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Annual Quality Improvement Report on the Nursing Home Survey Process

Minnesota Department of Health
*Report to the Minnesota Legislature for
Federal Fiscal Year 2012*

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I. Executive Summary

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

- The number, scope, and severity of citations by region¹ within the state;
- Cross-referencing of citations by region within the state and between states within the CMS region in which Minnesota is located;
- The number and outcomes of independent dispute resolutions;
- The number and outcomes of appeals;
- Compliance with timelines for survey revisits and complaint investigations;
- Techniques of surveyors in investigations, communication, and documentation to identify and support citations;
- Compliance with timelines for providing facilities with completed statements of deficiencies; and,
- Other survey statistics relevant to improving the survey process.

The Minnesota Department of Health (MDH) is also to identify inconsistencies, patterns, and areas for quality improvement in the report.

This report was prepared by staff of the Division of Compliance Monitoring. This report is the ninth annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year 2012 (FFY12), which occurred from October 1, 2011 through September 30, 2012.

While this is a legislatively mandated report, its development allows the Department to reflect on our past successes, as well as areas for improvement. Some successes seen in FFY12 include improved overall consistency and accuracy. From a large-scale perspective, Minnesota is tied for the highest percentage of surveys in our Region that would provide facilities an opportunity to correct identified deficiencies before remedies are imposed. On a smaller scale, data produced from a quality improvement method using Mix-Max surveys² shows the number of deficiencies issued by Mix-Max survey teams compared to non-Mix-Max survey teams is consistent, and only differentiated by less than 1 deficiency per survey. This indicates there is an overall low variability between districts and reflects survey consistency statewide.

This report also highlights opportunities for improvement. Some of these areas include the continuous goal of meeting 100% our time requirements and to focus on trending deficiencies issued relating to quality of life/quality of care to improve resident care.

¹ FFY12 resulted in more mixed teams to the extent that it was challenging to find relevant comparisons by district/region across the state. Data will be gathered in a meaningful way to analyze regional comparisons by FFY14.

² More information regarding Mix-Max Surveys is found later in this report

II. Introduction

A. Survey Process

1. General

The Licensing and Certification Program of the Division of Compliance Monitoring of MDH surveys nursing homes that are federally certified to provide care to Medicare and Medicaid clients using federal standards. MDH is under contract with the Center for Medicare and Medicaid Services (CMS) to conduct all federal certification inspections. There are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. MDH contracts with the Minnesota State Fire Marshal's (SFM) office to conduct the LSC portion of the inspection, which must be completed within seven days of the health portion of the recertification survey. It is federally mandated that recertification surveys be conducted at least every 15.9 months, though it is typical that a provider receives a recertification survey annually.

The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The LSC, which is revised periodically, is a publication of the National Fire Protection Association (NFPA), which was founded in 1896 to promote the science and improve the methods of fire protection. The basic requirement for facilities participating in the Medicare and Medicaid programs is compliance with the 2000 edition of the LSC.

Health surveys are performed by teams of MDH employees (usually three or four people) who are specialists in inspecting nursing home care. The surveyors have backgrounds in nursing, social work, dietetics, sanitation, health care administration and counseling. These individuals must complete required training and pass a test administered by the federal government to qualify as nursing home surveyors.

Surveys are unannounced and are conducted to make sure that the nursing home is meeting state licensing and federal certification standards. Surveys review quality of care and quality of life in the facility, whether residents' rights are observed, and whether the facility meets environmental standards of cleanliness and is hazard-free. Facilities that do not meet all these standards must correct these deficiencies or they face a variety of federal and/or state sanctions. A deficiency indicates a provider's failure to meet a state licensure or federal certification requirement. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm.

When surveyors find a facility out of compliance with a federal regulatory requirement, the survey team issues a deficiency and the facility is then required to correct the deficiency to come

into compliance with regulatory requirements. A Statement of Deficiencies (CMS-2567) is provided to the nursing home, which contains the findings of the survey. A written Plan of Correction (PoC) is then required and state surveyors conduct a revisit to determine whether substantial compliance has been achieved.

2. The Revisit Process

Since the PoC serves as the facility's allegation of compliance, a post certification revisit (PCR) is conducted to determine whether substantial compliance has been achieved. Substantial compliance cannot be ascertained and any remedies imposed cannot be changed or rescinded until facility compliance has been verified. Revisits may be conducted anytime for any level of noncompliance subject to the allowed number of revisits, and both paper/administrative reviews and onsite reviews are considered to be revisits. Two revisits are permitted at the State's discretion without prior approval from the regional office; a third revisit may be approved only by the CMS Regional Office. See Appendix A for more information regarding the federal revisit policy and timing.

3. QIS Survey Process

In 2005, CMS piloted a new nursing home survey process called the Quality Indicator Survey (QIS). The 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. Minnesota's training was completed in March of 2010. As of FFY11, all surveys in Minnesota were conducted by QIS survey process.

The QIS is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the Federal requirements³. The QIS was developed to produce standardized resident-centered, outcome-oriented reviews. It uses an automated process that guides surveyors to systematically and objectively review all regulatory areas. The QIS was designed to meet the following objectives:

- Improve consistency and accuracy of quality of care and quality of life problem identification by using a more structured process;
- Enable timely and effective feedback on survey processes for surveyors and managers;
- Systematically review requirements and objectively investigate all triggered regulatory areas within current survey resources;
- Provide tools for continuous improvement;
- Enhance documentation by organizing survey findings through automation; and

³ See *CMS Quality Indicator Survey* at <http://www.ucdenver.edu/academics/colleges/medicalschoo/departments/medicine/hcpr/qis/Documents/QIS-brochure-SC-08-21-01-2008.pdf>

- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

One of the other benefits of QIS survey process is the data that can be produced. The University of Colorado, under contract with CMS, creates and processes the Desk Audit Reports for State Agencies (DAR-SA) and Desk Audit Reports for Regional Offices (DAR-RO). These reports are derived from QIS data and are used by state agencies and CMS regional offices to evaluate variation in QIS survey results and to conduct quality assurance activities. This data can help survey staff identify variances and opportunities for quality improvement, and take corrective action when appropriate. Information regarding these reports will be discussed later.

