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Annual Quality Improvement Report on the Nursing Home Survey Process

Minnesota Department of Health
Report to the Minnesota Legislature for Federal Fiscal Year 2013

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I. Executive Summary

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

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

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

This report was prepared by staff of the Division of Compliance Monitoring. This report is the ninth annual report on the nursing home survey process, and is based on analysis of data representing status of the program during Federal Fiscal Year 2013 (FFY13), which occurred from October 1, 2012 through September 30, 2013.

While this is a legislatively mandated report, its development allows the Department to reflect on our past successes, as well as areas for improvement. Some successes seen in FFY13 include improved overall consistency and accuracy. From a large-scale perspective, Minnesota leads our federal Region V for the highest percentage of surveys that would provide facilities an opportunity to correct identified deficiencies before remedies are imposed. FFY13 also resulted in fewer surveys that involved deficiencies reflecting findings of actual harm.

On a smaller scale, data produced from a quality improvement method using Mix-Max surveys[1] continues to reflect cross-team consistency based on the number of deficiencies issued by Mix-Max survey teams compared to non-Mix-Max survey teams (difference of less than one deficiency). This indicates there is an overall low variability between districts and reflects survey consistency statewide.

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

[1] More information regarding Mix-Max Surveys is found later in this report

II. Introduction

A. Survey Process

1. General

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

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

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

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

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

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

2. The Revisit Process

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

3. QIS Survey Process

In 2005, CMS piloted a new nursing home survey process called the Quality Indicator Survey (QIS). The QIS originally started out as a pilot project with five states. In 2007, Minnesota was chosen by CMS to be the first state to implement QIS statewide beyond the demonstration states. Minnesota's training was completed in March of 2010. As of FFY11, all surveys in Minnesota were conducted by QIS survey process.

The QIS is a computer assisted long-term care survey process used by selected State Survey Agencies and CMS to determine if Medicare and Medicaid certified nursing homes meet the Federal requirements[2]. The QIS was developed to produce standardized resident-centered, outcome-oriented reviews. It uses an automated process that guides surveyors to systematically and objectively review all regulatory areas. The QIS was designed to meet the following objectives:

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

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

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

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

4. Survey Techniques

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use the worksheets in conjunction with the Guidance to Surveyors. The Guidance to Surveyors assists in gathering information in order to determine whether the facility has met the requirements[3]. An example might include the following:

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

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

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

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

B. Complaint Investigation Process

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

Minnesota state and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. A complaint is an allegation of noncompliance with federal and/or state requirements. The complaint process must ensure that a person who has complained, in good faith, about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of the complaint and procedures to ensure that the identity of the complainant will be kept confidential. All complaints are reviewed and triaged to achieve the best outcome for vulnerable adults. Therefore, OHFC may investigate complaints under state and/or federal regulations.

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

State law also mandates that allegations of maltreatment against a vulnerable adult or a minor be reported by the licensed health care entity. With the enactment of the Vulnerable Adults Act (VAA) in 1981, the responsibilities of OHFC were expanded to include investigations into claims of abuse and neglect of residents in licensed health care facilities, and to receive and evaluate incidents reported from facilities that may constitute violations of the VAA.

The Vulnerable Adults Act requires the reporting of abuse, neglect, and financial exploitation which is defined in Minnesota Statutes sec. 626.5572, subd. 15. Under Federal regulations, Medicaid/Medicare certified facilities are also required to report to OHFC allegations of alleged violations of abuse, neglect, mistreatment and misappropriation of property. These state and federal reports are referred to as "Facility Self Reports."

Under the Vulnerable Adults Act, a preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation. All substantiated or unsubstantiated determinations must be based on a preponderance of evidence which is defined as more than 50% of weighted evidence. This means that while an act of maltreatment may have occurred, enough evidence must exist to make it more likely than not that the allegation is true.

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

- ***Substantiated*** – A substantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred;

- ***False*** – "False" means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur; or,

- ***Inconclusive*** – A finding of inconclusive means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

As earlier mentioned, a preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation, just enough evidence to make it more likely than not that, the allegation is true. Findings of on-site maltreatment investigations are available on the MDH website.

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

III. Data Requirements

Minnesota is part of the Center for Medicare and Medicaid Services (CMS) Region V, which is comprised of six states. As mentioned in the previous section, there are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. The following section provides detailed information related to survey results and outcomes in FFY13 within our federal Region V and regional data within the state.

A. Number of Deficiencies Within Region V

1. Health Deficiencies Issued

In FFY13, Minnesota issued an average of 6.1 deficiencies per health recertification survey, which is a 13% reduction from the previous year's average of 7.0 deficiencies per health survey.

The table below provides the average number of health deficiencies per recertification survey in FFY13 for all states comprising CMS Region V. The regional average number of health deficiencies cited in FFY13 was 5.8.

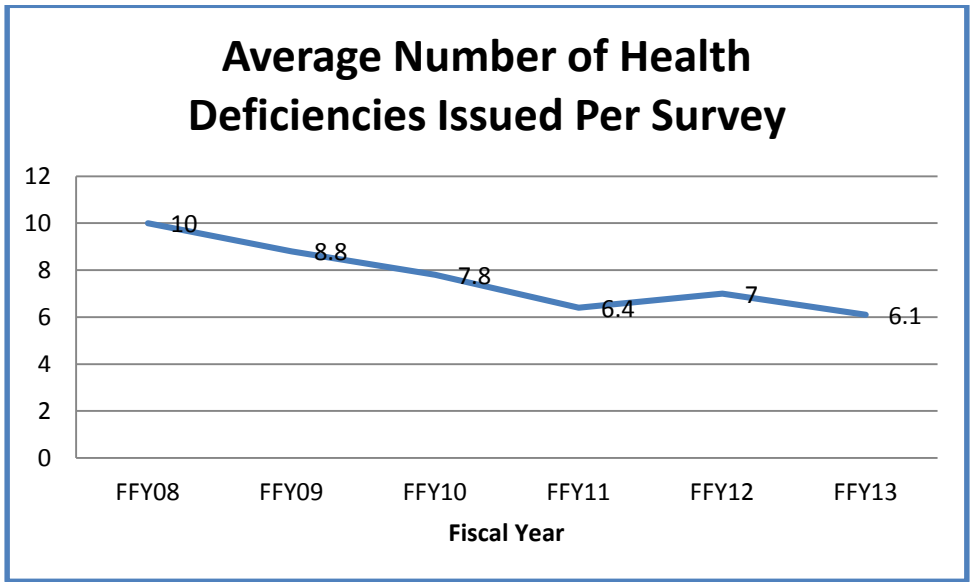
Table 1: Average Number of Health Deficiencies by States within CMS Region V

State	Surveys	Deficiencies Issued	Average
Illinois	798	4,200	5.3
Indiana	479	2,917	6.1
Michigan	439	2,758	6.3
Minnesota	379	2,338	6.1
Ohio	814	3,486	4.3
Wisconsin	351	2,282	6.5

Source: Federal CASPER Data System, FFY12

FFY13's average of 6.1 deficiencies issued per health recertification survey is consistent with the overall trend of a reduction in average number of health deficiencies issued per survey. The trend in the average number of health deficiencies issued per health recertification survey over a 6 year period is depicted in Figure 1 below.

