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# A REVIEW OF THE INSPECTION ACTIVITY IN HOSPITALS AND NURSING HOMES:

## RECOMMENDATIONS FOR THE COORDINATION OF INSPECTIONS IN HOSPITALS AND NURSING HOMES

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Report to the Minnesota Legislature

March 1990

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Article 1, Section 9, subd 3



# minnesota department of health

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March 29, 1990

Minnesota Legislature  
State Capitol  
St. Paul, Minnesota 55155

Dear Legislator:

The Department of Health was requested to prepare this report outlining the number and types of inspections held in hospitals and nursing homes. Inspections by the Department are used to determine compliance with laws and regulations which have been legislated by either federal or state governing bodies for the purpose of protecting the public. Such regulations serve a vulnerable subset of the public: the acutely ill experiencing a hospital stay, and the developmentally dependent and frail elderly who reside in nursing homes.

As a former hospital administrator, I am very aware of the number and intensity of the various inspections. As the Commissioner of Health I am also aware of my responsibility to the citizens of Minnesota regarding their public health and the enforcement of provisions designed to promote their health, safety and welfare. There is no denying the fact that there are a number of possible inspections and audits of nursing homes. The operative word is "possible" and the reader needs to be aware of this. The reader should also consider the value to our citizens and the rationale for inspection activity.

Inspections serve a purpose. Inspections are to check that minimal standards of quality for health and safety are being provided by a health care facility to its clientele. In nursing homes, the clientele is entirely dependent on the facility for the provision of life's basic needs - food, shelter, personal grooming. Additionally, many nursing home residents live with physical and mental impairments which necessitate greater dependence on the care providers. Often a resident's ability to articulate on his or her own behalf is limited because of various impairments. The State has an obligation to protect this vulnerable population. We have done so by establishing minimum standards of care and authorizing inspection activity to monitor facility compliance with these standards and assess the quality of care given to clientele. The State has also established ombudsman programs that are intended to promote and advocate for the well-being of residents outside of the constraints of the regulatory process.

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Minnesota Legislature

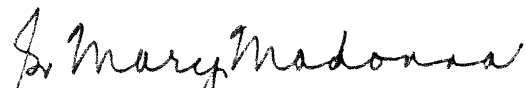
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The State also invests substantial funds in payment for services provided to clientele of health care facilities. The State has a compelling interest in determining if a facility is providing clientele the services the facility is reimbursed for. Limited financial resources require prudent use, and it is in the interest of all Minnesotans that both public and private dollars are spent appropriately.

This report provides a basis for review and assessment of the current regulatory mechanisms affecting hospitals and nursing homes. The Minnesota Department of Health welcomes the opportunity to explore methods of coordinating or reducing inspections which would not compromise the health, safety and welfare of Minnesotans utilizing hospital and nursing home services.

Sincerely yours,



Sister Mary Madonna Ashton  
Commissioner of Health

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**Report to the Minnesota Legislature**

**March 1990**



**Minnesota Department of Health**

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## Introduction

The 1989 Legislature required the Minnesota Department of Health to report on the Commissioner's efforts to encourage the coordination of hospital and nursing home inspections. Further, the legislature directed that this report contain a list of all agencies inspecting nursing homes and hospitals, the purpose, frequency and legal authority for the inspections, and recommendations to improve the coordination of the inspections identified.

A variety of agencies may enter hospitals, nursing homes and other health care facilities for inspection purposes. Several factors will influence the number of inspections, such as certification for participation in Title 18 (Medicare) or Title 19 (Medicaid) reimbursement programs. The vast majority of inspections, however, relate to the health and safety of patients, residents and employees. In addition to inspections, there are also audits and investigations. These latter activities are also influenced by several factors such as participation in Title 18 and Title 19 programs, or alleged violations of health and safety laws, or patient rights.

For purposes of this study, inspection, investigation, and audit are defined as follows:

**Inspection:** a site visit to ascertain a hospital or nursing home's compliance with applicable state or federal rules. **NOTE:** Federal regulations always refer to "inspections" as "surveys" unless regulations pertain to a complaint investigation. For purposes of this report "inspection" will be used through out.

**Investigation:** a visit to a hospital or nursing home which is initiated in response to a complaint or a specific issue of concern. This is not a routine visit.

**Audit:** a formal, periodic examination and checking of accounts and financial records to verify their correctness or a thorough examination and evaluation of a problem.

Many inspections and audits are federally mandated certification requirements, and the state implements these as an agent of the federal government. Many other inspections and audits are state mandated via state licensing laws. Licensing and certification are two distinct functions and serve two different purposes.

Licensure is state initiated, is mandatory for the operation of a hospital or nursing home, and is a pre-requisite to participation in federal certification programs.

Certification is based on federal regulation, is voluntary, and allows the facility to be reimbursed by Medicare and/or Medicaid.

A 1985 Minnesota law requires any facility certified as a Medicaid skilled nursing facility to participate in Medicare. Federal certification and state licensure are integral parts of nursing home and hospital reimbursement procedures. Medicare and Medicaid funds represent a significant portion of payment for services provided to nursing home residents and hospital patients. Medicare is a 100% federally funded program, available to adults aged 65 years or older (and under special circumstances under 65 years of age), who meet eligibility requirements referenced in Sec. 226 of the United States Code (42 U.S.C. S426).

Medicaid is a 42% state, 53% federal and 5% county funded program, and is an entitlement program for individuals whose income and resources are insufficient to meet the costs of specified medical services. Medicaid eligibility categories and criteria are established by the State. Medical conditions covered by that program are also determined by the State. The federal government has mandated minimum eligibility standards and covered services that states must provide.

For the 1990-91 biennium, the State of Minnesota has appropriated \$881,200,000 to the Medicaid budget, of which \$374,400,000 will go toward nursing home reimbursement and \$191,000,000 toward hospital reimbursement. The State of Minnesota has declared that as a matter of public policy it will be a prudent buyer of services and require review of Medicaid expenditures. This is also true of the federal government and the Medicare program. Therefore, many inspections and audits are essentially "reimbursement driven", that is they occur as a result of the facility's voluntary participation in the Medicare and Medicaid programs.

A core group of inspections applies to nearly all hospitals and nursing homes. This "core group" exists to establish and enforce minimum standards for the safety and well being of patients and residents within these facilities. In addition to this "core group" of inspections, which all licensed hospitals and nursing homes receive, there are some "special case" inspections which are triggered by unique features of the licensed facility and some "infrequent" inspections which occur randomly as a check on facility regulatory compliance or in selected facilities in response to complaints, alleged fraud, abuse, etc.

