

Complaint Investigations of Minnesota Health Care Facilities

*Report to the Minnesota Legislature
explaining the investigative process and
summarizing investigations from July 1, 2007
to June 30, 2010 and Information on
Deficiencies Issued by OHFC from October 1,
2009 to September 30, 2010*

Minnesota Department of Health

September 2011



Commissioner's Office
625 Robert St. N.
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-4989
www.health.state.mn.us

Complaint Investigations of Minnesota Health Care Facilities

***Report to the Minnesota Legislature
explaining the investigative process
and summarizing investigations from
July 1, 2007 to June 30, 2010 and
Information on Deficiencies Issued by
OHFC from October 1, 2009 to
September 30, 2010***

September 2011

**For more information, contact:
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970
Phone: (651) 201-4201
TDD: (651) 201-5797**

As requested by Minnesota Statute 3.197: This report cost approximately \$13,460 to prepare, including staff time, printing and mailing expenses.

Upon request, this material will be made available in an alternative format such as large print, Braille or cassette tape.
Printed on recycled paper.

Contents

Purpose of the Report.....	2
The Purpose and Mission of the Office of Health Facility Complaints.....	2
OHFC Responsibilities	3
OHFC Staffing.....	5
Part 1: State Fiscal Year Information.....	6
How OHFC Receives Information.....	6
Types of Maltreatment Allegations and Other Concerns Received by OHFC	6
How OHFC Receives and Reviews Information	11
Intake Process Recently Revised.....	11
Triage Process Revisited and Reaffirmed	11
Investigations	13
OHFC and Enforcement.....	15
OHFC and Education Efforts	16
OHFC and Collaboration Efforts	17
Trend Identification.....	18
OHFC’s Performance	21
Part 2: The Authority and Responsibility of the Office of Health Facility Complaints Regarding Federally Certified Nursing Homes	22
Immediate Jeopardy and Substandard Quality of Care Determinations	23
Results of OHFC Complaint Investigations in FFY10	24
Referrals to the Nurse Aide Registry or to Licensure Boards.....	26
Access to OHFC Investigative Reports.....	27
Independent Informal Dispute Resolution (IIDR) and Informal Dispute Resolution (IDR)	27
Reconsiderations and Appeals	27
Areas of Focus in FFY10	28
Areas of Focus for FFY11.....	28
Appendix A: OHFC Intake, Triage and Survey Process	30

Purpose of the Report

Minnesota Statutes, section 626.557, requires the Minnesota Department of Health (MDH) to annually report to the Legislature and the Governor information about alleged maltreatment in licensed health care entities.

Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), states:

Summary of reports. The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:

- (1) whether and where backlogs of cases result in a failure to conform with statutory time frames;
- (2) where adequate coverage requires additional appropriations and staffing; and
- (3) any other trends that affect the safety of vulnerable adults.

To provide context for the information required by the law, this report must address the department's complaint investigation responsibilities relating to health care facilities. This report includes:

- summary data relating to the number of complaints and facility reported incidents received during state FY08 to state FY10;
- summary data about the nature of the allegations contained within those complaints and reports;
- a description of the Office of Health Facility Complaints (OHFC) investigative process, from the intake function to completion of investigations (including issues relating to the performance of its responsibilities).

The latter category includes information on the ability to conform to statutory requirements, the effectiveness of current staffing and any trends relating to the safety of vulnerable adults. Since the complaint investigation function is also a critical component of the federal certification process, information about the federal requirements is included. Information on OHFC's issuance of federal deficiencies related to nursing homes is included in Part 2 of this Report.

The Purpose and Mission of the Office of Health Facility Complaints

The mission of the Minnesota Department of Health (MDH) is to protect, maintain, and improve the health of all Minnesotans. Within MDH, the Compliance Monitoring Division (CM) supports the MDH mission by monitoring compliance with laws and rules designed to protect the health and safety of Minnesota's nursing home residents, home care clients, hospital patients, health maintenance organization enrollees, clients of certain allied health professional groups and those involved in the disposition of the deceased. OHFC is a program within CM and is responsible for investigating complaints and facility reported incidents of maltreatment in licensed health care entities in Minnesota and for reviewing and investigating complaints under the federal Medicare and Medicaid certification requirements.

OHFC was created by the Legislature in 1976 to review allegations that licensed health care facilities were not complying with standards established by statute and MDH rules. With the enactment of the Vulnerable Adults Act (VAA) in 1981, the responsibilities of OHFC were expanded to include investigations into claims of abuse and neglect of residents in licensed health care facilities, and to receive and evaluate incidents reported from facilities that may constitute violations of the VAA.

There more than 2,000 licensed health care entities in the state. Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care agencies and other providers, including assisted living home care providers, hospice programs, hospice residences, End Stage Renal Disease facilities and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the department's responsibilities in this area. Many of these licensed health care entities are also federally certified for purposes of participation in the Medicare and Medicaid programs.

OHFC Responsibilities

OHFC has mandated responsibilities under both state and federal law and has statewide jurisdiction. While not specifically required to be included in this report under the reporting provisions outlined in Minnesota Statutes §626.557, subdivision 12b, clause (e), the department believes that it is appropriate to provide information relating to the activity and performance of OHFC under the federal certification requirements because this provides a more complete picture of the work of the program. Federal data and information specific to federally certified nursing homes is included in Part 2 of this report.

OHFC responsibilities mandated by state law include:

- receiving all complaints and facility reported incidents;
- gathering information that will assist in the review of this information;
- evaluating and triaging of this information;
- selecting the level of investigative response;
- notifying complainants and facility reporters of facility reported incidents as to the outcome of the review and any subsequent investigation;
- making determinations of maltreatment against facilities and individuals under Minnesota's Vulnerable Adult Act, Minnesota Statutes 626.5572 and certain instances under Minnesota's Maltreatment of Minor's law (Minnesota Statutes 626.556);
- reviewing facility and individual requests for reconsideration or requests for administrative hearings on findings of maltreatment;
- serving as state witness at Fair Hearings to uphold maltreatment determinations under Vulnerable Adult Act and Criminal Background Study disqualifications, Minnesota Statutes, Chapter 245C;
- reviewing of reconsideration requests* for individuals that have been disqualified under the provisions of Minnesota Statutes, Chapter 245C;

* The basis for a disqualified individual's reconsideration request is that the individual does not pose a risk of if the disqualified individual's reconsideration request is based on both the correctness or accuracy of the information the commissioner relied upon to disqualify the individual and the individual's risk of harm. (245C.22)

- issuing state correction orders;
- imposing fines or other remedies for facility non-compliance.

OHFC responsibilities mandated by the Centers for Medicare and Medicaid Services (CMS), the federal agency responsible for the certification of these facilities, include:

- receiving, processing and investigating all complaints involving federally certified entities;
- notifying complainants and facility reporters as to the outcome of the review and any subsequent investigation;
- investigating alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA) by hospitals;
- conducting complaint investigations authorized by the CMS Regional Office in accredited hospitals;
- investigating complaints against certified health care facilities or providers;
- issuing certification deficiencies;
- recommending fines or remedies for facility non-compliance;
- investigating facility reported incidents submitted by certified facilities under federal law.¹

State and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. State law also mandates that allegations of maltreatment against a vulnerable adult or a minor be reported by the licensed health care entity. Maltreatment is defined in Minnesota Statutes 626.5572 (Vulnerable Adults Act) as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statutes 626.5572, subd. 17(c)(5).²

The complaint process must ensure that a person who has complained, in good faith, about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of the complaint and procedures to ensure that the identity of the complainant will be kept confidential.

It is beneficial to everyone—the vulnerable adult, their family, the facility and the community for OHFC—to investigate under both applicable federal and state law because all regulatory requirements will be reviewed and any corrective action identified.

¹ Certified nursing homes and Intermediate Care Facilities for the Intellectually Disabled are required under federal regulations to report to the appropriate state authority allegations of mistreatment, neglect and abuse. See 42 CFR 483.13(c) and 42 CFR 483.420(d).

² While OHFC does conduct investigations relating to the maltreatment of minors in MDH licensed facilities, the information presented in this report will be based on complaints and facility reported incidents involving vulnerable adults. OHFC investigates very few cases involving a minor each year.

