



**Affinity Health Services, Inc.**

**August 31, 2009**

State of Minnesota

Department of Veterans Affairs

Minnesota Veterans Homes

Feasibility Cost/ Benefit Study for Medicare / Medicaid Certification

## **Phase II c**

# **Gap Analysis for Conditions of Participation in the Medicare and Medicaid Program**

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Phase II c Gap Analysis for Conditions of Participation in the Medicare and  
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## I Methodology

The Minnesota Department of Health (MDH) is contracted by the Centers for Medicare and Medicaid Services (CMS) to survey skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation in the Medicare or Medicaid programs. To participate as a skilled nursing facility the provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

A Life Safety Code Survey is conducted by the Minnesota Department of Public Safety to determine compliance with requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC) Chapter 19 Existing Health Care. In order to meet state licensure requirements, healthcare facilities must be in compliance with the 2007 Minnesota State Fire Code (MSFC). Compliance with state licensure requirements is also a condition of federal Medicare/Medicaid certification.

The MDH conducts the survey for initial certification as well as for the required annual re-certification surveys. If the Minnesota Veterans Homes pursue certification then each Home would go through an initial certification survey as well as a Life Safety Code inspection.

Affinity has been contracted to conduct a study and Gap analysis of each Home's current compliance with the CMS Conditions of Participation commonly known as federal regulations. A mock survey was completed in each Home to determine compliance. As part of the review process a Life Safety Code mock inspection was completed in each Home as well.

The mock survey process was conducted using a team of nurse consultants and a dietitian-former Pennsylvania Department of Health surveyor. The methodology used for the mock survey process encompassed the use of record reviews, interviews with staff and residents and observations throughout the Homes. The process used to survey the Homes was a combination of the Centers for Medicare and Medicaid Services' (CMS) Traditional Survey and Affinity's Advantage Award quality assurance review program.

The objective of each mock survey is to identify compliance or non-compliance with each Federal regulation, which is represented by a Federal tag (F tag).

The mock surveys did not include a review of the Minnesota Department of Health Nursing Home Rules as each Home is reviewed annually by the MDH and are all currently in compliance. The mock survey process also does not correlate to any internal VA survey that the Homes currently have conducted by VA representatives.

The consultant tasks included a review of each F tag and the corresponding policy, procedure, process, and observation with a final determination of outcome and compliance. The selection of residents for a review sample was done using data provided by the Homes that identified specific areas of care for each resident. Each care area reviewed by the team included a sample of three residents if the Home had that number of residents with that condition or need. If the Home did not have at least three residents, then the number of residents with that care need under three was reviewed. The sample was selected primarily off-site from data provided by the Homes. Residents were also added to the sample during the mock survey if those residents who had been preselected were no longer at the Home or if there was an additional care need identified based on the consultant's judgment.

The surveys began with a tour of the Home and were followed by an orientation to the Momentum software program. All MVH provided access to computer terminals for the survey team. Each Home provided data that had been requested in advance at the start of the survey. The surveys were a minimum of three days and a maximum of four days in duration.

On-site information gathering was compiled through record reviews, both electronic and hardcopy, interviews and observations with staff and residents through tasks assigned to each consultant. For consistency purposes, each consultant used the same review grids and processes at each Home. Throughout the survey, the Administrator and Director of Nursing were kept informed of the progress and need for additional information.

The Life Safety Code mock inspection at each Home was conducted by an expert in fire safety inspection and consultation. This was completed during the week of June 8<sup>th</sup> through 12<sup>th</sup>. The objective of the Life Safety Code inspection was to determine compliance with the requirements for federal participation.

The inspections were conducted in accordance with the Department of Health and Human Services Centers for Medicare & Medicaid Services (CMS) "Fire Safety Survey Report 2000 Code" the International Building Code® and the Minnesota State Fire Codes. This included a visual inspection and interviews with various individuals at each Home. In addition to compliance with the 2000 edition of the Life Safety Code (NFPA 101) requests were made to provide written documentation of certain Life Safety Code requirements, as well as documentation of code compliance with codes referenced in the Life Safety Code (i.e.: NFPA 13: Sprinkler Systems, NFPA 72: Fire Alarms, NFPA 99: Standards for Health Care Facilities, NFPA 90A/B: Heating and Cooling Systems, etc.). Deficient Life Safety Code practices were cited as K-tags and the standard scope and severity grid was utilized.





## II Analysis

A Gap analysis is used to determine what steps are needed to move from a current state to a desired future-state. In our analysis, through the mock survey process, we have identified where each Home currently meets the federal regulations for certification and then identified where each Home has “gaps” in compliance. The survey readiness report includes overall results of the mock surveys, statistical outcomes, and benchmarks.

The mock surveys were conducted in the Homes beginning July 14, 2009 through August 20, 2009. The determination of compliance is reflective of the staff on duty at the time, the particular residents and family members interviewed, and the federal regulations in effect at the time of each mock survey. Other variable factors could also have impact on the determination of whether the federal requirements were met or not met.

### A. Survey Readiness

#### a. Conditions of Participation

According to the CMS Nursing Home Compare website, the average number of deficiencies per nursing home in the United States is eight (8) and the average number of deficiencies in Minnesota is ten (10). The range of the number of deficiencies cited in Minnesota is 0-34. Skilled nursing facilities must be in substantial compliance with 180 different federal regulations.

The statistical information for the mock surveys conducted in the MVH indicate that the total number of deficiencies range from 38-54. There are 19 F tags that are consistently not met due to not participating in the Medicare / Medicaid certification program. Subtracting these 19 F tags from the total deficiencies indicates a range from 19-35, with an average of 30 deficiencies per Home. If the MVH choose to pursue Medicare and or Medicaid certification, the 19 requirements would need to be newly developed and implemented.