4. Survey Techniques

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use the worksheets in conjunction with the Guidance to Surveyors. The Guidance to Surveyors assists in gathering information in order to determine whether the facility has met the requirements⁴. An example might include the following:

The facility has care plan objectives, which are measurable. If the resident does not meet her/his goals, does the documentation reflect how the lack of implementation of the care prevents the resident from reaching her/his goals?

In addition, the surveyors include information about how the facility practice affected residents, the number of residents affected, and the number of residents at risk. There are also record reviews, observations, and formal and informal interviews conducted. This is important since the documentation gathered will be used both to make deficiency determinations and to categorize deficiencies for severity and scope.

Throughout the survey, surveyors discuss observations, as appropriate, with team members, facility staff, residents, family members, and the ombudsman. Maintaining an open and ongoing dialogue with the facility throughout the survey process is very important to MDH. This gives the facility the opportunity to provide additional information before the survey team makes any deficiency determinations.

⁴ See SOM Appendix P – Survey Protocol for LTC Facilities, http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_p_ltcf.pdf

B. Complaint Investigation Process

The Office of Health Facility Complaints (OHFC) is a section within the Division of Compliance Monitoring and is responsible for investigating complaints and facility-reported incidents of alleged violations of compliance with state and federal regulations, as well as allegations of maltreatment in licensed health care facilities in Minnesota. Although OHFC was created by the Legislature in 1976 to review and investigate allegations of non-compliance with state regulations, investigations of federal noncompliance were later added to OHFC's responsibilities to widen the safety net for vulnerable adults in Minnesota who reside in licensed facilities.

Minnesota state and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. A complaint is an allegation of noncompliance with federal and/or state requirements. 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. All complaints are reviewed and triaged to achieve the best outcome for vulnerable adults. Therefore, OHFC may investigate complaints under state and/or federal regulations.

The CMS State Operations Manual (SOM) outlines the protocols to be followed by the state survey agency for complaint and Facility Self Report 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.

State law also mandates that allegations of maltreatment against a vulnerable adult or a minor be reported by the licensed health care entity. 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.

The Vulnerable Adults Act requires the reporting of neglect, abuse, financial exploitation and resident to resident altercations that result in harm, which is defined in Minnesota Statutes 626.5572. Under Federal regulations, Medicaid/Medicare certified facilities are also required to report to OHFC allegations of alleged violations of abuse, neglect, and misappropriation. These state and federal reports are referred to as "Facility Self Reports."

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. Although a vulnerable adult or their health care agent can appeal an inconclusive finding, facilities and alleged perpetrators are limited to appealing only substantiated maltreatment determinations.

If an onsite investigation of maltreatment is conducted, the state VAA allows for one of the three following determinations:

- ***Substantiated*** – A substantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred;
- ***Not substantiated***– An unsubstantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur; or
- ***Inconclusive*** – A finding of inconclusive means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

As earlier mentioned, 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. Findings of on-site maltreatment investigations are available on the MDH website.

If an investigation substantiates noncompliance with state and/or federal regulations, deficiencies and/or state orders may be issued against the facility. The facility is responsible to correct violations and assure compliance with applicable regulations within a specific timeframe to avoid further licensing sanctions and/or penalties. Deficiencies of state and/or federal regulations are also posted on the MDH website.

III. Data Requirements

Minnesota is part of CMS Region V, which is comprised of six states. As mentioned earlier, there are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. The following sections detail information related to survey results in FFY12 within our region as well as within the state.

A. Number of Deficiencies Within Region V

1. Health Deficiencies Issued

In FFY12, Minnesota issued an average of 7.0 deficiencies per survey, which is slightly higher from the previous year's average of 6.4 deficiencies per survey. However, FFY12's average is lower than other recent years, which have resulted in the following averages: 7.8 in FFY10, to 8.8 in FFY09, and 10.0 in FFY08.

The table below shows the average number of health deficiencies per recertification survey in FFY12 for all states comprising CMS Region V.

Table 1: Average Number of Health Deficiencies by States within CMS Region V

State	Surveys	Deficiencies Issued	Average
Illinois	835	4,624	5.5
Indiana	468	2,795	6.0
Michigan	466	3,411	7.3
Minnesota	382	2,653	7.0
Ohio	733	3,639	5.0
Wisconsin	367	2,286	6.2

Source: Federal CASPER Data System, FFY12

2. Life Safety Code Deficiencies Issued

The Life Safety Code (LSC) is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic.

The average number of deficiencies per LSC survey during FFY12 for Minnesota was 1.8 (Table 2). Minnesota continues to issue the fewest number of LSC deficiencies in the region. The national average number of LSC deficiencies cited in FFY12 was 4.4.

Table 2: Average Number of LSC Deficiencies by States within CMS Region V

State	Surveys	Deficiencies Issued	Average
Illinois	835	5,528	6.6
Indiana	468	1,876	4.0
Michigan	466	2,508	5.4
Minnesota	382	692	1.8
Ohio	733	2,753	3.8
Wisconsin	367	1,787	4.9

Source: Federal CASPER Data System, FFY12

B. Survey Outcomes and Remedies

1. Time Requirements for Statement of Deficiencies

As previously mentioned, the Statement of Deficiencies (CMS-2567) contains the findings of the survey. Minnesota Statutes, section 144A.101, subdivision 2 requires the facilities be provided with a draft Statement of Deficiencies at the time of the survey exit, and with completed Statement of Deficiencies within 15 working days of the exit conference.

Draft Statement Left at Facility

Of the surveys with deficiencies exited during FFY12, draft statements of deficiencies were left at all but three of the facilities at the time of their survey exits. This translates to a 99% compliance rate with this requirement for the draft Statement of Deficiencies.

15 Working Day Requirement

Completed statements of deficiencies are then mailed to the facility after the survey exit. The statute that requires facilities be provided a completed Statement of Deficiencies within 15 working days of the exit conference.

In FFY12, there were a total of 382 recertification surveys completed for nursing facilities. Of the 382 surveys, 369 (or 97%) met the 15 working day requirement for delivering final Statement of Deficiencies forms. Of the 13 that were late, one survey

was a Special Focus Facility, and three of them were No Opportunity to Correct that resulted in deficiencies of actual harm (a scope and severity level “G” or higher).