By law, OHFC must initiate complaint investigations within certain time frames, based on the assessed level of severity of the complaint. These time frames frequently present a challenge to OHFC management as they adjust priorities in response to incoming complaints of greater urgency, realigning and dispatching staff to investigate newly received high urgency complaints, and making sure investigators have been able to gather sufficient information to form the basis for determining the outcome of every investigation.

OHFC Staffing

OHFC's management consists of a Director, Assistant Director, Nurse Supervisor, and a Supervisor Management Analyst 2. There are 14 investigators assigned to the Office; 10 are assigned to the St. Paul office and the remaining four are located in the MDH offices in Fergus Falls and Rochester. In 2010, a full time investigator was added (and is included in the complement above) to conduct only state licensed facility and Vulnerable Adult Maltreatment complaints. There are four individuals responsible for the intake of complaints and facility reported incidents, and five administrative support staff. The Supervisor Management Analyst 2 position supervises support staff and analyzes data to provide necessary information to the director to conduct long and short-range planning, quality assessment of current activities and employment of staff.

In addition to complaint related activities, OHFC is also responsible for activities related to the processing of criminal background checks, reconsiderations of disqualified individuals who provide services in licensed health care facilities. Two professional staff are assigned to this activity.

Vacancies in investigator positions clearly impact OHFC's ability to complete its work within prescribed timelines. Beginning in March 2009, OHFC implemented a proactive system for hiring and retaining trained investigators. It takes about six months to train a Registered Nurse (RN) with the requisite knowledge and mentoring experiences to become a proficient investigator. Investigators, all RNs, must also complete federal survey training, and pass a federal examination, called the Surveyor Minimum Qualified Test, to be a qualified surveyor. As a result, posting of vacancies on the state employment opportunity website is completed in advance of planned separations such as retirements, medical leaves and job changes.

In addition, efforts to adjust workload, streamline operations and monitor output has increased the stability and capability of the workforce to ensure the continuity and quality of services provided by OHFC. Given the economic reality of the state's budget, currently authorized staffing levels, if filled, are considered appropriate to complete the work of OHFC. However, OHFC must continue efforts to identify and adopt new and more efficient processes to investigate complaints and facility incidents, keeping the focus on the health and safety of vulnerable persons. It would not be prudent or possible to conduct an onsite investigation of every complaint or facility reported incident received by OHFC. **All complaints and facility reported incidents are triaged.** Those requiring onsite investigation are identified and assigned for review, following established criteria, and always addressing the most serious and egregious allegations.

Part 1: State Fiscal Year Information

How OHFC Receives Information

Concerns about issues or situations in licensed health care entities come to OHFC in one of two ways: a complaint or a facility reported incident (FRI). A complaint is an allegation relating to maltreatment or any other possible violation of state or federal law that is made by an individual who is not reporting on behalf of the facility. A FRI is received from a designated reporter (a person reporting on behalf of the facility) in a facility and describes a suspected or alleged incident of maltreatment as defined in the Vulnerable Adults Act.

Table 1, below, includes the numbers of complaints and facility reported incidents received during the past three state fiscal years by facility type.

**Table 1: Complaints and Facility Reported Incidents by Facility Type
SFY08, SFY09, SFY10**

Complaints Received	SFY08	SFY09	SFY10
Nursing Home	979	883	830
Hospital	300	292	303
Home Health	531	653	460
Other Licensed Entities	177	208	351
* Total Complaints Received	1987	2036	1994
Facility Reported Incidents	SFY08	SFY09	SFY10
Nursing Home	4376	6750	8333
Hospital	93	85	102
Home Health	554	595	377
Other Licensed Entities	484	725	847
** Total Facility Reported Incidents Received	5507	8155	9659
*** Grand Total	7494	10,191	11,603

Types of Maltreatment Allegations and Other Concerns Received by OHFC

Each complaint or FRI might contain more than one allegation, each of which must be reviewed for investigative purposes. For example, an allegation that a resident was neglected might state the nature of the specific concern but also indicate that inadequate staffing was also a concern. Complaints and FRIs are coded to identify various categories of maltreatment and other violations of state and federal law. Table 2 illustrates the recording of allegations for nursing homes for state FY08, FY09 and FY10, the maltreatment allegations and concerns identified by complainants, and the maltreatment allegations and concerns contained in facility reported incidents. Tables 3, 4 and 5 on the following pages summarize allegations for the other licensed health care entities.

Table 2: Nursing Home Allegations from Complaints and Facility Reported Incidents SFY08, SFY09, SFY10

	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	15	241	12	343	23	458
Physical Abuse	58	352	48	419	28	509
Sexual Abuse	32	64	31	185	23	136
Self Abuse	0	20	5	108	2	130
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	15	136	4	264	6	442
Exploitation by other	9	150	3	311	6	266
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	318	361	228	482	299	602
Falls	59	1174	44	1431	54	1600
Medications	35	218	35	442	35	344
Decubiti	10	3	8	5	9	0
Dehydration	3	0	1	0	0	0
Nutrition	0	1	1	1	1	1
Neglect, Failure to notify MD	1	0	1	0	0	1
Neglect of Supervision	33	1088	37	2559	11	3636
Failure to Report	2	0	0	2	0	0
Entrapment	0	2	0	6	0	4
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegation: Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	20	983	17	1213	11	1748
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	173	55	182	42	148	34
Nursing, Infection Control, Medications	224	15	227	15	207	3
Failure to Report	2	0	0	2	0	0
Other	205	24	157	41	121	29

**Table 3: Hospital Allegations from Complaints / Facility Reported Incidents
SFY08, SFY09, SFY10**

	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	2	7	4	12	0	5
Physical Abuse	12	10	7	20	0	11
Sexual Abuse	5	26	15	20	7	20
Accident	0	1	0	0	0	1
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	0	1	0	1	0	0
Exploitation by other	0	0	0	1	0	0
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	32	3	21	4	5	3
Falls	2	7	8	3	1	1
Medications	6	0	4	1	2	0
Decubiti	1	0	2	1	0	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	1	0	0	0	0	0
Neglect of Supervision	9	56	9	56	2	74
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	2	2	2	1	1	3
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	121	4	103	6	125	10
Nursing, Infection Control, Medications	49	1	47	0	62	0
ER Services	31	0	16	1	17	0
Discharge Planning	18	0	21	0	20	0
EMTALA	7	3	9	1	5	0
Other	54	2	22	2	21	0

**Table 4: Home Health Care Allegations from Complaints / Facility Reported Incidents
SFY08, SFY09, SFY10**

	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	23	30	13	33	20	42
Physical Abuse	28	34	23	41	18	40
Sexual Abuse	11	6	11	17	13	12
Accident	0	1	0	6	0	6
Self Abuse	1	6	4	12	3	8
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	44	82	24	76	34	76
Exploitation by other	7	24	18	58	6	43
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	175	51	81	57	116	70
Falls	8	152	17	163	14	62
Medications	31	30	24	28	23	53
Decubiti	8	3	3	0	2	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	0	0	0	0	0	0
Neglect of Supervision	22	106	44	182	55	204
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	7	60	10	45	9	66
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	130	21	241	27	176	13
Nursing, Infection Control, Medications, Shortage Staff	92	10	191	4	146	3
Other	42	4	35	6	52	6

**Table 5: Other Licensed Entities Allegations from Complaints / Facility Reported Incidents
SFY08, SFY09, SFY10**

	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Abuse	Comp	FRI	Comp	FRI	Comp	FRI
Emotional Abuse	8	13	2	21	2	24
Physical Abuse	9	24	20	44	8	23
Sexual Abuse	9	3	11	1	8	4
Accident	0	0	1	3	0	0
Self-Abuse	0	1	0	177	1	3
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Exploitation	Comp	FRI	Comp	FRI	Comp	FRI
Exploitation by staff	5	18	2	28	4	12
Exploitation by other	0	11	0	25	0	13
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : Neglect	Comp	FRI	Comp	FRI	Comp	FRI
General Health Care	34	47	15	33	24	23
Falls	3	20	8	30	2	17
Medications	4	24	1	50	2	78
Decubiti	0	0	1	1	1	1
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	0	0	0	0	0	0
Neglect of Supervision	10	81	17	104	11	87
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegation : Unexplained Injury	Comp	FRI	Comp	FRI	Comp	FRI
	10	273	9	371	6	251
	FY 2008	FY 2008	FY 2009	FY 2009	FY 2010	FY 2010
Allegations : General	Comp	FRI	Comp	FRI	Comp	FRI
Patient Rights	66	11	77	12	92	10
Nursing, Infection Control, Medications, Shortage Staff	23	4	41	6	36	1
Other	35	7	60	7	51	5

How OHFC Receives and Reviews Information

OHFC receives and reviews complaints and FRIs following intake process and triage processes. (For additional detail on the intake and triaging processes, refer to Appendix A).

