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Annual Quality Improvement Report: The Nursing Home Survey Process

REPORT TO THE MINNESOTA LEGISLATURE FOR FEDERAL FISCAL YEAR 2014

HEALTH REGULATION DIVISION

Annual Quality Improvement Report: The Nursing Home Survey Process

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Executive Summary

Minnesota Statutes, section 144A.10, subdivision 17 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 region 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 Health Regulation Division. This report is the tenth annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year 2014 (FFY14), which occurred from October 1, 2013 through September 30, 2014.

The development of this report allows the Department to reflect on both successes, as well as areas for improvement. One highlight reflects improvements of consistency across the state between regional survey teams. In FFY14, a regional comparison within Minnesota reflects a small difference of just a little over one deficiency in the average number of health deficiencies issued per survey (1.1 deficiencies per survey). This indicates there is an overall low variability between districts and reflects survey consistency statewide.

This report also highlights opportunities for improvement, such as the 15 working-day requirement for delivering the final Statement of Deficiencies. While 95% of surveys met the 15 working-day requirement for delivering final Statement of Deficiencies form in FFY14, it is a continuous goal to 100% of our time requirements.

Introduction

Survey Process

General

The Licensing and Certification Program of the Health Regulation Division at the Minnesota Department of Health 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.

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.

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.

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. 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 from the facility, and state surveyors conduct a revisit to determine whether substantial compliance has been achieved.

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 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.

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.

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 requirements[1]. 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
- Focus survey resources on facilities (and areas within facilities) with the largest number of quality concerns.

[1] See *CMS Quality Indicator Survey* at *http://www.ucdenver.edu/academics/colleges/medicalschool/departments/medicine/hcpr/qis/Documents/QIS-brochure-SC-08-21-01-2008.pdf*

One of the other benefits of the 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.

Survey Techniques

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use 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 requirements[2].

In addition, the surveyors include information about how the facility's 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.

Complaint Investigation Process

The Office of Health Facility Complaints (OHFC) is a section within the Health Regulation Division 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

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

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 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.

Vulnerable Adults Act

State law also mandates that allegations of maltreatment against a vulnerable adult 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, neglect, and financial exploitation of residents in licensed health care facilities, and to receive and evaluate incidents reported from facilities that may constitute violations of the VAA.

The VAA requires the reporting of abuse, neglect, and financial exploitation which are defined in Minnesota Statutes, section 626.5572, subdivision 15. Under federal regulations, Medicaid/Medicare certified facilities are also required to report to OHFC allegations of alleged violations of abuse, neglect, mistreatment and misappropriation of property. Reports made to OHFC by providers are referred to as “Facility Self Reports.”

Under the VAA, 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. All substantiated determinations must be based on a preponderance of evidence which is defined as more than 50% of weighted evidence. This means that while an act of maltreatment may have occurred, enough evidence must exist to make it more likely than not that the allegation is true.

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;
- ***False*** – "False" 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 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 provider. The provider is responsible to correct violations and assure compliance with applicable regulations within a specific timeframe to avoid further licensing sanctions and/or other penalties.

Data Requirements

Minnesota is part of the Center for Medicare and Medicaid Services (CMS) Region V, which is comprised of six states. As mentioned in the previous section, there are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. The following section provides detailed information related to survey results and outcomes in FFY14 within our federal Region V and regional data within the state.

Number of Deficiencies – Region V

Health Deficiencies Issued

In FFY14, Minnesota issued an average of 6.3 deficiencies per health recertification survey, which is consistent with the FFY13 average of 6.1 deficiencies per survey.

Table 1 reflects the average number of health deficiencies per recertification survey in FFY14 for all states comprising CMS Region V. The average for Region V was 5.7 health deficiencies per survey.