These 19 F tags include requirements under the subcategories:

- Resident Rights:
  - F 153, F 156, F 159, F 160, F 161, F 162, F 163, F 167, and F 177
- Admission, Transfer, & Discharge Rights:
  - F 201, F 202, F 203, F 204, F 205, F 206, F 207, and F 208
- Resident Assessment:
  - F 285 and F 287

The results of the mock surveys for the MVH indicate a consistency in the conditions of participation requirements not met. The information outlined below provides the Federal requirements, as found within subcategories, which identifies the consistent F tags and does include the aforementioned 19 F tags that appear in **bold** type:

- Resident Rights
  - **F 153, F 156, F 159, F 160, F 161, F 162, F 163, F 167 and F 177**
- Admission, Transfer and Discharge
  - **F 201, F 202, F 203, F 204, F 205, F 206, F 207 and F 208**
- Resident Behavior and Facility Practices
  - F 221, F 222 and F 226
- Quality of Life
  - F 241
- Resident Assessment
  - F 272, F 273, F 274, F 278, F 279, F 283, F 284, **F 285 and F 287**
- Quality of Care
  - F 309, F 314, F 321, F 322, F 323, F 329, F 334
- Nursing services
  - F 356
- Dietary
  - F 371

- Physician services
  - F 388
- Rehabilitation
  - F 406 and F 407
- Pharmacy Services
  - F 431
- Infection control
  - F 444
- Administration
  - F 500

During the mock survey process no areas were identified that would be considered actual harm, that is not immediate jeopardy, or any immediate jeopardy to resident safety or health.

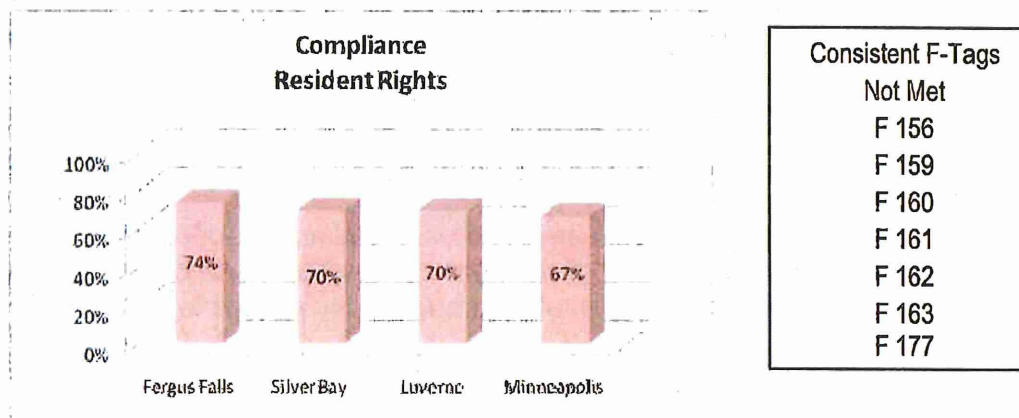
It is notable that some areas not in compliance found during the mock surveys were due to policies that were not up-to-date to industry best practices or no policy at all and not directly related to a negative resident outcome.

## Condition of Participation Requirements Met

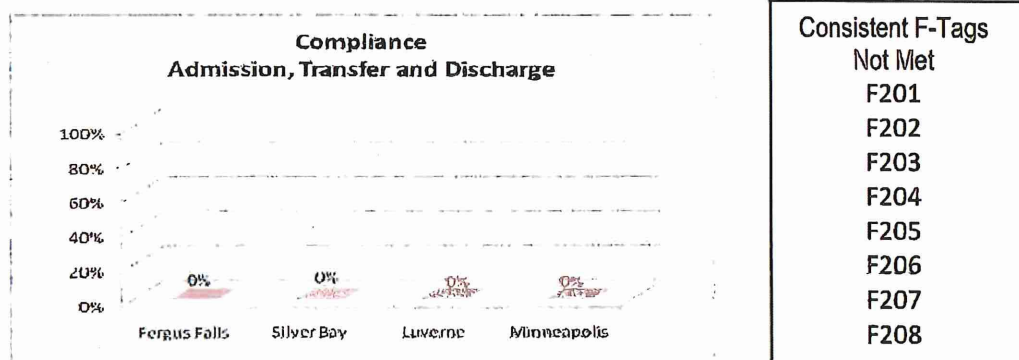
### MVH Comparison

The following graph charts indicate the percentage of compliance to the federal regulations that were met during the mock survey reviews. The charts to the right of each graph indicate the consistent federal regulations, noted as F tags, which were not met for most of or all of the MVH. There are 15 subcategories with condensed explanations about the regulation.

**Resident Rights:** The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident. Some examples of these rights include choosing their own physician, voicing grievances, providing privacy with visitors, mail, and use of the telephone, and self-administering medications.

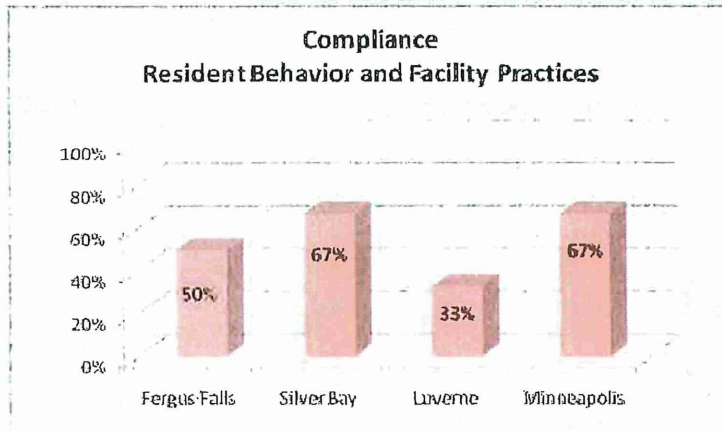


**Admission, Transfer and Discharge Rights:** Transfer and discharge refers to movement of a resident to a bed outside the certified facility whether that bed is in the same physical plant or not. This provision applies to transfers and discharges initiated by the facility, not by the resident.