Intake Process Recently Revised

Intake staff review each complaint or FRI as it is received. Intake staff are trained to follow specific protocols and policies in assessing which investigative option the complaint or FRI should be assigned. The intake process is continuously revised in response to complaint trends and state and federal regulations. For example, the increase in number of FRIs over the past couple of years has resulted in procedural changes within the Intake Unit to more efficiently process both complaints and FRIs. A LEAN review (a four day focused process to identify inefficiencies in a process, bringing together everyone involved in the process) was done to identify ways to handle this increased volume and maintain timely processing of complaints and FRIs. The LEAN review resulted in the creation of a new phone system “call center”, which will be in place by the end of calendar year 2011. Adjustments to the Intake process included:

- streamlining steps used in logging complaints/FRIs;
- increasing the use of technology to gain efficiency in tracking status of complaints in the triage process;
- providing timely customer service in acknowledging receipt of/response to complaints and FRIs;
- better aligning and using skill sets of Intake staff including assignment of administrative reviews to RN investigator Intake staff;
- refocusing effort on accurate and timely triage to continue meeting required timelines for assignment of complaints for investigation.

Triage Process Revisited and Reaffirmed

The need to set priorities and triage allegations is specifically recognized in both state and federal law. The VAA requires that each lead agency “...shall develop guidelines for prioritizing reports for investigation. Minnesota Statutes 626.557, subd. 9b.” In addition, the Centers for Medicare and Medicaid Services (CMS) also require that the state survey agencies develop triage criteria to govern the review of complaints and FRIs. Both the state VAA and federal requirements specify time frames for the initiation and completion of certain types of investigations.³

Once the intake process is completed, the information will then be reviewed to determine the extent of any further investigative review by OHFC following an established triage process.

³ Chapter 5 of the State Operations Manual outlines the state survey agency responsibilities for the complaint review and investigation process. The State Operations Manual is published by CMS and is required to be used by the survey agencies in implementing the Medicare and Medicaid certification process for nursing homes. Online access to the SOM, publication 100-07, is available at the following website:
<http://www.cms.hhs.gov/Manuals/10M/list.asp>

A number of investigative options are possible, and include:

- **No further review or investigation will occur.** This would happen when there is no alleged violation of rules or regulations (for example, the complaint does not involve a health care facility), when sufficient information is not available (due to length of time since the incident occurred, for example) or when requested medical and other records have been reviewed and no possible violations were identified.
- **Handling the complaint as an administrative review.** The administrative review is used in situations when no actual harm exists to an individual receiving services or potential for harm to other residents and records and information provided from the facility would be considered reliable and credible and an onsite investigation would not add to the investigative review. In this situation, OHFC will contact the facility, indicate that a complaint has been filed, and require the facility to submit to OHFC information relating to the allegation and the steps taken to address those concerns. Cold food and resident room temperatures are examples of common allegations that are handled by an administrative review.
- **Referring the complaint to the Licensing and Certification Program.** The allegation is forwarded to the licensing and certification staff and will be reviewed during the next survey process. Unlike complaints triaged for administrative review, these complaints require an onsite investigation. These complaints are usually of a general nature not involving an allegation of abuse or neglect. Examples of such complaints include neglect issues that do not result in actual harm or that are not recurring; verbal or mental abuse that does not result in a resident feeling frightened or threatened; patient rights issues; physical plant complaints that do not pose immediate threat to the safety of patient/residents; and dietary and housekeeping complaints that do not impact care.
- **Assigning the complaint or FRI for an onsite investigation.** Complaints and FRIs that are determined to require this level of investigation are typically the most egregious and serious in nature. Examples include situations when a potential immediate jeopardy concern has been identified; or when serious neglect concerns are raised such as situations causing fractures, pressure ulcers, or significant weight loss.
- **Referral to another agency.** Stopping abuse or neglect of vulnerable persons is a community effort, and best utilization of resources will ultimately produce maximum results. If the complaint or FRI could be better handled by another agency, OHFC will refer the complaint or incident to them. This would include forwarding possible crimes to local law enforcement officials, discharge concerns and patient rights issues to the appropriate ombudsman, or adult protection issues to county adult protection. OHFC works closely with a number of agencies to broaden the base to respond effectively and timely to complaints and incidents, and avoid duplication of investigation.

Under all investigative options, the complainant or reporting entity is notified of the disposition of the complaint, and their identity is confidential.

The results of the triage process for state FY08, FY09 and FY10 are shown in Table 6.

Table 6: Complaints and Facility Report Incidents Assigned for Further Review *
SFY08, SFY09, SFY10

	FY08	FY09	FY10
Onsite	446	505	440
Administrative Review	373	495	351
Refer to Survey	161	140	112

*These numbers do not reflect referrals made to other agencies or boards or complaints triaged as “no action” required.

Investigations

OHFC’s “investigative process” is used in response to allegations of violations of both state and federal law and regulations. If it has been determined that an onsite investigation of a complaint or FRI is required, further prioritization is completed to assure a timely response based on the nature of the allegation. For example, an onsite investigation of a complaint or FRI that alleges immediate jeopardy must be initiated within two working days of receipt of the allegation. Immediate jeopardy includes those situations which are, or have the potential to be, life threatening or resulting in serious injury.

Complaints and FRIs that allege a higher level of actual harm will be investigated onsite within 10 working days of receipt of the complaint, and consist of situations that result in serious adverse consequences to patient/resident health and safety but do not constitute an immediate crisis and delaying an onsite investigation would not increase the risk of harm or injury. Examples include situations when neglect has led to pressure sores or significant weight loss; when physical abuse has been alleged; when unexplained or unexpected death may have resulted from neglect or abuse; physical abuse of residents; mental or emotional abuse which threatens or intimidates residents; or failure to obtain medical intervention.

Complaints and reports assessed as not having a higher level of actual harm, but having the potential to do so, are assigned for onsite investigation within 45 days. These types of complaints and FRIs include resident care issues, inadequate staffing that has a negative impact on resident health and safety, and patient rights issues.

Complaints that allege a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), often referred to as “patient dumping”, must be investigated within a five-day period.

Two years ago, OHFC management reviewed the amount of time OHFC investigators spent conducting onsite investigations and the amount of time those investigators spent completing the state mandated public VAA maltreatment reports. The ratio of onsite investigation to in-house report writing was about one day to four days respectively – clearly an imbalance in use of investigator time.

As required under the VAA, OHFC is required to complete a public report that is available to complainants, vulnerable individuals and facilities involved with the investigation, and to any person requesting the report. This public report must include items mandated in Minnesota

Statutes, section 626.557, subdivision 12b; however, the public report had become lengthy, included extensive narrative, and required many hours of investigator’s time to write the report. As a result, investigators spent more time in the office documenting their investigations instead of conducting onsite investigations and being visible within the provider community. In addition, the information contained in the previous report did not provide sufficient identity protection for individuals providing evidence during the course of the investigation. There needed to be a better balance between the time necessary to write the public report and the time needed onsite to investigate complaints and FRIs.

A new public report format was developed and implemented in Spring of 2010. The new public report includes all information required in the VAA and is a better format for educating the public on what portions of an OHFC investigation are conducted under Minnesota law (the VAA) and what portions of the investigation are based on violation of state licensure regulations or violation of federal certification regulations. **The new public report is easier to read, reduces the number of hours required to complete the report, resulting in more onsite investigations and visibility in the provider community and allowing OHFC to focus its mission of protecting vulnerable adults in Minnesota’s health care facilities.** In addition, the new report offers increased identity protection for persons involved in the investigation, which encourages sharing information related to complaints and FRIs.

When an onsite investigation is completed, the findings are either substantiated, not substantiated or inconclusive. **A substantiated finding means** a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred. **A not substantiated finding (false) means** a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur. **A finding of inconclusive means** that there is not a preponderance of evidence to show that maltreatment did or did not occur. A preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation, just enough evidence to make it more likely than not that the allegation is true.