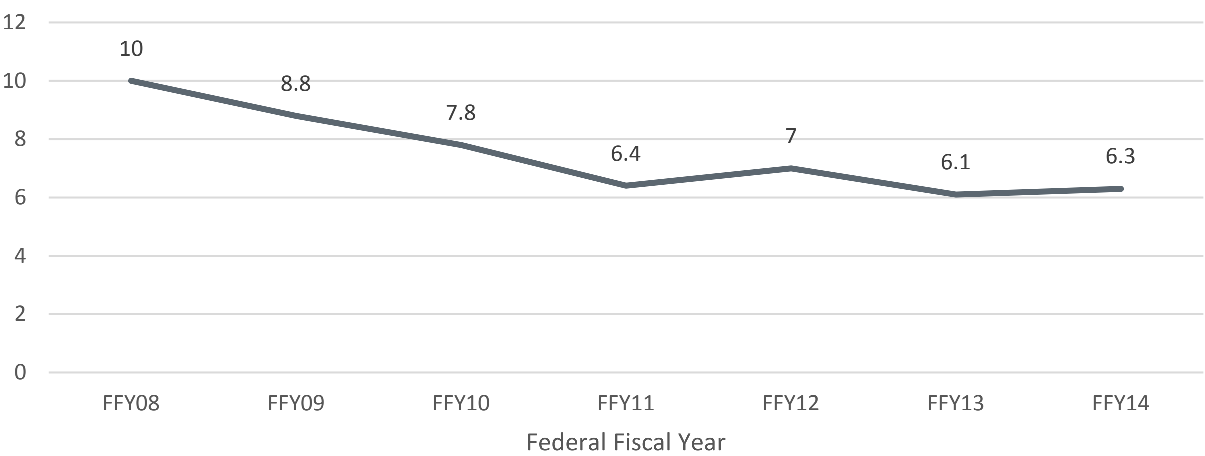
TABLE 1: AVERAGE NUMBER OF HEALTH DEFICIENCIES BY STATES WITHIN CMS REGION V

	Surveys	Deficiencies Issued	Average Number of Deficiencies per Survey
Illinois	799	4,339	**5.4**
Indiana	509	2,977	**5.8**
Michigan	431	2,523	**5.9**
Minnesota	377	2,370	**6.3**
Ohio	756	2,955	**3.9**
Wisconsin	382	2,348	**6.1**

Source: Federal CASPER Data System, FFY14

Figure 1 reflects the trend of the average number of health deficiencies issued per health recertification survey over a seven year period.

FIGURE 1: AVERAGE NUMBER OF HEALTH DEFICIENCIES ISSUED PER SURVEY



Source: Federal CASPER Data System, FFY14

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. A recertification survey for a nursing home contains both a health and a LSC portion of the survey.

Table 2 below shows the average number of LSC deficiencies per recertification survey in FFY14 for all states comprising CMS Region V. Minnesota continues to issue the fewest number of LSC deficiencies within our federal region, with the average number being 1.7 per LSC survey in FFY14.

TABLE 2: AVERAGE NUMBER OF LSC DEFICIENCIES BY STATES WITHIN CMS REGION V

	LSC Surveys	LSC Deficiencies Issued	Average Number of LSC Deficiencies per Survey
Illinois	799	7,532	**9.4**
Indiana	507	2,272	**4.5**
Michigan	431	2,287	**5.3**
Minnesota	377	638	**1.7**
Ohio	754	2,579	**3.4**
Wisconsin	382	1,804	**4.7**