This report is separated into three sections. Section A contains descriptive information on nursing homes and Section B contains descriptive information on hospitals. The two Sections are subdivided into categories of inspections, audits and investigations. Section C contains comments on and recommendations for the coordination of the inspections described in this report.

## Section A - Nursing Homes

Section A provides a descriptive listing of the inspections, audits and investigations conducted in nursing homes. Section C of the report contains comments on and recommendations for coordination of these activities.

### I. Inspections

A. The "Core Group". The "core group" for the majority of nursing homes consists of four mandated inspections.

1. Licensure and certification inspections are conducted by the Survey and Compliance Section of the Minnesota Department of Health. Surveys, visits and investigations are conducted to determine compliance with state and federal laws, rules and regulations. The state has established minimum licensure standards for the construction and operation of nursing homes to assure the health, treatment, comfort, safety and well being of nursing home residents. The State statute mandates, at a minimum, biennial surveys to each facility. The federal law mandates annual survey visits to all nursing homes desiring reimbursement under Titles 18 and 19 of the Social Security Act to assess compliance with federal health, safety and quality standards.

Surveys are conducted according to provisions of state law and federal laws and rules following established procedures. During the annual inspection the entire facility is reviewed for compliance with applicable state and federal rules. A reinspection visit is made to ascertain correction of previously issued state correction orders and a post certification revisit (PCR) is made to determine the status of corrective action on previously issued federal deficiencies. The follow-up visits are combined whenever possible. These follow-up visits are usually confined to verifying compliance with the previously issued orders or deficiencies involved but may expand to other areas based on findings or observations made at the time of the reinspection. The time frame for conducting federal inspections is determined by the length of a facility's provider agreement. Federal complaint investigations are conducted in accordance with federal procedures.

The Health Department conducts both the licensing and certification inspections. In the year in which the licensing inspection is conducted, it is done in conjunction with the certification inspection (if the facility is certified). Surveyors are in a facility an average of 3 - 4 days. Legal authority: Minnesota Statutes Chapter 144A for licensing and Social Security Act Titles 18 and 19, Sections 1864 and 1902 for certification.

2. Quality Assurance and Review (QA&R) inspections are conducted by the Quality Assurance and Review Section of the Minnesota Department of Health. This activity fulfills the federal requirement for the state to conduct an annual Inspection of the Care for all recipients of care under Title 19 (Medicaid), in order to assure that the quality and quantity of services provided are appropriate to the recipients' medical, physical, and psycho-social needs. In addition to the federally required inspection of the care review, all residents in Medicaid certified nursing homes are also reviewed at the same time to establish case mix classifications for Minnesota's case mix reimbursement system administered by the Minnesota Department of Human Services. The average inspection of care and case mix review takes one-half hour per resident to complete.

In addition to the review of 55,000 residents in nursing homes, regional treatment centers and community based ICF/MR facilities, the Section also processes 150,000 classifications, 3500 reconsiderations and 16,000 on-site audits throughout the State annually.

As of October 1990, Inspection of Care will no longer be required by the federal government but will be reimbursed by the federal government as a state option. The case-mix requirements will need to be continued since this process is integral to the Medicaid reimbursement to nursing homes. The continuation of the Inspection of Care functions, which include the development of program strengthening recommendations, will be assessed in conjunction with other major federal initiatives contained in the Nursing Home Reform Act. Legal authority: 42 CFR - 456.600-.613, (Title XIX of the Social Security Act); Minnesota Statutes Sections 144.072 and 144.0721.

3. Fire Safety Inspection is done by the State Fire Marshal Division of the Department of Public Safety. Both state and federal rules require that a nursing home be reviewed at least annually for compliance with fire safety rules. The State Fire Marshal inspects for Medicare and Medicaid certification under contract with the Minnesota Department of Health.

As of January, 1990, federal regulations require that the Life Safety Code (fire) inspection be done in conjunction with the survey and compliance annual survey to avoid facility pinpointing of the arrival of the survey and compliance surveyors. Prior to that date, the fire inspections were required to be conducted approximately 30 days in advance of the Health Department inspections. The Health Department needs State Fire Marshal clearance to continue to license a nursing home. Legal authority: M.S. Chapter 299F; Minnesota Rules: 4660.0300, subpart 5; Titles 18 and 19 of the Social Security Act.

4. Boiler inspections are conducted annually by the Minnesota Department of Labor and Industry. Pressure vessel inspections are conducted biennially. Legal authority: M.S. Chapter 5225. NOTE: This inspection requirement applies to all buildings, not just health care facilities.

#### B. Special Case Inspections

1. Program Licensing. Nursing homes that have chosen to provide certain additional or specialized services beyond the basic nursing home level are subject to special program licensing by the Minnesota Department of Human Services and undergo an annual review by the Minnesota Department of Human Services for compliance with program licensing and rules. Program licenses are issued in five areas and include: adult day care, mentally retarded, chemically dependent, adult mentally ill, and physically handicapped. A total of 38 individual program licenses are issued to nursing homes. Legal authority: M.S. Chapter 245A.02 Subd. 14.

2. Beauty salon or barber facilities within a nursing home are subject to inspection by the Minnesota Department of Commerce. Salons are inspected annually to check for proper licensing of personnel and the salon itself, and for compliance with safety and sanitation regulations for the protection of clients and operators. The average length of inspection is 2 hours. Legal authority: M.S. Chapter 155A.08 and .09.

3. Engineering Inspections include inspectors from the Minnesota Department of Health and building inspectors from the county or local jurisdiction agency. Minnesota Department of Health engineers will visit a facility to review compliance with state licensing of physical plant codes and building inspectors for building code inspection. Engineer inspections are triggered by one or more of the following events: new construction, new license, plan review, remodeling, change in use or space utilization, validation inspection for certification, initial inspection for fire safety, and consultation requests. Length in the facility varies and is dependent upon the nature of the inspection. Legal authority: M.S. Chapter 144.55; 144.56. The State Fire Marshal must also review a facility for fire safety when there is remodeling or new construction. The Survey and Compliance Section of the Minnesota Department of Health notifies the State Fire Marshal when there is a fire safety inspection needed as a result of remodeling or new construction.