Of the 440 onsite investigations assigned in SFY10, 430 were completed in SFY10. Table 7 conveys all onsite investigations that were COMPLETED in the state fiscal year, including any onsite investigations that were not completed in the previous state fiscal year.

**Table 7: Results of Completed Onsite Investigations
SFY08, SFY09, SFY10**

	SFY08		SFY09		SFY10	
	Number	Percent	Number	Percent	Number	Percent
Substantiated	137	32.2	160	32.0	187	21.0%
Inconclusive	114	26.8	126	25.0	200	23.0%
Not substantiated (false)	175	41.0	216	44.0	494	56.0%
Total	426	100	502	100	881	100

Additional staffing in the past two years has assisted in reducing the investigative time frame by decreasing the number of new assignments given to the current complement of investigators, allowing investigators to focus on conducting thorough investigations and completion of supporting documentation. Currently, OHFC assigns approximately 40 onsite complaint

investigations monthly. As noted below, the average number of hours for the completion of onsite investigations, whether or not the investigation is subsequently substantiated, is considerable. The hours reflected are directly related to a decrease in documentation time.

The average hours for completing an investigation are as follows:

	<u>SFY08</u>	<u>SFY09</u>	<u>SFY10</u>
Complaint substantiated	50.6 hrs	32.9 hrs	26 hrs
Complaint unsubstantiated	31.3 hrs	19.3 hrs	16 hrs
Inconclusive	31.2 hrs	25.9 hrs	23 hrs

All VAA investigative reports are referred to the Medicaid Fraud Division of the Attorney General's Office and the long-term care ombudsman receives copies of all public reports. If maltreatment is substantiated, a copy of the report is provided to the Minnesota Department of Human Services, MDH Licensing and Certification, the city and/or county attorney, the local police department, and any affected licensing board.

OHFC and Enforcement

Statistics, such as number of deficiencies and correction orders issued by OHFC, provide a point of reference for purposes of measurement and comparisons; however, the numbers do not always provide an accurate picture of the work undertaken by OHFC. Quality of investigations and community impact are important benchmarks of a successful OHFC program, not merely the number of deficiencies or correction orders issued.

OHFC is devoting more time to serious allegations, which are more clinically complicated and take more time to review. Investigative focus is always getting to the most egregious complaints (which will require a two or 10 day onsite response) and to those health care entities with chronic or a demonstrated pattern of complaints. Special Focus Facilities (SFFs) are an example of one type of health care facility, a nursing home, with federal designation as a poor performing facility. The objective of the SFF program is to decrease the number of persistently poorly performing nursing homes by focusing more attention on a small number of homes in each state with a record of poor quality performance. CMS uses a methodology to identify these SFF candidate facilities. The methodology assigns points to deficiencies on standard surveys and complaint investigations, and to revisits associated with deficiencies cited on standard surveys. Increased oversight from OHFC is given to designated SFFs.

Once OHFC makes a finding of maltreatment involving a nursing assistant working in a nursing home, those findings are reported to the Nursing Assistant Registry (NAR). The NAR is responsible for notifying the nursing assistant and informing the nursing assistant of their appeal rights. When the appeal process is complete, any finding of maltreatment is entered on the Registry, the individual is permanently prohibited from working in a nursing home. These individuals are also referred to the Minnesota Department of Human Services for disqualification under the Background Study Act, Minnesota Statutes 245C, as are other individuals who have maltreated an individual, for whom disqualification is required.

Number of employees with substantiated maltreatment findings:

SFY08	SFY09	SFY10
82	60	56

Number of hearings requested:

SFY08	SFY09	SFY10
19	11	13

OHFC and Education Efforts

OHFC is using its findings to structure training for providers, noting an increase in deficiencies in a particular area and sharing that information with providers. For example, this federal fiscal year, OHFC noticed an increase in the issuance of FTag 323 free of accident/hazards/supervision/devices. Upon further examination, OHFC noted that the increase was largely due to neglect of care due to problems in using Hoyer lifts. OHFC alerted the nursing home professional associations about this discovery and the associations were able to alert providers to take measures to train or retrain in the use of this lift to prevent accidents and reduce the issuance of FTag 323. Part of OHFC's mission is to identify these types of situations where preventive measures can be undertaken to reduce or eliminate future incidents.

Another issue that OHFC addressed together with providers was the federally required reporting of "neglect" incidents "immediately" but no longer than 24 hours from the discovery of the reportable incident. Perhaps to prevent being cited by MDH for not reporting, facilities have been "over reporting" incidents, resulting in an inefficient use of facility and OHFC staff time associated with these reports. OHFC conducted a video conference for providers to educate them about and define reporting requirements in an effort to reduce unnecessary reporting. There is still an education need in this area as the number of facility reported incidents continue to increase.

Work continues with MDH's Licensing and Certification Section to identify and resolve any inconsistencies in survey protocol implementation between the two sections, as well as joint efforts in provider education.

OHFC remains committed to participating in professional education and development efforts in furtherance of its mission. Presently, OHFC is revising the orientation of new investigators to focus early attention on developing investigation techniques, allowing new investigators more time to work with experienced investigators in the field to develop investigative skills. Federal training will start after the investigator has had field experience in how to conduct a thorough investigation. This training sequence will promote optimal application of the information covered in the federal training.

OHFC and Collaboration Efforts

One of MDH's five value statements is: "Collaboration. We value the diversity and unique contributions of our employees and partners. We develop positive relationships, foster innovative solutions, and strengthen our capacity to accomplish our mission."

Regulation and enforcement, on the surface, may not seem compatible with the practice of collaboration. However, OHFC actively seeks opportunities to collaborate with advocates, providers and consumers to improve the delivery of health care services to Minnesota's vulnerable citizens. With improved delivery of those services, we can achieve the goal of an increasingly positive outcome for the recipients of those services. There continues to be a growing number of Minnesotans, especially vulnerable children and adults, who need health care services at a time when financial and human resources to pay for and deliver that care are insufficient to meet demand.

Government resources are finite and stretched. The reality is that not every complaint OHFC receives can, nor should be, investigated onsite; there are not sufficient resources. Over the past two years, OHFC has collaborated with a number of government and private sector non-profits agencies to work together to strengthen everyone's ability to meet the needs of vulnerable persons. Examples include:

- The Licensing and Certification Section in the Compliance Monitoring Division worked to identify facilities with chronic compliance problems and develop solutions to bring about compliance as well as consistency of effort.
- The Home Care and Assisted Living Program (HCALP) in the Compliance Monitoring Division, that conducts surveys of licensed only home care providers. OHFC monitors complaints and FRIs received and notifies HCALP staff of providers that may be faltering based on the number and nature of complaints and FRIs received. HCAP may elect to adjust the survey schedule in response to this information.
- The Department of Human Services (DHS) and OHFC work together to avoid duplication of services and over-regulation related to dually licensed facilities, such as investigation of complaints when both agencies issue a license. For example, a Supervised Living Facility, or SLF, receives a program or treatment license from DHS and a physical plant license from MDH. There is now an integrated system to conduct background studies on facility staff. Changes to legislation to improve interdepartmental efficiencies are mutually identified, reviewed and supported.
- The Office of Ombudsman for Long-term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities to maximize assistance with addressing and resolving consumer complaints, and identifying systemic compliance issues that may require legislative or policy changes to correct. Although the advocacy agencies, such as these ombudsman offices, may have a different focus than a regulatory program, all are committed to improving the quality of care provided to and the protection of vulnerable adults in Minnesota. Ombudsman provide: information and consultation about consumer

rights and the regulations that apply to various health care settings; handle complaints and problems relating to quality of care, rights violations, service termination, discharge or eviction; and advocate for reform in health care delivery systems through changes in state and federal law and administrative policy. OHFC works with ombudsman staff on specific resident and enforcement issues, and seeks input on process issues. For example, OHFC is currently working with the long-term care ombudsman on a nursing home discharge process to assure that residents receive appropriate notice and discharge planning assistance.

- OHFC staff has served on the Vulnerable Adult Justice Project (VAJP) since its inception in 2007. This group is a vehicle where public advocacy organizations, elder and disability organizations, health care providers, area agencies on aging, adult protection staff, city and county prosecutors, state agencies, and elder law attorneys can come together and build consensus on efforts to improve the lives of the vulnerable adults in the state's various health care settings. OHFC works with this group to promote changes to Minnesota laws, rules, and policies to protect vulnerable adults. This collaboration provides a vehicle for OHFC to be proactive in preventing the abuse and neglect of all vulnerable adults.