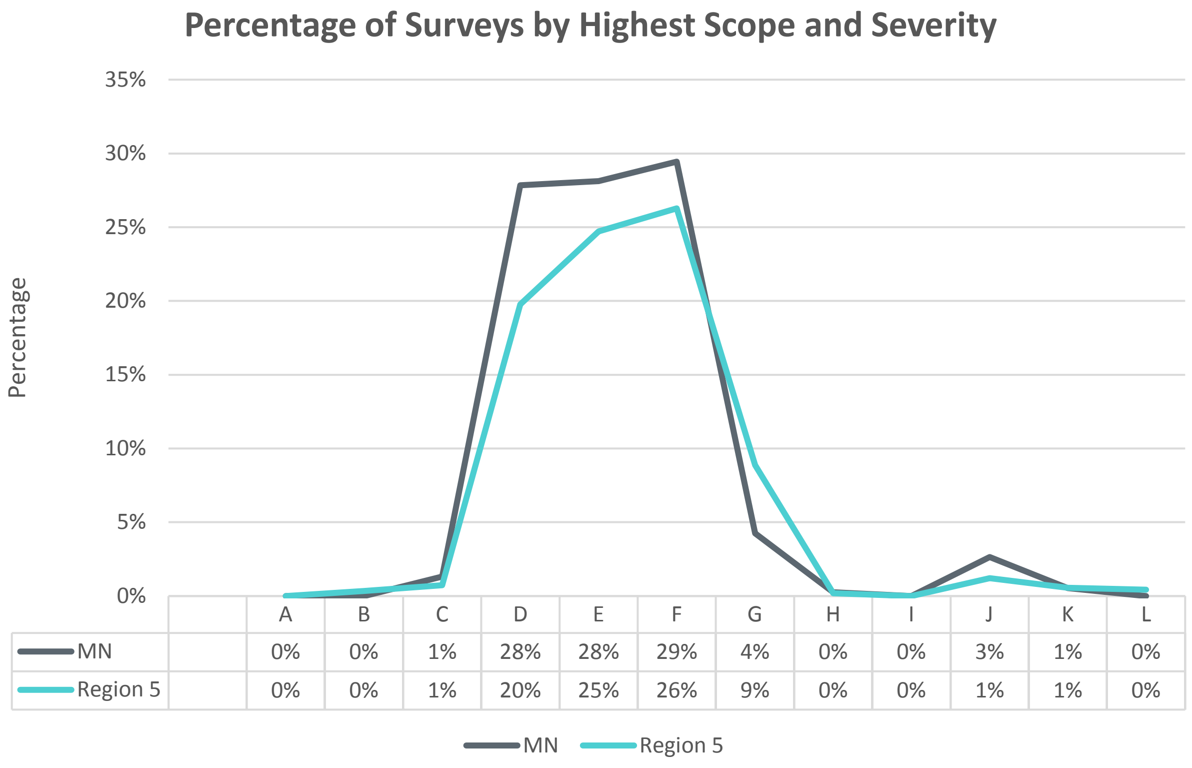
Source: Federal CASPER Data System, FFY14

Scope and Severity of Citations – Region V

Scope and severity is a system of rating the seriousness of deficiencies. Every federal deficiency issued as a result of a survey or complaint investigation is assigned a scope and severity level, ranging from A through L. The highest scope and severity level of deficiencies found determine the overall scope and severity of the survey[3].

Figure 2 reflects the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V.

FIGURE 2: PERCENTAGE OF HIGHEST HEALTH SCOPE AND SEVERITY LEVEL - MINNESOTA COMPARED TO REGION V



	A	B	C	D	E	F	G	H	I	J	K	L
MN	0%	0%	1%	28%	28%	29%	4%	0%	0%	3%	1%	0%
Region 5	0%	0%	1%	20%	25%	26%	9%	0%	0%	1%	1%	0%

The graph above reflected the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V, and Table 3 below contains a greater breakdown of the information found in Figure 2. Table 3 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.

[3] See Appendix B for the CMS grid used to determine scope and severity.

Also included in Table 3 are "clean" surveys, which are surveys where no health deficiencies were issued at the time of the health recertification survey.

TABLE 3: HIGHEST SCOPE AND SEVERITY LEVEL

	Clean	A	B	C	D	E	F	G	H	I	J	K	L	Total Surveys
IL	54 (7%)	0	3	8 (1%)	135 (17%)	195 (24%)	306 (38%)	77 (10%)	0	0	7 (1%)	6 (1%)	8 (1%)	799
IN	61 (12%)	0	2	1	103 (20%)	171 (34%)	107 (21%)	57 (11%)	0	0	3 (1%)	3 (1%)	1	509
MI	16 (4%)	0	3 (1%)	2	71 (16%)	101 (23%)	167 (39%)	56 (13%)	3 (1%)	0	8 (2%)	2	2	431
MN	21 (6%)	0	0	5 (1%)	105 (20%)	106 (25%)	111 (26%)	16 (9%)	1 (0.3%)	0	10 (3%)	2 (1%)	0	377
OH	132 (17%)	0	4 (1%)	8 (1%)	212 (28%)	219 (29%)	125 (17%)	48 (6%)	0	0	6 (1%)	1	1	756
WI	40 (10%)	0	0	2 (1%)	71 (19%)	79 (21%)	110 (29%)	59 (15%)	3 (1%)	0	9 (2%)	6 (2%)	3 (1%)	382
Region V	324	0	12	26	698	871	926	313	7	0	43	20	15	