Figure 1: Minnesota's Average Number of Health Deficiencies Issued Per Recertification Survey



2. Life Safety Code Deficiencies Issued

The Life Safety Code (LSC) is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. A recertification survey contains both a health and a LSC portion of the survey.

The average number of LSC deficiencies per recertification survey during FFY13 was 1.9, which is almost exactly the same average seen in FFY12 (1.8).

Table 2 below shows the average number of LSC deficiencies per recertification survey in FFY13 for all states comprising CMS Region V. Minnesota continues to issue the fewest number of LSC deficiencies within our federal region. The regional average number of LSC deficiencies cited in FFY12 was 3.8.

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

State	Surveys	Deficiencies Issued	Average
Illinois	798	6,262	7.8
Indiana	479	1,956	4.1
Michigan	439	2,084	4.7
Minnesota	379	731	1.9
Ohio	814	2,953	3.6
Wisconsin	351	1,722	4.9

Source: Federal CASPER Data System, FFY13

B. Survey Outcomes and Remedies

1. Survey Outcomes by Region Within the State – Number of Deficiencies

Minnesota Statutes, section 144A.10, subd. 17, requires the reporting of the number, scope, and severity of citations by region within the state. Table 3 reflects the number of surveys completed within each region, the number of deficiencies issued within each region, and the average number of deficiencies issued per health recertification survey by region in FFY13. Note that the data represents health recertification survey data only, and therefore does not contain outcomes from complaint investigations.

Table 3: Number of Health Recertification Surveys and Deficiencies Issued, by Region*

Region	Number of Surveys	Number of Deficiencies Issued	Average Number of Deficiencies Per Survey
North	105	730	6.96
Central	71	410	5.77
Metro	114	664	5.8
South	89	529	6.02

*Surveys, completed by survey teams in the regions, are used to compare data. Bemidji, Duluth, Fergus Falls survey teams comprise the North region; two Saint Cloud teams comprise the Central region; three metro teams comprise the Metro region; and Mankato and Rochester comprise the South region.

As reported in the previous section, FFY13 resulted in a state average of 6.1 deficiencies issued per health recertification survey. Within Minnesota, the largest regional difference of the average number of health deficiencies issued per recertification survey is just a little over one deficiency, or 1.19 deficiencies per survey.

2. Survey Outcomes by Region Within the State – Scope and Severity

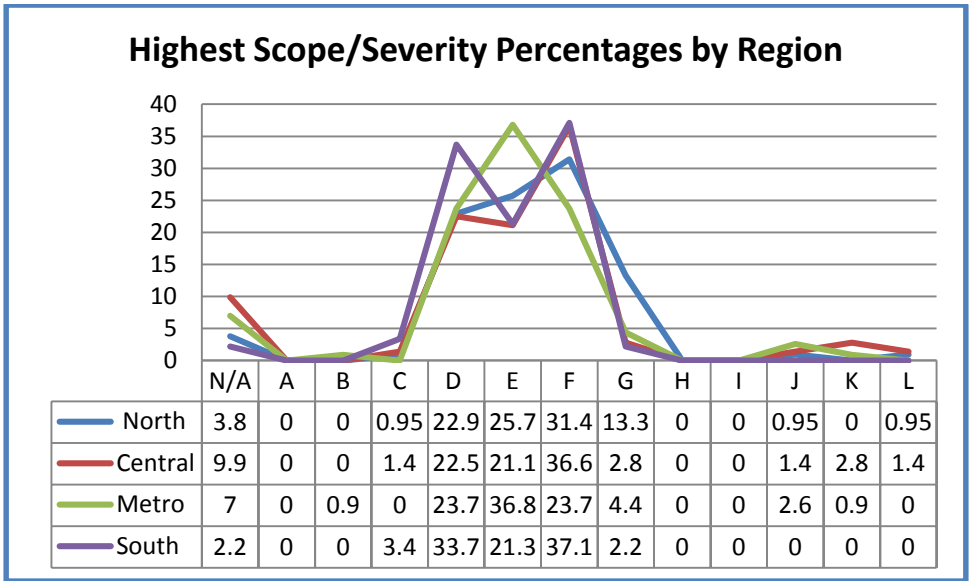
During a survey (or a complaint investigation), each federal deficiency is assigned a scope and severity level, ranging from A through L. Scope and severity is a system of rating the seriousness of deficiencies. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from finding there is a potential for minimal harm if the deficient practice is not corrected, to findings of immediate jeopardy to resident health or safety.

The highest scope and severity levels of deficiencies found determine the overall scope and severity of the survey. See Appendix B for the CMS grid used to determine scope and severity.

Figure 2 reflects the highest overall scope and severity **percentages** per health recertification survey (by region in FFY13). Table 4 below reflects **counts** of the highest overall health scope and severity level per recertification survey, by region in FFY13. Figure 2 contains percentages based on the total number of overall scope and severity level of the survey divided by the total number of surveys conducted in that region, whereas Table 4 simply contains raw counts. Please note that while similar, the number of surveys conducted within each region varies slightly making percentages a better tool for comparisons.

To provide a general picture of regional recertification survey outcomes, Figure 2 reflects the highest overall scope and severity percentages per health recertification survey (by region). Scope/severity levels of a "G", "H", & "I" or above represent deficiencies of actual harm. Scope/ severity levels of "J", "K" & "L" represent deficiencies that are an immediate jeopardy to resident health or safety.

Figure 2: Highest Overall Survey Scope/Severity Percentages, by Region



	N/A	A	B	C	D	E	F	G	H	I	J	K	L
North	3.8	0	0	0.95	22.9	25.7	31.4	13.3	0	0	0.95	0	0.95
Central	9.9	0	0	1.4	22.5	21.1	36.6	2.8	0	0	1.4	2.8	1.4
Metro	7	0	0.9	0	23.7	36.8	23.7	4.4	0	0	2.6	0.9	0
South	2.2	0	0	3.4	33.7	21.3	37.1	2.2	0	0	0	0	0

While the northern region had the second lowest percentage of an overall scope and severity level related to immediate jeopardies, the highest percentage of an overall scope and severity level of a "Level G" (deficiencies of actual harm) fell into that region. It is also interesting to note that the two regions that had the highest percentages of "clean" surveys (Central and Metro regions), also had the highest percentages of recertification surveys resulting in deficiencies representing an immediate jeopardy to resident health or safety.

Table 4 reflects counts of the highest overall health scope and severity level per recertification survey, by region in FFY13. Note that a scope/severity level of N/A indicates a "clean" survey, or a survey where no health deficiencies were issued at the time of the survey.