4. Environmental health inspections. A 1989 state infectious waste law was passed which has potential impact for those nursing homes which generate infectious waste on their premises. The law requires all generators of infectious waste to submit an infectious waste control management plan to the Minnesota Department of Health by January of 1990. Minnesota Department of

Health environmental health personnel will follow-up on the management plans submitted. Some routine (but random) inspection of facilities generating infectious waste is possible. Inspection would be for compliance with the infectious waste plan submitted. Inspectors would go into a facility if a complaint was filed. Legal authority: M.S. Chapter 116.75-.83. If a nursing home has a private well, swimming or therapy pool, or restaurant open to the public, that nursing home would be subject to additional environmental health inspections conducted by Minnesota Department of Health personnel or by county personnel if these functions have been delegated under provisions of the Community Health Services Act. Legal authority: M.S. Chapter 157.

There are some local city and municipal agencies which still conduct inspections of nursing home kitchens, but these numbers are few and decreasing.

5. County, City and Municipality Inspections. Minnesota has 87 counties and there is the potential for any or all of them to generate inspection requirements for nursing homes. Cities and municipalities may require building code inspections for new or planned construction, fire safety inspections and similar physical plant operations.

6. Elevator inspections are conducted annually by local city and municipal building inspectors in those municipalities which have requisite personnel. In 1989, the State legislature assigned this inspection function to the Minnesota Department of Labor and Industry for municipalities in Greater Minnesota. Legal authority: M.S. Chapter 183.

### C. Infrequent Inspections

1. Monitoring surveys are conducted by the surveyors of the federal Health Care Financing Administration, Regional Office. The purpose of this inspection is to compare the federal surveyors findings with the findings of the state surveyors. In FY 89 seven of 436 eligible nursing homes were reviewed. In 1990, the inspection will affect approximately 2% of all certified nursing homes. Inspections are done on a sample basis and take approximately 3 - 4 days per facility to complete. Legal authority: Section 1910(c) of the Social Security Act.

2. Employee Safety Inspections. The Minnesota Department of Labor and Industry is charged with the responsibility of enforcing federal and state occupational safety and health standards (OSHA). Inspections are done only for employee health and safety standards and occur in all Minnesota work sites. Because of the numerous facilities to be inspected, a routine inspection occurs approximately once every five years. Facilities are placed on an inspections scheduling list and

randomly selected off the list. Complaints or fatalities will automatically trigger an investigation. Inspections last, on average, one day. Legal authority: M.S. Chapter 182.

3. A Pollution Control Inspection could occur in a nursing home if that nursing home has an incinerator. The Pollution Control Agency will inspect for air quality purposes. The inspections generally occur only in response to problems which come to the Pollution Control Agency's attention. Legal authority: M.S. Chapter 115.04 and M.S. Chapter 116.091.

## II. Audits - Nursing Homes

### A. Annual Audits

1. Rule 50 Field Audit. This Medicaid compliance audit, conducted by the Department of Human Services, is required by both the federal and state governments. Providers submit an annual cost report which is subjected to a desk audit that establishes payment rates. The purpose of the field audit is to verify the information submitted on the provider's annual cost report through an on site review of the provider's records. The Department of Human Services has the authority to conduct field audits. Also at this time, the auditors reconcile the funds held in trust for the resident's personal needs. The Audit Division is responsible for this function by Statute.

An audit normally covers a four year time period. Audit results are issued in a report to the provider. In addition, should questionable items be noted during the field audit, referrals are made to the Minnesota Department of Human Services Survey and Utilization and Review Unit and the Medicaid Fraud Unit of the State Attorney General's Office for further investigation. Legal authority: M.S. Chapter 256B.

2. Medicare Fiscal Intermediary Audit. This audit is conducted by Blue Cross/Blue Shield of Minnesota, Minnesota's federally designated Medicare fiscal intermediary. This is a financial audit to monitor compliance with skilled nursing facility Medicare utilization. Nursing home audits are done in-house at BC/BS on an annual basis. Only one nursing home field audit was done in 1988. The frequency of these on-site audits could change if skilled nursing facility Medicare utilization increases. Legal authority: CFR 405. NOTE: A small number of nursing homes operated by national chains have been given permission by the federal Department of Health and Human Services to utilize one intermediary for all of their facilities and thus do not utilize Minnesota Blue Cross/Blue Shield.

## B. Special Audits

1. Survey and Utilization Review (SUR). These audits are conducted by a section of the Minnesota Department of Human Services to verify vendor billing for reimbursable Medicaid services. Medicaid reimbursable services are not included in a nursing home facility's per diem rate and include such services as occupational therapy, physical therapy, and speech/language therapy. These ancillary services must be medically necessary and appropriate to the medical condition of the recipient. Audits are not done on individual nursing homes, but rather on "individual vendors" who are not employees of the nursing homes. Individual vendors are practitioners such as occupational therapists, physical therapists, speech language pathologists. "Exception profiles" are generated and, when an irregular exception profile is detected, SURS may enter a nursing home to check vendor (practitioner) records for fraud and abuse.

SURS also responds to complaints concerning patient trust funds; conducts periodic surveys of prescription drugs in nursing homes to verify pharmacy drugs billed to the Minnesota Department of Human Services; and conducts audits of "hold" bed days to confirm the 93% occupancy rate because Medicaid will pay to hold beds if a facility maintains a 93% occupancy rate. SURS establishes probable cause for Medicaid fraud and turns suspected cases over to the attorney general for criminal prosecution. Abuse cases are pursued by SURS with assistance from the attorney general as civil cases. Legal authority: M.S. Chapter 256B.

2. Compliance with Veterans Contract Audits. The U.S. Department of Veteran's Affairs, Region 18 Office does an annual desk review of state and federal written inspection material on all nursing homes which have agreed to provide contract slots for veterans. Based on review of that material, plus reports from monthly on-site visits to contracting facilities, the VA may opt to do a full facility review more frequently than the facility review conducted every 3 years. The reviews conducted by the VA pertain only to those nursing home residents which have a veterans contract. Each contract resident is seen on-site, monthly, by a social worker and registered nurse team. The inspection is a quality of care/quality of life inspection which focuses on the individual patient and does not repeat state inspections for compliance with minimum standards. Inspectors also review facility sanitation, throughout and in dietary areas because of the impact of sanitary conditions on residents.

In Minnesota, 123 nursing homes have veterans contracts representing approximately 230 individuals. Legal authority: Geriatrics and Extended Care, Nursing Home Care, M-5, Part 2, July 19, 1988, U.S. Department of Medicine and Surgery.