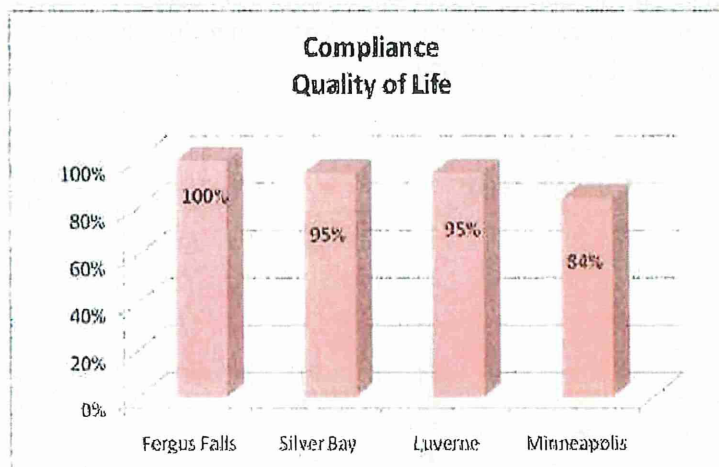
**Resident Behavior and Facility Practices:** The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This requirement includes physical and chemical restraints, and staff treatment of residents including abuse.



Consistent F-Tags  
Not Met

F 221  
F 222  
F 226

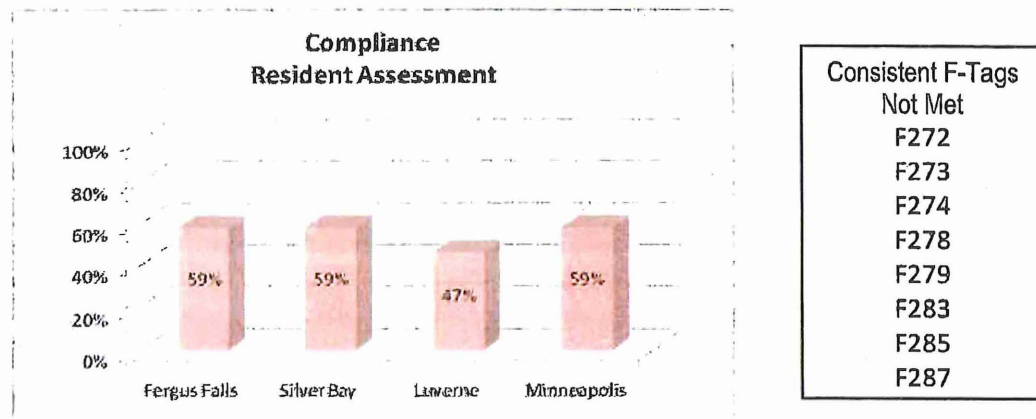
**Quality of Life:** A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. It is the facility's responsibility toward creating and sustaining an environment that humanizes and individualizes each resident. Some examples are dignity, personal preferences, and accommodation of needs, self determination, sanitary and orderly interior, and activity programming.