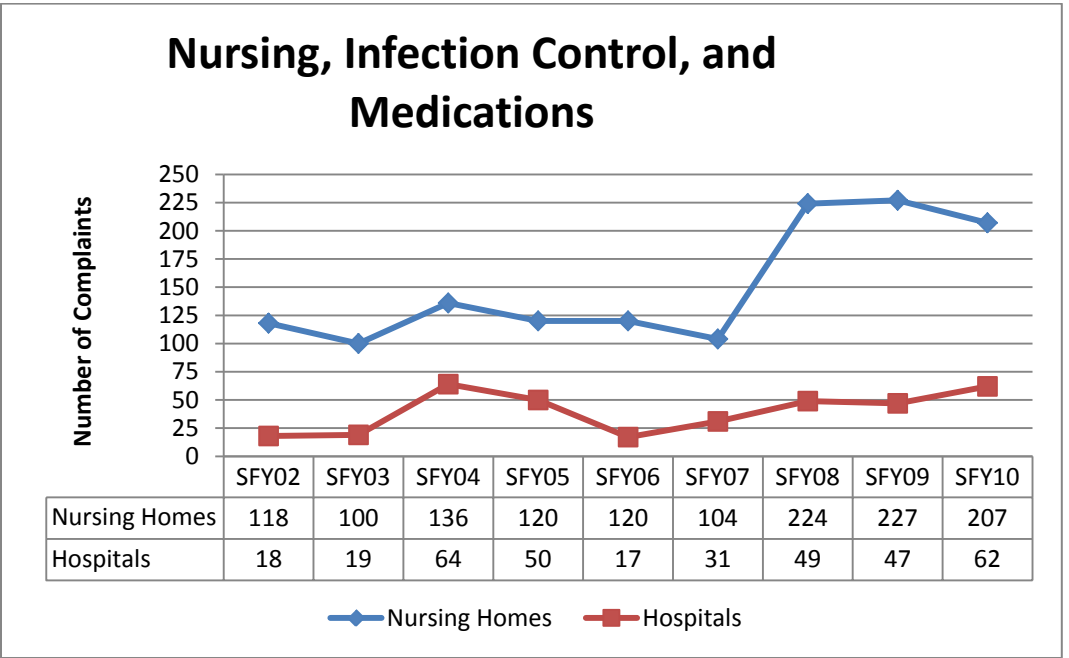
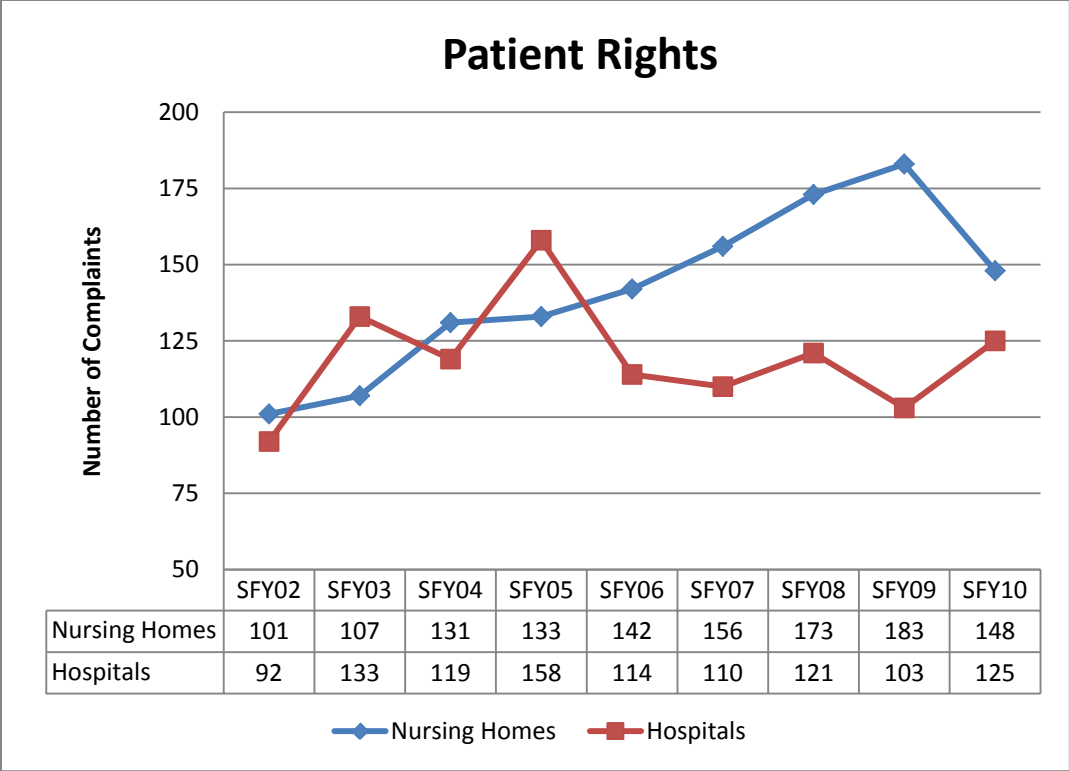
Work with these various entities has promoted a framework for a comprehensive approach to providing training and resources for education efforts and resolution of complaints that OHFC is not able to address.

Trend Identification

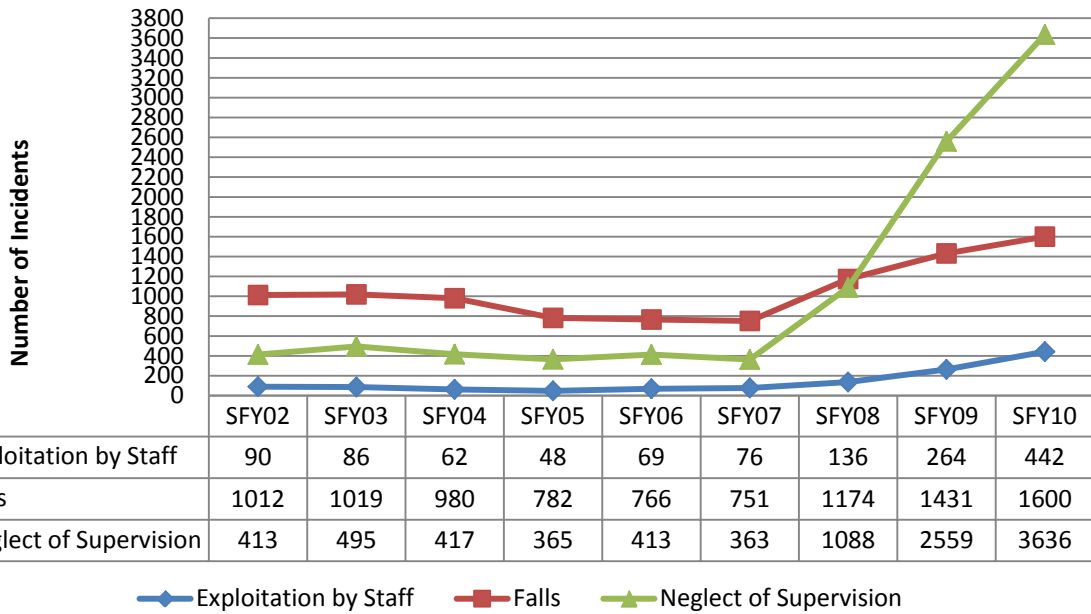
Data collected for this required annual report dates back to SFY02. Since that time, there have been some notable trends, including:

- Increases in the number of complaints about patient rights in hospitals and nursing homes;
- Increases in specific areas of complaints such as nursing, infection control, and medications in nursing homes and hospitals;
- Increases in the number of FRIs related to exploitation of residents by staff, falls and neglect of supervision in nursing homes;
- Increases in aggregated complaints and FRIs about home health providers and other licensed entities;