Survey Outcomes and Remedies

Survey Outcomes by Region Within the State – Number of Deficiencies

Minnesota Statutes, section 144A.10, subd. 17, requires the reporting of the number, scope, and severity of citations by region within the state. Minnesota has ten survey teams that cover the different areas across the state. In order to create regions within the state, these survey teams were grouped together to create North, Central, Metro and South "regions[4]". The surveys completed within each region are compared for the purposes of regional analysis.

Table 4 reflects the number of surveys completed within each region, the number of deficiencies issued within each region, and the average number of deficiencies issued per health recertification survey by region in FFY14.

[4] Bemidji, Duluth, Fergus Falls survey teams comprise the North region; two Saint Cloud teams comprise the Central region; three metro teams comprise the Metro region; and Mankato and Rochester comprise the South region.

TABLE 4: NUMBER OF HEALTH RECERTIFICATION SURVEYS AND DEFICIENCIES ISSUED, BY REGION

Region	Number of Surveys	Number of Deficiencies	Average Number of Deficiencies Per Survey
North	99	682	**6.9**
Central	72	402	**5.9**
Metro	118	756	**6.4**
South	88	507	**5.8**

The largest regional difference of the average number of health deficiencies issued per recertification survey is just a little over one deficiency, or 1.1 deficiencies per survey.

Survey Outcomes by Region Within the State – Scope and Severity

As mentioned previously, every federal deficiency issued 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 a potential for minimal harm if the deficient practice is not corrected, to immediate jeopardy to resident health or safety[5]. 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 3 reflects the highest overall scope and severity **percentages** per health recertification survey by region in FFY14. Table 5 below reflects **counts** of the highest overall health scope and severity level per recertification survey, by region in FFY14. Figure 3 contains percentages based on the total number of overall scope and severity level of the survey divided by the total number of surveys conducted in that region, whereas Table 5 simply contains raw counts. Please note that while similar, the number of surveys conducted within each region varies slightly making percentages a better tool for comparisons.

[5] Scope/severity levels of a "G", "H", & "I" or above represent deficiencies of actual harm. Scope/ severity levels of "J", "K" & "L" represent deficiencies that are an immediate jeopardy to resident health or safety.