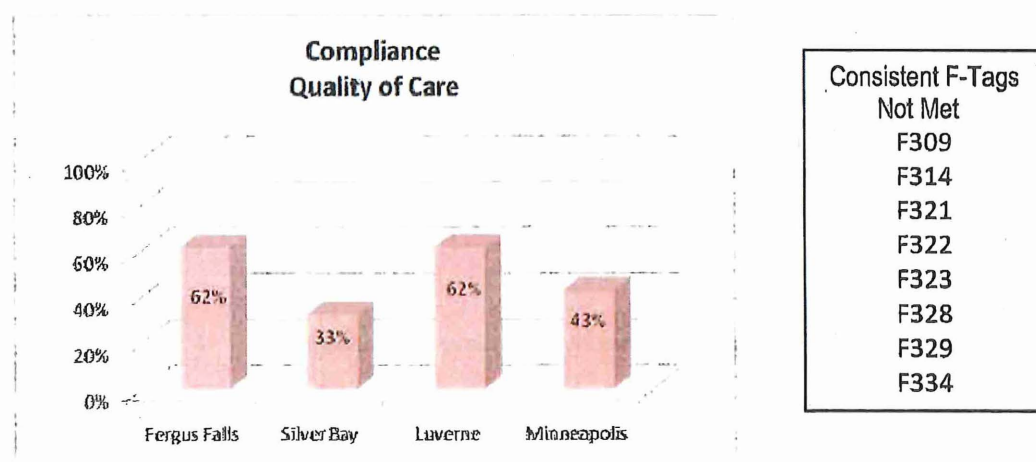
Consistent F-Tags  
Not Met

F 241

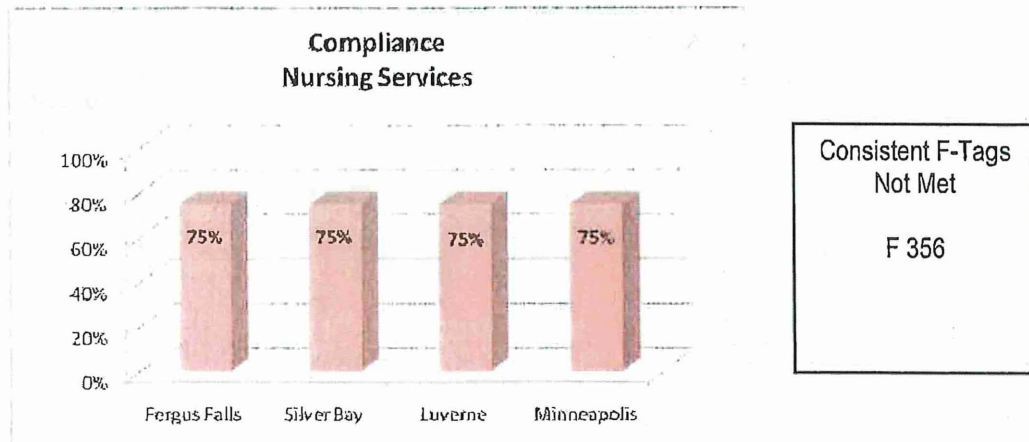
**Resident Assessment:** The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. The intent is to provide the facility with ongoing assessment information necessary to develop a care plan, to provide the appropriate care and services for each resident, and to modify the care plan and care/services based on the resident's status.



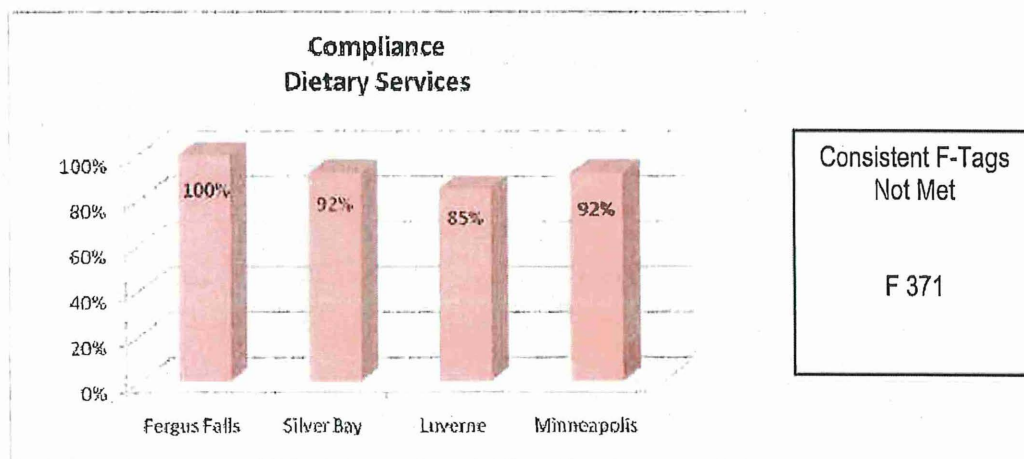
**Quality of Care:** Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. The quality of care requirements include assessment and care plans consistently carried out, assessing for risks, providing interventions through identified resident needs, goals, and recognized best practice. Examples for this requirement includes care for end-of-life, diabetes, renal disease, fractures, pain management, urinary incontinence, activities of daily living, accident prevention, drugs and medications, and skilled services such as tube feedings, ventilators, tracheostomy care, and intravenous therapy.



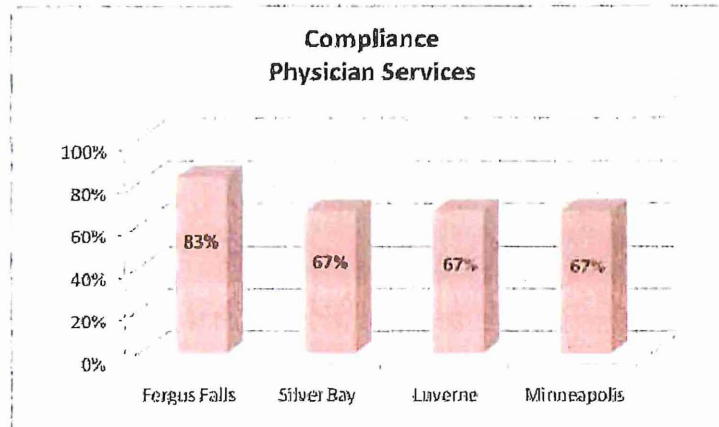
**Nursing Services:** The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. This regulation includes sufficient staff, registered nurse and director of nursing requirements, and posting of nurse staffing information daily.



**Dietary Services:** The facility must provide each resident with a nourishing, palatable, well balanced diet that meets the daily nutritional and special dietary needs of each resident. The requirement includes the use of a qualified dietitian, sufficient staff, meal planning, substitute foods, consistency of foods per assessment and care planning, and to store, prepare, distribute, and serve food under sanitary conditions, which includes safe food handling by non-dietary personnel.



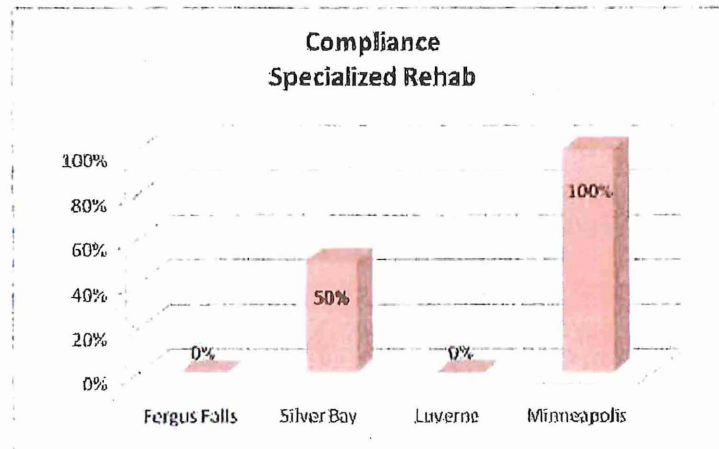
**Physician Services:** A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. Some examples of this requirement include physician supervision, physician visits, timing of physician visits and emergency care.



