act (GPRA) Goals
Reduce Prevalence of Pressure Ulcers and Physical Restraints

Pressure Ulcer Reduction

According to the Graph below, Minnesota's pressure ulcer rates have been consistently lower than the national and CMS Region V rates for several years now. In the third quarter of 2003, Minnesota had a pressure ulcer rate in nursing homes of 6.3% compared to the national rate of 8.8% and the CMS Region V rate of 8.3%. In the first quarter of 2010, the Minnesota rate was 5.6%, whereas the national rate was 7.8% and the CMS Region V rate was 7.1%.

Graph 1: GPRA Pressure Ulcer Rates, Calendar Year 2003-2010



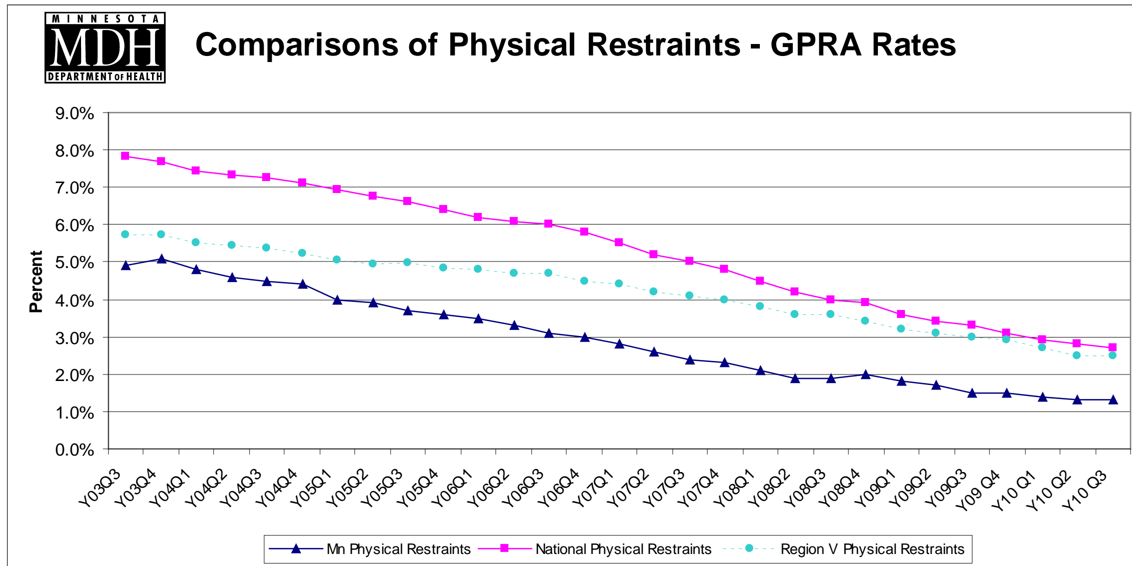
Source: CMS PDQ Data

The second quarter of 2010, the Minnesota pressure ulcer rate in nursing homes was 5.1% and was still lower than the National and Region V rates. The data for the first quarter of 2010 showed a drop in the pressure ulcer rate from 5.6% to 5.1%. The data for the third quarter of 2010 showed a slight increase to 5.3% in the pressure ulcer rate.

Physical Restraint Reduction

Minnesota's physical restraint rate showed continued decline since fourth quarter of 2003 (Graph 2 below). The physical restraint rate in Minnesota nursing homes fourth quarter of calendar year 2003 was 5.1%. Minnesota's rate at the end of third quarter of 2010 was 1.3%. In comparison with the national and CMS Region V rates, Minnesota's physical restraint rate declined from 1.4% in the first quarter of 2010 to 1.3%. The national rate went from 2.9% to 2.7% and CMS Region V rate went from 2.7% to 2.5%. Minnesota's rates for physical restraints have always been below the national and CMS Region V rates.

Graph 2: GPRA Physical Restraint Rates for Minnesota, CMS Region V, and Nationally Calendar Years 2003-2010



Source: CMS PDQ Data

APPENDIX H

Evaluation of the Revised Post Certification Revisit Process

As explained in previous Legislative Reports, on November 3, 2006, MDH revised its process for performing federal post certification revisit (PCR) follow-up surveys for nursing facilities (Appendix H-1). PCR follow-up surveys are conducted to assure providers have corrected deficiencies found during an annual survey.

When a federally certified provider receives a deficiency at a B scope and severity level or above (see Appendix B for CMS' Scope and Severity Matrix), federal regulations require them to complete and submit to MDH an acceptable plan of correction (PoC). The PoC must include the following elements to be considered acceptable:

- address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- indicate how the facility plans to monitor its performance to make sure that solutions are sustained;
- include dates when corrective action will be completed; and,
- include signature of provider and date.