### C. Infrequent Audits

1. The Utilization Control Unit of the Minnesota Department of Human Services designates the Institution of Mental Disease (IMD) status of nursing homes and boarding care homes. Utilization control contracts with nurses to determine the appropriate IMD status of residents in IMD designated nursing homes and boarding care homes. These nurses conduct their reviews on-site, and the reviews are done when federally mandated (through OBRA changes, etc.) and do not conform to any regular schedule. In Minnesota, 16 nursing homes and boarding care homes have IMD status. Legal authority: 42 CFR, Part 456; M.S. Chapter 256.05.

### **III. Investigations**

Investigations are done in response to complaints or requests. Investigations, by their very nature, are not predictable in terms of frequency or duration. The following agencies have authority in Minnesota to conduct investigations in nursing homes.

1. Survey and Compliance Section of the Minnesota Department of Health will enter a facility to investigate in response to state complaints or concerns, federal complaints, and when there is an employee strike of any type to evaluate patient care and requires corrective action. Legal authority: M.S. Chapter 144A.10 and the Social Security Act Section 1864 Agreement between the federal Health and Human Services Department and the Minnesota Department of Health. The complaint activity of the Survey and Compliance Section primarily focuses on complaints which are based on allegations of federal regulations since state licensing violations are investigated by the Office of Health Facilities Complaints (OHFC). Staff from the Survey and Compliance Section will assist OHFC complaint investigations especially in situations where serious allegations are raised and when Survey and Compliance staff in district offices are closer to the facility at which complaints are being investigated.

2. Office of Health Facility Complaints (OHFC) of the Minnesota Department of Health. The OHFC investigates hundreds of complaints each year of possible violations of applicable state rules and laws governing licensed health care facilities so corrective action can be taken. The OHFC also helps patients and residents enforce their rights. In addition, licensed facilities report thousands of incidents each year under the Vulnerable Adults Act to OHFC. On-site investigations are conducted as necessary of reports received by the OHFC. Complaints which are not under the OHFC jurisdiction are referred to the appropriate agency. Legal authority: M.S. Chapter 144A.53.

3. Ombudsman for Long-term Care of the Minnesota Department of Human Services. The ombudsman role is one of advocacy. The

ombudsman helps to resolve misunderstandings between and among residents, staff, etc. The ombudsman may enter any long-term care facility without notice at any time; communicate privately and without restriction with any client (in accordance with M.S. Chapter 144.651); and inspect records of a long-term care facility that pertain to the care of a client according to M.S. Chapters 144.335 and 144.651. If the ombudsman discovers a regulatory problem that cannot be resolved, the ombudsman will file a complaint with the OHFC or with the Department of Health, Survey and Compliance Section, if the complaint involves federal certification issues. Ombudsman staff are frequently on-site in nursing homes, and often at the nursing home's request. Legal authority: M.S. Chapter 256.9741.

4. Ombudsman for Mental Health and Mental Retardation of the Department of Human Services. The ombudsman role is one of advocacy for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance. The ombudsman may mediate or advocate on behalf of a client; investigate the quality of services (within certain defined parameters) provided to clients which are paid for by public funds; examine records (within certain defined parameters); while conducting a review, enter the premises of an agency, facility, program; attend Minnesota Department of Human Services review board proceedings; access specified private data; review complaints, conduct investigations, issue recommendations; and must inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program. Legal authority: M.S. Chapter 245.92.

5. Office of the Attorney General, Medicaid Fraud Unit. This agency investigates potential Medicaid fraud and/or abuse cases. In 99 out of every 100 cases, the attorney general will have a criminal search warrant for investigating billing abuses. Legal authority: 42 USC, Section 1320 a-7 (b) (12) (D).

6. County Social Service Agencies. These agencies will investigate to enforce the Vulnerable Adult Protection Law. State law requires the investigation of all reporting of suspected abuse or neglect of vulnerable adults. Since the allegations will also relate to potential licensure violations, the Health Department does attempt to coordinate inspections and investigations with counties. The provisions of the Vulnerable Adult Act mandate the investigation by the county and licensing agencies. Legal authority: M.S. Chapter 626.5571.

7. Local law enforcement agencies in criminal situations that warrant their involvement.

8. The Occupational Health Unit of the Minnesota Department of Health contracts with the Minnesota Department of Labor and

Industry to enforce industrial hygiene and health standards as part of the Minnesota OSHA Program. Personnel from the Occupational Health Unit or the Occupational Safety and Health Division of the Department of Labor and Industry will enter a facility in response to: a fatality; catastrophe (defined as the hospitalization of 5 or more people); an employee or union complaint; an increase in the worker's comp rate of incidence; or for "special emphasis" program review at the directive of federal or state authorities. Legal authority: M.S. Chapter 182.65.

9. The professional Licensing Boards, such as Nursing and Medical Examiners, may also enter a nursing home to review records if a licensee is the subject of an investigation involving professional misconduct, neglect, which occurred in a nursing home.

## **Section B - Hospitals**

This section provides a descriptive listing of the inspections, audits and investigations conducted in hospitals. Section C contains comments on and recommendations for coordination of these activities.

### **I. Inspections**

#### **A. Core Group**

1. Joint Commission on the Accreditation of HealthCare Organizations (JCAHO). This accreditation is granted by the JCAHO which is a private, non-profit organization. The State of Minnesota recognizes federal Medicare rules as state licensing standards. JCAHO accredited hospitals are deemed to meet Medicare standards. Because these JCAHO accredited facilities meet Medicare standards they are also deemed to meet state licensing requirements. Therefore, JCAHO accreditation is recognized in lieu of state survey activity. Legal authority: M.S. Chapter 144.50 Subd. 3.

2. The Survey and Compliance Section of the Minnesota Department of Health conducts the licensing and Medicare certification surveys of those hospitals which do not have JCAHO accreditation. Post certification re-visits are conducted in non-JCAHO hospitals receiving deficiencies as a result of the full survey. In Minnesota, this represents 56 of 166 licensed hospitals. M.S. Chapter 144.54 and 144.653 subd. 2 mandate biennial licensing surveys. The federal Department of Health and Human Services requires that 75% of all non-JCAHO hospitals be surveyed annually. Medicare standards have been adopted as the State licensing standards. Therefore, surveys of non-JCAHO hospitals meet both State and Medicare requirements.