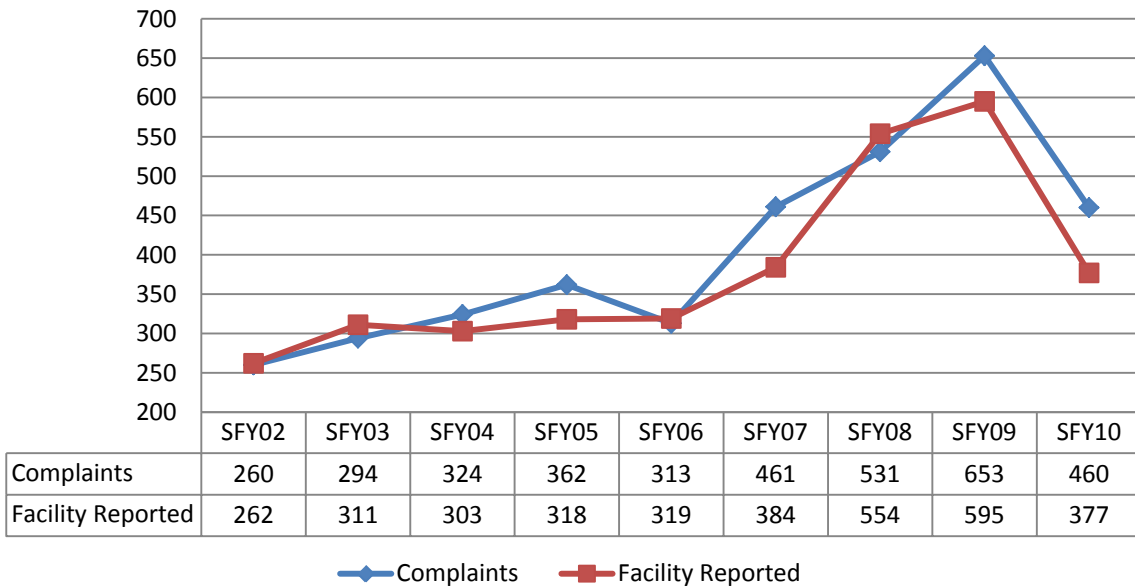
The graphs below show the selected trends:

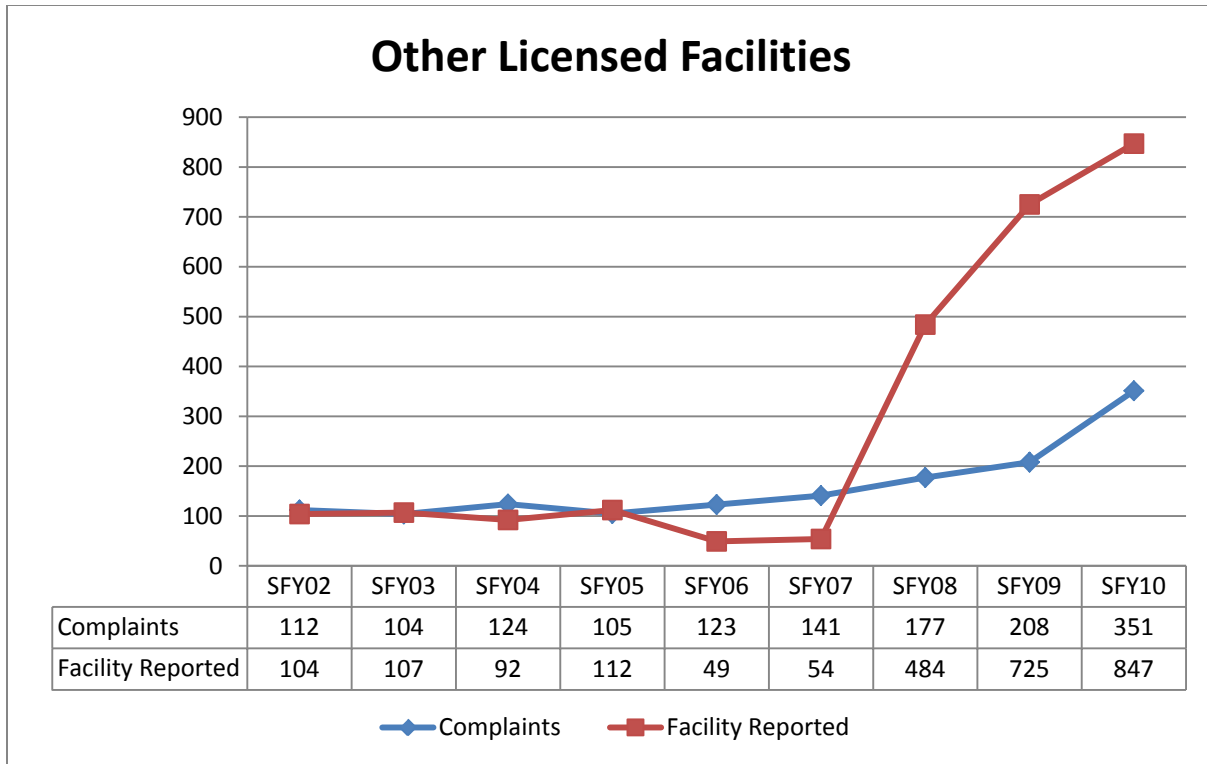


Facility Reported Incidents in Nursing Homes



Home Health





OHFC will take a more critical look at these and other historical data collected and evaluate this information along with making improvements in the office’s internal data management processes. Both efforts will inform future quality improvement goals.

OHFC’s Performance

OHFC has initiated efforts to streamline its operations for maximum efficiency, has identified ways to leverage resources to do more with less, and has undergone extensive reviews by CMS assessing its performance. As a result, OHFC has initiated additional staff training in the following areas:

- 1) triage, to assure that the most egregious complaints are investigated according to federal time frames;
- 2) thoroughness of investigation, to assure that all final determinations are made on all relevant information and evidence;
- 3) refocused efforts on assuring compliance with state and federal regulations in the writing of public reports, issuance of state orders and federal deficiencies; and
- 4) improved investigation techniques used in maltreatment investigations so that MDH findings, when challenged, are sustained in hearings.

One of the areas required to be addressed in this report is whether or not there is a backlog of cases and whether OHFC investigative activities conform to statutory time lines.

Under the provisions of the VAA, OHFC as the “lead agency” has a number of specific time frames to meet. These include providing information on the initial disposition⁴ of a report within five business days from receipt; completing the final disposition within 60 days of its receipt; providing a copy of the investigative report within 10 days of the final disposition to parties identified in the VAA and responding to requests for reconsideration within 15 days of the request.

The most significant time frame relates to the completion of the final disposition within 60 days. As defined in the VAA, the final disposition is the determination as to whether or not the maltreatment report will be substantiated, inconclusive, etc.

OHFC has generally met the time frames for the initiation of onsite investigative reviews; however, completion of the investigative reports does not meet the 60 day time limit in the VAA, which includes the issuance of the public report. The average completion days for VAA resolved reports have been an average of 107.5 days for SFY08, 142.7 days for SFY09 and 136.9 days for SFY10. The goal of OHFC is to reduce the time frame between an onsite investigation and issuing the public report on the investigation’s result to within 60 days.

Part 2: The Authority and Responsibility of the Office of Health Facility Complaints Regarding Federally Certified Nursing Homes

While not specifically required to be included in this report under the reporting provisions outlined in Minnesota Statutes §626.557, subdivision 12b, clause (e), the department believes that it is appropriate to provide information relating to the activity and performance of OHFC under the federal certification requirements; this provides a more complete picture of the work of the program. Funding formulas for OHFC activities are derived from both state and federal funding sources. In addition, CMS and the state of Minnesota have recognized the benefit to vulnerable adults when OHFC follows the thorough protocols of CMS when conducting complaint investigations.

Chapter 5 of the CMS State Operations Manual (SOM) outlines the protocols to be followed by the state survey agency for complaint investigations. Due to the similarities between the state and federal regulations for nursing homes, these federal protocols are utilized for nursing home investigations under both federal and state law.

The OHFC triage policy incorporates the more precise federal requirements for determining the type of allegations and the timeline for the initiation of a complaint investigation. It is these provisions that mandate that investigations of allegations of immediate jeopardy are to be investigated within two days and that investigations of allegations of “high actual harm” are to be investigated within 10 days. 87% of the total number of onsite nursing home investigations (416 of the 477) conducted by OHFC fell within those two categories in FFY10.

⁴ As defined in the VAA, the initial disposition is the lead agency’s determination as to whether the report will be assigned for further investigation.

Table 8 identifies the number of investigations that needed to be initiated within two days and the number of investigations that needed to be initiated within 10 days. The compliance percentage is also included.

