Annual Quality Improvement Report on the Nursing Home Survey Process

Report to the Minnesota Legislature, including updates on other legislatively directed activities

Minnesota Department of Health

Federal Fiscal Year 2006
Released April 2007

MINNESOTA MDH DEPARTMENT OF HEALTH

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Contents

List of Tables and Graphs

Executive Summary

The Minnesota Department of Health (MDH) Division of Compliance Monitoring, Licensing and Certification Program licenses and inspects hospitals, nursing homes and other health care providers. MDH also certifies health care facilities and other providers who take part in the federal Medicare and Medicaid programs, as part of a federally funded process known as "survey and certification." MDH employs surveyors who perform annual certification inspections known as "surveys" to evaluate the degree to which nursing homes that are Medicare and/or Medicaid certified are in compliance with a detailed set of federal regulations known as the "Conditions of Participation." These regulations also require nursing homes to comply with applicable state and local laws. When surveyors find a nursing home practice that is out of compliance with a federal regulatory requirement, the survey team issues a "deficiency" and the nursing home then is required to correct the practice to come into compliance with regulatory requirements.

In 2003, Commissioner of Health Dianne Mandernach initiated several activities aimed at improving the consistency and accuracy of the survey process across the 10 districts throughout the State. The Commissioner established the Long Term Care Issues Ad Hoc Committee[1], which includes a variety of stakeholders that meet quarterly to discuss and advise the Commissioner on issues relating to improving the nursing home survey process. In response to concerns raised there and in other forums, MDH undertook a number of activities aimed at improving and ensuring the consistency and accuracy of the survey process, and improving communication with providers, consumers, and consumer advocates. MDH reported on activities undertaken in 2004 and 2005 in previous annual quality improvement reports to the legislature (See Appendix E for a link to these reports). This report discusses activities during the past year, focusing on the Federal Fiscal Year (FFY) 2006, which ran from 10-1-05 through 9-30-06.

As noted in last year's Legislative Report, the following five special focus areas were identified as areas to continue making improvements in the nursing home survey process during FFY 2006:

A. Allocation of Survey Hours to Achieve Maximum Resident Benefit. MDH developed a revised post certification revisit process, obtained feedback from the Long Term Care Issues Committee, and implemented the new process effective for all surveys exited after November 3, 2006. The Department will monitor and evaluate the new process over the next year.

B. Rochester/Mankato Pilot Project. After approximately one year of implementation, MDH concluded its pilot project in the Rochester and Mankato survey districts, which involved having one "field" supervisor provide onsite coaching and mentoring supervisory support to both teams, and a second supervisor provide document review and processing oversight to both teams. Although the pilot addressed some consistency issues, it posed new logistical challenges for the two survey districts. The increased communication necessary for the two supervisors to keep "on the same page," as well as

[1] Information about the Long Term Care Committee's charge, membership and activity is available at http://www.health.state.mn.us/ltc/.

increased travel and moving paper around to complete packages, resulted in inefficiencies, and delays in meeting deadlines in package completion. MDH went back to their customary way of providing supervisory support in October 2006.

C. Statewide and Regional Efforts to Improve Communications. MDH continued meeting with the Long Term Care Issues Committee on a quarterly basis, and met regularly with the provider associations, professional associations, and consumer advocates. MDH, with the help of these stakeholders, developed a training video to promote understanding of the survey process and communication expectations for all parties involved in the survey process. The video was distributed to a variety of stakeholders including Minnesota licensed nursing homes, provider and professional associations, consumer advocates, nurse training programs and a host of other interested parties. The regional stakeholders group in the Duluth met on a monthly basis in 2006, and conducted regional provider training sessions on conducting individualized comprehensive assessments. The group plans to continue meeting in 2007 and offer additional educational programs.

D. Collaborating on Provider Quality Improvement Initiatives. MDH and the joint training planning group developed and implemented trainings/tools on several new or revised CMS guidelines that were issued this past year. MDH is in the process of monitoring and evaluating the pressure ulcer and urinary incontinence training which was conducted in 2005 to determine the effect it has had on resident quality of care. MDH also conducted additional training on the Life Safety Code requirements, and participated in the Culture Change Coalition and the seminar they held for providers and surveyors on the culture change model in October of 2006.

E. Continuing Efforts to Improve Consistency Across Survey Teams. MDH communicates regularly with surveyors on implementation of the survey process and citing deficiencies. The Department continues to review and analyze deficiency data on a regular basis to identify deficiency patterns and assure the overall integrity of the survey process. Information from these reviews is also used to provide guidance to surveyors and determine training needs. MDH has also worked with researchers to understand factors, besides surveyor characteristics (e.g. resident and provider/facility characteristics), that may be contributing to the variation in deficiencies between survey districts in the state.

This report also contains information on: compliance with time lines for delivering statements of deficiencies and for completing revisits after a nursing home has implemented corrective actions; independent dispute resolution; and, the status of a process to address defensive documentation.

During the current year, MDH will be giving special attention to the following areas:

A. **Monitor and Evaluate the Revised Post Certification Process.** MDH will examine the efficiency and effectiveness of verifying compliance when not conducting an onsite revisit. In evaluating the revised process, MDH will look at results of random visits to

see if providers are in compliance, determine if there is an increase in complaints or other activities concerning facility compliance, and monitor staff resources. MDH will also review results of subsequent recertification or complaint investigation and determine ongoing compliance. The outcome of this evaluation will be shared with the LTC Issues Committee and discussed in the 2007 Report to the Legislature.

B. **Culture Change**. MDH supports resident-centered care and will continue to work collaboratively with stakeholders towards the shared vision of a long term care system that ensures quality of care and quality of life for every resident. MDH will continue to seek opportunities to integrate resident-centered focus in joint training activities, and to communicate with providers, advocates, residents and families about strategies to ensure that adoption of resident-centered practices in nursing homes also meet regulatory requirements.

C. **Continued Efforts to Improve Consistency.** MDH will continue to evaluate survey and survey team performance across the state. Deficiency data and information from survey teams following surveys will be analyzed and used by L&C Management to identify variations in the application of the survey process and to provide training and guidance to surveyors. The Department has applied to participate in the CMS Quality Improvement Survey (QIS) Pilot Project. Currently there are six states that participate in the pilot project. CMS will be expanding its pilot to include 8-10 additional states. Besides looking at surveyor characteristics, MDH will also look at resident (MDS data) and facility characteristics that may be contributing to the variation in deficiency citations across teams. Additionally, MDH will continue activities initiated in FFY 2005 focused on recruitment and retention of qualified survey staff and particularly as it relates to training and maintaining a quality supervisory team.

Introduction

This report fulfills the legislative requirement for providing an annual nursing home survey and certification quality improvement report and progress reports on other legislatively directed activities. A copy of Minnesota Session Laws 2004, Chapter 247 is attached as Appendix A.

The nursing home survey and certification program is a federal regulatory program funded by the Centers for Medicare and Medicaid Services (CMS), a division of the U.S. Department of Health and Human Services. CMS contracts with each state to administer the survey and certification program. This report is based on analysis of data representing status of the program during Federal Fiscal Year (FFY) 2006, which ran from October 1, 2005 through September 30, 2006.[2]

The report is organized into four parts. Part I provides the data and other information required to be included in the annual report. Part II describes the Department's progress on the other legislatively directed activities. Part III includes a summary of some of the activities implemented to improve the nursing home survey process. Part IV identifies areas that MDH intends to focus on in the future.

[2] As noted, in a few instances, the report contains data outside of this reporting period.

I. Annual Survey and Certification Quality Improvement Report

Minnesota Statutes, section 144A.10, subdivision 17 (2004) requires the Commissioner to submit to the legislature an annual survey and certification quality improvement report. The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;
(2) cross-referencing of citations by region within the state and between states within the CMS region in which Minnesota is located;
(3) the number and outcomes of independent dispute resolutions;
(4) the number and outcomes of appeals;
(5) compliance with timelines for survey revisits and complaint investigations;
(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;
(7) compliance with timelines for providing facilities with completed statements of deficiencies; and
(8) other survey statistics relevant to improving the survey process.

The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

A. Number, Scope, and Severity of Citations by Region within the State

Data Source

The data provided in this report has been extracted from the Centers for Medicare and Medicaid Services (CMS) Online Survey Certification and Reporting System (OSCAR), a federal database of federal survey data, and Paradise, a state database of state and federal survey data. Tables identify data from the most recent nursing home survey in the database.[3]

Background

Federal law requires that each nursing home be surveyed annually during each federal fiscal year. Surveys can be conducted up to 15 months from the last survey; however, states are required to maintain a 12 month statewide average among all nursing homes. Surveys evaluate

[3] Data from each survey is entered into the OSCAR database following completion of the survey. The time required for data entry creates a time lag between completion of the survey and data entering the OSCAR database of approximately 45 days.

the nursing homes' compliance with federal regulations, which are contained in 42 Code of Federal Regulations (CFR) 483.1 to 483.75. A nursing home is issued a Statement of Deficiencies for findings of noncompliance. The Statement of Deficiencies is written on Federal Form Number CMS 2567 (2567). The 2567 statement identifies each area of noncompliance by referencing a specific deficiency ("tag") number.

Health tags have the prefix F (e.g., F-309). The tag numbers are contained in interpretive guidelines for the nursing home regulations issued by CMS. The 2567 restates the regulatory language and specifies the survey findings that support the findings of noncompliance.

The federal health regulations cover 15 major areas including resident rights, quality of life, quality of care, and physical environment. The 2567 also identifies the scope and severity of the deficient practice. CMS has developed a scope and severity grid which allows for the classification of deficiencies based on the extensiveness of the deficient practice and the degree of harm presented to residents. 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 CMS Scope and Severity Matrix is attached as Appendix B. The grid identifies 12 levels, labeled A through L, of deficiencies based on a combination of scope and severity score for a deficient practice.

MDH is required to follow the survey process and survey protocols issued by CMS.[4] These provisions are detailed and address specific procedures that must be completed during each survey, including: entrance interview, tour of the facility, selection of resident sample for review, interviews with residents, facility staff, and family members, observations of care received by residents, observation of medication passes and kitchen sanitation, observation of staff interaction with residents, review of individualized resident assessment, individualized care plan, care plan implementation, ongoing assessment and revision of care plan based on ongoing assessment, review of policies and procedures, etc. The CMS survey protocols contain specific criteria for determining circumstances requiring additional sampling of residents for review/observation and for extending survey observation and investigation. CMS Interpretive Guidelines provide information which surveyors are required to review and consider during the decision making process of the survey.

Once the survey is complete, MDH staff provide a draft 2567 to the nursing home at the time of the exit conference, then prepare and send a final 2567 after the supervisory review is complete.

Deficiency Citations[5]

Variation between the states has been identified in the past and has been the subject of reports from the Government Accountability Office and the Office of the Inspector General of the federal Department of Health and Human Services. CMS has been reviewing this issue and has

[4] Survey protocols are in Appendix PP of the CMS State Operations Manual. See Appendix C of this report for links to Federal regulations, manuals, and program transmittals.
[5] This analysis and discussion is based only on health survey tags. An additional set of regulations, the Life Safety Code, is discussed later in the report.

identified 12 tags that had significant variation among states. CMS has been working on revising clinical guidance, investigative protocols and guidance for surveyors for these tags. Revised investigative protocols and guidance for surveyors were issued for Pressure Ulcers in November 2004, Urinary Incontinence in June 2005, Medical Director in November 2005, Quality Assurance, Activities, and Psychosocial Severity in June 2006 and Unnecessary Drugs and Pharmacy Services in September 2006. CMS also issued new guidelines for Influenza and Pneumonia in September 2006. More guidelines will be issued in 2007. In addition, the CMS regional office holds monthly conference calls for State Agency program managers and MDH staff participates in these calls. MDH staff also attend regional and national CMS meetings.

Minnesota Compared to National Data and Region V in Deficiency Citations

For the "current survey cycle"[6] ending on 10/01/06, Minnesota's average deficiencies per health survey was 9.7. The average deficiencies per health survey for all states in Region V was 5.6, and Minnesota ranked first.

Table A-1: Average Deficiencies Per Health Survey, CMS Region V
Current Survey Federal Oscar Data System, 10/01/06

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	817	3,791	4.6	3.0
Indiana	511	3,381	6.6	6.0
Michigan	425	3,313	7.8	7.0
Minnesota	398	3,854	9.7	9.0
Ohio	1,097	4,469	4.1	3.0
Wisconsin	398	1,562	3.9	3.0
Total	**3,646**	**20,370**	**5.6**	**4.0**

The national average deficiencies per health survey was 6.7 and Minnesota ranked ninth. A table of average number of health deficiencies per survey for the U.S. is attached as Appendix D. The Department continues to monitor the average deficiencies issued per health survey by MDH in comparison with other states. Further exploration and analysis are required to uncover factors that may contribute to Minnesota's average deficiencies per health survey being higher than other states in Region V. MDH continues to work with researchers both internally and externally to explore and analyze factors that contribute to variation in survey results. Organizations participating in this research include Stratis Health,[7] University of Minnesota, CMS and the Minnesota Department of Human Services.

[6] "Current Survey Cycle" includes the most recent survey of each facility.
[7] Stratis Health is the CMS Quality Improvement Organization for Minnesota. CMS funds Stratis Health to perform quality improvement consulting to health care providers within the state. See Appendix C.