FIGURE 3: HIGHEST OVERALL SURVEY SCOPE/SEVERITY PERCENTAGES, BY REGION

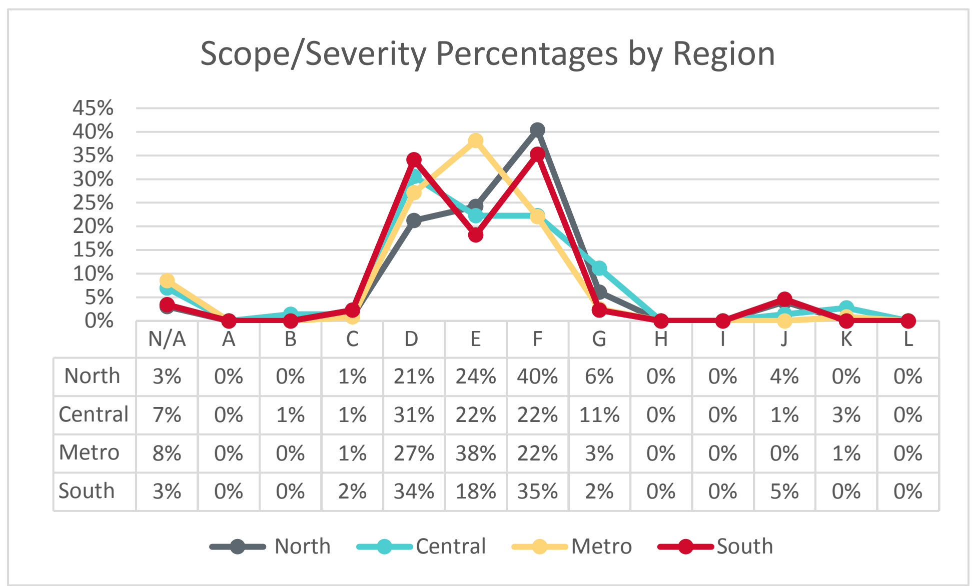


Table 5 reflects counts of the highest overall health scope and severity level per recertification survey, by region in FFY14. Note that a scope/severity level of N/A indicates a “clean” survey, or a survey where no health deficiencies were issued at the time of the survey.

TABLE 5: HIGHEST OVERALL HEALTH SCOPE/SEVERITY LEVELS PER RECERTIFICATION SURVEY, BY REGION

Scope/Severity	North	Central	Metro	South
N/A	3	5	10	3
A	0	0	0	0
B	0	1	0	0
C	1	1	1	2
D	21	22	32	30
E	24	16	45	16
F	40	16	26	31
G	6	8	3	2
H	0	0	0	0
I	0	0	0	0
J	4	1	0	4
K	0	2	1	0
L	0	0	0	0

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 imposed, it is in accordance with the scope and severity matrix in Appendix B.[6]

A complete listing of remedy categories follows. MDH typically recommends only a few of these options for imposition, which was the case in FFY14 and in recent years past. Many factors are used to determine which and how many remedies to impose within the available remedy categories for particular levels of noncompliance.

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 the overall scope and severity level of a survey may result in immediate remedies, there are other situations where remedies may be triggered during the survey process. One 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. The survey in this example may have started out without remedies, but now has remedies imposed due to the uncorrected revisit.

In FFY14 a total of 42 remedies were imposed – it is important to note that multiple kinds of remedies may be imposed during one "survey process" or "enforcement case". For example, a survey resulting in remedies imposed may involve two civil money penalties (one for each "G" or above deficiency) and state monitoring. This would be reflected in Table 6 as one count of imposed state monitoring and one count of imposed Civil Money Penalty (CMP).

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

While there were 42 remedies imposed in FFY14, there were a total of 54 total remedies imposed in FFY13. This reflects a 22% decrease in remedies imposed compared to the previous fiscal year, and a nearly fifty-percent change from two years prior in FFY12.

Table 6 below illustrates the total types of all remedies imposed in Minnesota for all enforcement cases (both recertification and complaint surveys) over a four year period FFY11-FFY14.

TABLE 6: TOTAL NUMBER OF REMEDIES IMPOSED

Type of Remedy	FFY11	FFY12	FFY13	FFY14
Imposed State Monitoring	49	37	26	19
Imposed CMPs	50	35	18	21
Imposed DOPNA	5	8	10	2
Total Remedies Imposed	104	80	54	42

Source: Federal CASPER Data System

Timelines in relation to imposed remedies

Survey Revisits

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 FFY14, there were 26 surveys (or complaint investigations) where CMS imposed federal Category 2 or 3 remedies. Nineteen of these 26 cases received revisits within the 15 calendar day requirement. Therefore, revisits were conducted within the 15 day requirement for 73% of the applicable surveys.

TIME REQUIREMENTS FOR STATEMENT OF DEFICIENCIES

The Statement of Deficiencies (CMS-2567) is a form that 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 FFY14, draft statements of deficiencies were left at all but one of the facilities at the time of their survey exits. Consistent with previous years,

this reflects a 99% compliance rate with the 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 requires that facilities be provided a completed Statement of Deficiencies within 15 working days of the exit conference.

In FFY14, there were a total of 377 recertification surveys completed for nursing facilities. Of those 377 surveys, 357 (95%) met the 15 working-day requirement for delivering final Statement of Deficiencies forms.

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 FFY14, there were no appeals initiated at the federal level from facilities in Minnesota.

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, the two types of dispute resolution processes are the Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR). The purpose of this informal process is to give providers an opportunity to refute cited deficiencies after any survey. 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]

IDR Outcomes

When MDH receives a request for an IDR, the review is performed by a supervisor who has not previously been involved with the survey or complaint investigation. During FFY14, there were 11 IDR requests involving 26 deficiencies.