Consistent F-Tags  
Not Met

F 388

**Specialized Rehab:** Provision of services includes specialized services such as, but not limited to physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, that are required in the resident's comprehensive plan of care. The services are either provided by house staff or outside resources that are qualified and ordered by a physician.



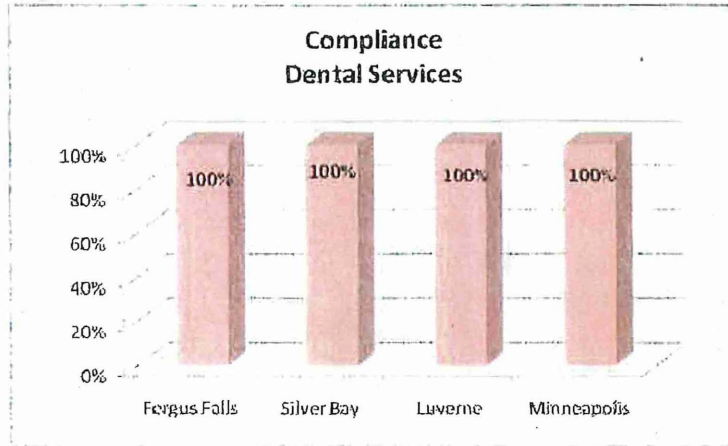
Consistent F-Tags  
Not Met

F 406

F 407



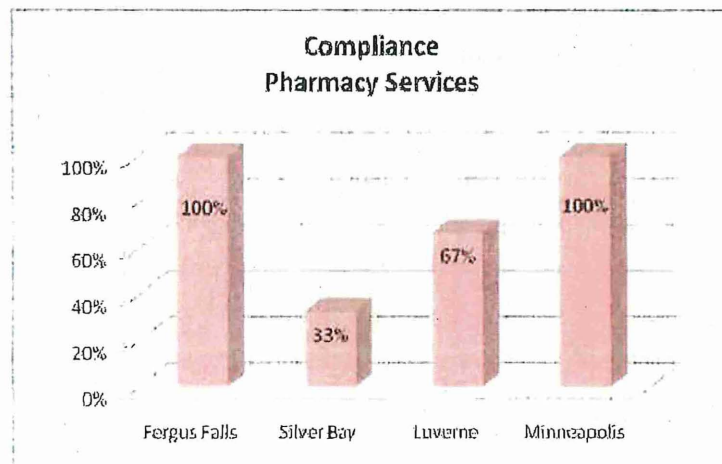
**Dental Services:** The facility must assist the residents in obtaining routine and 24-hour emergency dental care. For Medicaid residents, the facility must provide the resident, without charge, all emergency dental services, as well as those routine dental services that are covered under the State Plan.



Consistent F-Tags  
Not Met

All were met

**Pharmacy Services:** The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement as described in §483.75(h) of this part. The requirement includes consultation services, labeling, storage, controlled substances, and monthly drug regimen reviews.

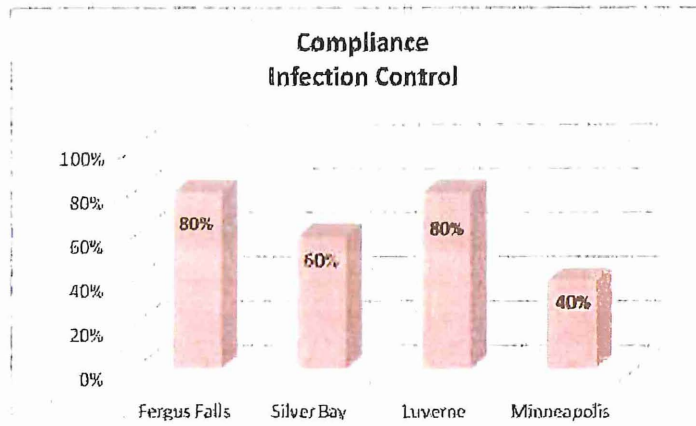


Consistent F-Tags  
Not Met

F 431



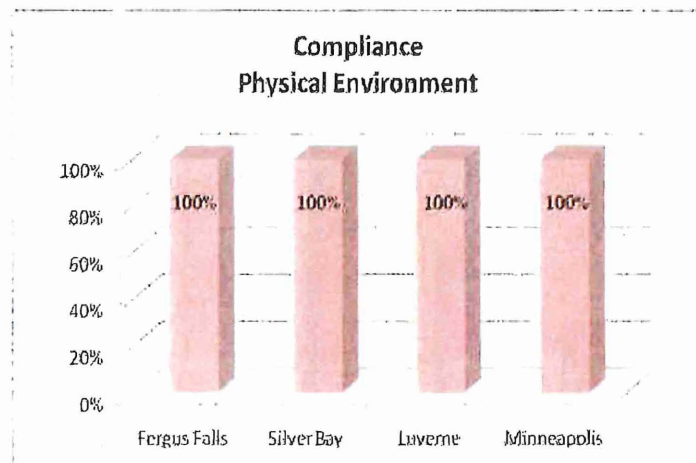
**Infection Control:** The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent development and transmission of disease and infections. Some examples of this requirement include monitoring of infections, staff education, employee health, hand washing, and environmental factors.