2. Opportunity to Correct vs. No Opportunity to Correct

The following information contains data derived from the total number of “enforcement cases” in FFY12. An “enforcement case” is created anytime a survey or a complaint investigation results in deficiencies with a scope and severity level of a “D” or higher (more about scope and severity levels to follow). An enforcement case remains open until all deficiencies are determined corrected and the facility is back in substantial compliance with state and federal regulations. If an enforcement case is created due to a recertification survey, and the Office of Health Facility Complaints receives a complaint that also results in deficiencies of a “D” level or higher, all deficiencies issued (both from the recertification survey and the complaint investigation) must be corrected before the enforcement case can be closed.

An enforcement case can sometimes involve multiple combinations of surveys/investigations: a recertification survey and a complaint (or multiple complaints), just one complaint investigation, or an enforcement case consisting of multiple complaint investigations are some examples. Therefore, since some enforcement cases are comprised of complaint investigation(s) only, there are always more enforcement cases than there are recertification surveys in any given year. In FFY12, there were 438 enforcement cases and 382 recertification surveys.

If there are deficiencies issued once a recertification survey or a complaint investigation is completed, facilities may be given an opportunity to correct the identified deficiencies before remedies are imposed. Neither CMS nor the state agency has an obligation to provide a facility an opportunity to correct deficiencies prior to imposing remedies.

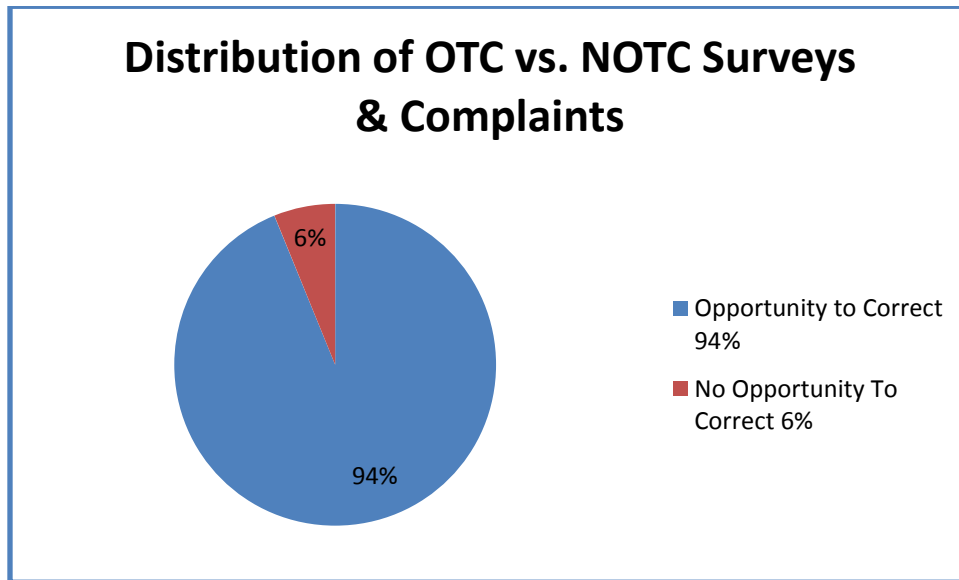
There are two “categories” of surveys/investigations (enforcement cases), which are based on the scope and severity level of the identified deficiencies. If the facility is given an opportunity to correct the identified deficiencies before remedies are imposed, the survey/investigation (enforcement case) is considered an Opportunity to Correct (OTC) case. If the facility is not given an opportunity to correct the identified deficiencies before remedies are imposed, the survey/investigation (enforcement case) is considered a No Opportunity to Correct (NOTC) case. While there are a number of triggers for a facility to not have the opportunity to correct deficiencies before remedies are imposed, the most common reason is due to the current survey or investigation resulting in deficiencies of actual harm (Level G or above).

The data depicted below reflects the distribution of OTC and NOTC⁵ of the total 438 enforcement cases (therefore reflecting results of both surveys and complaints) in FFY12.

- **Opportunity To Correct – 411**
- **No Opportunity To Correct – 27**

⁵OTC and NOTC data includes recertification surveys and complaints.

Figure 1. Distribution Percentages of OTC vs. NOTC Surveys & Complaints



The distribution of OTC versus NOTC recertification surveys and complaint investigations (enforcement cases) is important to note since it indicates that 94% of the time in FFY12, the facility was given the opportunity to correct the identified deficiencies before remedies and were imposed. The same exact distribution of OTC vs. NOTC percentages were found in FFY11, showing consistency across the two years.

The following table reflects OTC vs. NOTC data for all of Region V. Minnesota is tied with Indiana for the highest amount of OTC surveys and thus also the lowest amount of NOTC surveys in our Region. Our state also has almost half as many NOTC surveys as the regional average (6% vs. 11%).