Table 4: Highest Overall Health Scope/Severity Levels per Recertification Survey, by Region

Scope/Severity	North	Central	Metro	South
N/A	4	7	8	2
A	0	0	0	0
B	0	0	1	0
C	1	1	0	3
D	24	16	27	30
E	27	15	42	19
F	33	26	27	33
G	14	2	5	2
H	0	0	0	0
I	0	0	0	0
J	1	1	3	0
K	0	2	1	0
L	1	1	0	0

3. Opportunity to Correct vs. No Opportunity to Correct & Enforcement Cases

The following information contains data derived from the total number of "enforcement cases" in FFY13. An "enforcement case" is created anytime a survey or a complaint investigation results in deficiencies with a scope and severity level of a "D" or higher. An enforcement case remains open until all deficiencies are determined corrected and the facility is back in substantial compliance with state and federal regulations.

An enforcement case can sometimes involve multiple combinations of surveys/investigations: a recertification survey and a complaint (or multiple complaints), just one complaint investigation, or an enforcement case consisting of multiple complaint investigations are some examples. If an enforcement case is initiated due to a recertification survey, and the Office of Health Facility Complaints receives a complaint that also results in deficiencies of a level "D" or higher, all deficiencies issued (both from the recertification survey and the complaint investigation) must be corrected before the enforcement case can be closed.

Therefore, since some enforcement cases are comprised of complaint investigation(s) only, there are always more enforcement cases than there are recertification surveys in any given year. In FFY13, there were 417 enforcement cases and 379 recertification surveys.

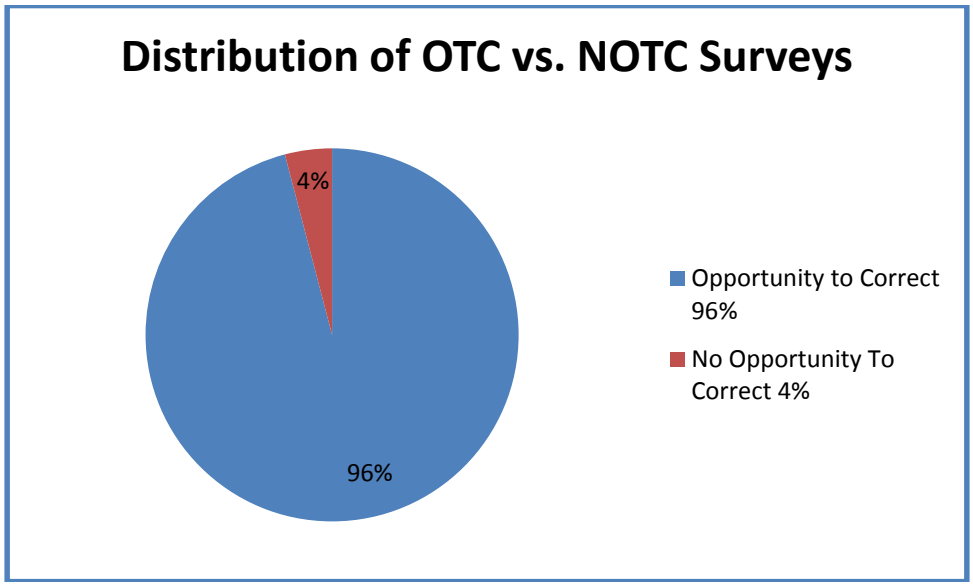
There are two "categories" of enforcement cases, which are based on the scope and severity level of the identified deficiencies. If there are deficiencies issued once a recertification survey or a complaint investigation is completed, facilities may be given an opportunity to correct the identified deficiencies before remedies are imposed. Note that neither CMS nor the state agency has an obligation to provide a facility an opportunity to correct deficiencies prior to imposing remedies.

If the facility is given an opportunity to correct the identified deficiencies before remedies are imposed, the survey/investigation (enforcement case) is considered an Opportunity to Correct (OTC) enforcement case. If the facility is not given an opportunity to correct the identified deficiencies before remedies are imposed, the survey/investigation (enforcement case) is considered a No Opportunity to Correct (NOTC) enforcement case. While there are a number of triggers that would not allow the facility the opportunity to correct their deficiencies before remedies are imposed, the most common reason is due to the current survey or investigation resulting in deficiencies of actual harm (Level G or above).

The data depicted below reflects the distribution of the FFY13 OTC and NOTC[4] enforcement cases (therefore reflecting results of both surveys and complaints).

- **Opportunity To Correct Enforcement Cases – 400 (96%)**
- **No Opportunity To Correct Enforcement Cases– 17 (4%)**

Figure 3. Distribution Percentages of OTC vs. NOTC Surveys & Complaints



[4]OTC and NOTC data includes both recertification surveys and complaint investigations.

The distribution of OTC versus NOTC enforcement cases is important to note since it indicates that 96% of the time in FFY13, the facility was provided the opportunity to correct the identified deficiencies before remedies and were imposed. The FFY13 percentage of OTC enforcement cases also increased compared to the two previous years; both FFY12 and FFY11 resulted in 94% OTC enforcement cases compared to 96% of enforcement cases allowing the facilities the opportunity to correct identified deficiencies before remedies were imposed in FFY13.

The following table reflects OTC vs. NOTC data for all states comprising Region V. Minnesota is tied with Indiana for the highest amount of OTC surveys and thus also the lowest amount of NOTC surveys in our Region. Our state also has less than half as many NOTC surveys as compared to the regional average (4% vs. 10%).