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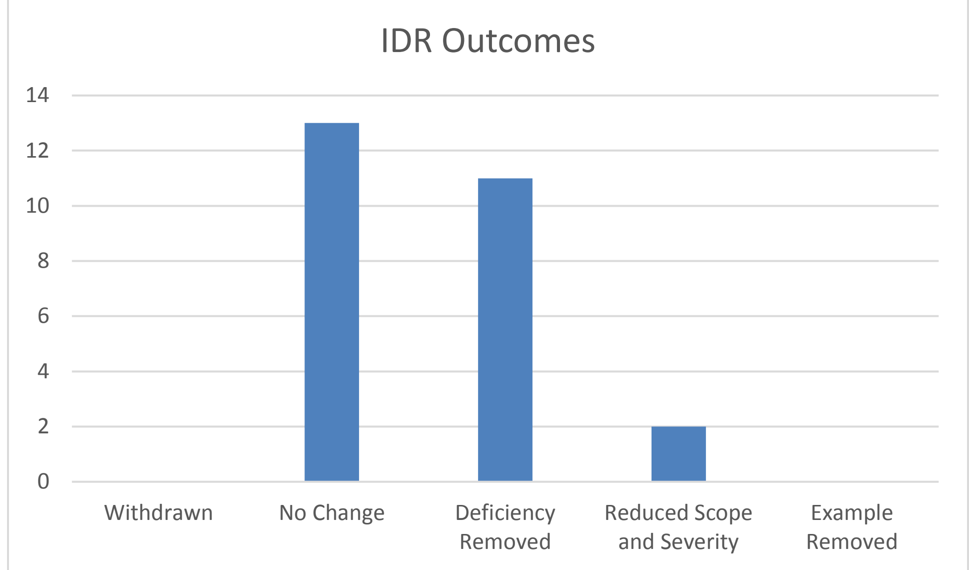
[7] State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR.

Of the 26 FFY14 deficiencies disputed through an IDR, 13 resulted in no change, 11 deficiencies were removed, 2 resulted in a reduced scope and severity, no disputed deficiencies resulted in a change in documentation (example removed), and none were withdrawn.

FIGURE 4: OUTCOMES OF INFORMAL DISPUTE RESOLUTIONS



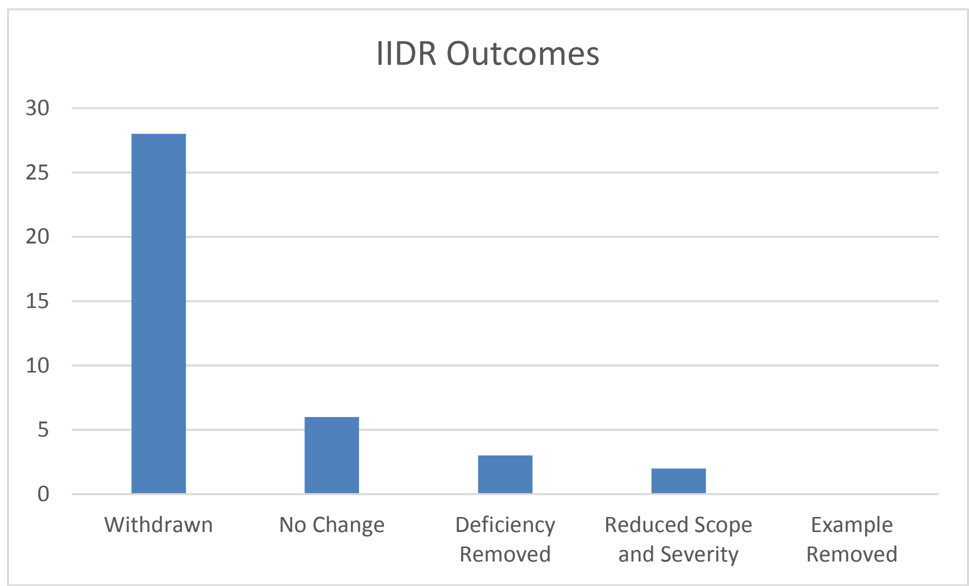
Source: Federal Aspen Central Office Data System, FFY14

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 FFY14, there were 8 IIDR requests involving 39 deficiencies. Of the disputed deficiencies, 28 deficiencies were withdrawn by the facility prior to the hearing, 6 resulted in no change, 3 deficiencies were removed, 2 resulted in a reduced scope and severity level, and none of the disputed deficiencies resulted in a change in documentation (example removed).