Consistent F-Tags  
Not Met

F 444

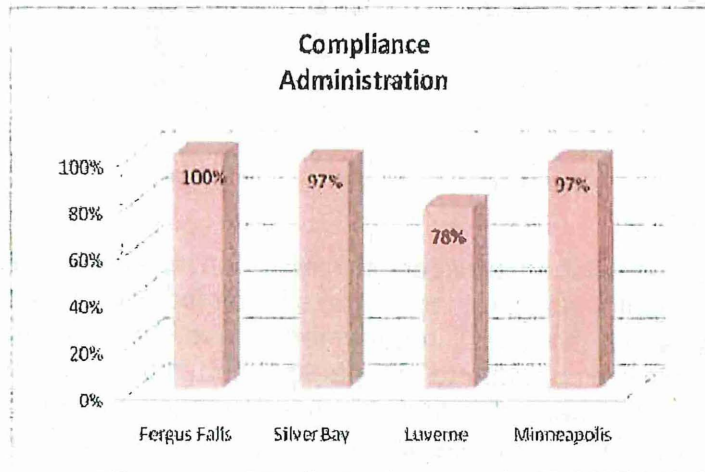
**Physical Environment:** The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public. Some examples of these requirements are Life Safety from fire, emergency power, emergency water, handrails, and pest control and documentation requirements.



Consistent F-Tags  
Not Met

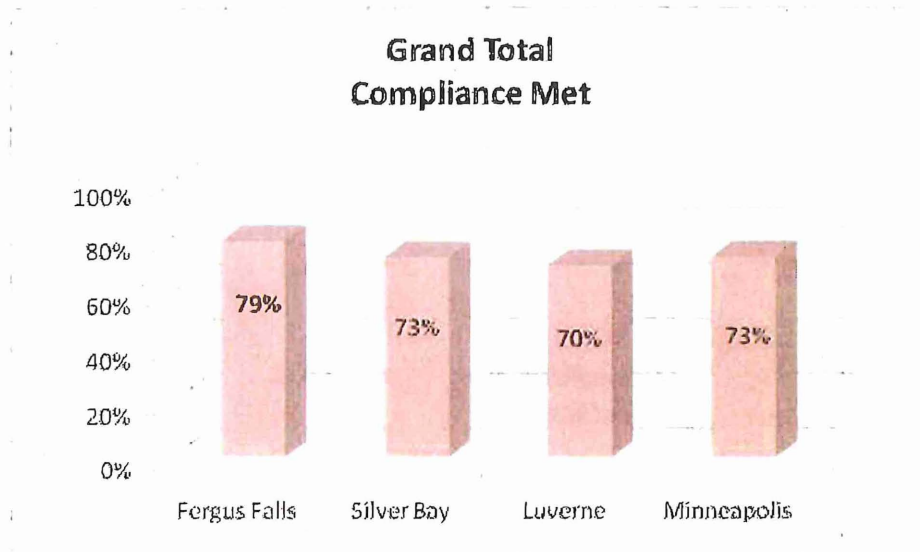
All were met

**Administration:** A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Some examples under this requirement include ensuring competency of nurse aides, checking the State nurse aide registry prior to serving as a nurse aide, documentation of regular in-service education of nurse aides, having dialysis and hospice contracts when using outside resources and a transfer agreement with a MC/MA certified hospital.



Consistent F-Tags  
Not Met

Mostly met



The MVH are well established providers of care in the nursing home industry. The mock survey results indicate that the gaps identified have two primary themes. The first is that the federal requirements have some unique standards, which are not met, due to non participation in the Medicare / Medicaid programs. The second is that some of the policies identified during the mock survey were not up-to-date with industry standards or current best practices.

Updating policies to industry standards or current best practices are done throughout the healthcare industry. Healthcare industries may utilize different mechanisms in order to provide care within established best practices, i.e. clinical pathways, policies, procedures, evidence-based clinical courses and principles from established organizations such as the American Medical Directors Association (AMDA) or National Pressure Ulcer Advisory Panel (NPUAP). Whether the MVH choose to pursue or not pursue Medicare/Medicaid certification, it would be in the best interest of the residents, staff, and community to engage in the pursuit of best practices and policy development.

The Gap analysis indicates there are similarities between the Homes as well as differences with each having a unique personality and culture. Each Home and management team has individual strengths and weaknesses. The MVH can easily work together, by assisting and providing support to each other, in any path that is chosen.

## **Quality Indicator Survey in Minnesota**

The new QIS Federal Nursing Facility survey process began in Minnesota in 2008 and according to Minnesota Care Providers Association, by April 2010, 100% of nursing home "annual" surveys in Minnesota will be conducted via the Quality Indicator Survey (QIS) process. The QIS process is a computer-driven survey method that relies heavily on forms and specific interview questions of residents, staff, and family members.

The Minnesota Department of Health has shared the training schedule for the remaining survey teams to be trained on the QIS process from late September 2009 through March 2010. Once the final teams have been trained on the QIS process, then the surveys should be 100% QIS in Minnesota for standard surveys. At this point in time the QIS abbreviated survey process, to be used for complaint surveys, has not been designed or implemented in Minnesota, therefore complaint surveys will use the traditional abbreviated survey process in the interim.

The Minnesota Department of Health has been able to verify the type of survey they would use to do an initial certification survey. According to Centers for Medicare and Medicaid Services (CMS), there is no process in place to do an initial certification survey using QIS. The QIS process requires the use of submitted MDS data, which is done by certified Medicare/Medicaid facilities and since the MVH are not certified and do not submit MDS data to the state repository, the survey agency would not be able to do a QIS survey. Therefore, the Minnesota Department of Health would use the Traditional Survey process as the initial certification survey for the MVH if they should choose to pursue certification.