Table 5: Minnesota compared to Region V - OTC vs NOTC Surveys and Complaints

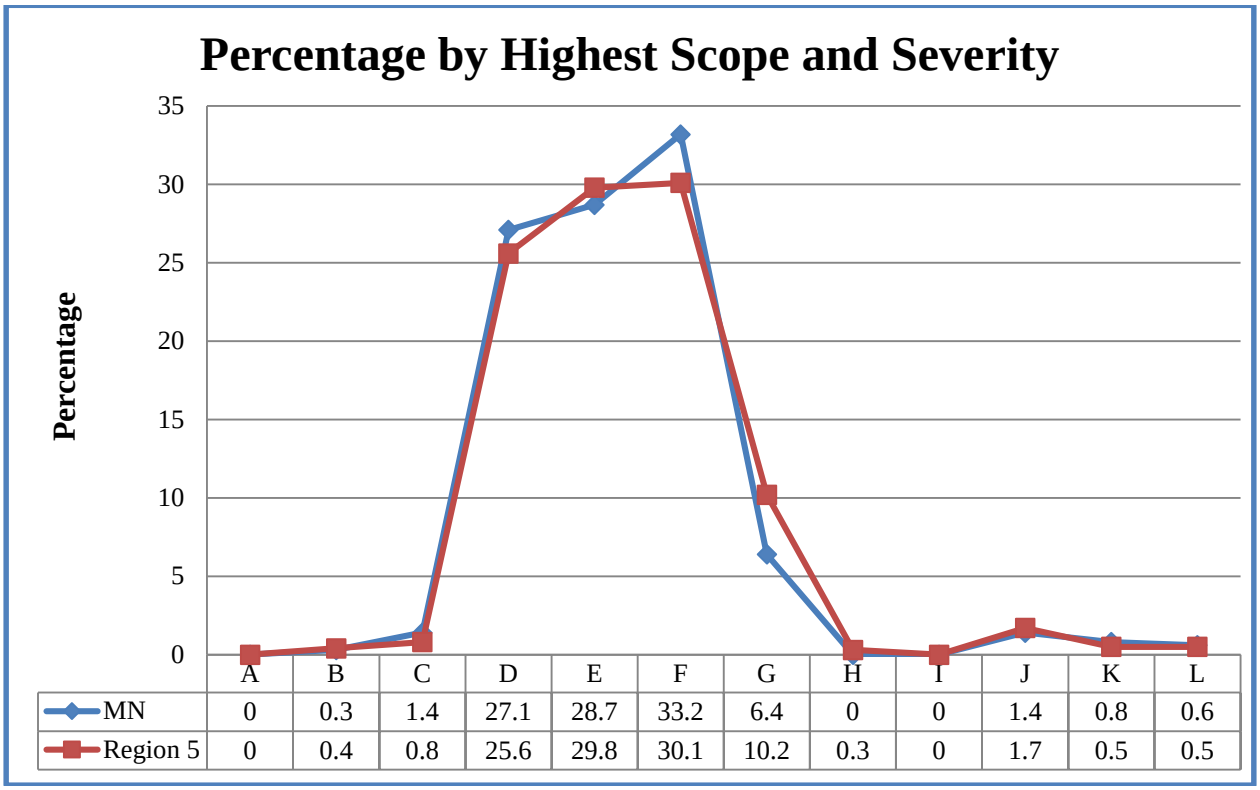
State	Number of OTC Surveys	% OTC Surveys	Number of NOTC Surveys	% of NOTC Surveys
IL	1,285	92%	105	8%
IN	969	95%	46	5%
MI	698	81%	166	19%
MN	400	96%	17	4%
OH	993	89%	124	11%
WI	515	88%	71	12%
Region V	4871	90%	539	10%

As previously described, scope and severity is a system of rating the seriousness of deficiencies. At the time of a survey or complaint investigation, every federal deficiency that is issued is assigned a scope and severity level, ranging from A through L. The highest scope and severity levels of deficiencies found determine the overall scope and severity of the survey[5]. Since the most common reason a facility is not given the opportunity to correct deficiencies before remedies are imposed is due to the survey or investigation resulting in deficiencies of actual harm (Level G or above), the high percentage of OTC surveys/complaints (enforcement cases) places a positive light on the overall health and safety for Minnesota's residents residing in nursing facilities. In other words, while deficiencies may be found at the time of a survey or complaint investigation, they are not very likely to not be reflective of findings of actual harm.

For further regional comparison of survey outcomes, Figure 4 below reflects the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V (the information below contains health recertification data only, and therefore does not include complaint data).

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

Figure 4. Minnesota compared to Region V - Percentage of Highest Health Scope and Severity Level for Health Recertification Surveys



	A	B	C	D	E	F	G	H	I	J	K	L
MN	0	0.3	1.4	27.1	28.7	33.2	6.4	0	0	1.4	0.8	0.6
Region 5	0	0.4	0.8	25.6	29.8	30.1	10.2	0.3	0	1.7	0.5	0.5

Source: Federal CASPER Data System, FFY13

Since overall scope and severity determines whether the survey is considered either Opportunity to Correct (OTC) or a No Opportunity to Correct (NOTC) before remedies are imposed, Minnesota's higher distribution of overall scope and severity levels ranging from A-F is consistent with the data above reflecting Minnesota as having higher percentage of OTC enforcement cases.

The above graph reflected the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V, and Table 6 below contains a greater breakdown of the information found in Figure 3. Table 6 provides overall scope and severity percentages, but also includes this information for each state in Region V. In addition to the highest overall scope and severity percentages by state, the chart below reflects the total counts of health surveys by the highest overall scope and severity level.

Also included in Table 6 are "clean" surveys, which are surveys where no health deficiencies were issued at the time of the health recertification survey. As with Figure 3 above, Table 6 below does not contain complaint data (recertification health surveys only)

Table 6: Total Number of Recertification Surveys by Highest Scope and Severity Level

State	Highest Overall Scope and Severity of Health Surveys - Counts and Percent													Total Surveys
	Clean	A	B	C	D	E	F	G	H	I	J	K	L	
IL	61	0	3	6	171	216	244	74	1	0	8	6	8	798
	7.6%	0.0%	0.4%	0.8%	21.4%	27.1%	30.6%	9.3%	0.1%	0.0%	1.0%	0.8%	1.0%	
IN	55	0	0	1	131	147	102	37	2	0	2	1	1	479
	11.5%	0.0%	0.0%	0.2%	27.3%	30.7%	21.3%	7.7%	0.4%	0.0%	0.4%	0.2%	0.2%	
MI	18	0	3	2	79	107	150	61	1	0	16	2	0	439
	4.1%	0.0%	0.7%	0.5%	18.0%	24.4%	34.2%	13.9%	0.2%	0.0%	3.6%	0.5%	0.0%	
MN	21	0	1	5	97	103	119	23	0	0	5	3	2	379
	5.5%	0.0%	0.3%	1.3%	25.6%	27.2%	31.4%	6.1%	0.0%	0.0%	1.3%	0.8%	0.5%	
OH	148	0	5	8	220	218	151	49	2	0	11	2	0	814
	18.2%	0.0%	0.6%	1.0%	27.0%	26.8%	18.6%	6.0%	0.2%	0.0%	1.4%	0.2%	0.0%	
WI	34	0	0	2	50	79	115	53	3	0	8	2	5	351
	9.7%	0.0%	0.0%	0.6%	14.2%	22.5%	32.8%	15.1%	0.9%	0.0%	2.3%	0.6%	1.4%	
Region V	337	0	12	24	748	870	881	297	9	0	50	16	16	3,260
	10.3%	0.0%	0.4%	0.7%	22.9%	26.7%	27.0%	9.1%	0.3%	0.0%	1.5%	0.5%	0.5%	

4. Remedies

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

The chart below is a complete listing of remedy categories available. MDH typically recommends only a few of these options for imposition, which was the case in FFY13 and in recent years past. Many factors are used to determine which and how many remedies to impose within the available remedy categories for particular levels of noncompliance.

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

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

While the overall scope and severity level of a survey may constitute a NOTC enforcement case in and of itself, there are other situations where remedies may be triggered during the survey process. An example of this would include a facility not correcting previously-issued deficiencies at the time of an onsite revisit, which would result in finding the facility in continued non-compliance. The survey in this example may have started out as an OTC enforcement case, but now has remedies imposed due to the uncorrected revisit.

Another reason why more remedies may exist than the total number of NOTC enforcement cases is because multiple types of remedies may be imposed during one enforcement case. For example, an enforcement case resulting in remedies imposed may involve three civil money penalties (one for each "G" or above deficiency) and state monitoring. This would be reflected in Table 7 as one count of imposed state monitoring and one count of imposed CMP.