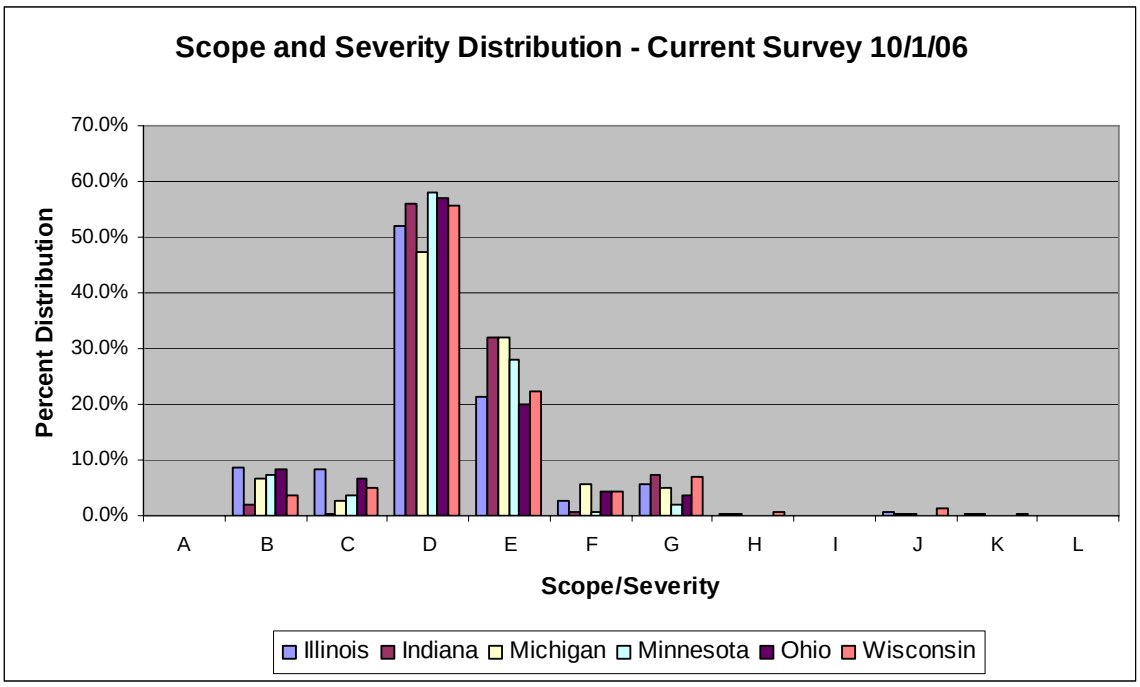
Minnesota Compared to Region V in Scope and Severity of Deficiency Citations

In Minnesota the greatest number and percent of tags were issued at scope and severity levels D and E, comparable to other states in Region V. Minnesota had fewer tags written at scope and severity G and above, compared to other states in Region V. Overall, the numbers of tags written at the most serious levels are small, compared to lower level tags in all states in Region V.

Table A-2: Number of Tags Issued in Each Scope and Severity, CMS Region V
Current Survey, Federal OSCAR Data System, 10/1/06

State	A	B	C	D	E	F	G	H	I	J	K	L	Total
Illinois	0	332	314	1,968	802	108	223	7	1	23	10	3	3,791
Indiana	0	65	16	1,899	1,096	24	240	7	0	16	18	0	3,381
Michigan	0	226	80	1,568	1,063	190	167	3	0	11	3	2	3,313
Minnesota	0	277	147	2,238	1,083	28	74	1	0	4	2	0	3,854
Ohio	0	352	312	2,543	887	193	173	4	0	5	0	0	4,469
Wisconsin	0	58	80	885	332	64	111	9	0	16	5	2	1,562
Total	0	1,310	949	11,101	5,263	607	988	31	1	75	38	7	20,370

Graph 1



It is significant to note that although maximum total deficiencies are higher than other states in Region V, they are similar to those states in that the vast majority of tags issued are at the D&E scope and severity level (58% were at D and 28% were at E). MDH continues to analyze the significance of these patterns.

Variation of Deficiency Citations within Survey Districts in Minnesota

Minnesota's survey teams work out of seven district offices, with four metro teams housed in one of them. MDH has looked at the average number of deficiencies issued by survey district on a monthly basis since FFY 2005, and shares this information with nursing home provider organizations. MDH also analyzes the median number of deficiencies by survey district on a monthly basis. Monthly reports also compare the average and median numbers of deficiencies issued by "Mix/Max" teams.[8]

Since FFY 2004, MDH has undertaken a number of initiatives to address variation in deficiency citations between survey districts. These initiatives are described in previous Reports to the Legislature (See Appendix E for a link to the 2004 and 2005 Report). Continuation of these activities and development of additional initiatives to address the issue of consistency of the survey process are discussed later in this report.

For FFY 2005, MDH survey program management identified as a quality improvement target goal:

> "The median number of tags issued per survey by team will vary no more than +/- 2 tags from the statewide median."

This target continued to be a goal for FFY 2006, and MDH is committed to this goal again for FFY 2007 (See Appendix F for the 2007 Quality Improvement Plan for Survey Agency).

The purpose of expressing a target was to have a meaningful reference measurement for purposes of comparison and analysis, not to set a quota. For data reported in 2005, reflecting the "current survey cycle", one district was outside (above) the target range (Table A-4). For the survey cycle ending at the end of FFY 2006, two districts were outside (above) the target range (Table A-5).

[8] "Mix/Max" or mixed teams are teams that have approximately half the survey team from each of two survey teams. The Mix/Max teams were used during FFY 2004 as a quality improvement initiative. During FFY 2005, MDH scheduled approximately one Mix/Max survey per month in each district. Due to the high cost of mix/max surveys, MDH is performing fewer of them in FFY 07. However, they continue to be a key strategic approach to quality assurance.

Table A-4: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts, 10-1-04 through 9-30-05 MDH Paradise Data System, 9-30-05

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	43	300	7.0	6.0
Duluth	28	393	14.0	13.5
Fergus Falls	41	249	6.1	5.0
Mankato	61	361	5.9	5.0
Metro A	29	229	7.9	8.0
Metro B	30	228	7.6	8.0
Metro C	32	264	8.3	7.0
Metro D	32	215	6.7	5.0
Rochester	39	386	9.9	9.0
St Cloud	33	220	6.7	7.0
Mix/Max	27	321	11.9	12.0
Total	**395**	**3,166**	**8.0**	**7.0**

Table A-5: Average and Median Deficiencies Per Health Survey, Minnesota Survey Districts, 10-1-05 through 9-30-06 MDH Paradise Data System, 10-01-06

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Bemidji	42	409	9.7	9.0
Duluth	37	444	12.0	11.0
Fergus Falls	41	356	8.7	8.0
Mankato	65	490	7.5	7.0
Metro A	33	311	9.4	10.0
Metro B	24	282	11.8	12.0
Metro C	32	333	10.4	9.0
Metro D	31	320	10.3	9.0
Rochester	41	482	11.8	12.0
St Cloud	37	335	9.1	9.0
Statewide Team	6	68	11.3	11.5
Mix/Max	12	158	13.2	13.0
Total	**401**	**3,988**	**9.9**	**9.0**

Data in Tables A-4 and A-5 (above) reflect a 23.8% increase in average number of deficiencies and a 28.6 % increase in median number of deficiencies statewide from FFY 2005 through FFY 2006. Staff is working to understand the reason for this increase, and believe it may be due in part to the change in the "cross-referencing" policy which will be discussed in Section I. B. of this report. It may also be due in part to the increase in the pressure ulcer and urinary incontinence deficiency tags, since CMS revised the guidelines and MDH conducted training and began surveying under the new guidelines. An evaluation of the training and effect it has had on

deficiency citation rates is discussed in Section III., D of this report, under Evaluation of Joint Training Activities.

Additionally, the range of citation variance between the high and low survey district averages has decreased over the past year. In FFY 2005 the district mean citations issued ranged from a low of 5.9 and high of 14.0. The current district mean range is a low of 7 and high of 13. This reflects a 2.1 decrease in the range between the highest citing district and the lowest citing district.

The range citation variance between the high and low survey district median has also decreased over the past year. In FFY 2005 the district median citations ranged from a low of 5.0 and high of 13.5. The current district median range is a low of 7 and high of 12. This reflects a 3.5 decrease in the range between the highest citing district and the lowest citing district. MDH will continue to review both survey team mean and median as a measure to monitor survey process variance.

Historically, the Duluth district has been known to be the highest deficiency citing district in the state. More recent data (June 2006) shows that Duluth is no longer in that position. It is difficult to know which of the many initiatives MDH has undertaken has played a role in changing those statistics. MDH continues to conduct monthly review of variabilities and evaluate where there are differences in teams.

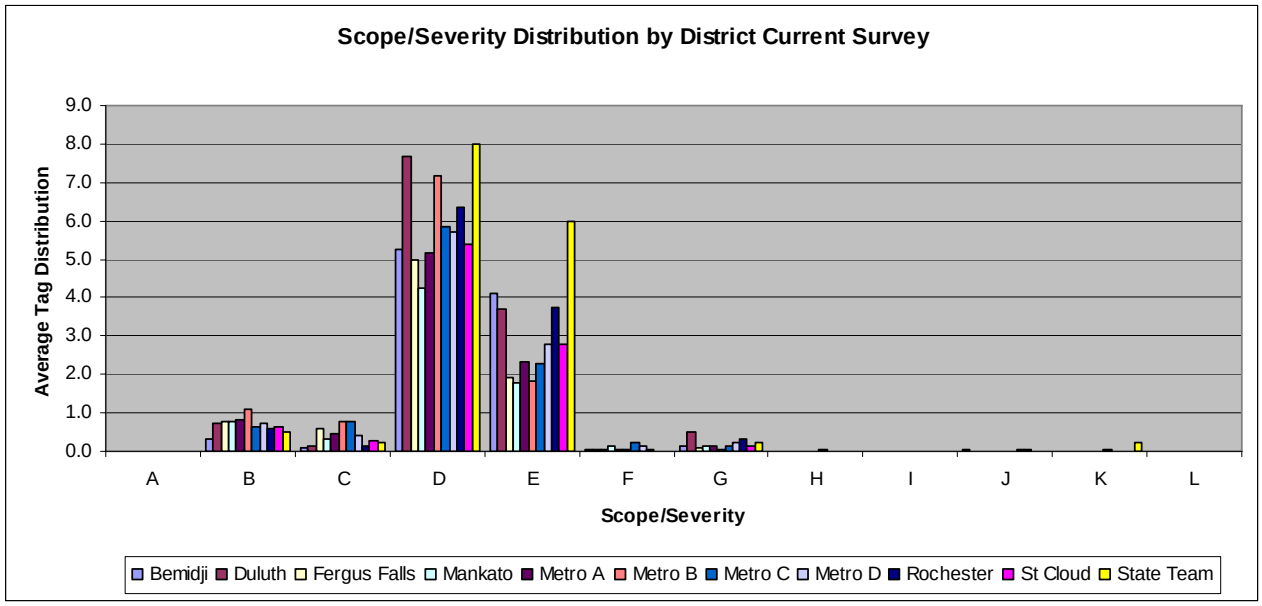
Scope and Severity of Deficiency Citations within Minnesota Survey Districts

State wide approximately 86% of health deficiencies cited are of D and E scope and severity. This indicates no actual harm with a potential for more than minimal harm that is not immediate jeopardy. This scope and severity pattern is fairly consistent with past years. As the number of citations increases, there tends to be a greater rate at which D and E level deficiencies are cited. Deficiencies with a scope and severity level of G or above constitute only 2% of deficiencies written statewide. The range of deficiency citations at a level G range from a low of .4% in Metro B to 4.0% in Duluth.

Table A-8: Minnesota Survey Districts, Average Tags per Survey in Each Scope and Severity Current survey, Federal OSCAR Data System, 10/01/06

District	Surveys	A	B	C	D	E	F	G	H	I	J	K	L	Total
Bemidji	39	0.0	0.3	0.1	5.3	4.1	0.0	0.1	0.0	0.0	0.0	0.0	0.0	9.9
Duluth	35	0.0	0.7	0.1	7.7	3.7	0.0	0.5	0.0	0.0	0.0	0.0	0.0	12.7
Fergus Falls	43	0.0	0.8	0.6	5.0	1.9	0.0	0.1	0.0	0.0	0.0	0.0	0.0	8.4
Mankato	66	0.0	0.8	0.3	4.2	1.8	0.1	0.1	0.0	0.0	0.0	0.0	0.0	7.3
Metro A	38	0.0	0.8	0.5	5.2	2.3	0.0	0.1	0.0	0.0	0.0	0.0	0.0	9.0
Metro B	23	0.0	1.1	0.8	7.2	1.8	0.0	0.0	0.0	0.0	0.0	0.0	0.0	11.0
Metro C	38	0.0	0.7	0.8	5.8	2.3	0.2	0.2	0.0	0.0	0.0	0.0	0.0	9.9
Metro D	30	0.0	0.7	0.4	5.7	2.8	0.1	0.2	0.0	0.0	0.0	0.0	0.0	10.0
Rochester	43	0.0	0.6	0.1	6.3	3.7	0.0	0.3	0.0	0.0	0.0	0.0	0.0	11.2
St Cloud	39	0.0	0.6	0.3	5.4	2.8	0.0	0.2	0.0	0.0	0.0	0.0	0.0	9.3
State Team	4	0.0	0.5	0.3	8.0	6.0	0.0	0.3	0.0	0.0	0.0	0.3	0.0	15.3
Total	398	0.0	0.7	0.4	5.6	2.7	0.1	0.2	0.0	0.0	0.0	0.0	0.0	9.7

Graph 2, Federal OSCAR Data System, 10/01/06



Life Safety Code Enforcement

The federal government has adopted National Fire Protection Association Standard 101 (Life Safety Code, 2000 edition) as the minimum standard for fire and life safety in all certified health care facilities. Life Safety Code (LSC) surveys are conducted by the Department of Public Safety, State Fire Marshal (SFM) Division, under contract with MDH. LSC deficiencies are data tag K. All states experienced an increase in Federal Monitoring Surveys (FMS) beginning in

FFY 2005. These monitoring surveys resulted in a significant number of LSC deficiencies. A review of the monitoring surveys indicated that the approach to surveys used by SFM staff and CMS staff is somewhat different. SFM and MDH staff have adjusted their approach to more closely follow the approach used by CMS. This adjustment has also resulted in a significant increase in the number of LSC deficiencies issued to facilities, particularly long-term care facilities. SFM and MDH have communicated these changes to the provider community.