Table 8: FFY10 OHFC Onsite Nursing Home Complaint and Facility Reported Incident Investigations Required within 2 or 10 Days

Type of complaint or incident	Onsite investigations	Onsite investigations within required time	Percent within required time
Nursing home	477 total	397 of 416	95.4%
Nursing home required within 10 days	364	347	95.3 %
Nursing home required within 2 days	52	50	96.1%

Immediate Jeopardy and Substandard Quality of Care Determinations

If it is determined that investigative findings identify that substandard quality of care⁵ exists, a partial extended survey will be completed. This is defined as follows:

Partial extended survey means a survey that evaluates additional participation requirements and verifies the existence of substandard quality of care during an abbreviated standard survey.

During FFY10, OHFC conducted six partial extended surveys out of the 477 onsite nursing home investigations. The completion of the partial extended survey was required as the result of the issuance of six federal deficiencies. Of the six, five were both immediate jeopardy (IJ) and substandard quality of care tags (SQC). Table 9 summarizes the tags issued.

Table 9: Deficiencies Issued as a Result of Partial Extended Survey FFY10

Nursing Home	Tag and Scope and Severity	Immediate Jeopardy	Substandard Quality of Care
#1	F333 - K	Yes	Yes
#2	F323 - J	Yes	Yes
#3	F323 - K	Yes	Yes
#4	F333 - J	Yes	Yes
#5	F323 - K	Yes	Yes
#6	F323 - H	No	Yes

⁵ "Immediate jeopardy" is defined as a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. "Substandard quality of care" means one or more deficiencies related to the requirements under 42 CFR 483.13, resident behavior and facility practices (Tags 221-226), 42 CFR 483.15, quality of life (Tags 240-258), or 42 CFR 483.25, quality of care (Tags 309-333), that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F).

The requirements for a partial extended survey are specified in Section III of Chapter 7 of the SOM.

Results of OHFC Complaint Investigations in FFY10

During FFY10, 83 of 477 OHFC onsite nursing home investigations resulted in the issuance of 150 federal certification deficiencies. Licensing and Certification (L&C) surveyors issued an additional 31 deficiencies when surveyors substantiated complaints referred by OHFC for investigation at the time of a recertification survey (these deficiencies were issued during 15 recertification surveys). Deficiencies were issued to 56 separate nursing homes by OHFC. An additional 13 nursing homes were issued deficiencies as the result of more than one complaint investigation by OHFC.

Although maltreatment may not be determined, due to burden of proof requirements in the VAA such as availability of evidence to support preponderance of evidence, OHFC has moved in the direction of issuing more state correction orders and federal deficiencies for violations of regulations. This has a systemic effect on facility compliance. For example, citing the violations requires the facility to take corrective measures, and in order to correct it must figure out the cause of non-compliance. This allows the facility to identify and implement corrective action and prevent further incidents and OHFC intervention.

The systemic change can also be attributed to OHFC working closely with the Licensing and Certification Program to recognize possible violations and to avoid incidents of maltreatment, with the end result being an increase in the safety of vulnerable adults in health care facilities.

A total of 102 state licensing orders were issued to 56 different nursing homes during FFY10 as a result of an onsite OHFC investigation. All but two licensing orders were found to be in compliance within the required time period; and two state penalty assessments were issued as a result of those 102 licensing orders. The potential fine amounts for these licensing orders ranged from \$0 per day/per order to \$500 per day/per order.

Table 10: Deficiencies and State Licensing Orders Issued FFY10

Note: Deficiencies and Licensing Orders correspond as listed

Federal Deficiencies:	State Licensing Orders:
F157 – Failure to Report Significant Change 7-D; 1-G	MN Rule 4658.0085A-E Notification of Change in Resident Health Status (6) \$350 daily
F202 – Transfer or discharge & documentation 1-D	
F203 – Transfer or Discharge/notice before 3-D	144.651, subd. 29, \$250 (2)
F205 – Notice of Bed-hold & Readmission 1-D	
F221 – Physical Restraints 1-D	4658.0300, Use of Restraints, subp 1-5, (2) \$300-\$500 daily
F225 – Not Employ Persons Guilty of Abuse 18-D; 1-E	626.557, subd.3 (8), \$250; subd. 4 (2), \$100; subd. 14 a&b(5), \$100
F226 – Abuse; intent: facility policies and implementation 12-D; 3 -E; 1-F	
F241 – Dignity 3-D; 4-E	144.651, subd. 5 (4), \$250
F246 – Accommodation of Needs 1-D	144.651, subd. 6 (1), \$250
F248 – Activities 1-E	
F253 – Housekeeping/maintenance services (interior) 3-E	4658.1415, subp. 4(1) \$200
F271- Admission orders 1-D	
F272 – Comprehensive Assessment 6-D; 1-G	4658.0400 Comprehensive Resident Assessment (5) \$300 daily
F274 – Significant change 1 -D	
F278 – Accuracy of Assessment 1-D; 1-G	
F279 – Comprehensive Care Plans 4-D; 2-E; 1-G	4658.0405 subp.2, Comprehensive Plan of Care, Contents (7), \$300 daily
F280 – Dev Prep/Review of Comprehensive Care Plan 1-D	4658.0405 subp.1&4, Comp Plan of Care, Development & Revision (1), \$300 daily
F282 – Services Provided in Accordance with Care Plan 6-D; 1-G	4658.0405, subp.3, Comprehensive Plan of Care, Use (4) \$300 daily
F309 – Fail to Provide Necessary Care 4-D; 6-G	4658.0520, subp.1, Adequate and Proper Nrsng Care, Care in general (6) \$350 daily
F312 – Necessary services for maintaining ADLs 1-D	4658.0520, subp 2(1) \$250 & subp. 6B(1) \$350
F314 – Pressure Sores 1-G	
F315 – Urinary Incontinence, 3-D; 1-E	4658.0520, subp. 2 Adequate and Proper Nrsng, Criteria for Determining (1) \$300-\$350 daily
F323 – Accident 12-D; 1-E; 23-G; 1-H; 1-J; 2-K	4658.1400 Physical Environment (7) \$200 daily; 4658.0520 subp. 1 Adequate Nrsng Care, Care in General (21) \$350 daily
F327 – Hydration 1-G	
F328 – Proper Treatment/Care for Special Care Needs 1-D	4658.0525 subp.8 Rehab Nrsng Care & Prosthetic Devices (1) \$350 daily
F329 – Unnecessary Medications, 1-D	4658.1315 Unnecessary Drugs ABCD (1)
F332 – Med Error Rates of 5% or More 1-D; 1-E; 1-G	4658.1320 subp.A Med Errors (3) \$500
F333 – Medication Errors 1-D; 1-J; 1-K	
F353 – Suf Nrsng Staff on a 24 hr basis 3-E; 1-F	
F356 – Nurse staffing information 1-C	
F364 – Food 2-E	
F425 – Pharmacy Services 2-D; 1-E; 1-F	4658.1325 subp.1 Admin of Meds Pharmacy Services (1) \$500; 4658.1305 subp.A&B Pharm Servs Consultation (1) \$500;
F428 – Drug regimen review 1-D	4658.1310 subp.A (1) \$300

Federal Deficiencies:	State Licensing Orders:
F431 – Labeling and Storage of Drugs 1-E	4658.1340 subp.1 Medicine Cabinet, Storage (1) \$300
F441 – Facility Estab Infection Control Program 4-D; 2-E; 1-J	4658.0800 subp.1 Infection Control Program (2) \$300 daily; 4658.0800 subp. 4 policies and procedures (2) \$300 daily
F444 – Hand Washing 1-D	
F465- Other Environmental Conditions, 3-E; 1-F	4658.1415 subp.2 & 3, Plant Housekeeping, Operation/Maintenance, Grounds (2) \$200 daily
F467 – Adequate ventilation 2-E	4658.5405 (1) \$200 daily
F497 – Regular Inservice Education 1-D	
F514 – Clinical Records Meet Appropriate Stnds 1-F	4658.0450 Clinical Record Contents subp 1A-P (1) \$300 daily

86 post certification revisits were conducted by OHFC during FFY10. These revisits were generally conducted onsite. A phone or written verification of compliance occurs rarely, if at all.

During FFY10, 20 federal civil money penalties (CMPs) were recommended by OHFC. CMS imposed 20 civil money penalties. OHFC recommended the imposition of 135 denial of payments for new admissions and five were imposed by CMS.

During FFY10, the remedies, other than civil money penalties, recommended and imposed as the result of onsite investigations is as follows:

TYPE	RECOMMENDED	IMPOSED
State Monitoring	24	24
Discretionary Denial of Payment	135	5
23-Day Termination	0	0

During FFY10, the following civil money penalties were recommended and imposed:

TYPE	RECOMMENDED	IMPOSED
Per Instance	19	19
Per Day	1	1

CMS imposed CMPs as recommended by OHFC.

Referrals to the Nurse Aide Registry or to Licensure Boards

OHFC is required to make referrals to appropriate licensure boards under the provisions of Minn. Stat. §626.557, subd. 9c, clause (g).

It is the practice of OHFC to refer all substantiated maltreatment reports involving licensed nurses to the Board of Nursing (BON). The report includes private data. The BON then determines which nurse(s), if any, to contact. In addition, if an investigation identifies that maltreatment by unlicensed personnel occurred due to inadequate training, supervision, or direction by a licensed nurse or nurses, the report will be forwarded to the BON for review.

Similarly, the nursing home administrator is responsible for the operation and management of the nursing home. In accordance with the Board of Examiners for Nursing Home Administrators (BENHA), OHFC refers all substantiated maltreatment reports to BENHA for its review.

42 CFR 488.335 (f) also requires that OHFC report substantiated findings of abuse, neglect or misappropriation of resident property to the Nurse Aide Registry. During FFY10, 36 such findings were made against nursing assistants and submitted to the Registry. Names are now reported to a national database to better track substantiated perpetrators of abuse across state lines.

Access to OHFC Investigative Reports

A copy of each completed OHFC investigation, including a copy of any deficiencies or correction orders issued as a result of the investigation, can be accessed at the following link: <http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm>

Independent Informal Dispute Resolution (IIDR) and Informal Dispute Resolution (IDR)

Any deficiency issued by OHFC is subject to the IIDR or IDR process utilizing the same process that is in place for deficiencies issued by the Licensing and Certification program.

During FFY10, 15 of the 181 deficiencies issued by OHFC and L&C (in response to complaint investigations) were the subject of either an IIDR or IDR. Table 11 summarizes the type of review requested and scope and severity (s/s) of tags disputed.

Table 11: IDR and IIDR Reviews Requested and Tags Disputed FFY10

	IDR	IIDR
Total requested	26	11
# of tags disputed	54	24
# that involved OHFC	9	2
# of OHFC tags disputed	13	2
Scope and severity of OHFC tags	6 D, 1 E, 4 G, 1 K, 1 L	1 G, 1 E
Resolution of OHFC tags	1 E to D 1 K to D delete 1 D 1 G to D No change: 5 D, 3 G, 1 L	No ALJ reviews pending 1 Freedom of Information Request Pending (FOIA) involving G tag 1 review withdrawn by nursing home prior to IIDR involving 1 tag @ s/s E

Reconsiderations and Appeals

Under the provisions of the VAA and federal regulations relating to findings of maltreatment against nursing home personnel, if a facility or an individual is determined to have neglected, abused or financially exploited a nursing home resident, the facility or individual can request an informal reconsideration. If the facility or individual is not satisfied with the decision after this

reconsideration process, a fair hearing under the provisions of MN Statute 256.045 can be requested.

Under the federal regulations, specific findings of neglect, abuse or financial exploitation are also submitted to the Nurse Aide Registry once any requested reconsiderations or hearings have been completed. During FFY10, findings of neglect, abuse, or financial exploitation for 36 individuals were added to the Registry.

Under the provisions of Minnesota Statutes §626.557, subd. 9d, clause (b), a vulnerable adult or other interested party not satisfied with the results of an investigation can request a review of these findings under the provisions of Minnesota Statutes §256.021. During FFY10, two requests were made for these reviews.

New legislation passed in 2011 will increase vulnerable adults' participation in hearings related to overturning maltreatment findings against an individual and against a facility. These changes include a stronger notification system and consideration of written impact statement.

Areas of Focus in FFY10

OHFC completed work in all areas of focus for federal fiscal year 2010:

- the hiring of an investigator to focus on and work with state licensed facilities in a variety of capacities;
- continued work on refining protocols and streamlining the triaging and investigative process to decrease the timeframe for completion of investigations and the issuance of the public report;
- cross training of support staff to assure uninterrupted work flow;
- creation of a proactive process to identify retirements and terminations to prevent open investigator positions for prolonged periods of time.

Areas of Focus for FFY11

OHFC is committed to continuous quality improvement. To that end, OHFC will focus on the following areas in FY2011:

- Needed improvements in the Office's data management systems and processes;
- Additional and ongoing training in investigative techniques;
- Revisions to orientation and mentoring programs to provide comprehensive and consistent support for staff;

- Further refine systems to decrease the time between onsite investigation and completion of a public report;
- Additional provider education to reduce the reporting of unnecessary FRIs

The federal Elder Justice Act of 2009, which is part of the Affordable Health Care Act, contains a new requirement related to reporting of suspicion of crimes in nursing homes, within 24 hours to OHFC and law enforcement. OHFC will assume the lead role in working with all stakeholders affected by this requirement to assure a smooth transition.

Appendix A: OHFC Intake, Triage and Survey Process

Chapter 5 of the SOM outlines the protocols to be followed by the state survey agency for complaint investigations. Due to the similarities between the state and federal regulations for nursing homes, these federal protocols are utilized for nursing home investigations under both federal and state law.

Complaint investigations in certified nursing homes are referred to as abbreviated standard surveys. This term is defined in § 7001 of the SOM as follows:

Abbreviated Standard Survey means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern.

Section 7203 E, of Chapter 7 of the SOM outlines the expectation for an abbreviated standard survey:

This survey focuses on particular tasks that relate, for example, to complaints received, or a change of ownership, management, or Director of Nursing. It does not cover all the aspects covered in the standard survey, but rather concentrates on a particular area of concern(s). The survey team (or surveyor) may investigate any area of concern and make a compliance decision regarding any regulatory requirement, whether or not it is related to the original purpose of the survey complaint.

Sections 5400 to 5450 of the SOM contain specific requirements and outline specific tasks to be completed during the abbreviated standard survey. These tasks include the following:

- **Section 5410 - Offsite Survey Preparation:** This includes the review of the allegation as well as other information that may have been received during the intake/triage process. It is during this process that other information regarding the facility such as prior survey and complaint history and discussions with the ombudsman about similar complaints would occur.
- **Section 5420 - Entrance Conference/Onsite Preparatory Activities:** Onsite investigations must be unannounced and at the time of the entrance, the general purpose of the visit will be provided. The investigator needs to assure that the confidentiality of individuals identified as part of the complaint, such as the reporter or specific residents, be protected.
- **Section 5430 - Information Gathering:** In addition to determining whether the complaint is substantiated, the OHFC investigative process is also required to determine the degree of facility compliance with the regulations and to determine if other residents, not specifically identified in the allegation, are at risk.

It is important to note that OHFC has the authority to investigate the allegations that initiated the onsite investigation, and an obligation to expand that review to assure that similar concerns do not affect other residents in the facility. For this reason, OHFC will review records of a number of residents, make required observations in the areas identified as a concern, review incident reports to determine frequency of concerns or whether there is a possible pattern of noncompliance, and complete other tasks as necessary to determine whether the facility is in compliance with a regulation and the scope and severity of any noncompliance. If during the course of the investigation other unrelated findings of noncompliance are identified, OHFC investigators are required to issue appropriate federal deficiencies or state correction orders. All OHFC investigators are qualified surveyors and have passed the federally required SMQT tests.

- **Section 5440 – Information Analysis:** This is the step that determines whether the information obtained during the investigation will substantiate the complaint and determine if the nursing home has violated any regulatory provisions, and whether corrective action had been initiated by the facility. Information gathered by the investigator is reviewed by either the Director or Assistant Director of OHFC. Decisions are made as to whether the information supports the investigator’s recommended deficiencies or correction orders or whether additional information is needed.
- **Section 5450 – Exit Conference:** Once the information analysis has been completed, including the required supervisory reviews, the investigator will advise the facility administrator whether deficiencies or correction orders will be issued.