## Summary of Frequently Cited F tags

### Statistical Data

#### Comparison: County Citations<sup>1</sup>

	Average F tags Cited
Otter Tail County (Fergus)	6
Lake County (Silver Bay) *	14
Rock County (Luverne)	10
Hennepin County (Minn.)	7.75

\*Only one nursing home to compare in the county

#### Comparison: National and Minnesota 2nd Quarter 2009 Oscar Data

	Average F tags Cited
Nation	6.9
Minnesota	9.9

#### TOP 10 Deficiencies Issued Nationwide (April to June 2009)

National Rank	Tag	% Facilities Cited	Description
<b>1</b>	<b>F 323</b>	<b>36.6%</b>	<b>Accidents and Supervision</b>
<b>2</b>	<b>F 371</b>	<b>35.1%</b>	<b>Store, Prepare, Distribute Food</b>
3	F 281	27.5%	Services Meet Professional Standards
4	F 309	26.8%	Quality of Care – Pain Management
<b>5</b>	<b>F 279</b>	<b>22.8%</b>	<b>Comprehensive Care Plans Based on Assessments</b>
<b>6</b>	<b>F 329</b>	<b>19.3%</b>	<b>Unnecessary Medications</b>
7	F 253	18.8%	Housekeeping and Maintenance Services
8	F 441	18.5%	Investigate, Control, Prevent Infections
<b>9</b>	<b>F 315</b>	<b>18.3%</b>	<b>Urinary Incontinence and Catheterization</b>
10	F 514	17.6%	Maintain Accurate Clinical Records

**BOLD** text Indicated the deficiency is on both the National and Minnesota Top Ten List

<sup>1</sup> 2009 Minnesota Survey data – state website



**TOP 10 Deficiencies Issued in Minnesota (April through June 2009)**

National Rank	Tag	% Facilities Cited	Description
1	F 329	<b>55.2%</b>	<b>Unnecessary Medications</b>
2	F 282	49.0%	Staff Following the Care Plan
3	F 272	48.2%	Comprehensive and Accurate Resident Assessment
4	F 315	<b>47.9%</b>	<b>Urinary Incontinence and Catheterization</b>
5	F 323	<b>47.7%</b>	<b>Accidents and Supervision</b>
6	F 314	45.1%	Pressure Ulcers
7	F 279	<b>40.7%</b>	<b>Comprehensive Care Plan based on Assessments</b>
8	F 371	<b>36.9%</b>	<b>Store, Prepare, Distribute Food</b>
9	F 465	34.0%	Safe, Functional, Sanitary, Comfortable Environment
10	F 428	28.9%	Monthly Drug Regimen Review by Pharmacist

**BOLD** text indicated the deficiency is on both the National and Minnesota Top Ten List.

**Selected State Veterans Homes – Certified**

	Average F tags Cited
6 states 13 homes	6

## b. Life Safety Code

This report is based on Fire and Life Safety Inspections conducted at the MVH.

### Life Safety Compliance Comparison MVH

#### Building Types

Building plans were not available for all buildings. Where plans were not available or incomplete, the building type was established based on visual conformation of building components.

Fergus Falls	Type V
Minneapolis	Type II
Hastings	Building 23 Type II - Building 25 Type II
Luverne	Type II
Silver Bay	Type II

#### Protection

All buildings inspected were protected by fully supervised automatic sprinkler systems and automatic fire alarm systems with smoke detectors and pull stations. Additionally all buildings had internal areas of refuge or had internal divisions which serve to compartmentalize the buildings during fires.

#### K-Tags

Each Home had at least one K-Tag (**bolded**) that were also among the top 10 cited deficiencies for Minnesota and the nation. Luverne had four K-Tags that are listed in the top 10 citations under Life Safety and Fergus Falls had only one, as identified in the next chart.

### Life Safety K-Tags per MVH

	Fergus Falls	Luverne	Minneapolis Building 17	Minneapolis Building 6	Silver Bay
Interior Finish		K014 K015			K014 K015
Smoke Compartmentation and Control	K025	K025	K025 K027	K025 K027	K027
<b>Corridor Wall and Doors</b>	<b>K018</b>	<b>K018</b>	K017 <b>K018</b> K022	K017 <b>K018</b>	
Vertical Openings		K033	K020	K020	
Hazardous Area	K029		K029	K011 K029	
Fire Alarm Systems					K054
<b>Automatic Sprinkler Systems</b>		<b>K062</b>	<b>K062</b> K064	<b>K062</b>	<b>K062</b>
Smoking Regulations	K066	K066			
Building Service Equipment		K067			K069
Furnishing and Decorations		K073 K074			K073 K074
<b>Electrical</b>		<b>K144</b>	K147	K147	<b>K 144</b>
Medical Gases and Anesthetizing Areas			K 141		
Miscellaneous	K 130	K130			K 130
<b>Total K-Tags</b>	<b>5</b>	<b>12</b>	<b>11</b>	<b>9</b>	<b>10</b>

**BOLD** text indicated the deficiency is on both the National and Minnesota Top Ten List

## Summary of Frequently Cited K tags

### Comparison: National and Minnesota 2nd Quarter 2009 Oscar Data

	Average K tags Cited
Nation	4.3
Minnesota	3.1

#### TOP 10 Deficiencies Issued Nationwide (April through June 2009)

National Rank	Tag	% Facilities Cited	Description
1	K018	29.2%	Construction of doors
2	K029	28.6%	Hazardous area separated by construction
3	K062	28.1%	Sprinkler system maintenance
4	K147	27.6%	Emergency plans
5	K038	21.1%	Exits accessible at all times
6	K025	19.8%	Smoke partition construction
7	K050	17.4%	Fire drills – all shifts at unscheduled times
8	K056	16.3%	Sprinkler system installed and maintained
9	K144	15.6%	Generators inspected, tested
10	K052	14.3%	Fire alarm system installed, tested, and maintained

#### TOP 10 Deficiencies Issued Minnesota (April through June 2009)

National Rank	Tag	% Facilities Cited	Description
1	K050	29.6%	Fire Drills – all shifts at unscheduled times
2	K052	23.7%	Fire Alarm System installed, tested, and maintained
3	K038	23.5%	Exits Accessible at all times
4	K029	23.3%	Hazardous Areas separated by construction
5	K056	22.7%	Sprinkler system installed and maintained
6	K067	19.6%	Corridors as plenums
7	K018	13.9%	Construction of doors
8	K062	13.4%	Sprinkler system maintenance
9	K144	12.6%	Generators inspected
10	K011	12.4%	Alcohol-based hand rubs installed properly