Therefore, the number of remedies imposed during a fiscal year is always expected to be higher than the total number of NOTC enforcement cases during that same year. In FFY13 there were 17 NOTC enforcement cases, and 54 total remedies imposed. It is noteworthy to mention that FFY13 resulted in 37% fewer NOTC surveys and a 32.5% decrease in remedies imposed compared to the previous fiscal year.

Table 7 below illustrates the total types of all remedies imposed in Minnesota for all enforcement cases (both recertification and complaint surveys) over a three year period FFY11- FFY13.

Table 7: Total Number of Remedies Imposed

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

Source: Federal CASPER Data System, FFY13, FFY12, and FFY11

Timelines in relation to imposed remedies

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

During FFY13, there were 29 surveys where CMS imposed federal Category 2 or 3 remedies. Twenty-one of these 29 cases received revisits within the 15 calendar day requirement; however two were unable to be completed timely due to the October 2013 federal shutdown. Therefore, of the 29 cases where CMS imposed federal Category 2 or 3 remedies, 23 received revisits within the 15 calendar day requirement.

Of the other six cases that did not meet the requirement, one was due to a Federal Monitoring Survey (FMS) conducted by CMS. When CMS conducts a FMS, MDH is prevented from conducting a revisit to the original recertification survey until CMS receives an acceptable Plan of Correction for the FMS survey (at which time, CMS alerts MDH that a revisit may be conducted for the recertification and FMS survey).

With the exclusion of this FMS survey and the two revisits MDH was unable to conduct due to the federal shutdown, MDH conducted revisits within the 15 day requirement for 79% of the applicable surveys.

5. Time Requirements for Statement of Deficiencies

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

Draft Statement Left at Facility

Of the surveys with deficiencies exited during FFY13, draft statements of deficiencies were left at all but three of the facilities at the time of their survey exits. This translates to a 99% compliance rate with this requirement for the draft Statement of Deficiencies.

15 Working Day Requirement

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

In FFY13, there were a total of 379 recertification surveys completed for nursing facilities. In FFY13, 34 surveys did not meet the 15 working-day requirement for delivering final Statement of Deficiencies forms; however, half of these (17) were due to the October 2013 federal shutdown where MDH staff were unable to conduct any federal work.

Of the surveys that were not affected by the shutdown, 362 (or 96%) met the 15 working-day requirement for delivering final Statement of Deficiencies forms. Of the 17 surveys that were late, six of them resulted in deficiencies of actual harm (a scope and severity level "G" or higher), including two immediate jeopardies and three instances of substandard quality of care.

6. Appeals, IDRs and IIDRs

Federal Level: Appeals

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

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

State Level: IDR & IIDR's

At the state level, there are two methods for facilities to informally dispute survey findings. Federal regulations require CMS and each state to develop an Informal Dispute Resolution process (42 CFR 488.331). In Minnesota, there are two types of dispute resolution processes: Informal Dispute Resolution (IDR) and Independent Informal Dispute Resolution (IIDR). The State statutory provisions for these two processes are found under Minnesota Statutes, Section 144A.10, subdivisions 15 and 16. IDR and IIDR decisions made by MDH are subject to CMS oversight.[7] The purpose of this informal process is to give providers an opportunity to refute cited deficiencies after any survey.

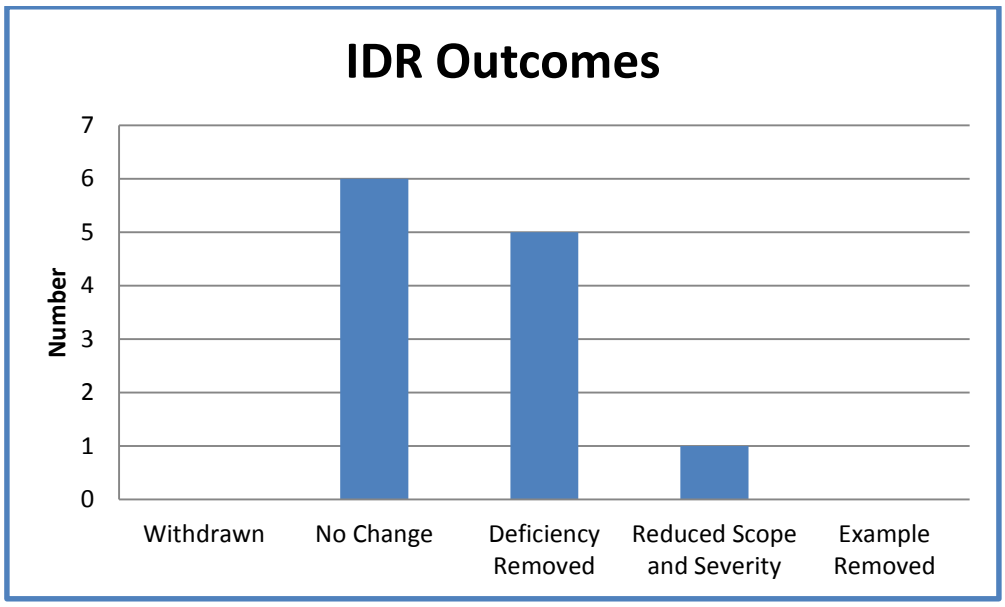
[7] State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR.

IDR Outcomes

When MDH receives a request for an IDR, the review is performed by a MDH Licensing & Certification or an Office of Health Facility Complaints survey supervisor who has not previously been involved with the survey or complaint investigation. During FFY13, there were 8 IDR requests involving 12 deficiencies.

Of the 12 FFY13 deficiencies disputed through an IDR, 6 resulted in no change, 5 deficiencies were removed, 1 resulted in a reduced scope and severity, no disputed deficiencies resulted in a change in documentation (example removed), and none were withdrawn.

Figure 5. Outcomes of Informal Dispute Resolutions



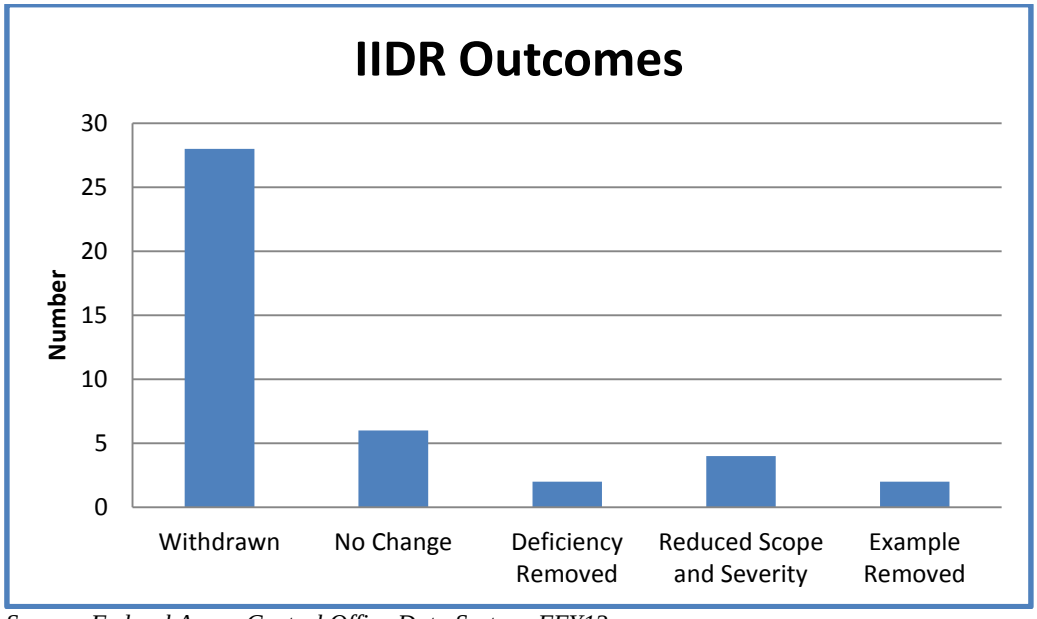
Source: Federal Aspen Central Office Data System, FFY13