FIGURE 5: OUTCOMES OF INDEPENDENT INFORMAL DISPUTE RESOLUTIONS



Source: Federal Aspen Central Office Data System, FFY14

Areas of Special Focus

MDH strives to continuously improve both internal and external processes. Below are a few areas of focus and highlights from FFY14.

Partnership to Improve Dementia Care for Nursing Homes

During FFY14, MDH actively participated on the Minnesota Partnership to Improve Dementia Care for Nursing Homes. The official measure of the Partnership is the percent of long-stay nursing home residents who are receiving an antipsychotic medication, excluding those residents diagnosed with schizophrenia, Huntington's disease or Tourette's syndrome.

Minnesota's involvement with the Partnership showed federal quarter 2 (January-March) in 2014 with the 9th lowest rate in the nation. Minnesota had the 11th lowest rate in the nation in the first quarter of FFY14.

Minnesota met the national goal of reducing by 15%, the percent of long stay nursing home residents receiving antipsychotic medication.

Awarded a National Pilot for CMS Dementia Focused Survey

The Minnesota Department of Health was selected by CMS as a pilot state to conduct national CMS Focused Dementia Care Survey.

The goal was to improve the onsite nursing home survey procedures related to dementia. Minnesota was one of only five states to conduct a national CMS Focused Dementia Care Survey Pilot in 2014.

The objectives of this pilot were to:

- Optimize survey effectiveness
- Determine ways in which the current survey process may be streamlined to more efficiently and accurately identify and cite deficient practice
- Examine the process for prescribing antipsychotic medication
- Document successful dementia care practices in nursing homes
- Review resident-level and organizational-level processes
- Evaluate issues such as symptom (e.g., pain) management, decision-making and caregiver stress
- Gain new insights about surveyor knowledge, skills and attitudes

Five Minnesota nursing homes participated in this pilot survey process. Three surveyors completed the survey that included six residents in each nursing home. The surveyors completed detailed observation on five residents that included observation of cares, activities, medication administrations, care conference meetings and behavior round meetings. The observations focused on non-pharmacologic interventions for those with a diagnosis of dementia. Record reviews were also completed.

Implemented New Federal Electronic System for Inspection Documents

Minnesota Department of Health sought and was selected by CMS to implement new electronic federal document processing related to electronic issuance of federal inspection reports for nursing homes. The new system also included the electronic plan of correction processing and resulted in improved efficiencies for both MDH and providers.

New Root Cause Analysis Kit for Nursing Homes

Through a contract to the Quality Improvement Organization, Stratis, MDH developed and piloted a Root Cause Analysis Tool Kit for Nursing Homes. MDH accomplished this new tool kit through use of federal Nursing Home Civil Monetary Funds. This kit was made available in early 2015.

Resident Care Improvements

Maltreatment Reporting Tools

MDH worked to improve resident care in nursing homes through joint development of new flow chart tools and made available on the MDH website related to:

- Federal Long Term Care Reportability Under F225 Injuries of Unknown Source
- Federal Long Term Care Reportability for Abuse Under F225 Resident to Resident Altercations

Tuberculosis Law Update

MDH worked to advance the prevention of tuberculosis through updating state law so that regulated health providers follow national current Centers for Disease Prevention and Control guidelines.

Appendices

APPENDIX A: CMS Revisit/Date of Compliance Policy

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

Appendix A - CMS Revisit/Date of Compliance Policy

Revisit/Date of Compliance Policy[8]

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 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 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 of the 3rd revisit.				Proceed to termination.

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.

[8] 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 Matrix

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX[9]

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

[9] *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*