Surveyors from this Section conduct validation surveys of the JCAHO accredited hospitals in response to federal directive and state law and also investigate federal complaints in JCAHO accredited hospitals. The Section also surveys JCAHO and non-JCAHO hospitals having licenses issued under the Clinical Laboratories Improvement Act under the Section 1864 Agreement with the federal Department of Health and Human Services. The federal government also requires surveys of psychiatric and rehabilitation units excluded from the prospective payment system. Survey and Compliance surveyors use specific federal criteria for these reviews. Legal authority: M.S. Chapters 144.50, 144.54, 144.653 subd. 2, 144.55 subd. 4, and Title 18 of the Social Security Act.

3. The State Fire Marshal of the Minnesota Department of Public Safety conducts an annual review for compliance with fire safety rules. Legal authority: M.S. Chapter 299F.

4. Environmental health inspections occur for public cafeterias, X-ray equipment, therapy pools and infectious waste. Inspections of cafeterias and X-ray equipment occur annually. All generators of infectious waste must submit an infectious waste control management plan to the Department of Health by January of 1990. The Health Department may inspect for compliance with the submitted plan. If there was improper disposal of infectious waste, both the Health Department and Pollution Control Agency would coordinate and investigate. Legal authority: M.S. Chapter 157 and M.S. Chapter 116.75-.83.

5. Elevator inspections are conducted annually by local city and municipal building inspectors in those municipalities which have requisite personnel. In 1989, the State legislature assigned this inspection function to the Minnesota Department of Labor and Industry for municipalities in Greater Minnesota. Legal authority: M.S. Chapter 183.

6. Boiler inspections are conducted annually by the Minnesota Department of Labor and Industry. Pressure vessels are inspected biennially. Legal authority: M.S. Chapter 5225.

#### B. Special Case Inspections

1. The Pollution Control Agency monitors the management of solid and hazardous waste products, as well as air quality. All facilities, including hospitals, which have an incinerator, or produce hazardous waste, are subject to rules and regulations governing the proper emission levels, storage and disposal of hazardous waste. Violations of those regulations may result in an inspection. Routine inspections are not done because of the large number of facilities. Legal authority: M.S. Chapters 115 and 116.

2. Engineering inspections include inspectors from the Minnesota Department of Health and building inspectors from the county or local jurisdiction agency. Minnesota Department of Health engineers will inspect a hospital to review compliance with state and federal physical plant licensing and certification rules whenever any licensed hospital remodels or constructs an addition. A representative from the Engineering Section conducts the Life Safety Code survey when validation surveys are conducted in JCAHO hospitals and for initial certification surveys. Legal authority: M.S. Chapter 144.55; 144.56, and Social Security Act.

3. Program Licensing. Hospitals that have chosen to provide certain additional or specialized services beyond the basic hospital services are subject to special program license from the Minnesota Department of Human Services and undergo an annual review by the Minnesota Department of Human Services for compliance with program licensing and rules. Program licenses include adult day care and chemical dependency. There are 26 individual program licenses issued to hospitals. Legal authority: M.S. Chapter 245A.02 Subd.14.

### C. Infrequent Inspections

1. Employee safety inspections. The Minnesota Department of Labor and Industry is charged with the responsibility of enforcing federal and state occupational safety and health standards (OSHA). Inspections are done only for employee health and safety standards and occur in all Minnesota work sites. Because of the numerous facilities to be inspected, a routine inspection occurs approximately once every five years. Complaints or fatalities will automatically trigger an investigation. Legal authority: M.S. Chapter 182.

## **II. Audits**

1. Peer Review for Medicare. The Foundation for Health Care Evaluation is the Peer Review Organization (PRO) for the State of Minnesota. Minnesota's PRO is a physician-sponsored, non-profit organization under contract with the federal government's Health Care Financing Administration (HCFA) to conduct medical peer review. It is the PRO's responsibility to assure that Medicare patients, Medicare beneficiaries enrolled in HMOs, residents of Medicare certified skilled nursing facilities, and clients of Medicare certified home health care agencies receive health care that is medically necessary, appropriate and of high quality. It is also the PRO's responsibility to assure that Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) patients receive hospital care that is medically necessary, appropriate and of high quality.

The PRO conducts reviews in the following circumstances: the PRO is required to investigate all complaints it receives from

beneficiaries regarding the quality of health care they received; the PRO is required to review a percentage of cases in which health care was received from a medicare certified skilled nursing facility or home health agency, if that care was administered between hospital readmissions occurring within 31 days of each other. Legal authority: Federal law.

2. Medicare Fiscal Intermediary Audit. This audit is conducted by Blue Cross and Blue Shield of Minnesota, Minnesota's federally designated fiscal intermediary. This is a financial audit to monitor compliance with Medicare reimbursement regulations. Auditors conduct on-site reviews in larger hospitals and in-house reviews for smaller hospitals. Audits are done annually. Legal authority: CFR 405.

3. The Minnesota Department of Human Services Inpatient Hospital Section contracts with Blue Cross and Blue Shield to monitor hospital compliance with Medicaid and General Assistance Medical Care Utilization Review rules and regulations. The utilization reviews are conducted on-site by BC/BS. Department of Human Services staff evaluates the reviews conducted by BC/BS. Legal authority: M.S. Chapter 256B.04 Subd. 15 and M.S. Chapter 256D.03 Subd. 7, MN Rule 9505.0500 -9505.0540.

The State of Minnesota has adopted the federal Medicare cost reporting regulations and uses the federal audit to satisfy State Medicaid requirements. Audits and payment adjustments are authorized by M.S. Chapter 256.969 Subd 5A.

### III. Investigations

1. The Survey and Compliance Section of the Minnesota Department of Health will conduct an investigation of a hospital in response to allegations or evidence of a condition adverse to the health and safety of patients in a JCAHO accredited hospital upon receiving a directive from the Chicago Regional Office of the federal Department of Health and Human Services. Hospitals must correct adverse conditions. Survey and Compliance investigates only as a result of a federal directive and in response to allegations of violations of federal Medicare requirements. Legal authority: Social Security Act Section 1864 Agreement between the federal Health and Human Services Department and the Minnesota Department of Health.

2. The Office of Health Facilities Complaints (OHFC) of the Minnesota Department of Health investigates complaints of possible violations of applicable state rules and laws governing hospitals so corrective action can be taken. The OHFC also helps patients enforce their rights and receives reports of vulnerable adult incidents. OHFC responds to state authority and cannot conduct investigations which are federally requested. Legal authority: M.S. Chapter 144A.53.