IIDR Outcomes

An IIDR involves a recommendation by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). The ALJ's recommendation is advisory to the Commissioner of Health and CMS, both of whom review the case and can accept or modify the ALJ's recommendation.

During FFY13, there were 15 IIDR requests involving 42 deficiencies. Of the disputed deficiencies, 28 deficiencies were withdrawn by the facility prior to the hearing, 6 resulted in no change, 2 deficiencies were removed, 4 resulted in a reduced scope and severity level, and 2 disputed deficiencies resulted in a change in documentation (example removed).

Figure 6. Outcomes of Independent Informal Dispute Resolutions



Source: Federal Aspen Central Office Data System, FFY13

IV. Areas of Special Focus during FFY13

A. Quality Improvement

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

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

1. Onsite Review

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

2. Deficiency Review

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

When it is found that the same deficiencies are being issued across units and regions at a high rate, MDH also communicates these trends with providers. A typical way to address commonly issued deficiencies across units and regions are identified through the issuance of Informational Bulletins. In FFY13, we found that the prevalence of these commonly-issued deficiencies decreased after being addressed through an Informational Bulletin.

3. DAR-SA and DAR-RO Reports

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

identify variances and opportunities for quality improvement, and take corrective action when appropriate.

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

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

4. Mix-Max Surveys

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

During FFY11, surveys were coded as Mix-Max when there was a mixture of 2 surveyors from one team and 2 surveyors from another team to form a 4-person survey team. Starting in FFY12, the definition of Mix-Max surveys expanded to be coded when at least one surveyor from a different team joined a survey team. One reason for this change is because when working with a team that is small (3-4 surveyors), it is justifiable that just one person can change the dynamic of a group or team. Mix-Max surveys continue to be defined as occurring when at least one surveyor from a different team joined a survey team in FFY13.

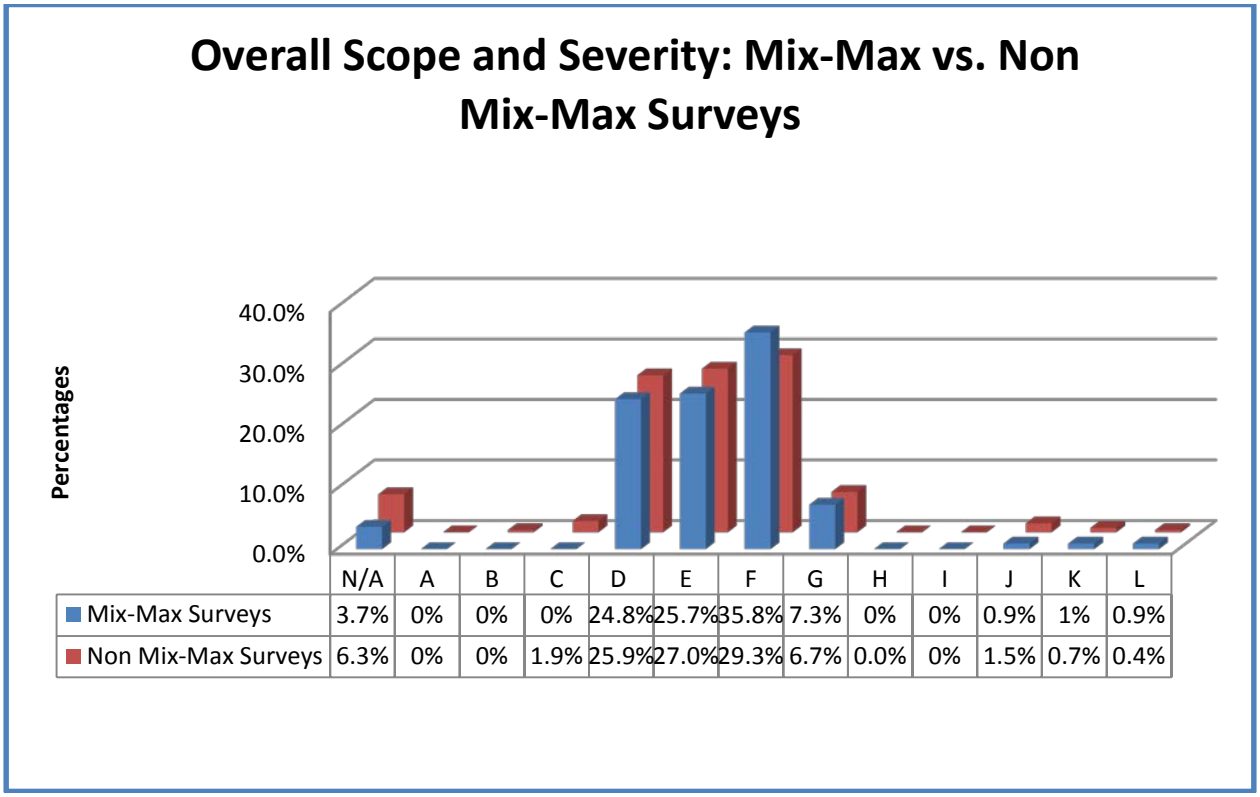
In FFY12, 30% of surveys completed in surveys were Mix-Max surveys. Staying consistent with the previous year, 29% of surveys completed in FFY13 were Mix-Max surveys (i.e. at least one surveyor from another team joined the survey team).

FFY13 Mix-Max Information

- Non-Mix-Max Surveys: 270 (71%)
- Mix-Max Surveys: 109 (29%)
- Average number of deficiencies per Non-Mix-Max Survey: 6.03
- Average number of deficiencies per Mix-Max Survey: 6.47
- Difference between number of deficiencies issued by Mix-Max Surveys and Non-Mix-Max Surveys: less than one deficiency (0.44)

Figure 6 below compares the highest overall scope and severity percentages (by health survey) for Mix-Max surveys compared to non-Mix-Max surveys. In the case of the chart below, N/A indicates what has been formally identified in this report as "clean" surveys, or surveys in which no health deficiencies were issued.