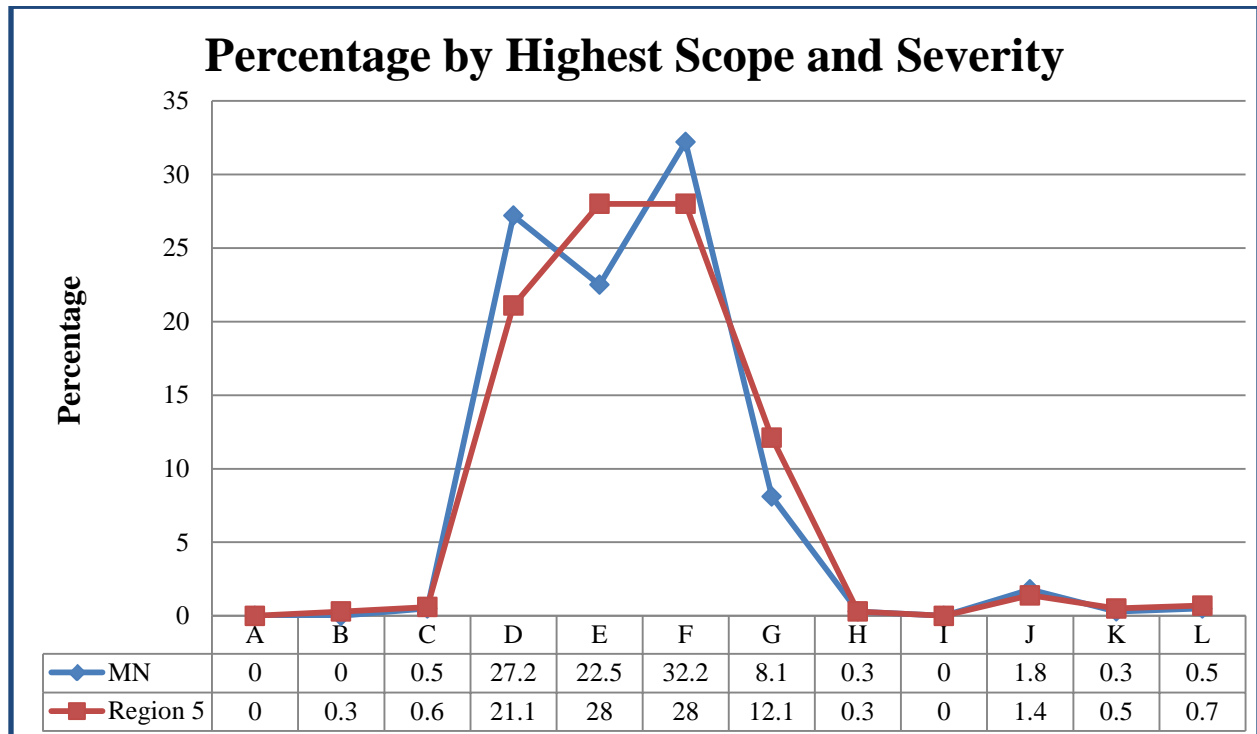
Table 3: Minnesota compared to Region V - OTC vs NOTC Surveys and Complaints

State	Number of OTC Surveys	% OTC Surveys	Number of NOTC Surveys	% of NOTC Surveys
IL	1,333	90%	150	10%
IN	953	94%	64	6%
MI	711	78%	200	22%
MN	411	94%	27	6%
OH	978	89%	121	11%
WI	506	89%	60	11%
Region V	4892	89%	622	11%

As mentioned above, the most common reason a facility is not given the opportunity to correct deficiencies before remedies are imposed is due to the survey or investigation resulting in deficiencies of actual harm (Level G or above). During a survey/investigation, each federal deficiency is assigned a scope and severity level, ranging from A through L. Scope and severity is a system of rating the seriousness of deficiencies. 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 highest scope and severity levels of deficiencies found determine the overall scope and severity of the survey. See Appendix B for the CMS grid used to determine scope and severity.

Figure 2 reflects the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V (the information below contains health recertification data only, and therefore does not include complaint data). Since overall scope and severity determines whether the survey is considered either OTC or a NOTC, Minnesota's higher distribution of overall scope and severity ranging from A-F is consistent with the data above reflecting Minnesota as having higher percentage of OTC enforcement cases.

Figure 2. Minnesota compared to Region V - Percentage of Highest Health Scope and Severity Level for Health Recertification Surveys



Source: Federal CASPER Data System, FFY12

While the chart above reflects the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V, Table 4 below contains a greater breakdown of this same information. Table 4 provides overall scope and severity percentages, but also includes this information for each state in Region V. In addition to the highest overall scope and severity percentages by state, the chart below reflects the total counts of health surveys by the highest overall scope and severity level. Surveys that are “clean” indicate that no health deficiencies were issued at the time of the health recertification survey. As with Figure 2 above, Table 4 below does not contain complaint data (recertification health surveys only)

Table 4: Total Number of Recertification Surveys by Highest Scope and Severity Level

State	Highest Overall Scope and Severity of Health Surveys - Counts and Percent													Total Surveys
	Clean	A	B	C	D	E	F	G	H	I	J	K	L	
IL	3 0.4%	0 0.0%	5 0.6%	8 1.0%	169 21.0%	218 27.1%	253 31.5%	122 15.2%	5 0.6%	0 0.0%	7 0.9%	4 0.5%	9 1.1%	803
IN	33 7.2%	0 0.0%	1 0.2%	4 0.9%	102 22.3%	141 30.8%	111 24.2%	55 12.0%	0 0.0%	0 0.0%	5 1.1%	3 0.7%	3 0.7%	458
MI	12 2.5%	0 0.0%	3 0.6%	1 0.2%	32 6.8%	159 33.8%	169 35.9%	76 16.1%	1 0.2%	0 0.0%	12 2.5%	4 0.8%	2 0.4%	471
MN	25 6.5%	0 0.0%	0 0.0%	2 0.5%	104 27.2%	86 22.5%	123 32.2%	31 8.1%	1 0.3%	0 0.0%	7 1.8%	1 0.3%	2 0.5%	382
OH	115 15.6%	0 0.0%	1 0.1%	3 0.4%	210 28.4%	201 27.2%	147 19.9%	57 7.7%	2 0.3%	0 0.0%	3 0.4%	0 0.0%	0 0.0%	739
WI	38 10.4%	0 0.0%	1 0.3%	0 0.0%	61 16.7%	95 26.0%	99 27.0%	49 13.4%	1 0.3%	0 0.0%	12 3.3%	4 1.1%	6 1.6%	366
Region V	226 7.0%	0 0.0%	11 0.3%	18 0.6%	678 21.1%	900 28.0%	902 28.0%	390 12.1%	10 0.3%	0 0.0%	46 1.4%	16 0.5%	22 0.7%	3,219

3. Remedies

As explained in the previous section, the highest levels of deficiencies of the survey determine the overall scope and severity of the survey. If the scope and severity of the survey met the criteria for no opportunity to correct, then immediate sanctions (or remedies) are required to be imposed. If remedies are imposed, the remedy (or remedies) imposed is in accordance with the scope and severity matrix in Appendix B.⁶

The chart below is a complete listing of remedy categories available, though MDH typically recommended only a few of these options for imposition, which was the case in FFY12 and FFY11. Many factors are used to determine which and/or how many remedies to impose within the available remedy categories for particular levels of noncompliance.

⁶ CMS makes the final determination on the imposition of all Category 2 and Category 3 remedies.