3. The Occupational Health Unit of the Minnesota Department of Health contracts with the Minnesota Department of Labor and Industry to enforce industrial hygiene and health standards as part of the Minnesota OSHA Program. Personnel from the Occupational Health Unit or the Occupational Safety and Health Division of the Department of Labor and Industry will enter a facility in response to: a fatality; catastrophe (defined as the hospitalization of 5 or more people); an employee or union complaint; an increase in the workers' compensation rate of incidence; or for "special emphasis" program review at the directive of federal or state authorities. Legal authority: M.S. Chapter 182.65.

4. Ombudsman for Mental Health and Mental Retardation of the Minnesota Department of Human Services. The ombudsman role is one of advocacy for persons receiving services or treatment for mental illness, mental retardation or a related condition, chemical dependency, or emotional disturbance. The ombudsman may: mediate or advocate on behalf of a client; investigate the quality of services (within certain parameters) provided to clients which are paid for by public funds; examine records (within certain defined parameters); while conducting a review, enter the premises of an agency, facility, program; attend Minnesota Department of Human Services review board proceedings; access specified private data; review complaints; conduct investigations, issue recommendations; and must inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program. Legal authority: M.S. Chapter 245.92.

5. Office of the Ombudsman for Older Minnesotans, Minnesota Department of Human Services. The ombudsman may enter any acute care facility without notice at any time; communicate privately and without restriction with any client (in accordance with M.S. Chapter 144.651); and inspect records of an acute care facility that pertain to the care of a client according to M.S. Chapters 144.335 and 144.651.

**Section C**  
**Discussion About and Recommendations for**  
**the Coordination of Inspections**

Coordination of inspections is good public policy. Coordination promotes optimal use of human and financial resources, minimizes disruption of residents, patients and staff, and may enhance effective working relationships between and among State and federal agencies. The Department of Health believes it is in the best interests of the consuming public (nursing home residents and hospital patients) and the agencies responsible for the protection of those consumers, to work in partnership with the Minnesota legislature to promote the coordination of required inspections where the coordination is beneficial and would not compromise the health, safety or welfare of the consuming public. If reduction of inspections is a goal, legislative involvement is necessary because some state laws will require modification to allow reduction to occur. Modification of federal law is not a prerogative of the state.

A review of the purpose of the various inspections affirms the fact that each inspection, audit or investigation is conducted for a specific purpose with authority given to a specific agency. Authority for the inspection, audit or review is derived from state, federal or local law. Each agency, and even divisions within agencies, operates in accordance with its authority for conducting reviews. These reviews often follow prescribed guidelines which mandate specific times for conducting reviews as well as specific conditions which must be reviewed. Agencies have developed their review schedules in accordance with federal and state mandates, and compliance with those schedules is necessary in order to ensure continued facility participation in government programs such as Medicare and Medicaid.

**Intra-Agency Coordination**

There are five areas of inspections that are within the jurisdiction of the Minnesota Department of Health. These include the inspection activities of the Survey and Compliance Section, the Quality Assurance and Review Section, the Engineering Section, and the Environmental Health Division, the Office of Health Facilities Complaints.

Some inspection activity has been coordinated, but perhaps the Health Department has not reached the optimal level of possible coordination. There are, however, some logistical and practical barriers to increased coordination that merit consideration. Summarily, the barriers include the different purposes of inspections and the requisite training and expertise necessary for individuals to conduct the inspections; the legal basis for

the Health Department's presence in a facility (federal versus state) and the inability of the state (Health Department) to act independent of federal requirements and whether coordination is possible given some of the federal requirements. These barriers must be examined in terms of the state's ability and willingness to remove them, and balanced against any gains or yields from their removal.

The Commissioner of Health has coordinated some inspections of hospitals and nursing homes that are under Health Department jurisdiction. These include the Survey and Compliance licensure and certification inspections and the timing of the Quality Assurance and Review Inspection of the Care reviews, and the Survey and Compliance and Office of Health Facilities Complaints investigations.

Coordination of inspections occurs in hospitals with attached nursing homes. When a team of surveyors from the Survey and Compliance Section are inspecting a hospital with a nursing home attached, both facilities are reviewed at the same time for the applicable licensing and certification rules. In hospitals, annual surveys conducted for swing beds (defined as non acute care provided in an approved hospital swing bed as per Minnesota Statute 144.562) and prospective payment system exclusions (currently in all JCAHO hospitals) are conducted at the same time in JCAHO hospitals and with the non-JCAHO hospital survey. This eliminates the duplication of inspections and fulfills both certification and licensing requirements.

Coordination of schedules between the Survey and Compliance Section survey (inspection) staff and the Quality Assurance and Review Section Inspection of the Care review staff is done to avoid being on a facility's premises at the same time. This has been done in response to nursing home facility concerns that the presence of both Survey and Compliance and Quality Assurance and Review staff is too disruptive to facility staff and residents.

Survey and Compliance and Office of Health Facilities Complaints complaint investigations are coordinated inasmuch as there is no duplication of investigations. Survey and Compliance is authorized to conduct investigations related to allegations of violations of federal certification and state licensing requirements, while Office of Health Facilities Complaints is authorized to address only allegations of violation of state law and requirements. Survey and Compliance refers all complaints associated with state law to the Office of Health Facilities Complaints and involves itself only in federally related complaints and only at the directive of the federal government.

The Engineer Section staff does work closely with the Survey and Compliance staff, and the State Fire Marshal's Office to coordinate inspections which validate that a facility meets state

fire safety rules and all other physical plant licensing requirements for operation, and federal certification. The Commissioner of Health has not actively promoted coordination of inspections between the Environmental Health Division and the remaining four areas under Health Department jurisdiction. One major reason the Commissioner has not promoted this coordination is that personnel in each of the four Health Department sections have specialized education and training and specific areas of expertise. The knowledge and skills required for one area do not transfer readily to another. For example, personnel in the Environmental Health Division are typically trained at the master degree level in environmental public health and conduct physical plant and technical kinds of inspections. Inspectors from environmental health are in hospitals and nursing homes on a very limited basis and do not have any direct interaction with patients or residents.

While the majority of the surveyors and investigators are registered nurses, inspection staff also includes sanitarians, and other individuals with varying health disciplines. However, the additional training needed to function as a surveyor is quite extensive. The federal government requires that surveyors complete additional training as a pre-requisite to inspecting medicare and medicaid certified facilities. In fact, federal requirements actually prohibit the state from using individuals who have not been trained in approved survey and compliance methods from conducting the annual inspections. Staff in the Quality Assurance and Review Section and Office of Health Facilities Complaints also receive training appropriate to the conduct of their activities. Activities of these individuals will require direct contact with patients and residents and contacts with personnel from all levels in the facility.