The average number of deficiencies per LSC survey nationally during FFY 2006 was 4.2 and the average in Minnesota was 6.4; Minnesota ranked ninth. Within CMS Region V, the average number of deficiencies per LSC survey was 4.9, and Minnesota ranked fourth. A table of average number of LSC deficiencies per survey for the U.S. is attached as Appendix G.

Table A-9: Average Deficiencies per LSC Survey, CMS Region V, OSCAR 10/01/06

District	Surveys	Tags From Each Group	Average Defs. Per Survey	Median Defs. Per Survey
Illinois	817	5,229	6.4	3.0
Indiana	511	1,851	3.6	5.0
Michigan	425	3,487	8.2	7.0
Minnesota	398	2,533	6.4	9.0
Ohio	1,097	3,668	3.3	3.0
Wisconsin	398	1,272	3.2	3.0
Total	**3,646**	**18,040**	**4.9**	**4.0**

B. "Cross-Referencing" of Citations by Region Within the State and Between States within CMS Region V

MDH continued to monitor the rates of citing associated tags within Minnesota and nationally. Data showed that Minnesota experienced an increase in deficiencies from 20.7% for the approximate year before the policy change (outcome tags cited only) to 62.7% for the approximate year after the policy change (outcome and assessment tags cited). For a history of the "cross-referencing" issue, see Appendix E for link to the 2005 Legislative Report.

MDH provided CMS with data on Minnesota and other states "cross-referencing" rate (Appendix H) and has had several conversations with CMS Region V regarding this issue. CMS advised MDH that they are issuing the citations correctly, and agreed to examine this issue further and look at every FOSS report at the regional level to identify where each state is at in issuing multiple citations.

Although the Department has not received "official" communication from CMS on their "cross referencing" study, MDH did receive an "unofficial" response from CMS Region V (Appendix H) explaining that they took a two prong approach to looking at multiple citations in FY 2006 The quantitative approach was the same data analysis that Minnesota did, which calculated the percent of surveys with an outcome tag that had a process tag on FOSS and comparative 2567s

for both the State and Regional Office. The qualitative approach reviewed five 2567s that had an outcome tag and a process tag, to see if they were related and then they reviewed three 2567s with just an outcome tag cited to see if a process tag should have been cited. CMS concluded, from this quantitative analysis, that Region V states had high multiple citation rates and that one state was significantly lower than the other five states. Regarding the qualitative analysis, CMS concluded that for at least half of the outcome tags they looked at for which there was no process tags, they believe, based on the evidence in the outcome tags, that process tags should have been written. CMS communicated this to all Region V states and agreed to monitor and enforce the issuance of independent but associated citations through their federal oversight process.

MDH will continue to monitor the "cross referencing" rates within Minnesota and by other states and communicate with CMS on this issue.

C. Number and Outcomes of Informal Dispute Resolutions

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: 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.[9]

IDR

The IDR is performed by an MDH employee who has not previously been involved in the survey. For surveys with exit dates during FFY 2005, 22 IDRs were requested, and as of 11/03/06, 18 of those were complete. A total of 42 tags were disputed (4 reviews have not been completed, involving 8 tags). Of the disputed tags, the reviewer's decision was to change the scope and severity for 3 tags, and to delete 4 tags, for a total of 7 tags (20%) changed or deleted. Although CMS has the option of reviewing these decisions, in practice the MDH decision has remained in place, and MDH issues a revised 2567 as soon as its decision process is complete.

IIDR

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, who reviews the case and can accept or modify the ALJ's recommendation.

Since the inception of the process in 2003, 84 IIDR requests have been made. Of these, 32 were withdrawn before the review with an ALJ. Four IIDRs were switched to an IDR process; three of these were at the request of the nursing home; one was at the request of MDH, which the facility agreed to. MDH rescinded tags in two IIDRs, and one nursing home has maintained its IIDR request on an indefinite hold. Of the nursing homes that progressed to an ALJ review, nursing homes had representation by an attorney in 27, and were represented by the administrator in 11

[9] State Operations Manual, Chapter 08, State Performance Standards, Section 7212C: Mandatory Elements of IDR. See Appendix C for a link to the State Operations Manual.

of the IIDRs. MDH has representation by a survey unit supervisor and does not involve an attorney.

Table C-1: Summary of IIDR Results, July 2004 – 11/03/06

Number of tags in dispute: 91

ALJ recommended action:		Number of tags:
Uphold tags as written		40
Uphold scope and severity, but delete some findings		8
Total tags upheld	**48**	
Dismiss		19
Adjust scope and severity		24
Total tags adjusted or dismissed	**43**	

Commissioner's decision:*		Number of tags:
Uphold tags as written		44
Uphold scope and severity, but delete some findings		7
Total tags upheld	**51**	
Dismiss tags		14
Adjust scope and severity		19
Adjust scope		1
Total number of tags adjusted or dismissed	**34**	

* 2 IIDR decisions pending, involving 6 tags

In April of 2006, MDH, provider associations, counsel representing some nursing homes, and other stakeholders, observed a teleconference training conducted by CMS Region V staff to the Minnesota ALJs. The purpose of the training was to educate the ALJs on CMS's approach to the rationale for accepting a tag modification or deletion. Following that training, in May of 2006, CMS advised MDH that the Department no longer needed to routinely send CMS Region V files for review. Rather, CMS Region V will request files as necessary.

As of November 3, 2006, CMS has reviewed 23 of the 30 IIDR reviews conducted before CMS training of ALJs in April of 2006 and has overruled the Commissioner's decision in most situations where she has recommended a change in the 2567. Until CMS completes its review of these IIDRs, MDH cannot issue a revised 2567.

Since CMS conducted the ALJ training in April of 2006, they have not requested to review any files for IIDR decisions rendered by the ALJs and the commissioner.

MDH reimburses OAH for costs associated with review of IIDR cases. Facilities reimburse MDH for the proportion of costs that are attributable to disputed tags on which MDH prevails.

Costs from the beginning of the IIDR process through September 30, 2006, are presented in Table C-2.

Table C-2: OAH Costs Paid by Nursing Homes and MDH through September, 2006 (36 IIDR reviews)

OAH Cost Apportionment	Number of Nursing Homes	Number of Tags	Cost Amount
Nursing Home paid 100% of costs	10	14	$17,492.25
Nursing Home split costs with MDH:	14	53	$43,994.32
Costs split – portion paid by NH		28	$24,972.92
Costs split – portion paid by MDH		25	$19,021.40
MDH Paid 100% of costs	12	18	$24,713.05

MDH uses a trained surveyor to review submitted materials and present MDH's position at the IIDRs. The IIDR process has required a considerable investment of staff time. Table C-3 presents a summary of supervisor and surveyor time spent on IIDRs compared to IDRs during FFY 2006.

Table C-3: Staff Time in Hours Spent on IDR and IIDR -- FY 2006

Process	Number of Reviews	Total Supervisor & Surveyor Time	Average Supervisor & Surveyor Time per Review
IIDR	15	778.0	52.0
IDR	18	166.0	9.2

MDH has used the information gained from the IIDR process to improve the survey process with respect to both identifying and documenting deficient practices, through information sharing with program management and a statewide videoconference presentation to surveyors, investigators and supervisors. MDH shares a status log of IIDRs with the two nursing home trade associations on a monthly basis, and with the LTC Issues Committee at its quarterly meetings.

D. Number and Outcomes of Appeals

The appeals process is a federal process. Nursing homes communicate directly with the CMS Region V Office in Chicago.

MDH is aware of three nursing homes that initiated appeals at the federal level during FFY 2006; one of those requests was subsequently withdrawn.

E. Compliance with Timelines for Survey Revisits and Complaint Investigations

If a survey team finds deficiencies at the B through L level, the nursing home is required to submit a plan of correction (PoC) to MDH. If necessary, a post certification revisit (PCR) is conducted to determine whether the deficiency has been corrected. Minnesota Statutes, Section 144A.101, subdivision 5, (Appendix A) requires the Commissioner to conduct revisits within 15 calendar days of the date by which corrections will be completed, in cases when category 2 or 3 remedies are in place. The statute allows MDH to conduct revisits by phone or written communication, if the highest scope and severity score does not exceed level E. MDH performs an onsite revisit for levels D and E in situations where the determination of whether a deficient practice has been corrected is based on observation. (See Section IV, A.) B and C level deficiencies do not require a revisit.

For facilities surveyed during FFY 2006, there were 60 facilities with surveys or revisits with category 2 or 3 remedies imposed. Eighty seven revisits were completed subsequent to the facility being notified of a category 2 or 3 remedy. Of these:

- 52 revisits (60%) were completed within the 15 calendar days after the facility's identified date of correction.[10]

- 35 revisits (40%) for 34 facilities were not completed within the 15 calendar days after the facility's identified date of correction. Of these 35 revisits not completed within the 15 calendar days after the facility's identified date of correction:

    - A. Twenty facilities did not suffer financial loss due to their failure to correct and the time of the visits.
    - B. Two of the facilities did suffer financial loss caused by a delay in providing an acceptable plan of correction which impeded MDH's ability to conduct a revisit within 15 days of the facility's identified correction date.
    - C. Nine of the facilities did suffer financial loss caused by their failure to correct as opposed to the timing of MDH revisits.
    - D. Two of the facilities did suffer financial loss caused by their failure to correct and the timeliness of MDH revisits.

Summary: The number of facilities having category 2 or 3 remedies increased from 28 in FFY 2005 to 60 in FFY 2006 (a 114% increase). This resulted in a required 87 revisits. The survey workload resources were managed so that revisits were conducted in a manner as not to cause the facilities financial loss due to the timing of revisits by MDH in 98% of the cases.

[10] When a facility returns a PoC, the facility must identify a date by which corrections will be completed.

F. Techniques of Surveyors in Investigations, Communication, and Documentation to Identify and Support Citations

A description of the activities taken during FFY 2004 and 2005 to ensure the accuracy, integrity and consistency of the survey process can be found in previous annual quality improvement reports to the legislature (See Appendix E for a link to these reports).

During FFY 2006, the following activities took place; some are continuing from measures taken during FFY 2004 and 2005, and some are new or modified initiatives:

- Federal and state training was provided to new surveyors. Federal and state in-service training was provided to all surveyors. Some existing surveyors participated in federal cross-training.[11]
- MDH implemented a permanent assignment of two statewide surveyor trainers, each working half time as surveyor and half time as trainer, to work in the field with new surveyors during their orientation.
- Supervisors provided mentoring and coaching to new staff, and continued onsite survey mentoring and coaching with existing staff.
- Supervisors reviewed all deficiencies before final 2567s were issued.
- Assistant Program Managers reviewed all deficiencies at level G and above before final 2567s were issued.
- Monthly statewide L&C management team meetings including all supervisors, program management and division management, were held. The meetings were used to discuss and reach consensus on clarification of survey procedures. The monthly minutes are distributed shortly after the monthly L&C management team meetings and are used as a written communication tool with all survey staff.
- Monthly team meetings involving the supervisor and all surveyors were held as a forum for supervision, clarification, and communication.
- Weekly statewide scheduling conference calls were continued.
- Quarterly statewide surveyor, supervisor and management videoconferences were conducted and used as a communication and training forum.
- The L & C Management Team continues to develop tools to help ensure consistent application of the survey process.

    - Specific guidance on investigative protocols for nursing homes was developed and field-tested for four tags that had the greatest variability between districts. The Nursing Home Surveyor Training Resources will be discussed later in this report.

    - "Quality Survey Task Guide," was developed to provide guidance and clarification for surveyors on the seven survey tasks.

[11] Surveyors must complete specific federal training for each type of federally certified provider before participating in federal certification surveys on that provider type (for example, SNF, NF, home care, hospice, critical access hospital).

- A "Quick Tag Reference Guide," that assists survey teams conduct their decision making process in a consistent manner, was used and revised as necessary on an ongoing basis. This tool has enhanced survey team communication during the survey, to ensure that thorough investigation has been conducted and that deficiency determinations are based upon objective information collected through observation, interview, and review of documentation, according to the State Operations Manual (SOM). A guide was also developed for critical access hospitals, ICF-MRs, and home health agencies.

- Post Certification Revisit Protocol was developed in April 2005 to promote consistency in conducting revisits across districts.

- Communication between surveyors, district office supervisors, and facility staff continues to be an area of special focus for quality improvement.

  - MDH continues to hold Verify Clarify meetings which allow for the exchange of information about concerns surveyors have identified during observation and investigation and provides the opportunity for facility staff to bring additional information to the survey team that may in some cases enable the team to determine that the facility satisfied regulatory requirements.

- At each survey exit conference, the team leader gives the facility administrator a "Provider Survey" feedback form to be mailed to the district office with the provider's comments and responses to questions about the survey process, including communication between facility staff and survey team. Return of the form is optional, and may be anonymous. The forms are returned to the district office then forwarded to the central office. A web-based form is also available. Survey teams and residents/families also complete feedback forms. Any concerns are followed up by management immediately and are discussed at the monthly L&C management team meetings.

Additional activities in the area of communication about the survey process are discussed later in this report.

G. Compliance with Timelines for Providing Facilities with Completed Statements of Deficiencies

Minnesota Statutes, section 144A.101, subdivision 2 requires the Commissioner to provide facilities with draft statements of deficiencies at the time of the survey exit and with completed statements of deficiencies (the 2567) within 15 working days of the exit conference (Appendix A).

Delivery of a draft statement of deficiencies at the time of the survey exit has been implemented. Managers review data periodically and follow-up with supervisors who have problems complying with the timelines. In FFY 2006, four hundred and two (402) surveys were exited and the rough draft statement of deficiencies was left with the facility at the survey exit in four hundred (400) instances. In the two cases the draft statement of deficiencies was not left with the

facility, it was because of extended surveys requiring additional documentation time and travel efficiencies. The exit conferences were conducted by telephone the day after the surveyors left the facilities and draft statements of deficiencies were faxed to the facilities at that time.