Remedy Categories		
Category 1	Category 2	Category 3
Directed plan of correction	Denial of payment for all new Medicare and/or Medicaid admissions (DOPNA)	Temporary management
State monitoring	Denial of payment for all Medicare and/or Medicaid residents by CMS	Termination of the provider agreement
Directed in-service training	Civil money penalties (CMPs)	Alternative or additional State remedies approved by CMS

While an overall scope and severity level that constitutes a NOTC survey is a reason in and of itself for remedies to be imposed, there are other situations where remedies may be triggered during the survey process. An example of this would include a facility not correcting previously-issued deficiencies at the time of an onsite revisit, which would result in finding the facility in continued non-compliance. Therefore, the number of remedies imposed during a fiscal year is expected to be higher than the total number of NOTC enforcement cases during that same year.

Table 5 below illustrates the total number of all remedies imposed in Minnesota for both recertification and complaint surveys in FFY11 and FFY12.

Table 5: Total Number of Remedies Imposed

Type of Remedy	Total FFY11	Total FFY12
Imposed State Monitoring	49	37
Imposed CMPs	50	35
Imposed DOPNA	5	8
Total Remedies Imposed	104	80

Source: Federal CASPER Data System, FFY12 and FFY11

Even though there were 27 NOTC enforcement cases in FFY12, and 25 NOTC enforcement cases in FFY11, the above table reflects fewer remedies imposed in FFY12. While it is expected that the total number of remedies imposed is higher than the total NOTC surveys, it is interesting to note that there was an overall reduction of total remedies imposed in FFY12 by 23%. This indicates that in FFY12, there were more facilities found in substantial compliance (i.e. corrected all outstanding deficiencies) when surveyors returned for a revisit.

Timelines in relation to imposed remedies

Different levels of remedies may be required (or optional) depending on the outcome of the survey and/or revisit results. In cases where federal Category 2 or Category 3 remedies are in place, Minnesota Statutes, Section 144A.101, subdivision 5, requires revisits be conducted within 15 calendar days of the date by which corrections are to be completed.

During FFY12, there were 46 surveys where CMS imposed federal Category 2 or 3 remedies. Thirty-eight of these 46 cases (83%) received revisits within the 15 calendar day requirement. Of the 8 cases that did not meet the requirement, one was due to a Federal Monitoring Survey (FMS) conducted by CMS. When CMS conducts a FMS, MDH is prevented from conducting a revisit to the original recertification survey until CMS receives an acceptable Plan of Correction for the FMS survey (at which time, CMS alerts MDH that a revisit may be conducted for the recertification and FMS survey).

With the exclusion of this FMS survey, MDH conducted revisits within the 15 day requirement for 85% of the applicable surveys. Either 83% or 85% reflects an improvement from the 76% rate seen in FFY11.

4. Appeals, IDRs and IIDRs

Federal Level: Appeals

Facilities have the right to formally appeal any Civil Money Penalties (CMP's) imposed by CMS. The appeal process is a federal process, where facilities communicate directly with the CMS Region V Office in Chicago.

In FFY12, four appeals were initiated at the federal level from facilities in Minnesota. Two facilities settled with CMS before a hearing, and two facilities withdrew their appeal before a hearing before an Administrative Law Judge.

State Level: IDR & IIDR's

At the state level, there are two methods for facilities to informally dispute survey findings. 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 processes: 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

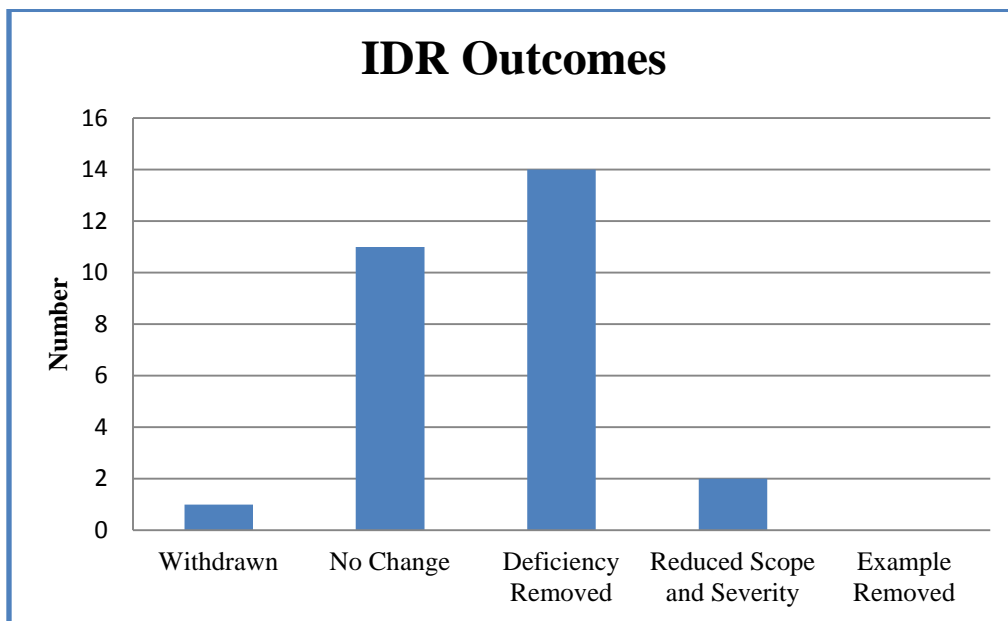
oversight.⁷ The purpose of this informal process is to give providers an opportunity to refute cited deficiencies after any survey.

IDR Outcomes

When MDH receives a request for an IDR, the review is performed by a MDH Licensing & Certification or an Office of Health Facility Complaints survey supervisor who has not previously been involved with the survey or complaint investigation. During FFY12, there were 18 IDR requests involving 28 deficiencies.

Of the 28 FFY12 deficiencies disputed through an IDR, 1 was withdrawn, 11 resulted in no change, 14 deficiencies were removed, 2 resulted in a reduced scope and severity, and no disputed deficiencies resulted in a change in documentation (example removed).