The various inspections conducted by the Health Department are not duplicated. Additional coordination of inspections would result in more personnel physically on site at one time because each of the inspections requires personnel with specific expertise. The actual number of inspections would not be reduced because each is required by state or federal law. The benefits of having more inspectors on site at one time would need to be weighed against the benefits of having inspectors present in the facility fewer (perhaps twice) times a year.

One of the most significant inspections occurring in a nursing home is the annual survey and compliance inspection. It is significant because it is thorough, intensive, and critical to assessing the facility's compliance with state and federal law. The licensing and monitoring inspections of nursing homes are conducted by the Survey and Compliance Section of the Minnesota Department of Health and are unannounced as per statutory directive (M.S. Chapter 144A.10 Subd. 2). The unannounced status of the inspection is important because the purpose of the

inspection is to determine whether the facility complies with relevant regulations on an ongoing daily basis, and not only when subjected to a "known" inspection.

The Survey and Compliance (S&C) Section must conduct the annual inspection in accordance with federal and state regulations and must adhere to a time table that meets federal criteria for renewing a facility's certification. Therefore, S&C establishes annual inspection schedules which are dictated largely by a facility's certification expiration date. The facility can begin anticipating the annual inspection several months prior to certification expiration. Coordination of nursing home inspections within the Health Department and between agencies would necessitate release of the Survey and Compliance Section's inspection schedule lists to these agencies. The schedules are obviously non-public. The wider distribution of the schedules increases the potential for security lapses, thereby jeopardizing the "surprise" element of an unannounced inspection. There are also federal sanctions for unauthorized release of the inspection schedule. The complexity and intensity of the inspection, coupled with federal guidelines and requirements, essentially limits the Commissioner of Health in her ability to expand coordination of inspections between agencies as regards the Survey and Compliance annual inspection.

#### **Inter-Agency Coordination**

Five additional state agencies are authorized to conduct a number of possible inspections or audits of hospitals and nursing homes. These state agencies include Labor and Industry, Commerce, Department of Human Services, Public Safety and Pollution Control.

The Minnesota Department of Health coordinates inspections of hospitals and nursing homes with the State Fire Marshal's Office of the Department of Public Safety. The Health Department has a contract with the Fire Marshall to conduct the Life Safety Code inspections required for federal certification. Clearance from the State Fire Marshal is necessary before certification can be conferred upon a facility. As a result of changes in federal procedures, the life safety inspections are conducted at the same time as the annual nursing home inspection by Survey and Compliance.

The Minnesota Department of Health, in conjunction with the Minnesota Department of Human Services, has recently reached an agreement designed to eliminate duplication of effort in the inspection of homes for the developmentally disabled. Recent changes in federal requirements, which increased the comprehensiveness of inspections, made the possibility of this agreement more probable. State human services licensing law allows for agreements between agencies that will eliminate

duplication of regulatory activity.

The Minnesota Department of Health, Occupational Health Unit, contracts with the state Department of Labor and Industry to enforce industrial hygiene and health standards as part of the Minnesota Occupational Safety and Health Program. Personnel from both Departments coordinate investigations in response to situations which warrant an investigation (see program description).

Again, the focus of other agency inspections is different than the focus of the primary Department of Health inspections. Additional coordination of inter-agency inspections would potentially reduce the number of times a year various inspectors enter a facility, but it would not reduce the number of inspections or the number of personnel with the required skills and expertise needed to conduct the inspections. Other agencies would need to conform their inspection schedules to the Health Department's Survey and Compliance review schedules. This would be necessary because the federal Provider Agreements for nursing homes essentially dictate the review schedule for each facility. Other agencies may need to conform their review schedules to the Joint Commission on the Accreditation of HealthCare Organization's review schedules since that Organization accredits the majority of Minnesota's hospitals and the state recognizes this accreditation in lieu of state Survey and Compliance inspection activity for licensure.

#### **Barriers to Increased Coordination**

##### **Jurisdiction and Legal Authority**

There are several additional factors which have impeded the Commissioner's ability to coordinate additional reviews. The two factors over which the Commissioner has no control are those of agency jurisdiction and the source of legal authority for conducting the review. Minnesota Statutes Chapter 144.55 Subd. 5 requires all state agencies which conduct routine inspections in hospitals to notify the Commissioner of Health of its intention to inspect and directs the Commissioner to authorize the inspection, and further to coordinate inspections to minimize the numbers of inspections to which a hospital is subject. This legislative directive has not been observed by other state agencies. In fact, the practical effect of the law is questionable given the fact that other state agencies are authorized to conduct inspections, the inspections are typically mandated, and the law does not include any enforcement provisions.

Although the requirement is legislatively mandated, it places the Commissioner of Health in an unusual situation of having to exercise administrative interference in other agencies'

legislatively mandated and authorized inspections of hospitals. Moreover, the requirement applies only to hospitals and the Commissioner of Health has very minimal regulatory activity in hospitals. As noted previously, the Joint Commission on the Accreditation of HealthCare Organizations accredits 65% of Minnesota's hospitals leaving the Health Department to inspect (for purposes of licensure) the remaining 35% of the state's hospitals.

The legislature has passed legislation placing additional requirements on facilities, but it has passed this legislation in independent pieces which does not provide for an assessment of the effect on the overall regulatory system. Several state legislative initiatives have resulted in increased consumer protection mechanisms by adding a consumer advocacy component to the regulatory system. However, the addition of the advocacy component has also authorized agencies to enter hospitals and nursing homes for inspection of records and investigative purposes. These legislative initiatives include the Mental Retardation and Mental Illness Ombudsman Act of 1987; the Patient Bill of Rights; the Reporting and Maltreatment of Vulnerable Adults; the Office of Ombudsman for Older Minnesotans (1987). All of these laws are intended to protect the health, safety, welfare, and rights of clients in long-term and acute care facilities. The focus of these initiatives is consumer advocacy. This differs from the focus of the mandated state and federal inspections for which the Department of Health has sole jurisdiction (Survey and Compliance annual licensing and certification inspections, for example).

### **Geographic Boundaries**

Another issue that limits the ability to coordinate reviews is the fact that many of the reviewers are located throughout the State. These individuals operate out of district offices or their own homes and the geographic areas they serve are often not identical. This variation in geographic size and differing boundaries of the regions creates difficulty in coordinating personnel among agencies for on-site facility reviews. Agencies attempt to schedule routine inspections for facilities which are located near each other during the same time frame in an effort to minimize travel time.