**BOLD** text indicates the deficiency is on both the National and Minnesota Top Ten List

## B. Reimbursement Related Functions

### a. Completing the MDS

The Omnibus Reconciliation Budget Act (OBRA) 1987 contained a requirement for nursing facilities to conduct a comprehensive assessment that is accurate, standardized, and reproducible assessment of each resident's functional capacity. The standardized instrument used is the Minimum Data Set (MDS). The MDS is also used to determine the amount of payment for Medicare. In Minnesota, the MDS information has been used to determine the amount of payment for Medicaid and private pay residents since October 2002. The nursing facilities in Minnesota must follow the federal requirements for using the MDS form, including the instructions on how to complete the MDS.

The Resident Assessment Instrument (RAI) is an instrument used to assess all residents in the Medicare and /or Medicaid certified facilities. The RAI consists of the MDS, Resident Assessment Protocols (RAPs), and the utilization guidelines. The RAPs are problem oriented frameworks for additional assessment based on problem identified items. The utilization guidelines are instructions from the federal government concerning when and how to use the RAI.

The MDS must be completed accurately to be successful with any case-mix classification system such as Medicare and Medicaid reimbursement. Adherence to item definitions and the appropriate time frames for observation and completion is critical to ensure the accuracy and reliability of the assessment, and to provide a clinical structure for providing care and services. Adherence to the rules for completion of the MDS will provide an accurate snapshot of the resident at various times, ensure accurate and reasonable reimbursement, and produce data for quality monitoring.

Accuracy includes compliance to the rules indicated in the RAI. This includes a system in place so that staff know when the MDS should be completed, what the assessment reference dates mean, the transmission time lines, errors, and how the MDS is used for billing. Internal audits of the accuracy of the MDS data is an important piece of Corporate Compliance as required by the Office of the Inspector General (OIG). The correction policy established by CMS for correcting errors must be followed.

Documentation guidelines are an important internal process for accurate completion of the MDS. CMS has termed the MDS as a "primary document", meaning that data entered on the MDS does not have to be substantiated elsewhere in the medical record. There are times that the MDS does not go into enough detail and there may be key issues that are not part of the MDS



data collected. An accurate assessment is to gather data and to follow good clinical practice for additional documentation needs.

The accuracy of the MDS is important because it is a tool that is used as an accepted clinical assessment, for nursing home quality indicators and reimbursement. Errors can be made when collecting MDS data and some nationwide examples include:

- Asking staff who are not trained to code the MDS
- Completing the MDS without the RAI manual or updated versions of the manual
- Completing the MDS without speaking with the resident, staff, or the family
- Not collecting data from all three shifts
- Scoring what the staff believes the resident is capable of instead of what the resident's performance really is
- Failure to follow the submission required transmission rules
- Failure to follow RAI rules for restorative nursing data
- Inaccurate data entry of therapy minutes

The MVH all complete the comprehensive assessment but are not transmitting to the state repository. If the MVH should pursue Medicare and or Medicaid certification they would be required to transmit completed MDS's to the state. The accuracy of the MDS is very important as outlined above. The Resident Assessment subcategory of the Conditions of Participation was reviewed during each mock survey. The four (4) Homes have an average of 53% compliance met under the resident assessment requirements. The generalized overall areas that would need improvement or additional training, if the MVH should choose to pursue Medicare or Medicaid certification, are noted in this Gap analysis:

- Assessment Reference Date (ARD) guidelines
- Signature guidelines
- Correction Modification guidelines
- Lack of a standardized process to determine when a quarterly or significant change assessment should be completed
- Lack of MDS worksheets for accurate data coding

- Discharge summary – recapitulation guidelines
- Comprehensive care plan guidelines
- Encoding process not in place
- Pre-admission screening for mental illness not in place
- Restorative / Rehabilitative Nursing guidelines
- Section G – ADL's guidelines
- Medicare PPS guidelines
- Minnesota Medicaid guidelines
- Internal audit systems for Corporate Compliance not in place
- Lack of experience with Minnesota Division of Compliance audit programs

The recommendations for training, process development, and organization of the nursing department are usually encompassed in training sessions when a facility chooses to improve or provide for more in-depth training on the comprehensive assessment process.

## C. Policy Development and Best Practices

Best practices in the nursing home industry are those methods, processes or activities that are believed to be most effective at delivering desired outcomes versus any other method or process available. Best practices can be found in professional associations and organizations, institutions for higher learning, quality improvement organizations and professional literature. Many best practices are now a part of the federal regulation interpretive guidelines for the nursing home regulations, and while not considered regulation, serve as a guide to both providers and surveyors in analyzing current facility practice.

Based upon changes in the federal interpretive guidelines for several F tags over recent years and changes in the industry's practice guidelines, the mock surveys revealed where the Homes would need to create or improve upon established policy and practice in order to move forward competitively and competently. Areas in which there are best practice standards in the nursing home industry and in which the MVH could pursue these standards to bring their policies and procedures up-to-date include the following:

F 221	Physical Restraints
F 222	Chemical Restraints
F 225-226	Abuse
F 272-278	Resident Assessment
F 283-284	Discharge Summary and Discharge Care Plan
F 309	Bowel Management
F 309	Pain Management
F 310-312	Restorative Nursing
F 314	Pressure Ulcers
F 321-322	Enteral Feedings
F 323	Accident Prevention and Accident Hazards
F 328	Special Needs
F 329	Unnecessary Drugs
F 371	Safe Food Handling by Non-dietary Personnel
F 387-389	Physician Services
F 500	Outside Resources - contracts