Figure 7: FFY13 Overall Health Scope and Severity: Mix-Max vs. Non Mix-Max Surveys



	N/A	A	B	C	D	E	F	G	H	I	J	K	L
Mix-Max Surveys	3.7%	0%	0%	0%	24.8%	25.7%	35.8%	7.3%	0%	0%	0.9%	1%	0.9%
Non Mix-Max Surveys	6.3%	0%	0%	1.9%	25.9%	27.0%	29.3%	6.7%	0.0%	0%	1.5%	0.7%	0.4%

Data from the previous page reported that the average number of deficiencies issued by Mix-Max survey teams compared to non-Mix-Max survey teams is consistent, with Non-Mix-Max surveys issuing an average of 6.03 deficiencies per survey, and Mix-Max surveys resulting in an average of 6.47 deficiencies per survey. The data represented in the above chart continues to indicate overall consistency in health survey findings when comparing the highest overall scope and severity of Mix-Max vs. Non-Mix-Max surveys. Overall scope and severity levels were issued at very similar rates with both survey "types" in FFY13.

Mix-Max and Non-Mix-Max surveys were almost equally likely to result in an Opportunity to Correct survey, based on overall scope and severity levels at level "F" or below[8]. In FFY13, 89.9% of Mix-Max surveys were resulted in an overall scope and severity level of F or below, compared to 90.7% of non-Mix-Max surveys.

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

Table 8 below lists the top 10 deficiencies issued during recertification surveys in FFY13, broken down by Mix-Max surveys versus non Mix-Max surveys. Though they may have "ranked" in different spots, 8 of the 10 top ten deficiencies were the same from FFY12 to FFY13. Deficiencies F428 (Drug Regimen Review) and F431 (Drug Records, Label/Store Drugs & Biologicals) were not one of the top ten deficiencies issued in FFY12.

Deficiencies that were in the top ten deficiencies issued in FFY12, but were not one of the top ten deficiencies in FFY13 include F225 (Investigate/Report Allegations/Individuals) and F272 (Comprehensive Assessment).

Table 8: FFY13 Top 10 Deficiencies Number & Percent Issued – Non-Mix-Max vs. Mix-Max

Deficiency	Non Mix-Max Surveys	Mix-Max Surveys
F371 Food Handling & Sanitation	37.8% (102)	43.1% (47)
F282 Prov. Care According to Care Plan	35.2% (95)	40.4% (44)
F329 Drug Regimen is Free From Unnecessary Drugs	36.7% (99)	36.7% (40)
F441 Infection Control	33.7% (91)	41.3% (45)
F309 Quality of Care	30.0% (81)	34.9% (38)
F323 Accidents/Supervision	25.9% (70)	25.7% (28)
F428 Drug Regimen Review	25.2% (68)	22.9% (25)
F431 Drug Records, Label/Store Drugs & Biologicals	24.4% (66)	23.9% (26)
F279 Comprehensive Care Plan	20.7% (56)	29.4% (32)
F226 Develop / Implement Abuse/ Neglect, Etc. Policies	23.3% (63)	18.3% (20)

All recertification surveys (regardless of Mix-Max status) are completed using the QIS survey process. As mentioned earlier in this report, the QIS uses an automated process that guides surveyors to systematically and objectively review all regulatory areas. In almost all instances, the top 10 deficiencies issued in FFY13 were issued at similar rates for Mix-Max surveys versus

non Mix-Max surveys. The general consistency in the issuance of the top 10 deficiencies of FFY13 is an indicator of survey consistency statewide.

B. Provider Outreach and Education

MDH communicates with and offers regular training opportunities to providers and other stakeholders. Provider outreach is in an effort to proactively improve provider compliance and to provide technical assistance using various tools and education for providers. In FFY13, provider outreach and education was primarily delivered through the following methods:

Statewide Calls

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

Joint Stakeholders Workgroup

Other outreach activities include Joint Stakeholders meetings. These meetings are periodically held with provider association representatives and stakeholders to discuss a variety of survey and LTC related issues.

Video Trainings/ Educational Resources

WebEx's are sometimes used as a method of providing training. WebEx's are online training sessions that are recorded and therefore can be viewed at any time, and as many times as the viewer desires.

There are also many educational resources posted to MDH's website throughout the year in the form of Informational Bulletins, in addition to optional tools and forms. Resources and guidance are also found on the MDH Clinical Web Window, which is an easily accessible place where clinical and regulatory issues can be presented on a regular basis. Its purpose is to provide a forum for discussion of the regulatory approach to clinical issues and will, when possible, alert practitioners to clinical issues that may come under increased scrutiny during surveys.

Through the above methods of outreach and education, the following topics were the areas of special focus during FFY13:

1. End of Life, Advance Directives, and Feeding Tubes

An Informational Bulletin (12-06) was released in December 2012 based on new Nursing Home Guidance to Surveyors from the Centers for Medicare and Medicaid Services (CMS). The purpose of the Information Bulletin was to inform providers and other interested parties about the revised federal nursing home guidance on End of Life (F309), Advance Directives (F155), Feeding Tubes (F322/F321).

Joint provider and MDH surveyor training was offered prior to the implementation of these guidelines by the Minnesota Department of Health (MDH) in conjunction with stakeholder groups.

Statewide Call (January 16, 2013) - Operational approaches related to the revised CMS nursing home surveyor guidance of F309, F155, and F322 was discussed during a statewide call with nursing facility providers. The discussion was conducted by a four-person panel that represented the following different perspectives:

• **Resident**: Natasha Merz, J.D., Regional Ombudsman, Office of Ombudsman for Long-Term Care

- Resident participation in advance care planning
- Resident decision making in end of life decisions
- Resident choice
- Resident rights
- How resident's voice is heard
- Role of Ombudsman

• **Attorney**: Barb Blumer, Attorney, Barb Blumer Law, P.A.

- Minnesota law on decision-makers other than the resident.
- Health Care Directive (HCD) and Minnesota Provider Order for Life Sustaining
- Treatment (POLST) and relationship to Minnesota law. Minnesota law does not have a substitute decision-maker statute that establishes alternate decision-makers, which is why HCD and POLSTs are important.
- Minnesota standard for capacity to execute and revoke a HCD.
- Minnesota standard for health care decision making capacity.
- Who decides whether principal has capacity for what?

• **Physician:** Dr. Edward Ratner, Associate Professor of Medicine, University of Minnesota

- Definition of and difference between Health Care Directive (HCD) and Minnesota
- Provider Order for Life Sustaining Treatment (POLST)
- How to work with physicians
- Physician relationships

- How physician assesses the resident
- Where to call if your physician needs information about how to implement HCD or POLST
- How does physician handle difficult situations?
- Differences between palliative, hospice and limited care plan.
- Training and implementation of Minnesota POLST in a nursing home.

• **MDH Surveyor**: Maria King, R.N. Supervisor Licensing and Certification Program MDH

- Key changes for surveyors in this guidance
- What will surveyors be looking at?
- How will this impact the QIS survey?
- Resident Rights and Quality of Care & relationship to tag severity citation

Statewide Call (March 18, 2013) **–** At the next quarterly statewide phone call, the same panel members from the January 16th Statewide Call were brought back for additional Q &A.