The personnel responsible for conducting inspections may not always be available at the same time, may have to coordinate schedules with several people if the facility is located in a region with minimal geographic overlapping, and may have different legislatively mandated time frames for periodic review. In addition to the geographic dispersion of facilities which requires extended travel time, personnel conducting inspections in Greater Minnesota may also have to attend to complaints or situations requiring immediate investigation. This results in a

disruption of routine inspections to attend to the pressing situation. The logistics of coordinating non-routine inspections or unannounced inspections becomes overwhelming when considering the unpredictability of these inspections.

### **Federal Changes**

There are new federal initiatives and changes affecting the future activities of the Survey and Compliance and Quality Assurance and Review Sections with respect to nursing home activities. The Minnesota Department of Health is examining the implication of these federal changes. These changes have redirected the focus of the certification survey so that aspects of the Inspection of the Care review conducted by the Quality Assurance and Review Section are becoming part of the Survey and Compliance certification review. This will result in an increase in Survey and Compliance Section survey time because the focus is much more directed toward assessing the quality of care given to residents. Department of Health Staff are attending federal meetings to improve the management and coordination of these two programs in response to the changes. Changes are scheduled to become effective in October of 1990.

The Inspection of the Care (IOC) review is no longer federally mandated and becomes a state option in October of 1990. The Minnesota Department of Human Services has, however, opted to retain the Inspection of the Care review because it is critical to the State's case mix reimbursement system. The Department of Human Services will continue to contract with the Minnesota Department of Health for that activity and efforts to coordinate the ICC review and S&C inspections can be further explored.

There are factors, however, that are within the purview of the Commissioner of Health to change and which changes may promote coordination or reduction of inspections. Efforts have been taken to coordinate inspections and reviews when law permits and the standards are the same for each review, such as the S&C and State Fire Marshal inspections and the inspections of homes for the developmentally disabled. Coordination is optimal when federal certification and state licensing standards are the same or very similar. Attempts have also been made to coordinate multiple inspections (licensure and quality assurance and review). However, health care facilities have complained that the number of review staff on-site at the same time was very disruptive to their facility staff and residents. There is a need to balance the pros and cons of this situation.

Consideration must also be given to the advantage of having more than one survey a year at which time direct care issues are reviewed. This provides nursing home residents with added surveillance. The average age of nursing home residents is increasing, and the level of care needed is also increasing.

Because of this change in the nursing home population, there may be merit in retaining a certain number of inspections to verify the quality of care provided to residents. Deficiencies issued by the Survey and Compliance Section of the Minnesota Department of Health have emphasized direct care issues. Recent statistics from the OHFC (see Appendix) show an increase in the following types of vulnerable adult complaints and percentage of complaints substantiated: neglect of care and supervision and physical and sexual abuse.

## **Recommendations**

Given the changing federal regulatory environment as a result of the Omnibus Reconciliation Act (OBRA) requirements affecting nursing home regulatory and inspection activity, the need to evaluate the state licensing law and rules for nursing homes in light of these major federal changes, and the Health Department's commitment to coordination of inspections when it is consistent with the State's obligation to protect vulnerable individuals while promoting cost containment efforts, the Department of Health recommends the following:

1. Change M.S. Chapter 145.55, Subd. 5, which currently requires all state agencies conducting routine inspections of hospitals to notify the Commissioner of Health of its intention to inspect and directs the Commissioner to authorize the inspection, to include enforcement provisions to induce agency compliance. Absent an enforcement provision, the practical effect of the requirement is negligible. Any proposed changes will need to be discussed with representatives from each of the affected agencies and must be based on an evaluation of the advantages and disadvantages that could result from such a provision.

2. It is recommended that the Legislature authorize and fund a comprehensive study of the regulation of long-term care facilities with recommendations for future legislation. Issues to be considered include the possibility of unifying the federal and state enforcement systems, effectiveness of the existing enforcement tools, appropriateness of current licensure standards, and alternative mechanisms for dispute resolution.

The Department of Health will be preparing a request for this study as part of the next biennial state budget. The need for a comprehensive review and examination of the state mandated requirements is critical. The major changes in the federal regulations and laws have resulted in a system which will impose differing and perhaps contradictory obligations on providers and

regulatory agencies. Because federal requirements have become more resident outcome-focused, it is an opportune time for the state to review state licensure laws and rules, and decide what provisions are needed for state residents in addition to federal requirements. This will be a major undertaking and will require consultation from nursing home residents, consumer groups and providers. This review would also take into consideration areas where coordination between entities could be enhanced.

**OHFC STATISTICS**  
C.Y. 1983 - F.Y. 1988

	<u>C.Y.</u> <u>1983</u>	<u>C.Y.</u> <u>1984</u>	<u>C.Y.</u> <u>1985</u>	<u>C.Y.</u> <u>1986</u>	<u>C.Y.</u> <u>1987</u>	<u>F.Y.</u> <u>1988</u>
<b>VAA Complaints/Reports Investigated*</b>	315	323	340	410	444	430
<b>Allegations Related to:</b>						
Neglect of Care/Supervision	307	352	437	496	442	415
Physical/Sexual Abuse	112	58	57	75	72	82
Failure to Report	76	56	32	44	49	52
All Others	120	67	96	86	81	56
<b>Percentage Substantiated</b>	20.5%	21.7%	20.1%	21.7%	32.2%	39.9%
<b>General Complaints Investigated*</b>	415	450	477	552	448	388
<b>Allegations Related to:</b>						
Patient Care/Staffing	141	219	298	447	390	352
Patient/Resident Rights	104	88	128	126	67	53
All Others	490	419	495	610	368	275
<b>Percentage Substantiated</b>	32.6%	29.0%	34.2%	33.2%	40.4%	45.7%
<b>Referrals to Other Agencies</b>	86	111	194	252	273	319
Board of Nursing	52	77	122	142	194	216
Board of Medical Examiners	11	14	27	34	42	45
All Others	23	20	45	76	37	58
<b>Correction Orders Issued</b>	344	406	485	483	519	564
<b>Violations Related to:</b>						
**Pt. Care/Staffing/Services	58	108	169	210	243	274
Patient/Resident Rights	30	34	53	56	52	63
Vulnerable Adults Act	41	72	59	54	75	89
All Others	203	180	175	137	149	138

\* An individual report/complaint may contain more than one allegation.

\*\* Nursing Homes and Boarding Care Homes Only)