Figure 3. Outcomes of Informal Dispute Resolutions



Source: Federal Aspen Central Office Data System, FFY12

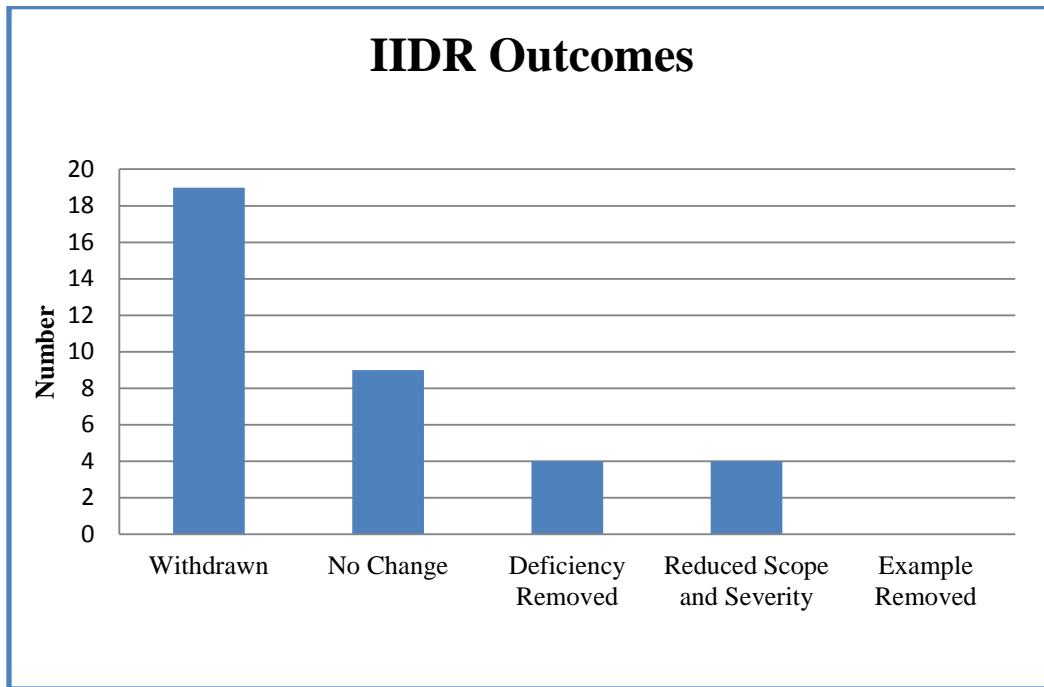
⁷ State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR.

IIDR Outcomes

An 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 of Health and CMS, both of whom review the case and can accept or modify the ALJ's recommendation.

During FFY12, there were 14 IIDR requests involving 36 deficiencies. Of the disputed deficiencies, 19 deficiencies were withdrawn by the facility prior to the hearing, 9 resulted in no change, 4 deficiencies were removed, and 4 resulted in a reduced scope and severity level. No disputed deficiencies resulted in a change in documentation (example removed).

Figure 4. Outcomes of Independent Informal Dispute Resolutions



Source: Federal Aspen Central Office Data System, FFY12

IV. Areas of Special Focus during FFY12

A. Quality Improvement

MDH provides a robust training program for surveyors. In addition to MDH's strong internal surveyor orientation program, all surveyors who will survey federally-certified nursing facilities must also pass CMS's QIS training protocol. The QIS training program involves very detailed performance feedback regarding their proficiency to conduct nursing facility surveys.

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

1. Onsite Review

Once a surveyor has passed and is certified to conduct QIS surveys, MDH survey supervisors and Assistant Program Managers of the Licensing & Certification Program go onsite with staff to continue to review survey technique. This onsite review is conducted especially as it relates to investigative technique. During an onsite review, there is active feedback between the reviewer and the surveyor so that education can be provided during the survey process.

2. Deficiency Review

One technique used for performing quality assurance is our deficiency review process. This practice is done by district supervisors across the state to ensure consistency and accuracy. Time is scheduled for this detailed review to occur regularly, in which the reviewers identify any quality problems which may need to be addressed. In FFY12, a large focus of the deficiency review was the consistent and accurate issuance of abuse tags across L&C and OHFC⁸. The reviewers help clarify understanding of when it is appropriate to issue certain deficiencies by communicating the results of these reviews and educating surveyors statewide.

3. DAR-SA and DAR-RO Reports

Another type of quality assurance technique is ongoing analysis of the DAR-SA reports, which is conducted beyond deficiency review. Desk Audit Reports for State Agencies (DAR-SA) and Desk Audit Reports for Regional Offices (DAR-RO) are used by state agencies and CMS regional offices to evaluate variation in QIS survey results. This data can help survey staff identify variances and opportunities for quality improvement, and take corrective action when appropriate.

⁸ More information about this is provided in a later section titled Statewide Calls

Starting in FFY12, MDH assigned dedicated staff (surveyors) to review the DAR-SA reports on a regular basis. The DAR-SA report provides detailed information that is surveyor-specific. A sampling from every team is taken and then a detailed review of surveyor notes and documentation is conducted. An internal form was developed specifically for DAR-SA feedback, and the results of this evaluation are communicated to each survey team on an ongoing basis.

This quality assurance time is built-in to survey time in order to ensure time for consistent completion of this quality assurance process. The feedback from this review includes positive feedback so that surveyors and survey-teams may know areas where they are performing very well, in addition to areas identified as needing improvements.

4. Mix-Max Surveys

Mix-Max surveys are an effective approach for an ongoing check and balance for potential variability between survey teams. They are used for health recertification surveys only, and are not used during complaint investigations or for Life Safety Code surveys.

During FFY11, surveys were coded as Mix-Max when there was a mixture of 2 surveyors from one team and 2 surveyors from another team to form a 4-person survey team. Starting in FFY12, the definition of Mix-Max surveys expanded to be coded when at least one surveyor from a different team joined a survey team. One reason for this change is because when working with a team that is small (3-4 surveyors), it is justifiable that just one person can change the dynamic of a group or team.