Upon receipt of the PoC, MDH verifies that compliance has been achieved by either conducting an onsite post certification revisit survey or an offsite acceptable PoC review (administrative paper review). The method of verification used is dependent upon the scope and severity level of the deficiency issued.

Prior to November 3, 2006, nursing homes that were issued a deficiency at a D level scope and severity or above were required to submit an acceptable plan of correction (PoC), and in most cases received an onsite PCR follow-up inspection. If corrections were not made, or additional non-compliance was found, citations were issued, another acceptable PoC was required, and an onsite PCR follow-up survey was scheduled.

As of November 3, 2006, the date the PCR policy revisions took effect, PCR follow-up visits were prioritized according to the severity of the citations issued. Those surveys with deficiencies indicating harm, substandard quality of care or immediate jeopardy to resident health or safety, and/or those facilities listed on CMS' special focus facilities list received a mandatory onsite PCR inspection. Surveys resulting in lower scope and severity deficiencies were randomly selected for an onsite, non-mandatory, PCR follow-up visit.

Providers not selected for an onsite, non-mandatory, PCR were required to complete and submit an acceptable PoC in writing to MDH. MDH performed that offsite, non-mandatory, review via an acceptable PoC verification.

Under the revised PCR process, approximately 25% of the providers with less than an F scope and severity level deficiency citation received an onsite follow-up inspection.

Since 2006, MDH has been monitoring deficiencies to determine the effectiveness of the revised policy in maintaining compliance with federal and state resident nursing home health and safety requirements. MDH used the three measures listed below to monitor the policy's outcome.

1. Do providers who are selected for random onsite, non-mandatory, PCR follow-up visits have deficiencies corrected at the time of the onsite follow-up inspection? Since approximately 75% of providers who are eligible for the random selection process would not receive an onsite PCR under the revised policy, MDH wanted to look at PCR surveys to verify that correction patterns were are not changing. If correction rates worsen, MDH would alter or eliminate the random follow-up process.

   Data below shows that, from FFY07 to FFY10, the number and percent of uncorrected PCR deficiencies on the first random offsite, non-mandatory (administrative paper review), follow-up visit continued to decline with 6 (3.1%) deficiencies that were not corrected in FFY07 to only 1 (0.47%) deficiency that was not corrected in FFY10. The onsite, non-mandatory, follow-up surveys showed a slight increase between FFY07 and FFY08 from 14 (19.4%) to 21 (27.3%) followed by a steady decline of 21 (27.3%) in FFY08 to 4 (19.4%) in FFY10. The overall trend seems to show a continued decline for both random, on-site inspection and for random offsite reviews with no significant changes in correction patterns.

2. Are complaint substantiation patterns different between providers randomly selected for onsite, non-mandatory, PCR follow-up surveys and those receiving offsite, non-mandatory, PCR inspections?

   The number and percent of complaints substantiated for offsite, non-mandatory, follow-up surveys declined slightly from FFY07 to FFY08 and then increased in FFY09. In FFY07, 39 or (17.4%) of the randomly selected offsite complaints were substantiated. In FFY08, 54 (17.0%) complaints were substantiated for the offsite, non-mandatory, PCRs. Whereas in FFY09 the number and percent of complaints substantiated for offsite, non-mandatory, increased to 63 (29.7%) and in FFY10 to 69 (27.3%). The number of the substantiated complaints for the random onsite follow-up visits declined from 23 in FFY08 to 18 in FFY10. Complaint substantiation patterns do not show a significant difference between providers randomly selected for offsite follow-up reviews and those receiving onsite PCR inspections.

3. Do the random on-site and random offsite, non-mandatory, review groups differ in issuance of the same deficiency tag to the same provider for two consecutive annual survey cycles? MDH was concerned that greater rates for repeated citation of the same deficiency in the random offsite group may indicate higher rates of uncorrected problems carrying forward into the next year.

Based on the number of randomly selected PCRs, the rates for the PCRs with repeat deficiencies showed no significant differences. In FFY07, the number and percent of offsite, non-mandatory, PCR reviews with repeat deficiencies were 156 (79.2%) and the number and percent of onsite, non-mandatory, PCRs were 57 (79.2%). The rates for the random onsite and random offsite PCRs were the same. In FFY08, number and percent of offsite PCRs with repeat deficiencies were 177 (81.2%) and the number and percent of onsite PCRs were 63 (81.8%). The trend for both of these groups changed in FFY09 when the rate for offsite, non-mandatory PCRs with repeat deficiencies declined to 73.7% and the rate for onsite, non-mandatory, PCRs with repeat deficiencies increased to 82.1%.

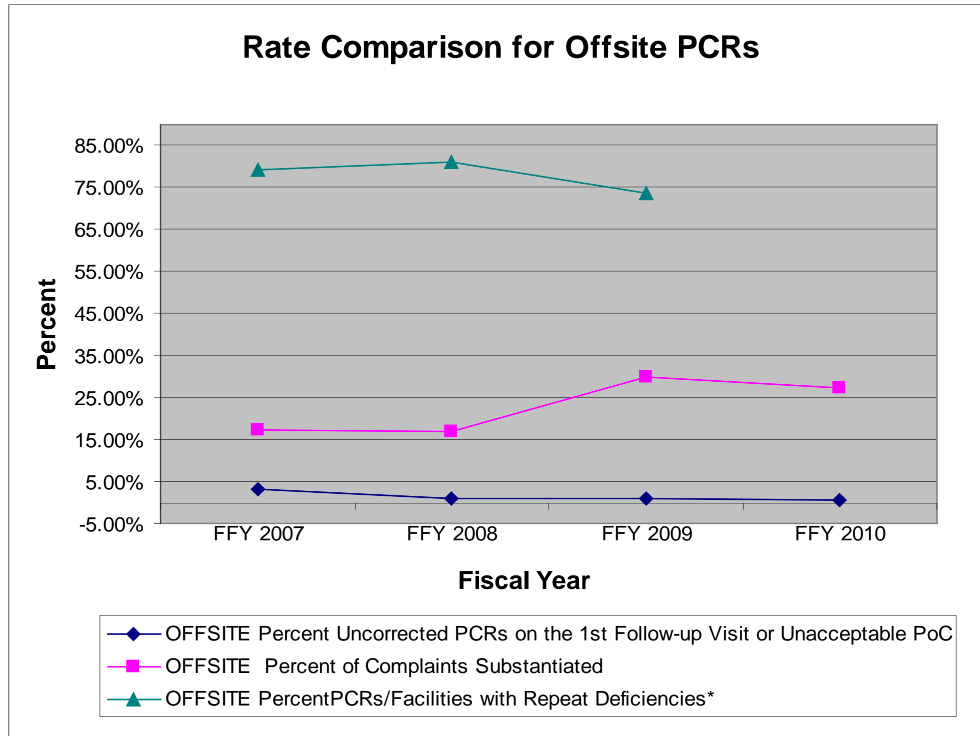
Table 1 and Graphs 1 and 2, below, summarizes data collected from FFY07 to FFY10 to evaluate the effectiveness of the PCR policy.

Table 1: Nursing Home Follow-up Surveys (PCRs), FFY07-FFY10

PCR Type	Number of Facilities/ PCR Surveys	Number & Percent of Uncorrected PCRs on the 1st Follow-up Visit or Unacceptable PoC	Number of Facilities with Complaint	Total Complaints Received	Number & Percent of Complaints Substantiated	Number & Percent of PCRs/Facilities with Repeat Deficiencies*
FFY 2007						
Offsite Non-Mandatory	197	6 (3.1%)	105	224	39 (17.4%)	156 (79.2%)
Onsite Non-Mandatory	72	14 (19.4%)	38	93	14 (15.1%)	57 (79.2%)
Onsite Mandatory	75	31 (41.3%)	46	213	40 (53.3%)	65 (86.67%)
FFY 2008						
Offsite Non-Mandatory	218	2 (0.92%)	115	318	54 (17.0%)	177 (81.2%)
Onsite Non-Mandatory	77	21 (27.3%)	46	124	23 (18.5%)	63 (81.8%)
Onsite Mandatory	73	21 (28.8%)	40	129	32 (43.8%)	68 (93.2%)
FFY 2009						
Offsite Non-Mandatory	232	2 (0.86%)	106	212	63 (29.7%)	171 (73.7%)
Onsite Non-Mandatory	67	7 (10.5%)	41	86	21 (24.4%)	55 (82.1%)
Onsite Mandatory	70	18 (25.7%)	39	120	46 (38.3%)	61 (87.1%)
FFY 2010						
Offsite Non-Mandatory	213	1 (0.47%)	118	253	69 (27.3%)	*Data Available FFY 2011*
Onsite Non-Mandatory	68	4 (5.9%)	38	77	18 (23.4%)	*FFY 2011 Data*
Onsite Mandatory	90	19 (21.1%)	58	165	53 (32.1%)	*FFY 2011 Data*

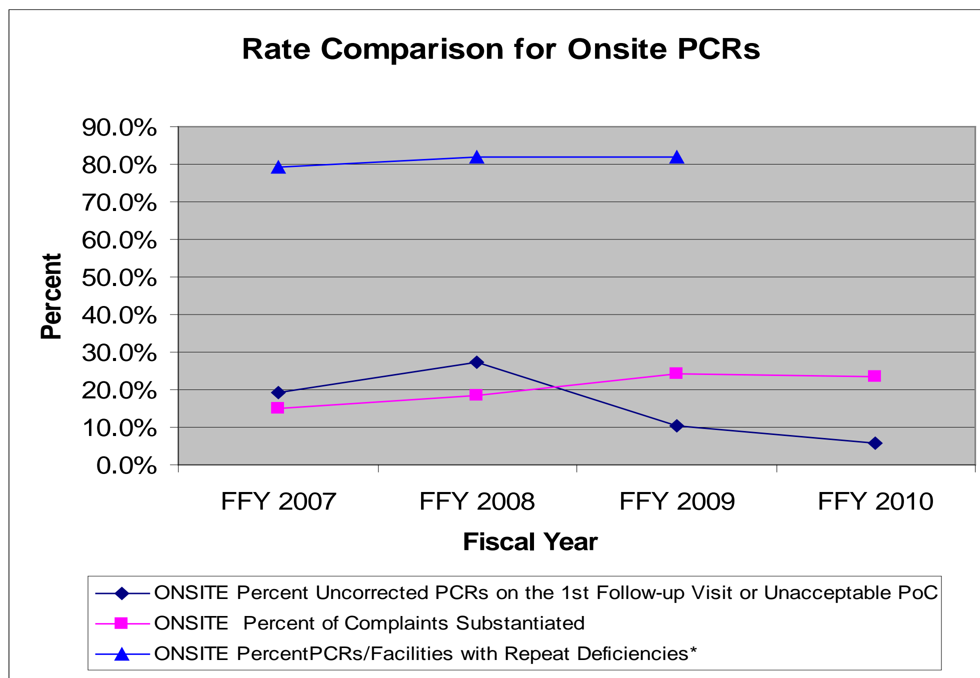
Source: Paradise Data System
**The repeat deficiencies for annual recertification survey data (FFY 2007 and 2008; FFY 2008 and 2009; FFY 2009-2010). Repeat deficiencies is when the identical tag is cited on two consecutive recertification surveys*

Graph 1: Rate Comparison for Offsite PCRs FFY07-FFY10



Source: Paradise Data System

Graph 2: Rate Comparison for Onsite PCRs FFY07-FFY10



Source: Paradise Data System

Conclusion

After three years of evaluating the revised Post Certification Revisit Process the Department has concluded that the revised process which allows for offsite, non-mandatory, PCR reviews is effective in achieving compliance. This is based on the data that shows: correction patterns between onsite and offsite non-mandatory PCRs have not changed or worsened; complaint substantiation patterns did not show a significant difference between providers selected for onsite, non-mandatory, PCRs and those selected for offsite, non-mandatory, follow-up reviews; and, there were no significant differences in repeat deficiencies between the two PCR follow-up methods that would warrant changing the policy. Therefore, the Department will continue to use the revised PCR process going forward.

APPENDIX H-1

Nursing Home Post Certification Revisit Process

The Minnesota Department of Health (MDH) is expanding its method of compliance verification. MDH will continue to use onsite post certification revisits as one method of verification, but on a less frequent basis. Below is the new post certification revisit process, effective for all nursing home surveys exited after November 3, 2006. This process is consistent with current federal policy and it is enhanced by the inclusion of random visits. The policy applies to all nursing home health and Life Safety Code deficiencies.

I. Mandatory Onsite Revisits

Onsite revisits will occur when any of the following situations apply:

A. when a facility has a deficiency finding of G and above on current survey;

B. when a facility has a deficiency finding of Substandard Quality of Care on current survey;

C. when a facility has been selected by CMS as a Special Focus Facility; or,

D. when a facility's prior survey or complaint investigation resulted in a deficiency finding of Substandard Quality of Care or immediate jeopardy.

II. Random Onsite Revisits

In addition to the mandatory revisits described above, MDH will conduct revisits to a percentage of facilities chosen at random. These random visits will provide the survey agency with an onsite sample to validate that Plans of Corrections are being implemented as written.

III. Verification of Compliance by Signature

The nursing home Plan of Correction (PoC) is the facility's plan to be in compliance and is approved by MDH. The facility's signature on the Plan of Correction will be considered verification that compliance has been achieved as of the latest date specified on the PoC and MDH may validate this verification by conducting an onsite revisit.

IV. Effective Date

This policy applies to all surveys exited after November 3, 2006.

V. Evaluation of Policy Change

This policy will be monitored and evaluated over the next year.