Also discussed at this time were the revisions that CMS issued on March 8, 2013 CMS relating to Advance Directive (F155) and Feeding Tubes (F322). Participants of the call were provided the revised CMS training materials, which provided additional clarification to the topics. The training materials were also added to the Clinical Web Window on MDH's website.

Statewide Call (June 17, 2013) **–** A citation update on Advance Care Planning (F155) and Feeding Tube (F322) was provided to participants of the call.

WebEx's – As mentioned above, WebEx's are online training sessions that are recorded and therefore can be viewed at any time, and as many times as the viewer desires. As part of MDH's educational efforts, a WebEx was recorded for each of three topics (End of Life, Advance Directive, Feeding Tubes). Handouts on each of the topics were also developed, along with a "print-out" version of the WebEx combined with the presentation script.

2. Partnership to Improve Dementia

In 2012, CMS launched the Partnership to Improve Dementia Care in Nursing Homes to promote comprehensive dementia care and therapeutic interventions for nursing home residents with dementia-related behaviors.

CMS issued a memorandum on the Partnership to Improve Dementia and also developed two mandatory surveyor training programs related to surveying for care of persons with dementia and unnecessary medication use in long term care facilities. The surveyor training content included:

1. How to identify whether an individualized, person-centered approach was implemented for a resident with dementia

2. How to identify that a systematic process is in place and has been followed for persons with dementia in the facility

3. How to evaluate the role of the consultant pharmacist, physician/NP/PA, medical director, direct care staff, family and other members of the interdisciplinary care team

4. Other associated tags related to care of persons with dementia and unnecessary medication use.

The third installment of the training addressed how to cite severity and scope and other aspects of deficiency citations in more detail, based on new guidance at F309, Care of Residents with Dementia, and revised guidance at F329.

Statewide Call (March 18, 2013) – During this March 2013 Statewide Call, MDH introduced the CMS memo on the Partnership to Improve Dementia, discussed survey documents, and directed providers to the mandatory surveyor training programs on Improving Dementia Care and Reducing Unnecessary Antipsychotic Medications in Nursing Homes.

Statewide Call (June 17, 2013) – At this Statewide phone call highlights of new CMS dementia guidance were discussed, in addition to updates on Minnesota's implementation of this new guidance.

Joint Stakeholder Group

Participants of the June 17th Statewide call also heard an update from the Minnesota Partnership for Dementia Care, which is a joint stakeholders group. Partners in this effort include representatives from Act on Alzheimer's, Aging Services of Minnesota, The Alzheimer's Association, Care Providers of Minnesota, Ecumen, HealthEast Bethesda Hospital, the Minnesota Board on Aging, the Minnesota Department of Health, the Minnesota Medical Directors Association, the Office of Ombudsmen for Long-Term Care, Stratis Health, and Thrifty White Pharmacy Consultants.

The Minnesota Partnership to Improve Dementia Care aims to:

- Identify opportunities to improve services and support to individuals with dementia and their caregivers

- Support providers and caregivers in their efforts to decrease the use of unnecessary antipsychotic medication use by focusing on a better understanding of the root causes of dementia-related behaviors

- Identify current activities in our state related to dementia care to avoid duplication and enhance efforts

- Identify expertise, knowledge, and evidence-based resources to improve dementia care—particularly those that offer alternatives to antipsychotic medications

- Assure that dementia-care resources and tools are widely-disseminated and easily accessible to individuals, providers, and caregivers.

Joint Training/Educational Resources

MDH, in conjunction with the Office of the Ombudsman for Long Term Care, Aging Services of Minnesota, Care Providers of Minnesota, Minnesota Medical Directors Association, Minnesota Directors of Nursing Association, Stratis and other interested individuals and organizations sponsored a joint training.

The training included written resources, CMS Surveyor Online Training and two additional Statewide Phone Calls that related specifically to dementia. These two statewide phone calls occurred on July 30, 2013 and July 31, 2013 (these calls were repeated and covered the same material).

Educational Resources and Optional Tools and Forms were also placed on the MDH Clinical Web Window under the heading "Dementia Care in Nursing Homes". There was no charge for these events or resources.

3. Additional Areas of Special Focus

Other topics or areas of special focus in FFY13 included:

1. Physician Delegation of Tasks in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs)

During the March 18, 2013 Statewide Call, MDH discussed recently issued CMS guidance relating to physician delegation of tasks, a topic that had been identified as an area of confusion. CMS had issued a memorandum, which discussed physician delegation of tasks in SNFs and NFs. The memo:

- Provided guidance revision: clarification of Federal guidance related to physician delegation of certain tasks in SNFs and NFs to non-physician practitioners (NPPs;

formerly “physician extenders”) such as nurse practitioners, physician assistants, or clinical nurse specialists

- Implemented Section 3108 of the Affordable Care Act (ACA): This section adds physician assistants to the list of practitioners that can perform Skilled Nursing Facility (SNF) level of care certifications and re-certifications.

- Clarified the policy on co-signing orders in SNFs and NFs.

2. New Dining Standards

The March 18, 2013 Statewide Call also covered another CMS memorandum that related to new dining standards. The memo included

- New dining practice recommendations for nursing home residents: recommendations were developed by an interdisciplinary task force sponsored by the Pioneer Network and the Rothschild Foundation

- Expanded diet options for older individuals: Research has indicated that many older individuals may not need to be limited to very restrictive diets, pureed foods, and thickened liquids even though they may have many chronic conditions. Conversely, restricting food choices can result in loss of appetite and eventual weight loss.

- Informed of a surveyor training video: a new 24-minute video training product was made available to all survey agencies with information on new dining standards of practice and therapeutic diets. This video, was an introduction to the New Dining Practice Standards, and was developed by several national professional organizations.

3. Electronic Plan of Correction (ePOC)

The June 17, 2013 Statewide Call discussed the upcoming 2014 implementation of the Electronic Plan of Correction (ePOC). Minnesota selected by CMS as one of three states to implement ePOC. States selected: Minnesota, Massachusetts, and North Carolina. MDH’s participation was strongly encouraged by representatives from Minnesota’s long term care industry.

Once a SNF/NF is enrolled, MDH will electronically issue 2567s and State Licensure orders. When a Minnesota provider agrees to participate in ePOC, they will also be agreeing the receipt of State licensure orders electronically.

MDH will utilize the ePOC process for review of all Federal SNF/NF plans of correction (POC) for recertification surveys, complaint surveys, Life Safety Code surveys, Revisit surveys, and Federal Monitoring Surveys.

At this time, SNF/NFs are the only provider with the ePOC option. In the future, all federally certified providers will have this option available.

V. Appendices

APPENDIX A: CMS Revisit/Date of Compliance Policy

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

Appendix A - CMS Revisit/Date of Compliance Policy

Revisit/Date of Compliance Policy[9]

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

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

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

Givens:

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

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

Appendix B - Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX[10]

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

Substandard quality of care is any deficiency in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15 Quality of Life, or 42 CFR 483.25, Quality of Care, that constitutes immediate jeopardy to resident health or safety; or a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Substantial compliance

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