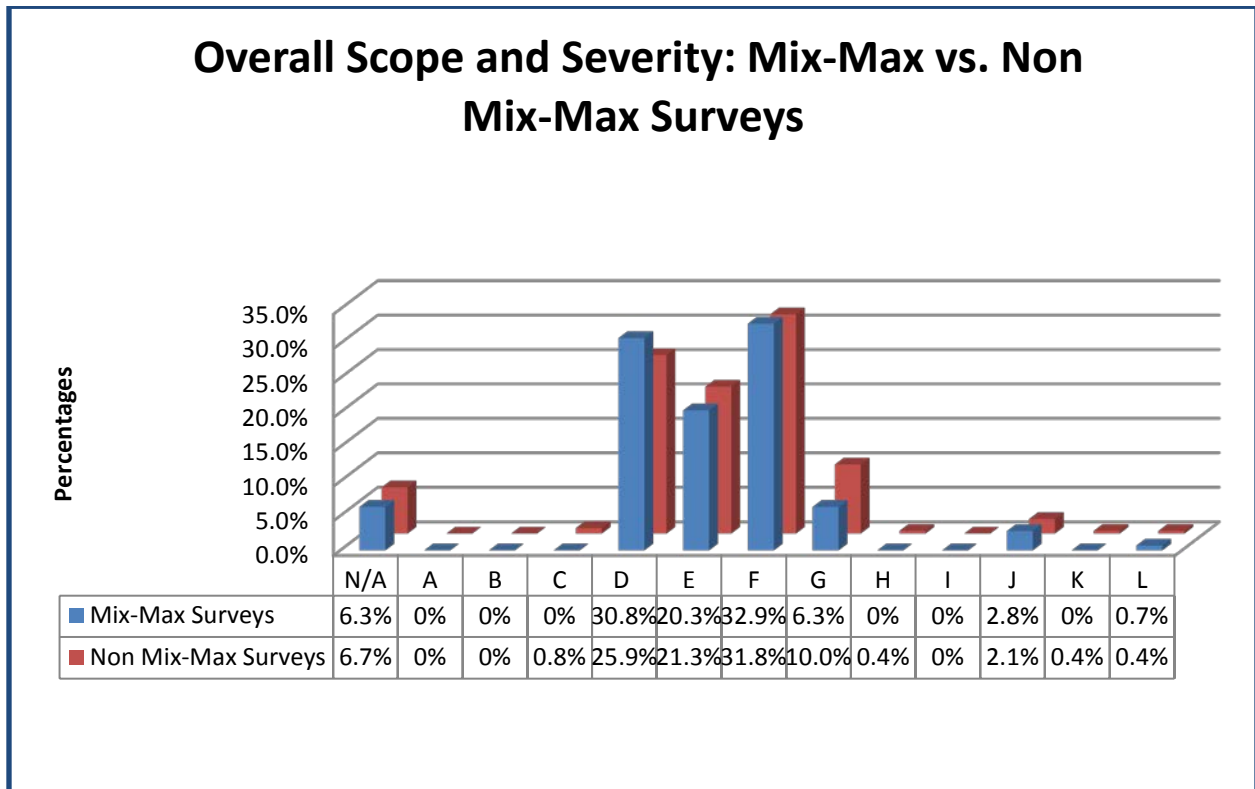
Approximately 10% of our surveys were conducted by a Mix-Max team in FFY11, which was a percentage that MDH intended to increase in FFY12. MDH did indeed increase the number of Mix-Max surveys completed, as 30% of surveys completed in FFY12 surveys were Mix-Max surveys (i.e. at least one surveyor from another team joined the survey team).

FFY12 Mix-Max Information

- Non-Mix-Max Surveys: 239 (70%)
- Mix-Max Surveys: 143 (30%)
- Average number of deficiencies per Non-Mix-Max Survey: 7.03
- Average number of deficiencies per Mix-Max Survey: 6.92
- Difference between number of deficiencies issued by Mix-Max Surveys and Non-Mix-Max Surveys: less than one deficiency (0.11)

Figure 5 below compares the highest overall scope and severity percentages (by health survey) for Mix-Max surveys compared to non-Mix-Max surveys. In the case of the chart below, N/A indicates what has been formally identified in this report as “clean” surveys, or surveys in which no health deficiencies were issued.

Figure 5: Overall Scope and Severity: Mix-Max vs. Non Mix-Max Surveys



Data from the previous page reported that the average number of deficiencies issued by Mix-Max survey teams compared to non-Mix-Max survey teams is consistent, with Non-Mix-Max surveys issuing an average of 7.03 deficiencies per survey, and Mix-Max surveys resulting in an average of 6.92 deficiencies per survey. The data represented in the above chart continues to indicate overall consistency in health survey findings when comparing the highest overall scope and severity of Mix-Max vs. Non-Mix-Max surveys. Overall scope and severity levels were issued at very similar rates with both survey “types” in FFY12. Mix-Max surveys were only slightly more likely to result in an Opportunity to Correct survey, based on overall scope and severity levels at level “F” or below⁹. In FFY12, 90.3% of Mix-Max surveys were resulted in an overall scope and severity level of F or below, compared to 86.5% of non-Mix-Max surveys.

Table 6 below lists the top 10 deficiencies issued in FFY12, broken down by Mix-Max surveys versus non Mix-Max surveys. Though they may have “ranked” in different spots, 9 of the 10 top ten deficiencies were the same from FFY11 to FFY12. In FFY12, F428 (Drug Regimen Review) was not one of the top ten deficiencies issued, whereas F225 (Investigate/Report Allegations/Individuals) was included this fiscal year as the 9th most frequently issued deficiency.

⁹ Note that some surveys with the highest scope and severity of a level G may also result in an Opportunity to Correct survey. Therefore, the actual number of Mix-Max vs. non-Mix-Max OTC surveys may be slightly higher.

Table 6: FFY12 Top 10 Deficiencies Number & Percent Issued – Non-Mix-Max vs. Mix-Max

Deficiency	Non Mix- Max Surveys	Mix-Max Surveys
F329 Unnecessary Medications	38.9% (93)	32.2% (46)
F282 Prov. Care According to Care Plan	37.7% (90)	31.5% (45)
F226 Develop / Implement Abuse/ Neglect, Etc. Policies	39.3% (94)	22.4% (32)
F323 Accidents/Supervision	31.8% (76)	30.1% (43)
F441 Infection Control	33.1% (79)	27.3% (39)
F371 Food Handling & Sanitation	30.5% (73)	25.9% (37)
F279 Comprehensive Care Plan	33.5% (80)	19.6% (28)
F309 Quality of Care	29.7% (71)	25.2% (36)
F225 Investigate/Report Allegations/Individuals	33.5% (80)	18.0% (26)
F272 Comprehensive Assessment	29.7% (71)	24.5% (35)

In most instances, the top 10 deficiencies in FFY12 were issued at similar rates for Mix-Max surveys versus non Mix-Max surveys. All long-term care surveys (regardless of Mix-Max status) are completed using the QIS survey process. As mentioned earlier in this report, the QIS uses an automated process that guides surveyors to systematically and objectively review all regulatory areas. The general consistency in the issuance of the top 10 deficiencies of FFY12 reflects survey consistency statewide.