Of the 381 surveys exited during FFY 2006, approximately 95% met the 15 day requirement for delivering final 2567s. Of the 21 surveys (approximately 5%) which exceeded the 15 day requirement, thirteen related to the Rochester/Mankato Survey Project which required additional time to transport survey forms and findings to a different geographic location for review. This project has ended and should resolve this issue. Six instances were due to delays caused by reduction of mail pick up. Two were related to surveys which required extra review due to complexity of deficiencies issued or additional information submitted by the facility.

H. Other Survey Statistics Relevant to Improving the Survey Process.

As mentioned in Section 1 A. of this report, MDH has been analyzing deficiency data to understand where there is variability in deficiency citations. Using the survey deficiency data from 2001-2004, MDH researchers examined over 64,000 surveys from across the country. This included citation patterns within states in CMS Region V, across Minnesota survey districts, and all CMS regions.

Researchers concluded that 64 of the 195 tags account for over half of the variation in all deficiencies cited nationwide. Through factor analysis[12], they analyzed the 64 tags and determined that they fell into 8 broad standards of quality compliance categories (See Appendix I for a table of tag groupings). Those categories are:

- Quality of Life/Resident Rights Deficiencies Score
- Quality of Care Deficiencies Score
- Resident Assessment Deficiencies Score
- Environment Safe, Sanitary, Prevents Spread of Disease Deficiencies Score
- Facility Administration Re: Quality of Care & Resident Rights Deficiencies Score;
- Quality of Diet Deficiencies Score
- Quality of Drug Management and Administration Deficiencies Score
- Quality of Clinical/Laboratory/Pharmaceutical Services Deficiencies Score

Research on Deficiency Variability and Quality Indicator Scores

MDH intends to continue the examination of citation variance and patterns. Researchers are evaluating the possibility of acquiring facility, resident, and surveyor characteristics to determine if variability in the survey process can be statistically attributed to citation rate variation. MDH and DHS staff are currently exploring the possibility of correlating Minimum Data Set (MDS)

[12] Factor analysis is a technique used to group data sets into categories or underlying factors based on statistical relationships and patterns of occurrence.

risk adjusted quality indicators with the survey results. This may allow for the expansion of bringing additional facility and resident characteristics into the exploration of survey variability. MDH plans to work on this data comparison through 2007.

Continued Analysis of Deficiency Data

In the coming year, MDH will continue to evaluate the possibility of collecting, analyzing, and examining a broader range of data sets to help determine the effect resident, facility, and survey administration factors have on deficiency variance. The extent to which MDH can pursue this effort may be largely dependent on CMS support for data at the national level for statistical model development. It is believed that state level data, using Minnesota's 400 annual survey observations, may not allow for the construction of a statistically reliable model. Some possibilities may include:

- Analyzing more recent deficiency data
- Obtaining Quality Indicator data from DHS from different time periods and correlate that data with deficiency data
- Gathering data on facility characteristics (e.g. facility size, change of administration)
- Obtaining data on length of stay
- Discussing the possibility of pursuing a CMS grant for study
- Making comparisons by Region

MDH realizes that studying this issue further will not eliminate the variation in its entirety, but believes this research is important to pursue in order to identify areas for quality improvement and training.

II. Progress Reports on Other Legislatively Directed Activities

The Laws of Minnesota 2004, Chapter 247, section 5 required the Commissioner to include in the December 15, 2004 Report to the Legislature a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;
(2) the nursing home providers work group established under Laws 2003, First Special Session, Chapter 14, article 13c, section 3; and,
(3) progress in implementing the independent informal dispute resolution process.

As noted in the December 15, 2005 Report to the Legislature, these activities required significant involvement of stakeholder participation, and at the time of that report, the first activity listed above (analysis of the frequency of and plan to minimize defensive documentation) was not complete, but and interim report was made. The current status of that activity will be discussed below. The nursing home providers work group and the progress in implementing the

independent informal dispute resolution process (IIDR) were discussed in the December 15, 2005, Report to the Legislature(See Appendix E for a link to the report). Status of the IIDR process is also discussed in Section I, C. of this report.

Analysis of the Frequency of and Plan to Minimize Defensive Documentation

As discussed in the December 15, 2005, Report to the Legislature, MDH deferred action on the issue of "defensive documentation" pending a report from the Minnesota Health and Housing Alliance Clinical Advisory Council. That group completed its recommendations and provided MDH with a summary report in January of 2006. One of the recommendations was for MDH to convene a work group with representation from MHHA, Care Providers, MDH survey staff and case mix staff to identify appropriate standards for documentation that would meet the requirements for both case mix and survey. This request was discussed with management and it was decided that due to limited resources, the provider association should develop appropriate standards and have MDH review the standards and provide comment. This plan of action was communicated to MHHA and they believed the approach to be reasonable.

MDH trainers provide training and ongoing support to facilities in their completion of MDS assessments and Resident Assessment Protocols (RAPs). MDH supports efforts to minimize situations where facilities are under a burden of providing the same information in different formats for different purposes.

MDH continues to meet with the e-Health Advisory Council, which includes representatives from the long term care industry, to discuss and implement best practices concerning the adoption of electronic health records.[13]

III. Summary of Improvements Made to Date on the Nursing Home Survey Process: Areas of Special Focus for 2006

The 2005 Report to the Legislature listed the following five areas of special focus for 2006.

A. Allocation of Survey Hours to Achieve Maximum Resident Benefit
B. Rochester/Mankato Survey Pilot
C. Statewide and Regional Efforts to Improve Communications
D. Collaborating on Provider Quality Improvement Initiatives
E. Continuing Efforts to Improve Consistency Across Survey Teams

The latter three special focus areas (C, D and E above) are continuing initiatives from the 2005 Quality Improvement Plan for the Nursing Home Survey Process. Progress on those three areas was discussed in the 2005 Legislative Report. (See Appendix E. for a link to this report). More recent progress on those three areas, as well as the other two special focus areas (A and B above), is described below.

[13] See Appendix E for links to the Minnesota e-Health Initiative and Advisory committee.

A. Allocation of Survey Hours to Achieve Maximum Resident Benefit

In the 2005 Legislative Report, MDH proposed to assess the options for the reallocation of some onsite revisit survey hours. This would allow for more frequent or extended recertification surveys, or special monitoring surveys in facilities that have demonstrated difficulty in achieving compliance with federal certification requirements and/or state licensing standards.

At the time of that report, MDH performed an onsite revisit for deficiency scope and severity levels D and E in situations where surveyor observation is used to determine if the practice has been corrected. Inasmuch as most D and E level deficiencies fall into this category, onsite revisits were conducted in most facilities each year, consuming a total of approximately 7127 survey hours.[14] A facility's history of regulatory compliance had not been a factor in determining whether an onsite revisit was warranted.

Because MDH survey hours are a finite resource, allocation decisions need to take into consideration the most effective way to achieve statewide regulatory compliance. MDH drafted a process to accomplish survey revisit tasks offsite, and determine compliance by reviewing the plan of care, requesting additional information, discussing via telephone, etc. without physically being onsite, except for certain situations. MDH reviewed this process with the Long Term Care Issues Committee at their April 2006 meeting, and the committee concurred with the proposed process. MDH also sought approval from CMS, and CMS affirmed that the State Survey Agency had the authority to adjust survey hours.

Initially the plan was to reallocate a portion of the onsite revisit survey hours to other survey activities, but pending budget restrictions for FFY 07 required MDH to further evaluate the PCR process and look at ways to expand compliance verification within a constrained budget. MDH developed the revised Post Certification Revisit Process, which is included in Appendix J. The revised process is effective for all nursing home surveys exited after November 3, 2006. It is consistent with the current federal policy, and is enhanced by the inclusion of random revisits. Those circumstances where an onsite revisit would be necessary <u>may include, but is not limited to</u> the following:

A. when a facility has a deficiency finding of G and above on current survey;

B. when a facility has a deficiency finding of Substandard Quality of Care on current survey;

C. when a facility has been selected by CMS as a Special Focus Facility; or,

D. when a facility's prior survey or complaint investigation resulted in a deficiency finding of Substandard Quality of Care or immediate jeopardy.

[14] This number represents revisits conducted during FFY 2005 to verify implementation of PoCs where the highest scope and severity deficiency being corrected was at level D or E. These revisits required 4.5 FTEs of surveyor time, and comprised 55.6% of the total survey hours devoted to revisits (12,812.5 hours). This time includes preparation, onsite, travel and documentation time.

In addition to the above criteria, and as indicated previously, some random revisits will be conducted. This is to assure that there is no absolute certainty and the facility would not know if they were back in compliance until they received the paperwork from the federal government.

MDH reviewed this revised process with the Long Term Care Issues Committee, at their October meeting, and agreed to monitor and evaluate the new process over the next year. In evaluating the revised process, MDH will look at results of random revisits to see if providers are in compliance, check to see if there is an increase in complaints or other activities concerning facility compliance, and monitor staff resources. MDH will also review results of subsequent recertification or complaint investigation and determine ongoing compliance.

B. Rochester/Mankato Survey Pilot

In October, 2005 MDH initiated a pilot project in the Rochester and Mankato survey districts. The pilot project consisted of having one "field" supervisor provide onsite coaching and mentoring supervisory support to both teams, and a second supervisor provide document review and processing oversight to both teams. The two supervisors provide backup for each other for phone communication with surveyors and providers. The goal of the project was to improve and maintain accuracy, consistency and integrity of the survey process, to ensure accurate, consistent, and timely completion and delivery of documentation, and to develop and maintain positive provider relationships. MDH agreed to evaluate the effectiveness of the pilot project and continue the model if it was determined to be successful.

An evaluation of the project showed some improvements in consistency issues, but it posed new logistical challenges for the districts. The increased communication necessary for the two supervisors to keep "on the same page," as well as increased travel and moving paper around to complete packages, resulted in inefficiencies, and delays in meeting deadlines in package completion. Some of these delays are reflected in Section I. G. of this report. Clerical/administrative support in the Rochester and Mankato area took on additional responsibilities and assisted supervisors with package processing and tracking to prevent further delays. Because of these challenges, in October of 2006 MDH made a decision to go back to the customary way of providing supervisory support by having one supervisor in each district responsible for all supervisory functions.

C. Statewide and Regional Efforts to Improve Communications

During FFY 2006, MDH continued work that was initiated in 2003 to improve communications and understanding of the survey process.

<u>Participation in Regional and Statewide Meetings and Training Sessions</u>

Since 2003 MDH has been meeting regularly with the Long Term Care Issues Committee, provider associations (Care Providers of Minnesota and the Minnesota Health and Housing Alliance), Minnesota Directors of Nursing Association (MN-DONA), Stratis Health, staff from the Office of the Ombudsman for Older Minnesotans, ElderCare Rights Alliance, AARP, and Minnesota Medical Directors Association (MMDA). MDH participated in monthly or quarterly

meetings, regional meetings, and annual meetings of some of these groups, to identify opportunities for improvement and create and implement action plans to improve the nursing home survey process.

Development of a Communications Video

The statewide Communications for Survey Improvement or "CSI-MN" Subcommittee of the Long Term Care Issues Ad Hoc Committee met April 27, 2005, and agreed to create a video about two-way communication during the survey process. The goal of the video was to demystify the survey process and help all parties (surveyors, facility staff, residents, families, and advocates) understand their role in the survey process and expectations for respectful, two-way communication throughout the survey.

A small group of CSI-MN members met regularly to develop the script and assist with other details of the video production. St. Therese Home, Inc. in New Hope, Minnesota volunteered to be the host facility. The project was co-sponsored by MDH, DHS, Office of Ombudsman for Older Minnesotans, and CMS Region V, with civil money penalty funds.

The video, titled "Making the Communication Connection: The Nursing Home Survey Process," was completed in November of 2006. Copies of the video were distributed to all licensed nursing homes and boarding care homes in the state, as well as to provider associations, advocacy organizations, training programs for nursing home administrators and nurses, other state survey agencies, and interested parties.

Regional Stakeholders Group Pilot

Communications for Survey Improvement –Duluth (CSI-Duluth), the regional stakeholders group that was formed in January 2005 in the northeast district of the state, continues to meet on a monthly basis. The current focus of the group is education and improved communications for everyone involved in the survey process in that district.

In May of 2006, CSI-Duluth conducted two training sessions for regional providers on writing comprehensive assessments and staying in compliance with this requirement. The training was targeted to interdisciplinary teams responsible for completing comprehensive assessments and any individuals assisting with data collection. Approximately 500 providers attended these trainings. The feedback CSI-Duluth received on this training was very positive and providers expressed a wish to continue regional trainings of this nature. CSI-Duluth posted their PowerPoint presentation titled "Comprehensive Assessments: The Key to Unlocking the Mystery of Assessments", as well as a "Complete Assessment" Regional Training Resource Guide on their website at http://www.health.state.mn.us/ltc/csiduluth/index.html. The committee continues to evaluate the impact of the regional trainings, for use in planning future trainings. They are also exploring the option of having their own regional website, independent of MDH, to be used by providers and the survey team to improve communication and share best practices.

In 2006 CSI-Duluth assessed their success and discussed whether or not to continue to meet. Members agreed that it had improved communications and relationships between providers and surveyors in their region. With specific plans to develop training for their region, they decided to continue to meet, and recommitted to monthly meetings. The group continues to have representatives from the survey team, family members, the Office of the Ombudsman for Older Minnesotans, and homes from both large provider associations are represented by administrators, directors of nursing, and nursing assistants.

Maintaining CSI-Duluth has required considerable investment of resources from both MDH and the stakeholders in the region. Although this type of group might benefit another region of the state, the CSI-Duluth members have advised the Commissioner and the Long Term Care Issues Committee to identify groups which already meet in other regions, and "piggy-back" on those meetings, rather than creating another new group. Examples of such current regional groups are the districts of the provider associations and the directors of nursing.

Internal Communication Improvement Initiatives

Internally, MDH continues to conduct statewide quarterly surveyor videoconferences, written clarifications related to regulations and annual surveyor face to face meetings. As discussed in Section 1, F. MDH developed a Quality Survey Task Guide to provide guidance and clarification for surveyors on the seven survey tasks. MDH also developed a Quick Tag Reference Guide that assists survey teams with conducting their decision making process in a consistent manner. In the fall of 2006 MDH conducted training for surveyors on investigative techniques and teamwork. These tools and trainings have continued to be effective in enhancing communication and administering a statewide program consistently. MDH continues to seek input from surveyors and managers on topics for additional trainings.

Nursing Home Report Card

MDH worked with DHS to create a Nursing Home Report Card that gives consumers the opportunity to obtain quality information on each nursing home in the state of Minnesota. The report card was unveiled to the public on January 20, 2006. A fact sheet which provides information about the Report Card is available on the Internet at http://www.health.state.mn.us/nhreportcard/nhreportcardfactsheet.pdf. Besides the fact sheet, the Report Card also includes a 12-page technical user guide and a section at the end for providing feedback

Approximately 300 queries a week are made to the Report Card website. The factors most often queried are quality of life, state inspection results, and Minnesota quality indicators. MDH is working with DHS to revise the calculation of "grades" for the indicator that reflects our work – namely, the state inspection results. It is important that there is distinction between the various grades and that a facility which has had survey results showing actual harm or immediate jeopardy, for example, is not at the same rating as another which does not have those results. MDH will continue to work with DHS to ensure that the Report Card site provides accurate, easy-to-use information about nursing homes.

D. Collaborating on Provider Quality Improvement Initiatives

Collaborative Joint Training

MDH continues to work with Stratis Health, provider associations and quality organizations, MN-DONA, MMDA, staff from the Office of the Ombudsman for Older Minnesotans, and ElderCare Rights Alliance and others to plan, implement, and evaluate collaborative training for surveyors and facility staff, as well as residents, families, and advocates, on new survey protocols, clinical guidelines, and interpretive guidelines issued by CMS.

Joint training has been implemented for pressure ulcers, urinary incontinence, medical director, and activities/activity director. Clinical tool kits have been developed and issued to providers for quality assessment and assurance and psychosocial severity guidelines. The joint training planning group is currently planning the next topic on unnecessary medications. Appendix K includes a chart that summarizes MDH's training initiatives on the revised guidelines.

Future revised guidelines that CMS plans to issue include accident and supervision, safe food handling, nutritional parameters, end of life issues and pain management, abuse, paid feeding assistants (new tag), and infection control. As new protocols are issued by CMS, training and guidance will be developed and protocols will be implemented.

Life Safety Code Training

The Department continues to provide training to health care facilities on life safety code regulations, in hopes of reducing the number of LSC deficiencies. In June of 2006, MDH provided training on the most common Life Safety Code deficiencies as well as issues specific to emergency electrical systems. Training was directed to building management directors and facility administrators. Sessions were held in three different locations throughout the state. Approximately 180 participants attended the trainings. Evaluations were positive, and providers believed the trainings were very helpful. Additionally, MDH provided the same training at the MHHA and Care Providers annual meetings. In the coming year the Department plans to provide training on sprinkler system and generator installation and maintenance.

Evaluation of Joint Training Activities

MDH continues to work with Stratis Health and researchers to develop measures and analysis to evaluate the effectiveness of joint training efforts. MDH has been monitoring deficiencies related to the pressure ulcer and urinary incontinence and catheter care tags and has shared this data with the providers associations, Stratis Health, the LTC Issues stakeholder group, and MDONA. Besides reviewing deficiency data, MDH is also working with stakeholders to evaluate the effectiveness of the training methods (e.g. face to face, video-conference) used to train surveyors and providers. This information will help to determine what techniques should be used for future trainings.

Experience in the state since implementation of the joint training indicates, that while providers, advocates and surveyors gave positive response to the clinical information and overall positive

responses to the training and methods following completion of the pressure ulcer and urinary incontinence training, the issuance of deficiencies went up for the revised F314 and F315 in all regions of the state (See graph in Appendix L). Issuance of associated tags also went up. At the same time, publicly reported quality measures and quality indicators developed and reported by CMS and by Minnesota DHS indicate that in comparison to other states, Minnesota nursing homes on average meet or exceed national goals in measures relating to pressure ulcers prevention and urinary incontinence. However individual facilities vary in their performance on quality measures/quality indicators.

Feedback from surveyors/survey teams and management team indicates that in the year following training on the revised pressure ulcer and urinary incontinence surveyor guidance, many facilities had not yet implemented the revised surveyor guidance.

Comments in the planning group cautioned that "providers cannot implement this many changes this quickly." In response to feedback from states, CMS agreed to slow down the release of revisions, and issue advance copies prior to implementation date. To assist providers further, MDH has delayed implementation of revised guidelines beyond CMS target dates. However, in 2006, three topics were grouped with a CMS effective date of June 1, 2006 and there are several other guidelines that are scheduled to be issued in the near future. Despite these plans, MDH remains committed to conducting joint training on revised guidelines before implementing and surveying on the revised guidelines.

MDH believes that overall, more time is needed to assess the impact of the collaborative joint training on pressure ulcers and urinary incontinence and catheter care. Data from the facilities second survey following the training should be more useful, because by that time providers will have had the chance to implement the training and researchers will be able to make comparisons between results on the current survey and last survey.

Meanwhile, providers continue to express concern about the number of deficiencies written for pressure ulcers and urinary incontinence. The issue appears to be, not that Minnesota is citing F 314 and F 315 tags more than other states, but rather, that MDH is citing both an outcome (prevalence) and assessment (prevention) tag. MDH has had discussions with CMS Regional Office on this issue and CMS has informed MDH that Minnesota is citing correctly. Despite this information, the provider associations continue to disagree with MDH on this matter and have recently written CMS Central Office asking for clarification on the regulations.

The Department has invested significant resources into the joint training program, as well as to communication with the provider community through meeting with the LTC Issues stakeholders group, professional and provider associations, and discussing survey issues with facilities by telephone. In the coming year, MDH will be conducting quarterly phone conferences with providers to address implementation of new guidelines regarding activities/activities director, quality assessment and assurance, and psychosocial outcome severity. These phone conferences will provide a forum for Q&A, updates, and clarifications. This is anticipated to be a valuable and effective way to reinforce learning, work out issues, and promote dialogue between MDH and providers. Participation levels and feedback from these sessions will be valuable in planning future sessions and in determining whether the provider and advocates needs are being met.

MDH will also continue their work with the collaborative training group of stakeholders to evaluate the success and make improvements to future joint training programs.

Government Performance and Results Act (GPRA) Goals

CMS is examining the relationship between nursing home quality measures[15] and deficiencies issued by State Survey Agencies. In an initiative under the Government Performance and Results Act of 1993 (GPRA),[16] CMS is looking at the relationship between deficiencies on survey and quality measure data in the areas of prevalence of physical restraints and prevalence of pressure ulcers in nursing homes.

CMS goals (national target FFY 2006) for nursing facilities include achieving a nationwide pressure ulcers rate of 8.8% and physical restraints rate of 6.4%. As of June 30, 2006, CMS data indicates that Minnesota's statewide pressure ulcer rate was 6.1% and its statewide physical restraint rate was 3.5%.

Meeting or exceeding the national GPRA goals related to pressure ulcers and physical restraint reduction for all facilities in Minnesota is a goal in MDH Licensing and Certification Programs 2007 Annual Quality Improvement Plan (Appendix F). MDH will not only work to improve the accuracy of MDS data through training, but will also work with stakeholders to develop a plan for following up with those facilities in Minnesota who are higher than the national average.

Culture Change Initiative

MDH continues to participate in the Culture Change Coalition with Stratis Health and stakeholders. The focus of the group is to identify ways that nursing homes can enhance quality of care and quality of life for residents by focusing attention at all levels on resident-centered care.

MDH Licensing and Certification management, supervisors and surveyors participated in the Culture Change Seminar that was held on October 10, 2006. The event was designed for surveyors, state agency and long term care organization staff. Topics discussed included how culture change can improve the quality of life for long term care residents, how federal and state regulations support culture change in skilled nursing facilities, and how providers and surveyors are working together to explore the culture change journey. A similar session is planned for legislators, consumers and other stakeholders in March of 2007. Prior to this seminar, surveyors and L&C supervisors and managers participated in four web cast training sessions required by CMS. CMS continues to provide ongoing training on this model.

Promoting nursing home culture change and regulatory compliance is a goal in MDH Licensing and Certification Program's 2007 Quality Improvement Plan. MDH will continue to seek opportunities to integrate resident-centered focus in the joint training activities, and to communicate with providers, advocates, residents and families about strategies to ensure that adoption of resident-centered practices in nursing homes also meet regulatory requirements.

[15] See Appendix C for a link to information on CMS quality initiatives and description of CMS quality measures.
[16] GPRA requires CMS and other federal programs to identify annual quality improvement goals.

Govdocs Subscription

In August of 2006, Govdocs Subscription was implemented for providers/public to receive monthly updates on News and Announcements posted on the MDH Health Facilities web pages. Monthly announcements direct viewer's attention to items of interest including training events, Clinical Web Window information relating to clinical care. Subscriptions are already in place for Information Bulletins and Nursing Home Survey Results; subscribers can keep those subscriptions if they want immediate notification for those two web pages. There are approximately 1400 subscribers which includes a mix of provider types and interested parties.

E. Continuing Efforts to Improve Consistency Across Survey Teams

As discussed previously, MDH has undertaken a number of activities to understand the variations in deficiency citations between districts within the state, and to improve the accuracy and consistency of the survey process. The degree to which these activities have had an impact on reducing variation among the ten district survey teams is discussed in section I., A. of this report.

Regular Review and Analysis of Data

MDH continues to use data strategically to prioritize focus areas for quality improvement. Since 2005, MDH has been conducting regular monthly reviews of survey data as a tool to understand deficiency patterns and improve integrity of the survey process. In addition to the monthly reports of overall deficiencies by district discussed above, on a semi-annual basis MDH reviews all deficiencies issued by F-Tag by each survey team. This information has been used by the L&C Management team to identify, analyze and provide guidance that is shared with surveyors statewide. The information is also used to identify training needs of surveyors.

MDH has also been working with researchers to understand factors that may contribute to the variation in deficiencies between survey districts in the state, including provider/facility characteristics, surveyor/survey team characteristics and resident characteristics. Factors in each of these three domains influence the rate of deficiencies. Some of the relationships have been researched but more work needs to be done (See Section I., H of this report).

Nursing Home Surveyor Training Resources

As discussed in the December 15, 2005 Legislative Report, in December, 2004, MDH identified twenty-two tags out of a possible total 371 tags that had greatest variation between districts. Ten of the twenty-two were prioritized by CMS for survey guidance. Therefore MDH chose not to focus on these at this time. Of the remaining twelve, MDH prioritized four resident outcome tag areas that were issued more frequently. These related to activities of daily living, range of motion, and dignity. The L&C management team developed training tools for these four tags to assist surveyors in implementing the survey process in a consistent manner. These training tools were shared statewide and field tested by survey teams. To date, three of the four training tools have been finalized and communicated to surveyors statewide. Those tools are Dignity (F-241), Activities of Daily Living (F-311), and Residents Unable to Carry Out Activities of Daily Living

(F 312). These training tools have also been posted on the Clinical Web Window. The training tool for Range of Motion With/Without Restorative Program (F 318) will be posted on the Clinical Web Window once it is finalized.

CMS Quality Indicator Survey Pilot Project

In September of 2005, CMS initiated a Quality Indicator Survey (QIS) Pilot Project in five states. The pilot project attempts to standardize deficiency citation patterns and increase efficiencies by relying on MDS data and surveyor observations and the recording directly into a laptop which generates potential deficiencies. MDH has been very interested in this project, and believes the design is consistent with Minnesota's quality improvement goals. In June of 2006, Commissioner Mandernach sent a letter to CMS requesting that Minnesota be given priority consideration for future participation in this pilot project. CMS responded by explaining that they did not know if they would continue to add additional states to the pilot project or roll it out to all states at once.

CMS recently sent a solicitation notice to all state survey agencies explaining that they plan to implement the QIS process in an estimated 8 to 10 additional selected states. The capacity of a state to implement QIS fully in the state will depend on several factors including the resources to purchase equipment, the number of nursing home surveyors in the state, and the number of staff that a state can devote to learning the QIS process while meeting their survey workload within statutory requirements. MDH has applied to participate in the CMS Quality Improvement Survey (QIS) Pilot Project.

IV. Areas of Special Focus for 2007

The following areas will be given special attention during FFY 2007:

A. Monitor and Evaluate the Revised Post Certification Revisit Process

In November of 2006 MDH revised their Post Certification Revisit Policy and expanded its method of compliance verification. The revised process was discussed in Section III., A. of this report and is included in Appendix J. MDH will evaluate this new process and examine the efficiency and effectiveness of verifying compliance when not conducting an onsite revisit. In evaluating the revised process, MDH will look at results of random visits to see if providers are in compliance, determine if there is an increase in complaints or other activities concerning facility compliance, and monitor staff resources. MDH will also review results of subsequent recertification or complaint investigation and determine ongoing compliance. The outcome of this evaluation will be shared with the LTC Issues Committee and discussed in the 2007 Report to the Legislature.

B. Culture Change

MDH supports resident-centered care and will continue to work collaboratively with stakeholders towards the shared vision of a long term care system that ensures quality of care and quality of life for every resident.

MDH will seek opportunities to integrate resident-centered focus in joint training activities, and to communicate with providers, advocates, residents and families about strategies to ensure that adoption of resident-centered practices in nursing homes also meet regulatory requirements.

C. Continue Efforts to Improve Consistency

MDH will continue to evaluate survey and survey team performance across the state. Deficiency data and information from survey teams following surveys will be analyzed and used by L&C Management to identify variations in the application of the survey process and to provide training and guidance to surveyors.

Minnesota has also applied to participate in the CMS' Quality Indicator Survey Pilot Project. As mentioned previously, the pilot project attempts to standardize citation patterns and increase efficiencies by relying on MDS data and surveyor observations and recording directly into a laptop which generates potential deficiencies. The pilot project is consistent with Minnesota's quality improvement goals and the Minnesota has been developing the infrastructure for this project and is ready to be part of the study.

Besides looking at surveyor characteristics, MDH will also look at resident (MDS data) and facility characteristics that may be contributing to the variation in deficiency citations across teams.

Additionally, MDH will continue activities initiated in FFY 2005 focused on recruitment and retention of qualified survey staff and particularly as it relates to training and maintaining a quality supervisory team.

V. Appendices

APPENDIX A.	Minnesota Session Laws 2004 – Chapter 247
APPENDIX B.	Assessment Factors used to Determine the Seriousness of Deficiencies Matrix
APPENDIX C.	How to Access CMS Regulations, Manuals, Updates, and Quality Initiative Information
APPENDIX D.	Average Deficiencies per Health Survey, National Data
APPENDIX E.	How to Access MDH Facilities Compliance Monitoring Information
APPENDIX F.	2007 Quality Improvement Plan for Survey Agency
APPENDIX G.	Average Deficiencies per Life Safety Code Survey, National Data
APPENDIX H.	Cross Referencing National Data (6-13-06) CMS [unofficial] "Report on Multiple Citation Review Region V"
APPENDIX I.	Table A-3 - Summary of Exploratory Factor Analysis 2001-2004 Nursing Home Survey Deficiency Data: Nationwide Database
APPENDIX J.	Nursing Home Post Certification Revisit Process
APPENDIX K.	Chart on MDH Collaborative Joint Training Activities on CMS Revised Guidelines
APPENDIX L.	F 314 and 315 Citation Rates Pre and Post Implementation (11-20-06)

APPENDIX A

Minnesota Session Laws 2004 - Chapter 247

Key: (1)~~Language to be deleted~~ (2)New language

Legislative history and Authors

CHAPTER 247-H.F.No. 2246

An act relating to health; modifying the nursing facility survey process; establishing a quality improvement program; requiring annual quality improvement reports; requiring the commissioner of health to seek federal waivers and approvals; amending Minnesota Statutes 2002, sections 144A.10, subdivision 1a, by adding a subdivision; 256.01, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 144A.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2002, section 144A.10, subdivision 1a, is amended to read:

Subd. 1a. [TRAINING AND EDUCATION FOR NURSING FACILITY PROVIDERS.] The commissioner of health must establish and implement a prescribed process and program for providing training and education to providers licensed by the Department of Health, ~~either by itself or~~ in conjunction with the industry trade associations, before using any new regulatory guideline, regulation, interpretation, program letter or memorandum, or any other materials used in surveyor training to survey licensed providers. The process should include, but is not limited to, the following key components:

(1) facilitate the implementation of immediate revisions to any course curriculum for nursing assistants which reflect any new standard of care practice that has been adopted or referenced by the Health Department concerning the issue in question;

(2) conduct training of long-term care providers and health department survey inspectors ~~either~~ jointly ~~or during the same time frame~~ on the department's new expectations; and

(3) ~~within available resources~~ the commissioner shall ~~cooperate in the development of clinical standards, work with vendors of supplies and services regarding hazards, and identify research of interest to the long-term care community~~ consult with experts in the field to develop or make available training resources on current standards of practice and the use of technology.

Sec. 2. Minnesota Statutes 2002, section 144A.10, is amended by adding a subdivision to read:

Subd. 17. [AGENCY QUALITY IMPROVEMENT PROGRAM; ANNUAL REPORT ON SURVEY PROCESS.] (a) The commissioner shall establish a quality improvement program for the nursing facility survey and complaint processes. The commissioner must regularly consult with consumers, consumer advocates, and representatives of the nursing home industry and representatives of nursing home employees in implementing the program. The commissioner, through the quality improvement program, shall submit to the

legislature an annual survey and certification quality improvement report, beginning December 15, 2004, and each December 15 thereafter.

(b) The report must include, but is not limited to, an analysis of:

(1) the number, scope, and severity of citations by region within the state;

(2) cross-referencing of citations by region within the state and between states within the Centers for Medicare and Medicaid Services region in which Minnesota is located;

(3) the number and outcomes of independent dispute resolutions;

(4) the number and outcomes of appeals;

(5) compliance with timelines for survey revisits and complaint investigations;

(6) techniques of surveyors in investigations, communication, and documentation to identify and support citations;

(7) compliance with timelines for providing facilities with completed statements of deficiencies; and

(8) other survey statistics relevant to improving the survey process.

(c) The report must also identify and explain inconsistencies and patterns across regions of the state, include analyses and recommendations for quality improvement areas identified by the commissioner, consumers, consumer advocates, and representatives of the nursing home industry and nursing home employees, and provide action plans to address problems that are identified.

Sec. 3. [144A.101] [PROCEDURES FOR FEDERALLY REQUIRED SURVEY PROCESS.]

Subdivision 1. [APPLICABILITY.] This section applies to survey certification and enforcement activities by the commissioner related to regular, expanded, or extended surveys under Code of Federal Regulations, title 42, part 488.

Subd. 2. [STATEMENT OF DEFICIENCIES.] The commissioner shall provide nursing facilities with draft statements of deficiencies at the time of the survey exit process and shall provide facilities with completed statements of deficiencies within 15 working days of the exit process.

Subd. 3. [SURVEYOR NOTES.] The commissioner, upon the request of a nursing facility, shall provide the facility with copies of formal surveyor notes taken during the survey, with the exception of interview forms, at the time of the exit conference or at the time the completed statement of deficiency is provided to the facility. The survey notes shall be redacted to protect the confidentiality of individuals providing information to the surveyors. A facility requesting formal surveyor notes must agree to pay the commissioner for the cost of copying and redacting.

Subd. 4. [POSTING OF STATEMENTS OF DEFICIENCIES.] The commissioner, when posting statements of a nursing facility's deficiencies on the agency Web site, must include in the posting the facility's response to the citations. The Web site must also include the dates upon which deficiencies are corrected and the date upon which a facility is considered to be in compliance with survey requirements. If deficiencies are under dispute,

the commissioner must note this on the Web site using a method that clearly identifies for consumers which citations are under dispute.

Subd. 5. [SURVEY REVISITS.] The commissioner shall conduct survey revisits within 15 calendar days of the date by which corrections will be completed, as specified by the provider in its plan of correction, in cases where category 2 or category 3 remedies are in place. The commissioner may conduct survey revisits by telephone or written communications for facilities at which the highest scope and severity score for a violation was level E or lower.

Subd. 6. [FAMILY COUNCILS.] Nursing facility family councils shall be interviewed as part of the survey process and invited to participate in the exit conference.

Sec. 4. Minnesota Statutes 2002, section 256.01, is amended by adding a subdivision to read:

Subd. 21. [INTERAGENCY AGREEMENT WITH DEPARTMENT OF HEALTH.] The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

Sec. 5. [PROGRESS REPORT.]

The commissioner of health shall include in the December 15, 2004, quality improvement report required under section 2 a progress report and implementation plan for the following legislatively directed activities:

(1) an analysis of the frequency of defensive documentation and a plan, developed in consultation with the nursing home industry, consumers, unions representing nursing home employees, and advocates, to minimize defensive documentation;

(2) the nursing home providers workgroup established under Laws 2003, First Special Session chapter 14, article 13c, section 3; and

(3) progress in implementing the independent informal dispute resolution process required under Minnesota Statutes, section 144A.10, subdivision 16.

Sec. 6. [RESUBMITTAL OF REQUESTS FOR FEDERAL WAIVERS AND APPROVALS.]

(a) The commissioner of health shall seek federal waivers, approvals, and law changes necessary to implement the alternative nursing home survey process established under Minnesota Statutes, section 144A.37.

(b) The commissioner of health shall seek changes in the federal policy that mandates the imposition of federal sanctions without providing an opportunity for a nursing facility to correct deficiencies, solely as the result of previous deficiencies issued to the nursing facility.

Presented to the governor May 18, 2004

Signed by the governor May 26, 2004, 9:00 p.m.

APPENDIX B

ASSESSMENT FACTORS USED TO DETERMINE THE SERIOUSNESS OF DEFICIENCIES MATRIX

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

Source: State Operations Manual, Chapter 7 - Enforcement and Survey Process for Skilled Nursing Facilities and Nursing Facilities, (Rev. 1, 05-21-04)
http://www.cms.hhs.gov/manuals/downloads/som107c07.pdf

APPENDIX C

How to Access CMS Regulations, Manuals, Updates, and Quality Initiative Information

Federal regulations are available at the CMS Laws and Related Regulations web page,
http://www.cms.hhs.gov/home/regsguidance.asp
This is a federal web page and MDH does not control its content.

The State Operations Manual, which contains survey protocols and interpretive guidelines for surveyors, is available from the CMS manuals web page,
http://www.cms.hhs.gov/manuals/
The same page contains a links to the Program Transmittals, which transmit updates to the manuals.

CMS Nursing Home Quality Initiative information is available from this CMS web page,
http://www.cms.hhs.gov/quality/nhqi/

Stratis Health, Quality Improvement Organization web site
http://www.stratishealth.org/

CMS Survey & Certification Online Training website
http://www.cms.internetstreaming.com/
CMS webcast training sessions are available on this website for one year from the date of original broadcast.

Links to the CMS web site are also provided from MDH's Facilities Compliance Monitoring web page. (See Appendix E). Nursing homes are encouraged to check both the MDH Facilities Compliance Monitoring web page and the CMS web site weekly for updated information.

APPENDIX D Average Health Deficiencies per Nursing Home Survey, by State OSCAR data system 10/01/06

State	Surveys	Average Number of Health Deficiencies
Puerto Rico (PR)	8	19.8
District of Columbia (DC)	20	13.7
Wyoming (WY)	39	11.8
California (CA)	1,281	10.8
Arkansas (AZ)	237	10.7
Idaho (ID)	80	10.6
Delaware (DE)	44	10.6
Nevada (NV)	47	10.1
Minnesota (MN)	398	9.7
Kansas (KS)	352	9.7
Colorado (CO)	210	8.9
Maryland (MD)	233	8.7
Connecticut (CT)	245	8.5
Oklahoma (OK)	338	8.5
South Carolina (SC)	176	8.4
Alaska (AK)	15	8.2
West Virginia (WV)	131	8.2
Florida (FL)	681	8.1
Maine (ME)	113	8.1
Guam (GU)	1	8.0
Arizona (AZ)	135	7.9
Michigan (MI)	425	7.8
Louisiana (LA)	295	7.8
Hawaii (HI)	46	7.4
Alabama (AL)	229	7.0
Georgia (GA)	359	7.0
New Mexico (NM)	73	6.9
Missouri (MO)	518	6.9
Vermont (VT)	41	6.8
Indiana (IN)	511	6.6
Texas (TX)	1,145	6.6
Montana (MT)	97	6.6
Washington (WA)	246	6.2
Tennessee (TN)	326	5.9
Virginia (VA)	279	5.7
New Hampshire (NH)	82	5.4
Pennsylvania (PA)	716	5.2
North Dakota (ND)	83	5.2
Kentucky (KY)	293	5.1
North Carolina (NC)	421	5.0
Utah (UT)	93	4.9
Massachusetts (MA)	455	4.9
South Dakota (SD)	111	4.8
Nebraska (NE)	225	4.7
Illinois (IL)	817	4.6
New York (NY)	658	4.5
Oregon (OR)	139	4.4
New Jersey (NJ)	362	4.4
Mississippi (MS)	203	4.2
Iowa (IA)	455	4.1
Ohio (OH)	1,097	4.1
Wisconsin (WI)	398	3.9
Rhode Island (RI)	87	3.7
Total	16,069	6.7

APPENDIX E How to Access MDH Facilities Compliance Monitoring Information

Annual Quality Improvement Report on the Nursing Home Survey Process
and Progress Reports on Other Legislatively Directed Activities, December 15, 2005 and 2004
http://www.health.state.mn.us/divs/fpc/legislativerpts.html

Long Term Care Issues Ad Hoc Committee home page
http://www.health.state.mn.us/ltc/

Survey Findings/Review Subcommittee Final Report, July 2004
http://www.health.state.mn.us/ltc/findings.html

Minnesota Health Care Facilities Home
http://www.health.state.mn.us/divs/fpc/fpc.html

Onsite Licensing and Certification Supervisor Quality Improvement Initiative,
Report to the LTC Ad Hoc Committee, January 20, 2005
http://www.health.state.mn.us/ltc/update1-05.pdf

Compliance Monitoring Division Resident and Provider Information
http://www.health.state.mn.us/divs/fpc/consinfo.html

Compliance Monitoring Division Bulletins, Reports, Manuals, Forms
Includes link to Information Bulletins
http://www.health.state.mn.us/divs/fpc/proinfo.html
Providers are encouraged to sign up for e-mail notification of MDH Information Bulletins and CMS Program Transmittals.

Compliance Monitoring Division Federal OBRA Survey Activity Report
http://www.health.stat.e.mn.us/divs/fpc/profinfo/progressreport.htm

Nursing and Boarding Care Home Inspections:
Information for Residents, Families and Visitors
http://www.health.state.mn.us/divs/fpc/nursingpamplet.htm

Nursing and Boarding Care Home Survey Inspection Findings
http://www.health.state.mn.us/divs/fpc/directory/surveyfindings.htm

Communications for Survey Improvement Minnesota (CSI-MN) Report, June 30, 2004
http://www.health.state.mn.us/ltc/communications.html

Communications for Survey Improvement Duluth (CSI-Duluth)
http://www.health.state.mn.us/ltc/csiduluth/index.html

MDH e-Health Initiative
http://www.health.state.mn.us/e-health/

APPENDIX F

2007 Quality Improvement Plan for Survey Agency - - Working Document

Mission of Minnesota Department of Health:
Keeping All Minnesotans Healthy

Vision of Licensing and Certification (L & C) Program:
Quality and Compassionate Care Every Time

Mission of Licensing and Certification Program:

To protect and improve the health, safety, comfort and well-being of individuals receiving services from federally certified and state licensed health care providers, and to monitor the quality of nursing assistant training programs.

This mission is accomplished through:

1. Issuance and renewal of licenses and certification/recertification activities for providers;
2. Surveying providers and enforcing compliance with federal and state statutes, regulations and guidelines;
3. Educating stakeholders via information sharing and training; and
4. Oversight of the nursing assistant registry and nursing assistant training programs.

Purpose of the Ongoing L & C Quality Improvement Plan:

To ensure that activities carried out by L&C staff are performed accurately and in accordance with established state and federal requirements to protect health, well-being, safety and comfort; to identify areas for improvement in performance and in systems; and to make those improvements.

The 2007 Quality Improvement Plan includes 4 goals:

1. Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.
2. All nursing facilities in Minnesota will meet or exceed the national Government Performance and Results Act* (GPRA) goals related to pressure ulcer and physical restraint reduction.
3. Improving and maintaining consistency and accuracy across survey teams.
4. Improving communication and promoting knowledge of the survey process.

**The Government Performance and Results Act (GPRA) of 1993, is to improve public confidence in the Federal Government by systematically holding Federal agencies accountable for achieving program results made public through annual performance goals, based on strategic goals and linked to budget. Two of CMS goals for nursing facilities include achieving nationwide Pressure Ulcers (PU): 8.8% and Physical Restraints: 6.4 %.*

Goal: Promote Nursing Home Culture Change and regulatory compliance, working jointly with stakeholders.

**Culture Change is an ongoing transformation in the physical, organizational, and psycho-social-spiritual environments that is based on person centered values. Culture Change restores control to elders and those who work closest to them.*

- Participate in the Minnesota Culture Change Coalition.
- Improve quality of life for long-term care residents by promoting awareness and understanding of culture change with stakeholders.
- Promote surveyors & providers understanding about how regulations support culture change in nursing facilities and visa versa.

Goal: All nursing facilities in Minnesota will meet or exceed the national GPRA goals related to pressure ulcer and physical restraint reduction.

- Improve accuracy of MDS data through training.
- Work with stakeholders to develop a work plan for follow-up with those facilities which exceed GPRA goals.

Goal: Improving and maintaining consistency and accuracy across survey teams.

Objective: Analyze variations and develop methods to reduce variation using a Plan, Do, Study, Act (PDSA) approach to quality improvement.

- Expand understanding about variances in survey data by conducting research that analyzes relationships between deficiencies issued, facility characteristics and MDS resident characteristics.
- Use PDSA approach for quality improvement to analyze variance(s) of greater than +/- 2 tags from the state median for tags issued per survey by team.
- Use PDSA approach for quality improvement to analyze variance(s) of greater than +/- 20% from the statewide average for tags issued by survey team.

Objective: Identify and correct known, suspected or potential problems with the survey process and identify opportunities for quality improvement.

- Identify opportunities for quality improvement by observing surveys in Wisconsin.
- Implement improvements in how to effectively investigate with decreasing & finite survey resources.
- Use mix/max survey teams, unit supervisors & managers, surveyor trainers & federal oversight surveys to capture observations and insights on survey process variances, and communicate information back to surveyors.
- Review all deficiencies prior to being finalized and issued.
- Develop surveyor-training tools, quality tag and survey task guides.

Objective: Attract and retain a professional survey workforce. Succession plan for staff as retirements take place.

- Maintain and implement a positive work environment that supports survey agency staff in their positions. Communicate together as a statewide team.
- Attract competent and knowledgeable individuals.
- Use available options to plan for succession of staff.
- Provide effective staff orientation using knowledgeable surveyor trainers.
- Solicit ideas from survey agency staff for quality improvement.

Objective: MDH will meet CMS Performance Standards.

Goal: Improving communication and promoting knowledge of the survey process.

Objective: Ensure ongoing flow of information between MDH staff, providers, and external stakeholders.

- Participate in Long Term Care Ad Hoc Committee with representatives from providers, advocates, families and the quality improvement organization. Solicit feedback from participants.
- Meet regularly with provider associations, MNDONA, Stratis Health, and resident advocates.
- Participate in Duluth joint stakeholder work group.
- Work jointly with stakeholders to plan regulatory related educational programs, and technical assistance around common clinical and regulatory change topics.

Objective: Simplify and streamline the process of soliciting feedback on surveys.

- Simplify the questionnaire format.
- Improve the online approach to soliciting survey feedback..

APPENDIX G Average LSC Deficiencies per Nursing Home Survey, by State, OSCAR data system 10/01/06

State	Surveys	Average Number of Life Safety Code Deficiencies
Kansas (KS)	352	10.8
Michigan (MI)	425	8.2
Montana (MT)	97	7.9
North Dakota (ND)	83	7.7
Colorado (CO)	210	7.7
Pennsylvania (PA)	716	7.2
Wyoming (WY)	39	6.6
Illinois (IL)	816	6.4
Minnesota (MN)	398	6.4
Nevada (NV)	47	6.0
California (CA)	1,281	5.8
Iowa (IA)	455	5.7
Puerto Rico (PR)	8	5.6
Texas (TX)	1,145	5.1
Utah (UT)	93	5.1
New Mexico (NM)	73	5.0
Alaska (AK)	15	4.7
Oregon (OR)	139	4.4
Arizona (AZ)	135	4.3
Alabama (AL)	229	4.1
South Dakota (SD)	111	3.9
Virginia (VA)	279	3.9
Delaware (DE)	44	3.8
Tennessee (TN)	326	3.7
Indiana (IN)	516	3.6
North Carolina (NC)	421	3.5
Ohio (OH)	1,097	3.3
Wisconsin (WI)	398	3.2
Oklahoma (OK)	338	3.1
Missouri (MO)	518	3.0
Georgia (GA)	359	2.9
West Virginia (WV)	131	2.9
Washington (WA)	246	2.7
Louisiana (LA)	295	2.7
Rhode Island (RI)	87	2.6
New York (NY)	658	2.5
Massachusetts (MA)	455	2.4
New Hampshire (NH)	82	2.0
Nebraska (NE)	225	1.8
Florida (FL)	681	1.8
Kentucky (KY)	293	1.7
Connecticut (CT)	245	1.5
South Carolina (SC)	176	1.5
Arkansas (AZ)	237	1.4
Vermont (VT)	41	1.4
Maine (ME)	113	1.4
District of Columbia (DC)	20	1.3
New Jersey (NJ)	362	1.2
Maryland (MD)	233	1.1
Mississippi (MS)	203	1.1
Guam (GU)	1	1.0
Idaho (ID)	80	1.0
Hawaii (HI)	46	0.5
Total	16,073	4.2

APPENDIX H

"Cross-referencing" how often when outcome tag (F0309, F0312, F0314, F0315, F0316) is cited is a process tag (F0280, F0282, F0272, F0276) also cited in states.

* Inspects retrieved from the Federal OSCAR Database on 6/13/06

State	Inspections Between 6/21/04 and 5/2/05	Tags From Each Group	Percentage	*Inspections After 5/2/05	Our Tags from Each Group	Our Percentage
Alabama (AL)	152	59	38.8%	152	45	29.6%
Alaska (AK)	12	2	16.7%	17	0	0.0%
Arizona (AZ)	96	5	5.2%	91	18	19.8%
Arkansas (AR)	225	52	23.1%	263	67	25.5%
California (CA)	1097	252	23.0%	1233	322	26.1%
Colorado (CO)	189	17	9.0%	216	16	7.4%
Connecticut (CT)	138	55	39.9%	283	119	42.0%
Delaware (DE)	38	13	34.2%	39	17	43.6%
District of Columbia (DC)	18	6	33.3%	18	12	66.7%
Florida (FL)	609	67	11.0%	677	113	16.7%
Georgia (GA)	316	74	23.4%	390	95	24.4%
Hawaii (HI)	25	4	16.0%	34	6	17.6%
Idaho (ID)	60	31	51.7%	79	36	45.6%
Illinois (IL)	707	70	9.9%	689	67	9.7%
Indiana (IN)	446	37	8.3%	443	48	10.8%
Iowa (IA)	358	36	10.1%	430	33	7.7%
Kansas (KS)	324	75	23.1%	330	145	43.9%
Kentucky (KY)	279	60	21.5%	297	46	15.5%
Louisiana (LA)	293	66	22.5%	200	51	25.5%
Maine (ME)	105	31	29.5%	104	40	38.5%
Maryland (MD)	189	20	10.6%	219	12	5.5%
Massachusetts (MA)	397	65	16.4%	482	85	17.6%
Michigan (MI)	370	18	4.9%	395	17	4.3%
Minnesota (MN)	358	74	20.7%	373	234	62.7%
Mississippi (MS)	168	17	10.1%	236	9	3.8%
Missouri (MO)	440	72	16.4%	497	89	17.9%
Montana (MT)	74	10	13.5%	82	11	13.4%
Nebraska (NE)	181	7	3.9%	192	17	8.9%
Nevada (NV)	43	15	34.9%	42	16	38.1%
New Hampshire (NH)	63	14	22.2%	84	22	26.2%
New Jersey (NJ)	309	20	6.5%	368	37	10.1%
New Mexico (NM)	63	10	15.9%	69	24	34.8%
New York (NY)	542	62	11.4%	655	73	11.1%
North Carolina (NC)	384	20	5.2%	442	45	10.2%
North Dakota (ND)	71	3	4.2%	82	6	7.3%
Ohio (OH)	826	55	6.7%	874	102	11.7%
Oklahoma (OK)	288	74	25.7%	373	85	22.8%
Oregon (OR)	122	29	23.8%	131	40	30.5%
Pennsylvania (PA)	650	62	9.5%	744	77	10.3%

Puerto Rico (PR)	7	4	57.1%		7	3	42.9%
Rhode Island (RI)	74	22	29.7%		98	15	15.3%
South Carolina (SC)	145	44	30.3%		176	66	37.5%
South Dakota (SD)	94	4	4.3%		109	5	4.6%
Tennessee (TN)	306	94	30.7%		338	128	37.9%
Texas (TX)	991	73	7.4%		1092	101	9.2%
Utah (UT)	74	2	2.7%		74	3	4.1%
Vermont (VT)	34	5	14.7%		36	14	38.9%
Virginia (VA)	222	44	19.8%		253	61	24.1%
Washington (WA)	236	49	20.8%		255	58	22.7%
West Virginia (WV)	101	12	11.9%		126	12	9.5%
Wisconsin (WI)	362	22	6.1%		404	46	11.4%
Wyoming (WY)	30	11	36.7%		38	19	50.0%
Total	**13701**	**2045**	**14.9%**		**15331**	**2828**	**18.4%**

APPENDIX H

Report on Multiple Citation Review
Region V
December 13, 2006

The Regional Office took a two prong approach to looking at multiple citations in FY 2006. The quantitative approach was the same as what MN did, i.e., calculate the percent of surveys with an outcome tag that had a process tag on FOSS and comparative 2567s for both the State and Regional Office. The qualitative approach was to review five 2567s that hand an outcome and a process tag and see if they were related and three 2567s with just an outcome tag cited to see if a process tag should have been cited. The outcome tags were: F309, F312, F314, F315 and F316. The process tags were: F272, F279, F280, F281 and F282.

Part I --Quantitative

Findings

- For the comparative survey 2567s based on the State findings, two States had no outcome tags cited; three States had at least one process tag on every 2567 that had an outcome tag (this included Minnesota); and one State had no process tag on the two surveys with outcome tags.

- For the comparative survey 2567s based on the Regional Office findings, five of six States had at least one process tag on 75% to 100% of surveys with and outcome tag (Minnesota had 100%). For one State, the Regional Office cited no outcome tags.

- For the FOSS 2567s based on the State findings, five out of six States had at least one process tag on 81.8% to 90.9% of the 2567s with at least one outcome tag cited (Minnesota had 88.9%). One State had a lower percentage, 66.7%.

- For the FOSS 2567s based on what the Regional Office thought should have been cited, the results are very similar to the State 2567 findings themselves. Five out of six States had at least one process tag on 81.8% to 90.9% of the 2567s with at least one outcome tag cited (Minnesota had 88.9%). One State had a lower percentage, 66.7%.

Conclusion

Based on an analysis similar to the one conducted by Minnesota across all States, the Region V States had high multiple citation rates. One State was consistently lower than the other five States.

Part 2 – Qualitative

In general, the process and outcome deficiencies that were cited were not always related.
For at least half of the outcome tags we looked for which there were not process tags, we believe, based on the evidence in the outcome tags, that process tags should have been written.

What we have done in the Region to deal with multiple citations

We have reinforced with our surveyors in training that where appropriate and the evidence supports it, separate outcome and process tags need to be written. We have directed the staff to consider this on every comparative survey. We have also directed staff to specifically consider this during a FOSS after Task 6 and before the debriefing to make sure that if there are outcome tags that should be cited whether there is evidence to cite process tags and to discuss it at the debriefing. The Regional Office Quality Review process also considers this for every comparative survey and FOSS that is conducted in Region V.

APPENDIX I

Table A3

Summary of Exploratory Factor Analysis of 2001-2004 Nursing Home Survey Deficiency Data: Nationwide Database (N = 64,354) [1]

Factor 1: Quality of Care (Y_{F1})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0157	Facility notifies resident/family of signif. chgs in health status/trtmt	0.320	7.97%	1
F0309	Provide care necessary for highest practical well being	0.598	24.90%	2
F0311	Resident given treatment to improve/maintain ADLs	0.546	4.04%	3
F0312	ADL care provided for dependent residents	0.743	11.62%	4
F0314	Proper treatment to prevent/heal pressure sores	0.721	15.61%	5
F0316	Appropriate treatment for incontinent residents	0.713	10.37%	6
F0318	Range of motion treatment & services	0.685	6.99%	7
F0322	Proper care & services for residents with NG tube	0.523	5.54%	8
F0324	Supervision/devices to prevent accidents	0.548	18.65%	9
F0325	Resident maintains nutritional status appropriate to clinical condition	0.415	7.44%	10
F0327	Facility provides sufficient fluid intake	0.569	4.42%	11
F0328	Proper treatment/care for special care needs	0.379	5.08%	12
F0353	Sufficient nursing staff on a 24-hour basis	0.530	2.87%	13

Factor 2: Resident Assessment (Y_{F2})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0272	Comprehensive resident assessments	0.650	10.19%	1
F0274	Assessment after a significant change	0.706	3.70%	2
F0276	Quarterly review of resident assessments	0.694	2.50%	3
F0278	Accuracy of assessments/coordination with professionals	0.752	9.44%	4
F0279	Development of comprehensive care plans	0.754	15.97%	5
F0280	Development/preparation/review of comprehensive care plan	0.623	9.99%	6
F0282	Services provided by qualified persons in accord with care plan	0.549	9.87%	7

[1] Based on tetrachoric correlations among deficiencies.

[2] "Weight" indicates relative amount of variance in deficiency citations nationwide during CYs 2001-2004 accounted for by the factors (i.e., factors = the common variance among the deficiencies listed under each factor). To create a single score for each factor and for each survey, either (1) these weights can be summed issued across all deficiencies listed under each factor can be simply counted. Option (1) distributes the variable weight on each factor more accurately, whereas option (2) may be more understandable.

Factor 3: Environment: Safe, Sanitary, Controls Spread of Infection/Disease (Y_{F3})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0252	Safe/Clean/Comfortable/Homelike Environment	0.254	6.82%	1
F0253	Housekpg. and maint. services ensure sanit,/orderly interior	0.700	17.41%	2
F0323	Environment is free of accident hazards	0.563	20.93%	3
F0371	Store/prepare food under sanitary conditions	0.530	31.08%	4
F0372	Dispose of garbage & refuse properly	0.626	3.41%	5
F0441	Facility Establishes Infection Control Program	0.424	13.88%	6
F0445	Staff handle linens to prevent spread of disease	0.554	3.23%	7
F0456	Essential equipment in safe operating condition	0.508	3.30%	8
F0463	Resident call system to nursing station functioning	0.525	2.65%	9
F0465	Environment is safe/functional/sanitary/comfortable	0.385	10.30%	10
F0469	Facility maintains effective pest control program	0.624	3.26%	11

Factor 4: Facility Administration Characteristics Re: Quality of Care and Quality of Life (Y_{F4})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0157	Facility notifies resident/family of signif. chgs in health status/trtmt	0.351	7.97%	1
F0224	Res. have right to be free from abuse, neglect, misapprop. of property	0.763	1.97%	2
F0225	Facility not to employ persons found guilty of F0224 issues	0.630	11.11%	3
F0226	Development and implementation of policies re: F0224 issues	0.470	9.15%	4
F0353	Sufficient nursing staff on 24 hour basis	0.479	2.87%	5
F0490	Facility administered to maintain highest practicable well-being	0.880	1.77%	6
F0497	Regular performance review & inservice education of nurse aides	0.530	2.13%	7
F0521	QA Committee meets qtrly/develops/implements plans re: care quality	0.798	1.85%	8

Factor 5: Quality of Diet (Y_{F5})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0326	Resident receives therapeutic diet when required	0.600	2.62%	1
F0363	Menus meet nutrition needs/prep in advance/followed	0.812	5.94%	2
F0364	Food properly prepared, palatable, etc.	0.700	7.49%	3
F0365	Food is prepared to meet individual needs	0.643	2.84%	4
F0367	Therapeutic diet prescribed by physician	0.533	2.65%	5
F0368	Appropriate Frequency of meals/intervals between meals	0.459	4.66%	6
F0371	Store/Prepare/Distrib food under sanitary conditions	0.583	31.08%	7

Factor 6: Quality of Drug Management and Administration (Y_{F6})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0176	Resident self-administration/documentation of drugs when safe	0.557	3.52%	1
F0328	Proper treatment/care for special care needs	0.393	5.08%	2
F0332	Medication error rates less than 5%	0.689	10.10%	3
F0333	Residents free of significant medication errors	0.640	3.84%	4
F0426	Facility provides pharmaceutical services that meet resident needs	0.512	7.17%	5
F0431	Drugs/biologicals labeled according to current professional principles	0.653	3.77%	6
F0432	Drugs/biologicals stored in locked, temperature controlled compartments	0.646	6.49%	7

Factor 7: Quality of Clinical, Laboratory, and Pharmaceutical Services (Y_{F7})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0329	Resident must be free from unnecessary drugs	0.696	12.17%	1
F0386	Physicians take active role in supervising resident care	0.562	1.96%	2
F0387	Frequency/timeliness of physician visits	0.593	2.55%	3
F0426	Pharmaceutical services meet the needs of residents	0.364	7.17%	4
F0429	Pharmacist must report drug irregularities to attending MD/DON	0.647	3.70%	5
F0430	DON/Attending MD must act on F0429 pharmacist report	0.657	2.69%	6
F0514	Completeness, accuracy, accessibility, organization of clinical records	0.525	12.96%	7

Factor 8: Quality of Life/Resident Rights (Y_{F8})

Deficiency Code	Description	Factor Weight [2]	Percent of Surveys	
F0156	Facility informs residents @ admission of rights responsibilities	0.418	3.88%	1
F0166	Facility shows prompt effort to resolve resident grievances	0.645	2.84%	2
F0167	Survey results readily accessible to residents	0.292	3.89%	3
F0241	Facility promotes resident care that enhances resident dignity	0.525	15.71%	4
F0242	Facility creates environment that promotes resident autonomy	0.578	2.01%	5
F0246	Facility accommodates resident needs & preferences	0.537	8.96%	6
F0248	Activity program meets individual needs	0.476	6.55%	7
F0250	Facility provides medically-related social svs to maint. res. well-being	0.481	6.27%	8

Total # of deficiency indicators of the 8 factors =	68
Mean # of deficiency indicators per factor =	8.5
Total # of unique deficiency indicators across the 8 factors =	63

* Notes: These eight "factors" can be considered broad "standards of quality compliance categories," and account for 51.96% of the variation in the deficiencies cited in the 64,354 surveys conducted nation-wide during this period.

APPENDIX J

Nursing Home Post Certification Revisit Process

The Minnesota Department of Health (MDH) is expanding their method of compliance verification. MDH will continue to use onsite post certification revisits as one method of verification, but on a less frequent basis. Below is the new post certification revisit process, effective for all nursing home surveys exited after November 3, 2006. This process is consistent with current federal policy and it is enhanced by the inclusion of random visits. The policy applies to all nursing home health and Life Safety Code deficiencies.

I. Mandatory Onsite Revisits

Onsite revisits will occur when any of the following situations apply:

A. when a facility has a deficiency finding of G and above on current survey;

B. when a facility has a deficiency finding of Substandard Quality of Care on current survey;

C. when a facility has been selected by CMS as a Special Focus Facility; or,

D. when a facility's prior survey or complaint investigation resulted in a deficiency finding of Substandard Quality of Care or immediate jeopardy.

II. Random Onsite Revisits

In addition to the mandatory revisits described above, MDH will conduct revisits to a percentage of facilities chosen at random. These random visits will provide the survey agency with an onsite sample to validate that Plans of Corrections are being implemented as written.

III. Verification of Compliance by Signature

The nursing home Plan of Correction (POC) is the facility's plan to be in compliance and is approved by MDH. The facility's signature on the Plan of Correction will be considered verification that compliance has been achieved as of the latest date specified on the POC and MDH may validate this verification by conducting an onsite revisit.

IV. Effective Date

This policy applies to all surveys exited after November 3, 2006.

V. Evaluation of Policy Change

This policy will be monitored and evaluated over the next year.

APPENDIX K

MDH Collaborative Joint Training Activities on CMS Revised Guidelines

Deficiency Tag #	Revised/New Guideline Deficiency Description	CMS Date Issued	Joint Training/Tools	MDH Implementation Date / Information Bulletin #	On Line CMS Training Available 24 hrs./day for 12+ months
F 314	Pressure Ulcers	Nov. 2004	Joint Training Sessions (12) held in Spring 2005. Clinical Tool Kit	May 31, 2005 IB 05-02 NH-110	X
F 315	Urinary Incontinence and Catheter Care	June 2005	Joint Training Sessions held on Sept. 12, 2005 (Phase 1) and Oct. 24-27, 2005 (Phase 2). Clinical Tool Kit	Nov. 7, 2005 IB 05-5 NH-111	X
F 501	Medical Director	Nov. 2005	CMS Webcast Telephone Conference Training held on Feb. 17, 2006	March 27, 2006 IB 06-06 NH 113	
F 248 -249	Activities and Activities Director	March 2006	Clinical Tool Kit. Joint Training Sessions (4) held in July and Aug. of 2006. Follow-up phone conferences scheduled for one year.	Oct. 1, 2006 IB 06-06 NH 115	X
F 520	Quality Assessment and Assurance	March 2006	Clinical Tool Kit w/CMS DVD issued in Aug. 2006. Follow-up phone conferences scheduled for one year.	Oct. 1, 2006 IB 06-04 NH-116	

Deficiency Tag #	Revised/New Guideline Deficiency Description	CMS Date Issued	Joint Training/Tools	MDH Implementation Date / Information Bulletin #	On Line CMS Training Available 24 hrs./day for 12+ months
	Psychosocial Outcome Severity Guidance	March 2006	Clinical Tool Kit issued in Aug. 2006 with CMS DVD & Deficiency Examples. Follow-up phone conferences scheduled for one year.	Oct. 1, 2006 IB 06-05 NH-117	X
F 334 (new)	Influenza and Pneumonia	Sept. 2006	CMS Issued Surveyor Guidance in Sept. 2006	Oct. 30, 2006	X
F 329 F 425, 428, and 431	Unnecessary Drugs and Pharmacy Services	Sept. 2006	CMS Webcast Dec. 15, 2006. Clinical Tool Kit. Joint Training Sessions are scheduled for Jan. and Feb. 2007.	April 15, 2007	X

Future CMS Guidelines to be Issued:

F 323-324	Accident and Supervision
F 371	Safe Food Handling
F 325	Nutritional Parameters
F 309	End of Life Issues and Pain Management
F 223-226	Abuse
F 373	Paid Feeding Assistants
F 441	Infection Control

As new guidelines are issued by CMS, MDH and the collaborative joint stakeholders group will develop training and guidance tools and implement new protocols.

APPENDIX L

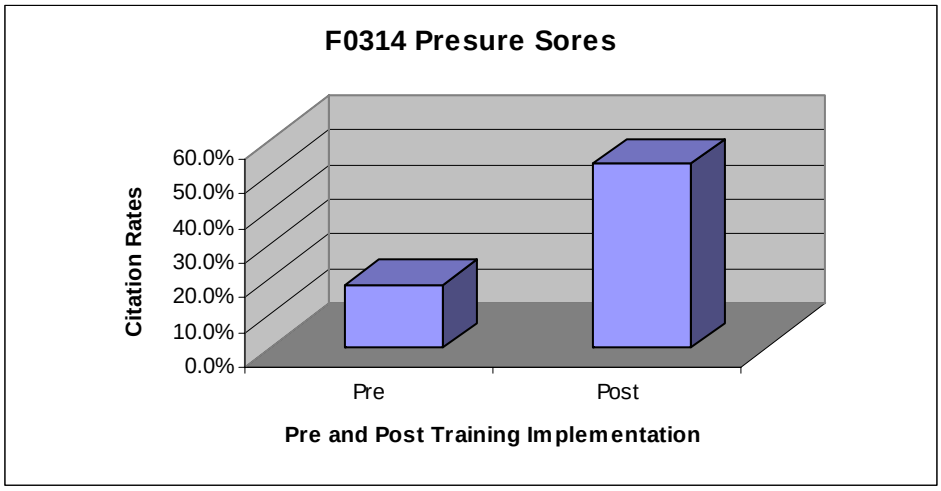
Minnesota Department of Health
Citations Rates Pre and Post Implementation
Citation Tags F0314, F0315

F0314, Proper Treatment to Prevent Pressure Sores

Date Ranges	Surveys	Citations	Rate
Pre - Implementation	427	77	18.0%
Post - Implementation	477	253	53.0%

Pre time frame is 6/1/04 through 5/31/05

Post time frame is 6/1/05 to surveys in OSCAR on 10/31/06



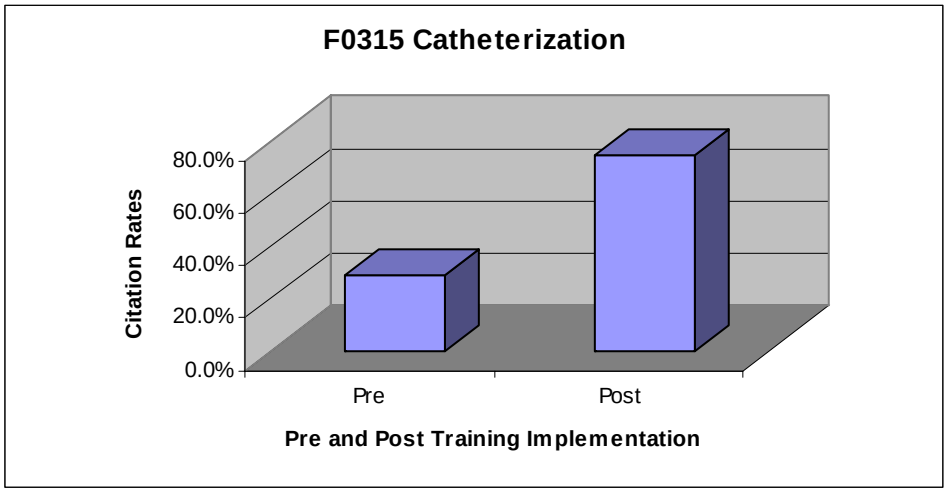
Pre	18.0%
Post	53.0%

F0315, Res not Catheterized Unless Unavoidable

Date Ranges	Surveys	Citations	Rate
Pre - Implementation	393	113	28.8%
Post - Implementation	320	239	74.7%

Pre time frame is 11/7/04 through 11/6/05

Post time frame is 11/7/05 to surveys in OSCAR on 10/31/06



Pre	28.8%
Post	74.7%