Note that FFY12 resulted in more mixed teams to the extent that it was challenging to find relevant comparisons by district/region across the state. Data will be gathered in a meaningful way to analyze regional comparisons by FFY14.

B. Provider Outreach and Education

MDH continues to communicate and offer regular training opportunities to providers and other stakeholders. This outreach is in an effort to proactively improve provider compliance and to provide technical assistance using various tools and education for providers. In FFY12, these opportunities included:

1. Statewide Calls

Throughout the year, MDH conducts regularly scheduled statewide calls with nursing facility providers. The agenda is different for each of these calls, but typical agenda items include focusing on any trends that we are seeing during surveys or complaints, news related to MDH and/or CMS, or the results of our own QA activities.

For example, one of the consistent topics on our agenda includes areas where we are finding new trending deficient practices on surveys across the state. We provide this feedback to providers in an effort to prevent the future issuance of these particular deficiencies. In FFY12 we found a trend in the increased issuance of F329 (Unnecessary Drugs). As part of one statewide call, we informed providers of the emerging trend, reviewed the regulation for F329 and then provided listeners with a review of the “QIS Critical Element Pathways” so that providers would understand exactly what surveyors are looking for during survey and what kinds of observations trigger this deficiency.

Another example of statewide call agenda topics are the results of MDH quality assurance practices. Just as MDH surveys providers in an effort to maintain compliance with their applicable regulations, CMS also surveys MDH’s compliance with CMS’s survey standards and guidelines. These quality assurance surveys that CMS conducts on MDH are called “CMS Oversight Surveys”. In FFY12, MDH was cited in relation to the issuance of F225 and F226 during one of these Oversight Surveys. On a subsequent statewide call, we shared these results from our CMS Oversight Survey with providers. The Licensing & Certification Program and the Office of Health Facility Complaints then worked together as a team in order to address the consistency and accuracy issues of these particular tags, shared some the examples of CMS’s findings, and then MDH provided guidance and Tips for Compliance in relation to these particular tags.

2. Joint Stakeholders Workgroup

Other outreach activities include Joint Stakeholders meetings. These meetings are held with provider association representatives and stakeholders on a quarterly basis to discuss a variety of survey and LTC related issues. In FFY12, the results of the CMS Oversight Survey were also addressed during a Joint Stakeholder Workgroup meeting.

In early 2012, both the Licensing & Certification Program and the Office of Health Facility Complaints agreed to host a focused group including Care Providers of Minnesota (CPM), Aging

Services of Minnesota (ASM), Minnesota Directors of Nursing (MNDONA), and the Office of the Ombudsman for Long Term Care to work on compliance with Federal Regulations: F223 through F226.

In May of 2012, representatives from MDH, CPM, ASM, MNDONA, met to review Federal Regulation F223 through F226. MDH subsequently issued two Informational Bulletins as additional guidance for providers - refer to Information Bulletin 13-01: Immediate Reporting to Administrator and Information Bulletin 13-02: Tool: Federal Long-Term Care Reportability for Abuse Under F225 Resident to Resident Altercations.

V. Appendices

APPENDIX A: CMS Revisit/Date of Compliance Policy

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

Appendix A

Revisit/Date of Compliance Policy¹⁰

Revisit	Substantial compliance	Old deficiencies corrected but continuing	Old deficiencies corrected but continuing	Noncompliance continues	Any noncompliance
1st revisit	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st revisit, or correction date on the PoC.	1. A 2nd revisit is discretionary if acceptable evidence is provided. When evidence is accepted with no 2nd revisit, compliance is certified as of the date confirmed by the evidence. 2. When a 2nd revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2 nd revisit to be considered for the compliance date.	1. A 2nd revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd revisit to be considered for the compliance date.	1. A 2nd revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd revisit to be considered as the compliance date. 3. A remedy must be imposed.	
2nd revisit	Compliance is certified as of the date of the 2nd revisit or the date confirmed by the acceptable evidence, whichever is sooner.				1. A remedy must be imposed if not already imposed. 2. Either conduct a 3rd revisit or proceed to termination.
A 3rd REVISIT MUST BE APPROVED BY THE REGIONAL OFFICE					
3rd revisit	Compliance is certified as of the date				Proceed to termination.

Examples of acceptable evidence may include, but are not limited to:

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-service training.
- Interviews with more than one training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.



















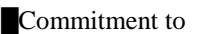













Givens:


- An approved PoC is required whenever there is noncompliance.
- Remedies can be imposed anytime for any level of noncompliance.
- Revisits can be conducted anytime for any level of noncompliance.


¹⁰ See *SOM Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities*, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf>

Appendix B

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX¹¹

Immediate jeopardy to resident health or safety	J  PoC  Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2 	K  PoC  Required: Cat. 3 Optional: Cat. 1 Optional: Cat. 2 	L  PoC  Required: Cat. 3 Optional: Cat. 2 Optional: Cat. 1 
Actual harm that is not immediate	G PoC Required* Cat. 2 Optional: Cat. 1	H PoC Required* Cat. 2 Optional: Cat. 1 	I  PoC  Required* Cat. 2 Optional: Cat. 1 Optional: Temporary Mgmt.
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D PoC Required* Cat. 1 Optional: Cat. 2	E PoC Required* Cat. 1 Optional: Cat. 2	F  PoC  Required* Cat. 2 Optional: Cat. 1 
No actual harm with potential for minimal harm	A  No PoC  No remedies   Commitment to  Correct  Not on CMS-52567	B  PoC     	C   PoC   
	Isolated	Pattern	Widespread

 Substandard quality of care is 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

¹¹ See SOM Chapter 7 – Survey and Enforcement Process for Skilled Nursing Facilities and Nursing Facilities, <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf>