Complaint Investigations of Minnesota Health Care Facilities

Report to the Minnesota Legislature explaining the investigative process and summarizing investigations from July 1, 2004 to June 30, 2007 and Information on Deficiencies Issued by OHFC from October 1, 2006 to September 30, 2007

Minnesota Department of Health

April 2008

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As requested by Minnesota Statute 3.197: This report cost approximately $4340.00 to prepare, including staff time, printing and mailing expenses.

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Printed on recycled paper.

Introduction

Minnesota Statutes, section 626.557, requires the Minnesota Department of Health (MDH) to annually report to the Legislature and the Governor information about alleged maltreatment in licensed health care entities.

Minnesota Statutes, section 626.557, subdivision 12b, paragraph (e), states:

> Summary of reports. The commissioners of health and human services shall each annually report to the legislature and the governor on the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. The report shall identify:
> (1) whether and where backlogs of cases result in a failure to conform with statutory time frames;
> (2) where adequate coverage requires additional appropriations and staffing; and
> (3) any other trends that affect the safety of vulnerable adults.

In order to provide an appropriate context for the information specified in the law, this report will also address the Department's complaint investigation responsibilities relating to health care facilities. This report will provide summary data relating to the number of complaints and facility reported incidents received during state FY 05 to state FY 07; will provide summary data as to the nature of the allegations contained within those complaints and reports; describe the Office of Health Facility Complaints (OHFC) process from the intake function to completion of the investigative process; and then address issues relating to the performance of its responsibilities. This latter category will include information on the ability to conform to statutory requirements, the effectiveness of current staffing, and any trends relating to the safety of vulnerable adults. Since the complaint investigation function is also a critical component of the federal certification process, information as to the federal requirements and performance evaluations will be included. Information on OHFC's issuance of federal deficiencies related to nursing homes is included in Part 2 of this Report.

Part 1: State Fiscal Year Information

Background

There are over 2,000 licensed health care entities in the state. Licensed health care entities include nursing homes, hospitals, boarding care homes, supervised living facilities, home care agencies, hospice programs, hospice residences, and free standing outpatient surgical facilities. The licensure laws contained in Minnesota Statutes Chapters 144 and 144A detail the Department's responsibilities in this area. In addition, MDH is the survey agency for the purpose of certifying a health care facility's participation in the Medicare and Medicaid programs.

The purpose of licensing and federally certifying health care facilities is to protect the health, safety, rights and well being of those receiving services by requiring providers of services to meet minimum standards of care and physical environment. The licensure laws at the state level and the federal certification requirements provide for the development of regulations that establish those minimum standards. MDH rules, the Vulnerable Adults Act (VAA), the Patients Bill of Rights, and federal

Medicare and Medicaid certification regulations are the primary legal foundation for patient/resident protection efforts.

In addition to the development of the regulations, the licensure and certification laws also provide the structure for monitoring performance in two ways: the survey process and a distinct mechanism to respond to complaints about the quality of the care and services provided. This report will focus on the complaint investigation process.

The Office of Health Facility Complaints is a program within the Minnesota Department of Health's Division of Compliance Monitoring. OHFC is responsible for investigating complaints and facility reported incidents of maltreatment in licensed health care entities in Minnesota.[1]

State and federal laws authorize anyone to file a complaint about licensed health care facilities with OHFC. State law also mandates that allegations of maltreatment against a vulnerable adult or a minor be reported by the licensed health care entity. Maltreatment is defined in Minnesota Statutes 626.5572 (Vulnerable Adults Act) as cases of suspected abuse, neglect, financial exploitation, unexplained injuries, and errors as defined in Minnesota Statutes 626.5572, subd. 17(c)(5).[2]

OHFC Responsibilities

OHFC is responsible for the receipt of all complaints and facility reported incidents; for gathering information that will assist in the appropriate review of this information; for evaluation and triage of this information and for selecting the level of investigative response. In addition, OHFC is required to notify complainants and reporters as to the outcome of the review and any subsequent investigation. These specific functions will be addressed later in the report.

A Director, an Assistant Director and a supervisor manage OHFC. There are 12 investigators assigned to the Office; 10 investigators are assigned to the St. Paul office and the remaining 2 are located in the MDH offices in Fergus Falls, and Rochester. There are 2 individuals responsible for the intake of complaints and facility reported incidents. There are 5 administrative support staff assigned to the Office. In addition to the complaint related activities, OHFC is also responsible for the activities related to the processing of criminal background checks and set asides. Two professional staff are assigned to this activity.

[1] Statutory authority for OHFC is found in Minnesota Statutes 144A.51 to 144A.54. In addition to the requirements of state law, OHFC is also the entity responsible for reviewing and investigating complaints under the federal Medicare and Medicaid certification requirements.
OHFC is the "lead agency" for the purposes of reviewing and investigating facility reported incidents of maltreatment under the provisions of the Vulnerable Adult Abuse Act, Minnesota Statutes 626.557 and the Reporting of Maltreatment of Minors Act, Minnesota Statutes 626.556.

[2] While OHFC does conduct investigations relating to the maltreatment of minors in MDH licensed facilities, the information presented in this report will be based on complaints and facility reported incidents involving vulnerable adults. OHFC investigates very few cases involving a minor each year.

TABLE 1
OHFC BUDGET AND STAFFING HISTORY

Fed Fiscal Year	Investigators	Supervisor Managers	Intake Staff	Admin. Staff	Total Staff	OHFC Funding
FFY07	12	3	2	5	21	Total Oper. Budget: $2,301,872 Medicare 38.10% Medicaid 28.4% State Licensure 33.50%
FFY06	15	2	2	5	24	Total Oper. Budget: $2,418,480 Medicare 38.6 0% Medicaid 29.2 0% State Licensure 32.30%
FFY05	15	2	2	5	24	Total Oper. Budget: $2,266,286 Medicare 38.60% Medicaid 29.2 0% State Licensure 32.30%

OHFC Funding sources are Medicare, Medicaid, and State Licensure Fees

How OHFC Receives Information

Concerns about issues or situations in licensed health care entities come to OHFC in one of two ways: **a complaint or a facility reported incident**. **A complaint** is an allegation relating to maltreatment or any other possible violation of state or federal law that is made by an individual who is not reporting on behalf of the facility. **A facility reported incident** is received from a designated reporter (a person reporting on behalf of the facility) in a facility and describes a suspected or alleged incident of maltreatment as defined in the Vulnerable Adults Act.

Table 2, below, includes the numbers of complaints and facility reported incidents received during the past three state fiscal years by facility type.

Table 2: Complaints & Facility Reported Incidents by Facility Type
FY05, FY06, FY07

Complaints Received	**FY05**	**FY06**	**FY07**
Nursing Home	866	886	892
Hospital	340	293	278
Home Health	362	313	461
Other Licensed Entities	105	123	141
*** Total Complaints Received**	**1673**	**1615**	**1772**
Facility Reported Incidents	**FY05**	**FY06**	**FY07**
Nursing Home	2849	3176	2769
Hospital	169	131	117
Home Health	318	319	384
Other Licensed Entities	112	49	54
**** Total Facility Reported Incidents Received**	**3448**	**3675**	**3324**
***** Grand Total**	**5121**	**5290**	**5096**

As shown in Table 2, OHFC yearly receives several thousand complaints and facility reported incidents. **OHFC reviews every complaint and facility reported incident**. State and federal law require that these complaints and facility reported incidents be reviewed to make a determination as to what investigative process will be employed to resolve the allegation.

Types of Maltreatment Allegations and Other Concerns Received by OHFC

Each complaint or facility reported incident might contain more than one allegation, each of which must be reviewed for investigative purposes. For example, an allegation that a resident was neglected might state the nature of the specific concern but also indicate that inadequate staffing was also a concern. Complaints and facility reported incidents are coded to identify various categories of maltreatment and other violations of state and federal law. Table 3 illustrates the recording of all allegations for nursing homes for state FY05, FY06 and FY07; the maltreatment allegations and concerns identified by complainants and the maltreatment allegations and concerns contained in facility reported incidents. Tables 4, 5 and 6 on the following pages summarize all allegations for the other licensed health care entities.

Table 3: Nursing Home Allegations from Complaints and Facility Reported Incidents FY05, FY06, FY07

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	33	171	29	156	26	187
Physical Abuse	55	205	64	227	63	251
Sexual Abuse	14	106	20	78	20	67

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	10	67	12	69	13	76
Exploitation by other	4	90	7	99	8	113

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	352	276	385	318	338	233
Falls	58	782	49	766	64	751
Medications	45	76	52	101	80	119
Decubiti	18	5	21	0	26	3
Dehydration	4	0	3	0	5	9
Nutrition	5	2	10	2	7	3
Neglect, Failure to notify MD	6	1	3	1	2	0
Neglect of Supervision	44	365	28	413	35	363

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegation: Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	14	456	29	829	22	667

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	133	58	142	57	156	39
Nursing, Infection Control, Medications	136	10	120	2	104	4
Other	120	10	137	6	142	16

Table 4: Hospital Allegations from Complaints / Facility Reported Incidents
FY05, FY06, FY07

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	1	9	2	9	0	9
Physical Abuse	4	2	11	12	4	22
Sexual Abuse	0	0	11	21	8	18
Accident	0	0	0	0	0	1

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	1	6	4	2	1	3
Exploitation by other	0	0	2	0	0	2

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	29	4	57	5	36	7
Falls	4	7	6	1	6	4
Medications	5	2	6	3	13	0
Decubiti	7	0	11	1	10	1
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	0	0	0	0	0	0
Neglect of Supervision	3	10	10	67	6	68

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegation : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	1	4	4	7	7	2

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	158	13	114	0	110	3
Nursing, Infection Control, Medications	50	12	17	0	31	0
ER Services	11	0	25	3	21	0
Discharge Planning	5	0	13	1	14	0
EMTALA	19	0	17	2	19	1
Other	64	4	19	0	27	1

Table 5: Home Health Care Allegations from Complaints / Facility Reported Incidents
FY05, FY06, FY07

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	25	24	19	22	24	32
Physical Abuse	13	7	18	20	32	32
Sexual Abuse	17	36	10	15	9	11
Accident	0	11	1	15	0	4

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	29	48	17	55	41	84
Exploitation by other	6	16	8	12	10	28

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	119	28	99	28	152	38
Falls	13	51	7	60	17	55
Medications	30	17	24	12	49	20
Decubiti	6	0	9	0	5	1
Dehydration	0	0	1	0	1	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	1	0	1	0	2	0
Neglect of Supervision	14	14	20	58	20	88

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegation : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	1	4	8	18	10	48

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	76	12	82	12	95	9
Nursing, Infection Control, Medications, Shortage Staff	59	1	42	1	41	2
Other	3	1	21	0	49	2

Table 6 : Other Licensed Entities Allegations from Complaints / Facility Reported Incidents

FY05, FY06, FY07

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	6	6	1	2	6	9
Physical Abuse	7	14	7	6	9	8
Sexual Abuse	1	3	2	1	1	1
Accident	0	1	0	0	0	1

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	5	2	1	1	1	1
Exploitation by other	1	1	1	2	0	1

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	16	13	22	9	20	4
Falls	2	12	1	1	0	0
Medications	8	20	6	2	3	5
Decubiti	3	0	1	0	0	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	0	0	1	0	0	0
Neglect of Supervision	3	25	14	9	4	16

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegation : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	6	9	1	9	1	12

	FY 2005	FY 2005	FY 2006	FY 2006	FY 2007	FY 2007
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	44	7	59	1	73	2
Nursing, Infection Control, Medications, Shortage Staff	6	2	17	0	15	2
Other	19	33	25	0	38	0

How OHFC Reviews Information – the Intake and Triage Processes

As described below, the OHFC review process consists of an intake process and triage process.

The need to set priorities or to triage the allegations is specifically recognized in both state and federal law. The VAA requires that each lead agency "…shall develop guidelines for prioritizing reports for investigation." Minn. Stat. 626.557, subd. 9b. In addition, the Centers for Medicare and Medicaid Services (CMS) also requires that the state survey agencies develop triage criteria to govern the review of complaints and facility reported incidents. CMS also specifies time frames for the initiation and completion of certain types of investigations.[3]

Intake Process

Intake staff review each complaint or facility reported incident as it is received. Intake staff are trained to follow specific protocols and policies in assessing which investigative option the complaint or facility reported incident should be assigned. In many situations, intake staff will request that additional information be provided for review. For example, intake staff will often request that a facility submit medical records and its own investigative reports to be reviewed as the result of a submission of a facility reported incident. Intake staff may also request more information from complainants to assist in the OHFC review process, receiving and placing over 8600 telephone calls a year related to complaint and facility reported incident activity

In situations when it is apparent that a complaint does not allege a violation of state or federal law, intake staff will assist in identifying appropriate referrals to other agencies, such as the Office of the Ombudsman for Older Minnesotans or to a licensure board.

There are multiple ways to address concerns about the care and services provided in our health care facilities. OHFC encourages residents, patients and families to raise concerns directly with the facility. Facility staff are more available and accessible, which hopefully will lead to a prompt resolution of the complaint or concern. Working with a family or resident council in a nursing home or other residential facility can provide a forum for raising issues and requesting that action be taken to address the concerns.

Minnesota also has a strong and effective ombudsman program that can work with residents, family members and others to advocate for changes within a facility outside of the regulatory process.

[3] Chapter 5 of the State Operations Manual outlines the state survey agency responsibilities for the complaint review and investigation process. The State Operations Manual is published by CMS and is required to be used by the survey agencies in implementing the Medicare and Medicaid certification process for nursing homes. Online access to the SOM, publication 100-07, is available at the following website:
http://www.cms.hhs.gov/Manuals/I0M/list.asp

The complainant is informed if the allegation has been referred to another agency and that no further action will be taken by MDH.

Triage Process

Once the intake process is completed, the information will then be reviewed to determine the extent of any further investigative review by OHFC. This information is reviewed on a daily basis. Intake staff will automatically start the process for an onsite investigation if serious allegations, such as sexual or physical abuse, are identified or allegations of potential immediate jeopardy concerns are noted.

OHFC has adopted a policy and procedure that outlines the factors that are considered to triage the complaints and facility reported incidents. This process will determine the extent of its investigative review. The policy and procedure is attached as Appendix A. OHFC also places a priority on those situations when action needs to be taken to determine whether an alleged perpetrator may be subject to disqualification or referral to the Nursing Assistant Registry with a finding of abuse or neglect.

A number of investigative options are possible, ranging from taking no further action to the initiation of an onsite investigation. Intermediate steps are also considered, such as requesting additional information from a provider if not already requested by Intake staff; requiring facilities to review complaint allegations and submit documentation for a desk investigation; making referrals to other entities such as the Office of the Ombudsman for Older Minnesotans or the appropriate licensure boards; or providing information to the Licensing and Certification program to review at the next scheduled survey of the facility as an "area of concern." The results of the triage process for state FY05, FY06 and FY07 are shown in Table 7.

The following investigative options are possible:

> **No further review or investigation will occur.** This would happen when there is no alleged violation of rules or regulations (for example, the complaint does not involve a health care facility), when sufficient information is not available (due to length of time since incident occurred, for example) or when requested medical and other records have been reviewed and no possible violations were identified. In addition, a review of information submitted by the facility may indicate that appropriate corrective action had been taken. The complainant or reporting entity is notified that OHFC has reviewed the information and no further investigative action will be taken. The complainant or the reporting entity is told to contact OHFC if there are questions regarding this decision.
>
> **The complaint could be handled as a desk investigation.** In this situation, OHFC will contact the facility, indicate that a complaint has been filed, and require the facility to submit to OHFC information relating to the allegation and the steps taken to address those concerns. This information is reviewed and a decision is made about the conclusion to the complaint, and the information is entered into the federal complaint tracking system. The complainant is notified of the disposition and finding of the complaint. Generally, the desk investigation is used in situations when concerns about resident care have been raised, but a review of the records and information provided from the facility would be considered reliable and credible and an onsite investigation would not add to the investigative review. For example, if concerns

were raised about the appropriateness of a medication regimen or the failure to obtain medical or other treatments, a review of the records may provide sufficient information. Dirty rooms, cold food and medication errors not resulting in harm are also common allegations.

The complaint is referred to the Licensing and Certification Program as an "area of concern". The allegation is shared with licensing and certification staff and will be reviewed during the next survey process. These "areas of concern" are usually of a general nature not involving an allegation of abuse or neglect. Examples of such complaints include neglect issues that do not result in actual harm or that are not recurring; verbal or mental abuse that does not result in a resident feeling frightened or threatened; patient rights issues; physical plant complaints that do not pose immediate threat to the safety of patient/residents; and dietary and housekeeping complaints that do not impact care.

The complaint or facility reported incident could be assigned for an onsite investigation. Complaints and facility reported incidents that are determined to require this level of investigation are typically the most egregious and serious in nature. Examples would include situations when a potential immediate jeopardy concern has been identified; or when serious neglect concerns are raised such as situations causing fractures, pressure ulcers, or significant weight loss. When a complaint is assigned for an onsite investigation, a letter is sent to the complainant notifying that this is the investigative procedure that will be used and a case number and the name of the investigator assigned is in the letter. When the onsite investigation is completed, a copy of the final report is provided to the complainant.

Table 7: Complaints and Facility Report Incidents Assigned for Further Review
SFY05, SFY06, SFY07

	FY05	FY06	FY07
Onsite	474	442	418
Desk	146	150	165
Refer to Survey	148	206	218

Onsite Investigations

After it has been determined that an onsite investigation of a complaint or facility reported incident is required, further prioritization is completed to assure a timely response based on the nature of the allegation. For example, an onsite investigation of a complaint or facility reported incident that alleges immediate jeopardy must be initiated within two working days of receipt of the allegation. Immediate jeopardy includes those situations which are, or have the potential to be, life threatening or resulting in serious injury.

Complaints and facility reported incidents that allege a higher level of actual harm will be investigated onsite within 10 working days of receipt of the complaint, and consist of situations that result in serious adverse consequences to patient/resident health and safety but do not constitute an immediate crisis and delaying an onsite investigation would not increase the risk of harm or injury. This would include situations when neglect has led to pressure sores or significant weight loss, when physical

abuse has been alleged, unexplained or unexpected death which may have been the result of neglect or abuse; physical abuse of residents; mental or emotional abuse which threatens or intimidates residents; or failure to obtain medical intervention.

Complaints and reports assessed as not having a higher level of actual harm, but having the potential to do so, are assigned for onsite investigation within 45 days. These types of complaints and facility reported incidents include resident care issues, inadequate staffing which has a negative impact on resident health and safety, and patient rights issues.

Complaints, which allege a violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), often referred to as "patient dumping", must be investigated within a two-day period.

Resolution of Onsite Investigative Reviews Conducted in State FY05, FY06, FY07

All onsite investigations are governed by the requirements defined in state laws and the federal laws and regulations governing the Medicare and Medicaid certifications programs. OHFC is responsible for forwarding all investigative reports to the facility and complainant when an investigation is completed. The VAA requires that investigations be completed within 60 days. If this is not possible, OHFC is required to provide an estimate as to when the investigation will be completed.

When an onsite investigation is completed, the findings are either substantiated, unsubstantiated or inconclusive. **A substantiated finding means** a preponderance of the evidence shows that the allegation occurred. **An unsubstantiated finding means** a preponderance of the evidence shows that the allegation did not occur. **A finding of inconclusive means** that there is not a preponderance of evidence to show that the allegation did or did not occur.

Of the 418 onsite investigations assigned in SFY07, 407 were completed in SFY07. Table 8 conveys all onsite investigations COMPLETED in the state fiscal year, including any onsite investigations that were not completed in the previous state fiscal year. There were 128 onsite investigations that were not completed in SFY06, but were completed by the end of calendar year 2006. This 128 is reflected in SFY07 data.

Table 8: Results of Completed Onsite Investigations SFY05, SFY06, SFY07

	SFY05		SFY06		SFY07	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Substantiated	165	34.8	164	39.0	187	31.4
Inconclusive	172	36.0	124	30.0	193	32.5
Un-substantiated	137	29.0	129	31.0	215	36.1
Total	474	100	417	100	595	100

All VAA investigative reports are referred to the Medicaid Fraud Division of the Attorney General's Office and the long-term care ombudsman receives copies of all public reports. If maltreatment is substantiated, a copy of the report is provided to the MN Department of Human Services, MDH

Licensing and Certification, the city and/or county attorney, the local police department, and any affected licensing board.

Public reports of all onsite investigations for the past two years are available on MDH's website: http://www.health.state.mn.us/divs/frp/directory/surveyapp/provcompselect.cfm

If OHFC makes a finding of maltreatment involving a nursing assistant working in a nursing home, those findings are reported to the Nursing Assistant Registry (NAR). The NAR is responsible for notifying the nursing assistant and informing the nursing assistant of the appeal rights. Once a finding is entered on the Registry, the individual is permanently prohibited from working in a nursing home. These individuals are also referred to the Minnesota Department of Human Services for disqualification, as are other individuals who have maltreated an individual, for whom disqualification is required.

Number of employees with substantiated maltreatment findings:

SFY05	SFY06	SFY07
66	75	68

Number of hearings requested:

SFY05	SFY06	SFY07
33	18	24

Number of people referred to the Nursing Assistant Registry with substantiated findings of abuse, neglect, or exploitation:

SFY05	SFY06	SFY07
58	75	41

Evaluation of the OHFC Complaint Process

Case Backlog and Conformance to Statutory Time Frames

One of the areas required to be addressed in this report is whether or not there is a backlog of cases and whether or not OHFC investigative activities conform to statutory time lines.

Under the provisions of the VAA, OHFC as the "lead agency" has a number of specific time frames to meet. These include providing information on the initial disposition[4] of a report within 5 business days from receipt; completing the final disposition within 60 days of its receipt; providing a copy of the investigative report within 10 days of the final disposition to parties identified in the VAA and responding to requests for reconsideration within 15 days of the request.

The most significant time frame relates to the completion of the final disposition within 60 days. As defined in the VAA, the final disposition is the determination as to whether or not the maltreatment

[4] As defined in the VAA, the initial disposition is the lead agency's determination as to whether the report will be assigned for further investigation.

report will be substantiated, inconclusive, etc. OHFC must meet investigation time frames under the federal certification program.

OHFC has generally met the time frames for the initiation of onsite investigative reviews; however, completion of the investigative reports does not meet the 60 day time limit in the VAA. The average completion days for VAA resolved reports have been an average of 102.3 days for SFY06 and 120.2 days for SFY07. To a large extent, delays in completion of reports are attributed to ongoing case assignment to the investigators and the working complement of investigative staff, as well as the need to meet federally mandated time lines for the start of the federal process. For SFY 05, 59% of the onsite investigations needed to be initiated within 10 days or less. This percentage was 66.6% in SFY 06 and 52% in SFY 07. In order to meet the federal performance standards, pressure is placed on the investigators to initiate an increasing number of investigations. This delays the ability to complete already assigned investigations.

While this delay is a concern, steps have been taken to speed up the process in situations when the investigation has resulted in a substantiated finding, when correction orders or federal deficiencies will be issued, or when findings leading to the potential disqualification of an individual will be made. Any identified deficiencies are issued within 15 working days, even if the investigative report is not complete. In the aforementioned situations, actions are required by the facility to take steps to come into compliance with state or federal regulations, the process for disqualification of an individual needs to commence, or referrals of substantiated findings to law enforcement personnel or to appropriate licensure boards needs to be made.

Adequacy of Staffing

As noted previously, OHFC is beyond the final disposition time frame of 60 days mandated by the VAA. To a certain extent, additional staffing resources would assist to reduce the time frame by reducing the number of new assignments given to the current complement of investigators. However, the need for new staff and the attendant costs need to be weighed against the potential benefits to be achieved and how this would improve the safety of patients and residents.

A more important variable relating to the adequacy of staffing is determining whether more investigative reviews, especially onsite investigations, will improve the safety of vulnerable adults. Several factors are taken into consideration, including the time for completion of onsite investigations and the types of issues that may not get reviewed as part of the complaint process.

As noted below, the average number of hours for the completion of onsite investigations, whether or not the investigation is subsequently substantiated, is considerable.

The average hours for completing an investigation are as follows:

	SFY05	SFY06	SFY07
Complaint substantiated	45.0hrs	51.6 hrs	50.2 hrs
Complaint unsubstantiated	29.2 hrs	30.0 hrs	28.2 hrs
Inconclusive	32.6 hrs	37.7 hrs	37.9 hrs

OHFC is devoting more time to serious allegations which will be more complicated to review. The appropriate triage and priority assignment for complaints is a major emphasis of CMS. OHFC is seeing a slight increase in the number of investigations that need to be assigned in less than 10 days. This means that cases involving higher levels of harm are increasing and it is reasonable to assume that these cases will be more clinically complicated. As hours for completion increase, this will reduce annual caseload for the investigators.

It is increasingly difficult to find qualified replacements for investigators leaving their employment with OHFC. The time devoted to hiring and training has an impact on workload performance. We will continue to review workflow and other components of the process to find ways to improve compliance with timelines while still doing thorough investigations.

Part 2: The Authority and Responsibility of the Office of Health Facility Complaints Regarding Federally Certified Nursing Homes

The Office of Health Facility Complaints (OHFC) is responsible for the review of complaints and facility reported incidents from all licensed and federally certified health care facilities in the state. While not specifically required to be included in this report under the reporting provisions outlined in Minnesota Statutes §626.557, subdivision 12b, clause (e), the Department believes that it is appropriate to provide information relating to the activity and performance of OHFC under the federal certification requirements; this provides a more complete picture of the work of the program.

OHFC is a distinct program within the Department's Compliance Monitoring Division. OHFC has statewide jurisdiction and is responsible for complaint and facility reported incident investigations in all licensed and certified health care facilities in the state. These facilities include hospitals, nursing homes, boarding care homes, supervised living facilities (SLF) and home health care providers, including assisted living home care providers. Specific responsibilities mandated by the Centers for Medicare and Medicaid Services (CMS), which is the federal agency responsible for the certification of these facilities, include the investigation of alleged violations of the Emergency Medical Treatment and Labor Act (EMTALA) by hospitals; conducting complaint investigations authorized by the CMS Regional Office in accredited hospitals; investigating complaints against certified health care facilities or providers; and investigating facility reported incidents submitted by certified facilities under federal law.[5]

During Federal Fiscal Year 2007[6] (FFY07) OHFC conducted 542 on-site investigations, of which 397 were in nursing homes. Part 2 of this report addresses the activities and responsibilities of OHFC as they relate only to certified nursing homes.

While some OHFC staff are located outside of the Department's St. Paul location, the Office does not assign investigators to precise geographical districts such as those created by the Division's Licensing and Certification Program. All investigative findings are reviewed in the St. Paul office. Final reports,

[5] Certified nursing homes and Intermediate Care Facilities for the Mentally Retarded are required under federal regulations to report to the appropriate state authority allegations of mistreatment, neglect and abuse. See 42 CFR 483.13(c) and 42 CFR 483.420(d).
[6] FFY 06 runs from October 1, 2005 to September 30, 2006.

correction orders and federal deficiencies are issued from that office. The data provided in this report and in past reports are compiled on a statewide basis. Unlike the Licensing and Certification Program, the classification of data by geographic districts is not a relevant factor in reviewing OHFC operations.

Legal Authority

The authority for the OHFC to conduct investigations in nursing homes is found in Minnesota Statutes §§144A.51-.54[7]; in Minnesota Statutes §626.557[8] and in federal statutes and regulations[9]. As the "state survey agency" for federal certification purposes, the Minnesota Department of Health is responsible for performing the complaint related functions described in federal law. These functions have been assigned to the Compliance Monitoring Division and OHFC is the designated entity within the Division responsible for these activities.

OHFC is required to follow the provisions of federal law as well as the provisions contained in the State Operations Manual (SOM), which is published by CMS. The SOM details the duties and responsibilities of the state survey agency and is the document that includes the various interpretive guidelines for certified facilities. Chapter 5 of the SOM details the specific requirements that are to be followed while conducting complaint investigations.

In addition to the specific laws requiring the establishment of a complaint office, state and federal law outlines the authorities for issuing correction orders, federal certification deficiencies and imposing fines or other remedies for facility noncompliance.[10] Under these provisions, OHFC has the authority to make findings, issue deficiencies and state licensing correction orders, issue state penalty assessments; and recommend to the CMS Regional Office the imposition of remedies against certified facilities. OHFC also makes determinations of maltreatment against facilities and individuals under the state VAA law and under the provisions of federal regulations. Facility and individual requests for reconsideration or requests for administrative hearings on those findings are processed by OHFC. OHFC staff are also responsible for the review of set-aside requests for individuals that have been disqualified under the provisions of Minnesota Statutes, Chapter 245C. OHFC staff are involved in any hearings or judicial challenges related to those decisions.

[7] Minn. Stat. §§ 144A.51-.54 establishes the Office of Health Facility Complaints and outlines its responsibilities to investigate complaints against health care facilities and providers.

[8] Minnesota Statutes §626.557, also known as the Vulnerable Adult Abuse Reporting Act, provides the authority and responsibility of a "lead agency," in this case, OHFC, to review and investigate allegations of maltreatment, i.e. abuse, neglect and financial exploitation reported by health care facilities.

[9] Sections 1819 (g)(4) and 1919(g)(4) of the Social Security Act require that the State survey agency maintain procedures and staff to investigate complaints of violations by nursing homes; 42 CFR 488.332 is the regulatory provision addressing state agency responsibilities for nursing home complaint investigations; and 42 CFR 488.335 requires that the state survey agency investigate all allegations that an individual in a nursing home might have abused or neglected a resident or misappropriated the residents property. This section requires that substantiated findings of abuse and neglect be reported to the state's Nursing Assistant Registry or to the appropriate licensure boards.

[10] Minnesota Statutes §144A.10 specifies the authority to issue correction orders and penalty assessments to nursing homes. Federal authority for the issuance of remedies can be found in 42 CFR Part 488. Chapter 7 of the SOM also addresses the specific duties of the state survey agency relating to nursing home enforcement.

Specific Components of the Investigative Process for Nursing Homes

Intake and Triage

The intake and triage process used by OHFC to review complaints and facility reported incidents is explained in Part 1 of this report.

Federal policy specifically assigns time lines to specific types of complaints. See §§ 5020 to 5030H in Chapter 5 of the SOM. There are no corresponding state timelines for the initiation of an onsite complaint investigation.[11]

The OHFC triage policy incorporates the more precise federal requirements for determining the type of allegations and the timeline for the initiation of a complaint investigation. It is these provisions that mandate that investigations of allegations of immediate jeopardy are to be investigated within 2 days and that investigations of allegations of "high actual harm" are to be investigated within 10 days. 64% of the total number of onsite nursing home investigations (256 of the 397) conducted by OHFC fell within those two categories in FFY07.

Table 9 identifies the number of investigations that needed to be initiated within 2 days and the number of investigations that needed to be initiated within 10 days. The compliance percentage is also included.

Table 9: FFY07 OHFC Onsite Nursing Home Complaint and Facility Reported Incident Investigations Required within 2 or 10 Days

Type of complaint or incident	Number of onsite investigations	Number of onsite investigations within required time	Percent within required time
Nursing home	397 total	250 of 256	97.7%
Nursing home required within 10 days	235	231	98.3 %
Nursing home required within 2 days	21	19	90.4%

[11] In accordance with Minn. Stat.§626.557, subd. 9c, OHFC is required to notify the reporter that the report has been received and provide information on the initial disposition of the report within 5 business days of the receipt of the report. As defined in section 626.5572, subd. 12, the "initial disposition" is the lead agency's determination as to whether the report will be assigned for further investigation. The VAA requires that the lead agency complete its investigation within 60 calendar days of the receipt of the report or provide information as to the reason for the delay and the projected completion date. See section 626.557, subd. 9c (d).

Abbreviated Standard Surveys

Chapter 5 of the SOM outlines the protocols to be followed by the state survey agency for complaint investigations. Due to the similarities between the state and federal regulations for nursing homes, these federal protocols are utilized for nursing home investigations under both federal and state law.

Complaint investigations in certified nursing homes are referred to as abbreviated standard surveys. This term is defined in § 7001 of the SOM as follows:

> **Abbreviated Standard Survey** means a survey other than a standard survey that gathers information primarily through resident-centered techniques on facility compliance with the requirements for participation. An abbreviated standard survey may be premised on complaints received; a change in ownership, management, or director of nursing; or other indicators of specific concern.

Section 7203 E, of Chapter 7 of the SOM outlines the expectation for an abbreviated standard survey:

> This survey focuses on particular tasks that relate, for example, to complaints received, or a change of ownership, management, or Director of Nursing. It does not cover all the aspects covered in the standard survey, but rather concentrates on a particular area of concern(s). The survey team (or surveyor) may investigate any area of concern and make a compliance decision regarding any regulatory requirement, whether or not it is related to the original purpose of the survey complaint.

Sections 5400 to 5450 of the SOM contain specific requirements and outline specific tasks to be completed during the abbreviated standard survey. These tasks include the following:

- **Section 5410 - Offsite Survey Preparation:** This includes the review of the allegation as well as other information that may have been received during the intake/triage process. It is during this process that other information regarding the facility such as prior survey and complaint history and discussions with the ombudsman about similar complaints would occur.
- **Section 5420 - Entrance Conference/Onsite Preparatory Activities:** On site investigations must be unannounced and at the time of the entrance, the general purpose of the visit will be provided. The investigator needs to assure that the confidentiality of individuals identified as part of the complaint, such as the reporter or specific residents, be protected.
- **Section 5430 - Information Gathering:** In addition to determining whether the complaint is substantiated, the OHFC investigative process is also required to determine the degree of facility compliance with the regulations and to determine if other residents, not specifically identified in the allegation, are at risk.

It is important to note that OHFC has the authority to investigate the allegations that initiated the onsite investigation, and an obligation to expand that review to assure that similar concerns do not affect other residents in the facility. For this reason, OHFC will review records of a number of

residents, make required observations in the areas identified as a concern, review incident reports to determine frequency of concerns or whether there is a possible pattern of noncompliance, and complete other tasks as necessary to determine whether the facility is in compliance with a regulation and the scope and severity of any noncompliance. If during the course of the investigation other unrelated findings of noncompliance are identified, OHFC investigators are required to issue appropriate federal deficiencies or state correction orders. All OHFC investigators are qualified surveyors and have passed the federally required SMQT tests.

- **Section 5440 – Information Analysis:** This is the step that determines whether the information obtained during the investigation will substantiate the complaint and determine if the nursing home has violated any regulatory provisions, and whether corrective action had been initiated by the facility. Information gathered by the investigator is reviewed by either the Director or Assistant Director of OHFC. Decisions are made as to whether the information supports the investigator's recommended deficiencies or correction orders or whether additional information is needed.
- **Section 5450 – Exit Conference:** Once the information analysis has been completed, including the required supervisory reviews, the investigator will advise the facility administrator whether deficiencies or correction orders will be issued.

Differences Between the Investigative Process and the Survey Process

OHFC is required to follow the federal regulations and the policies and procedures developed by CMS. However, there are some key differences in the process for an investigation as compared to a survey of a nursing home. One key difference is that most of the information required to support compliance during a survey process is gathered while the team is onsite. Therefore, at the time of the exit conference, the nursing home is notified of these findings. The nursing home is provided information identifying the findings of the survey process and informed that the survey team's supervisor will consult with Central Office staff, as appropriate, and make final decisions.

In contrast, OHFC investigations can rarely be concluded at the time of the onsite investigation, and for that reason, an exit conference is not conducted at the end of that onsite visit. The onsite investigation is in fact just one of the initial stages of the investigative process. It is the time when records are reviewed and obtained, when individuals needing to be interviewed will be identified and some of these interviews will be conducted.

Often the investigative activity is based on the off-site review of records, determining if additional records might be required and completing interviews of the individuals identified as having information or potentially having information related to the allegations.

Only when this process is completed and determinations made as to whether the allegations will be substantiated or not, and whether deficiencies or orders will be issued, will the "exit" conference be initiated. This is conducted as a phone call with the facility's administrator. The date of this exit is the date that is identified on any deficiencies or orders issued as a result of the investigation. OHFC places

priority on the completion of any necessary federal certification deficiencies and these will be issued shortly after the exit conference, in compliance with federal timelines.

Once deficiencies are issued, the OHFC investigator will complete the required investigative report. Federal provisions as well as the VAA specify the components that are to be contained in these reports. As noted previously, the VAA requires that the investigative reports be completed within 60 days of the date the report was received. Information relating to OHFC's compliance with this provision is contained in Part 1 of this report.

The conclusion of the report identifies whether the allegations are substantiated, unsubstantiated, or inconclusive. If maltreatment findings are substantiated, the report also identifies whether the facility or an individual is responsible.

Immediate Jeopardy and Substandard Quality of Care Determinations

If it is determined that investigative findings identify that substandard quality of care[12] exists, a partial extended survey will be completed. This is defined as follows:

> **Partial extended survey** means a survey that evaluates additional participation requirements and verifies the existence of substandard quality of care during an abbreviated standard survey.

During FFY 07, OHFC conducted 6 partial extended surveys out of the 397 on-site nursing home investigations. The completion of the partial extended survey was required as the result of the issuance of 6 federal deficiencies. Of the six, all were both immediate jeopardy (IJ) and substandard quality of care tags (SQC). Table 10 summarizes the tags issued.

Table 10: Deficiencies Issued as a Result of Partial Extended Survey FFY06

Nursing Home	Tag and Scope and Severity	Immediate Jeopardy	Substandard Quality of Care
#1	F324K	Yes	Yes
#2	F324J	Yes	Yes
#3	F323K	Yes	Yes
#4	F324J	Yes	Yes
#5	F225K	Yes	Yes
#6	F324K	Yes	Yes
	6 tags	6 tags	6 tags

[12] "Immediate jeopardy" is defined as a situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.
"Substandard quality of care" means one or more deficiencies related to the requirements under 42 CFR 483.13, resident behavior and facility practices (Tags 221-226), 42 CFR 483.15, quality of life (Tags 240-258), or 42 CFR 483.25, quality of care (Tags 309-333), that constitute either immediate jeopardy to resident health or safety (level J, K, or L); a pattern of or widespread actual harm that is not immediate jeopardy (level H or I); or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm (level F).

The requirements for a partial extended survey are specified in Section III of Chapter 7 of the SOM.

As noted previously, an investigative situation often requires follow-up interviews and record review that cannot be completed during the onsite investigative visit. Therefore, it is not always possible to precisely determine whether a partial extended survey will be needed while the investigator is onsite. In situations when immediate jeopardy may be identified, the OHFC investigator consults with OHFC managers to discuss the findings and determine whether facts support the IJ recommendation. OHFC managers also discuss these findings with the Director's Office before the final IJ determination is made.

As outlined in the triage policy, allegations that appear to create an immediate jeopardy situation must be investigated onsite within 2 working days. In these situations, the investigator reviews the allegation and if it appears the IJ allegation will be substantiated, then determines whether sufficient corrective measures have been implemented by the facility to assure that residents are not at risk. If the allegation was triaged at the IJ level, verifying whether or not an IJ exists can often be made at the time of the onsite investigation.

A final decision as to whether a facility meets the criteria for substandard quality of care cannot be made until deficiencies have been identified and the scope and severity of those deficiencies has been determined. If substandard quality of care is determined and the partial extended survey has not been conducted, it will be necessary for the investigator to complete the partial extended survey before the investigation can be concluded.

Results of OHFC Complaint Investigations FFY07

During FFY07, 48 of 397 onsite nursing home investigations resulted in the issuance of 77 federal certification deficiencies. These deficiencies were issued to 42 separate nursing homes. 5 nursing homes were issued deficiencies as the result of more than one OHFC onsite investigation.

A total of 57 state licensing correction orders were issued to 33 different nursing homes during FFY07 as a result of an onsite OHFC investigation. All correction orders were found to be in compliance within the required time period and no state penalty assessments were issued as a result of those 57 correction orders. The potential fine amounts for these correction orders ranged from $0 per day/per order to $500 per day/per order.

Table 11: Deficiencies and Correction Orders Issued FFY07

Note: Deficiencies and Correction Orders do not correspond as listed

Deficiencies:	Correction Orders:
F156 – Notification of Rights and Services 1-E	MN Rule 4658.0085 Notification of Change in Resident Health Status (6) $350 daily
F157 – Failure to Report Significant Change 6-D; 1-E; 1-G	4658.0100 Emp Orientation, subp 2 (1) $100 daily
F203 – Transfer or Discharge 3-D	4658.0105 Competency (1) $300 daily
F224 –Facility Prohibits Abuse Neglect 1-D	4658.0140 Type of Admission, subp. 2 (1) $250 daily
F225 – Not Employ Persons Guilty of Abuse 3-D; 2-K	4658.0400 Comprehensive Resident Assessment (2) $300 daily

Deficiencies:	Correction Orders:
F241 – Dignity 1-D; 2-E	4658.0405 Comprehensive Plan of Care (2) $300 daily
F272 – Comprehensive Assessment 1-G	4658.0505 DON Responsibilities F (2) $100 daily
F278 – Accuracy of Assessment/Coordination with Professionals 1-G	4658.0520 Adequate and Proper Nursing Care, subp. 1 (12) $350 daily
F279 – Dev Comprehensive Care Plans 2-D; 1E	4658.0525 Rehabilitation Nursing Care, subp.3B (1) $350 daily, subp.5A (1) $350 daily subp.7B (1) $350 daily; subp.9 (1) $350 daily
F282 – Services Provided in Accordance with Care Plan 1-G	4658.0600 Nutritional Status, subp 2 (1) $350 daily
F309 – Fail to Provide Necessary Care 10-D; 3-G	4658. 1200 Specialized Rehab Services, subp.2 (1) $350 daily
F314 – Proper Treatment for Pressure Sores 1-G	4658.1310 Drug Regimen Review AB (2) $300 daily
F315 – Urinary Incontinence 1-D	4658.1315 Unnecessary Drugs A (1) $300 daily
F322 – Proper Care & Services for Res with NG Tube 1-G	4658.1320 Med Errors AB (3), A(1), B(1) all $500 daily
F323 – Accident 1-D; 2-K (tag was combined with F324 and implemented by MDH 10-1-07)	4658.1325 Admin of Meds, subp.1 (1) $500 daily
F324 – Provide Supervision Prevent Accidents 4-D; 2-G; 2-J; 1-K	4658.1330 Written Authorization Drugs (2) $350 daily
F325 –Res Maintain Nutritional Status Unless Unavoidable2-G	4658.1400 Responsibilities of the Administrator in Charge (1) $50
F327 – Hydration 3-G	4658.1415 Housekeeping, subp.11(1) $200 daily
F329 – Unnecessary Medications 1-D	MS 144.651 Health Care Bill of Rights, subd 4 (1) $100, subd. 5 (1) $250, subd 6 (1) $250, subd. 14 (1) $500, subd. 29 (3) $250
F332 – Med Error Rates of 5% or More D-1	MS 626.557 Reporting of Vulnerable Adults, subd 3 (2) $250, subd 4A (2) $100,
F333 – Medication Errors 3-D; 2-G	
F354 – Use of Charge Nurse & Registered Nurse 1-E	
F406 – Facility Provides Specialized Rehab Servs 1-D	
F425 – Facility Provides Drugs and Biologicals 2-D	
F426 - Pharmacy Services and Procedures 1-D; 1-E	
F428 – Res Drug Regimen Reviewed Monthly by Pharmacist 1-D; 1-G	
F497 – Regular Inservice Education 1-D	
F514 – Clinical Records Meet Appropriate Stnds 1-E	

48 post certification revisits were conducted by OHFC during FFY 07. These revisits were generally conducted onsite. A phone or written verification of compliance occurs rarely, if at all.

During FFY 07, 6 federal civil money penalties (CMPs) were recommended by OHFC. CMS imposed 6 civil money penalties. OHFC recommended the imposition of zero denial of payments for new admissions and zero were imposed by CMS.

During FFY 07, the remedies, other than civil money penalties, recommended and imposed as the result of onsite investigations is as follows:

TYPE	RECOMMENDED	IMPOSED
State Monitoring	6	6
Discretionary Denial of Payment	0	0
23-Day Termination	0	0

During FFY 07, the following civil money penalties were recommended and imposed:

TYPE	RECOMMENDED	IMPOSED
Per Instance	6	6
Per Day	0	0

CMS imposed CMPs as recommended by OHFC.

Referrals to the Nurse Aide Registry or to Licensure Boards

OHFC is required to make referrals to appropriate licensure boards under the provisions of Minn. Stat. §626.557, subd. 9c, clause (g).

It is the practice of OHFC to refer all substantiated maltreatment reports involving licensed nurses to the Board of Nursing (BON). The report, including private data, is sent without identifying any particular nurse. The BON then determines which nurse(s), if any, to contact. In addition, if an investigation identifies that maltreatment by unlicensed personnel occurred due to inadequate training, supervision, or direction by a licensed nurse or nurses, the report will be forwarded to the BON for review.

Similarly, the nursing home administrator is responsible for the operation and management of the nursing home. In accordance with the Board of Examiners for Nursing Home Administrators (BENHA), OHFC refers all substantiated maltreatment reports to BENHA for its review.

42 CFR 488.335 (f) also requires that OHFC report substantiated findings of abuse, neglect or misappropriation of resident property to the Nurse Aide Registry. During FFY 07, 32 such findings were made against nursing assistants and submitted to the Registry.

Access to OHFC Investigative Reports

A copy of each completed OHFC investigation, including a copy of any deficiencies or correction orders issued as a result of the investigation, can be accessed at the following link: http://www.health.state.mn.us/divs/fpc/directory/surveyapp/provcompselect.cfm

Timelines for the Issuance of Deficiencies and Conducting of Revisits

Minnesota Statutes §144A.101 contains two provisions setting timelines for the performance of survey related functions – the issuance of federal deficiencies and the timing of revisits when remedies are in place. These provisions do not apply to the complaint investigation process. Minnesota Statutes § 144A.101, subdivision 1 states that 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." As previously discussed, complaint investigations conducted by OHFC are "abbreviated standard surveys" or "partial extended surveys." Specific definitions of the terms "abbreviated standard survey," "extended survey," and "partial extended survey" are found in 42 CFR 483.301. The term "expanded survey" is defined in Section 7001 in Chapter 7 of the SOM. The Department is not aware of a federal definition for a "regular" survey, and it has been the Department's interpretation that this term means a "standard survey" as defined in 42 CFR 483. 301.

The Department believes that it is appropriate to evaluate how well OHFC complies with these measures as they are important to the certification process.

Issuance of Certification Deficiencies

Minnesota Statutes §144A.101, subdivision 2 requires that draft statements of deficiencies be provided to the nursing home at the time of the exit conference and that completed statements of deficiencies be issued within 15 working days of the exit.

As previously discussed, the exit conference process for an OHFC investigation is different than the process used for standard surveys. This exit is conducted by phone and the investigator informs the facility administrator of the conclusion of the investigation and whether deficiencies will be issued. At the time of this phone call, the contents of the statement of deficiencies have been reviewed and approved for mailing. Of the 52 sets of federal deficiencies issued in FFY07, 51 were issued within 15 working days of the date of exit.

Timelines for Survey Revisits

Minnesota Statutes §144A.101, subdivision 5 requires that revisits be conducted within 15 calendar days of the date that corrections will be completed by the nursing home in situations where a category 2 or category 3 remedy is in place. **A revisit cannot occur until the nursing home has submitted a Plan of Correction (PoC) that is accepted by the Department.** The Department's compliance with this provision is discussed in the Department's 2007 Annual Quality Improvement Report on the Nursing Home Survey Process. Twenty-three revisits were identified as not complying with the statutory provision; 3 of those were revisits conducted by OHFC. A summary of these 3 situations follows:

- One facility submitted a PoC with an identified date of correction that predated the acceptable plan of correction by 13 days and the post certification revisit (PCR) was completed within five days of receiving acceptable PoC. However, because the PoC was back dated OHFC was beyond the 15 days. The timing of the revisit did not result in the facility having increased financial loss.

- One facility submitted a PoC affiliated with an OHFC complaint investigation and there was a Licensing and Certification survey during the time the PCR was to occur. CMS requires coordination of a PCR between OHFC and L&C. MDH scheduling issues did result in the late PCR, and the facility was not found to be in compliance at the time of the OHFC PCR in accordance with the facility's PoC date. As a result of not being in compliance the facility did incur a financial loss. If the facility had been in compliance at the time of the OHFC PCR, the facility would not have incurred a financial loss.

- One facility submitted a PoC with an identified date of correction that predated the acceptable PoC by 10 days. L&C conducted a survey during the time the PCR was to occur. CMS requires coordination of a PCR between OHFC and L&C. MDH scheduling issues did result in the late PCR, and the facility was found to be in compliance. The timing of this revisit did not result in the facility having increased financial loss.

Independent Informal Dispute Resolution (IIDR) and Informal Dispute Resolution (IDR)

Any deficiency issued by OHFC is subject to the IIDR or IDR process utilizing the same process that is in place for deficiencies issued by the Licensing and Certification program.

During FFY07, 10 of the 77 deficiencies issued by OHFC were the subject of either an IIDR or IDR. Table 12 summarizes the type of review requested and scope and severity (s/s) of tags disputed.

Table 12: IDR and IIDR Reviews Requested and Tags Disputed FFY07

	IDR	IIDR
Total requested	15	14
# of tags disputed	31	31 (plus 2 tags from an FFY06 request heard in Jan 07)
# that involved OHFC	0	5 (1 review from FFY06 conducted in Jan 07)
# of OHFC tags disputed	0	10 (12 tags due to Jan 07 review)
Scope and severity of OHFC tags	NA	4 D, 2 E, 1 G, 1 J, 2 K (2 tags @ s/s J from Jan 07 review)
Resolution of OHFC tags	no reviews requested	2 ALJ reviews involving 3 tags completed: 1 tag valid: 1 @ s/s K; 2 tags in that IIDR withdrawn by facility @ s/s E 2 tags recommended as deleted @ s/s J (Jan 07 review) no ALJ reviews pending 4 reviews withdrawn by nursing home prior to IIDR involving 7 tags: 4 @ s/s D 1 @ s/s J 1 @ s/s G 1 @ s/s K

Reconsiderations and Appeals

Under the provisions of the VAA and federal regulations relating to findings of maltreatment against nursing home personnel, if a facility or an individual is determined to have neglected, abused or financially exploited a nursing home resident, the facility or individual can request an informal reconsideration. If the facility or individual is not satisfied with the decision after this reconsideration process, a fair hearing under the provisions of MN Statute 256.045 can be requested. A hearing judge employed by the Department of Human Services conducts the fair hearings. During FFY 07, 24 hearings were requested as the result of 68 substantiated findings in nursing home investigations.

Under the federal regulations, specific findings of neglect, abuse or financial exploitation are also submitted to the Nurse Aide Registry once any requested reconsiderations or hearings have been completed. During FFY 07, findings of neglect, abuse, or financial exploitation for 32 individuals were added to the Registry.

Under the provisions of Minnesota Statutes §626.557, subd. 9d, clause (b), a vulnerable adult or other interested party not satisfied with the results of an investigation can request a review of these findings under the provisions of Minnesota Statutes §256.021. During FFY07, 6 requests were made for these reviews.

Areas of Focus in FFY07

1. Comparison with Region V States

Complaint activities are increasingly being scrutinized by CMS Regional Office staff to assure that complaint allegations are appropriately triaged, that required investigations are initiated within the specified time limits and that the complaint process, including any issued deficiencies, is completed in accordance with the federal process.

Minnesota remains an outlier in terms of the number of deficiencies issued on complaint investigations. Minnesota is well below the number of complaint deficiencies issued by the other 5 states in Region V. Tables 13 and 14 identify the number of complaint investigations conducted in FFY07 by states in Region V and the number of deficiencies that have been issued as the result of these investigations.

Table 13: FFY07 Complaint Surveys in Region V by State & Nursing Home Count as of 9/30-07

Illinois	2,762 surveys (801 nursing homes)
Indiana	1,582 surveys (513 nursing homes)
Michigan	551 surveys (428 nursing homes)
Minnesota	402 surveys (395 nursing homes)
Ohio	2,225 surveys (961 nursing homes)
Wisconsin	888 surveys (396 nursing homes)
Region V	8,410 surveys (3494 nursing homes)

source: Federal CASPER (Certification and Survey Provider Enhanced Reporting) System

Table 14: FFY07 Deficiencies by Scope and Severity Issued as a Result of a Complaint Survey in Region V by State

S/S	B	C	D	E	F	G	H	I	J	K	L	Total
Region V	171	111	3,388	832	68	897	18	1	283	58	17	5,844
Illinois	92	59	829	142	20	299	5	0	136	13	13	1,608
Indiana	8	4	892	234	7	297	4	1	54	20	2	1,523
Michigan	3	1	340	93	4	91	1	0	37	16	1	587
Minnesota	0	0	39	8	0	19	0	0	0	3	0	69*
Ohio	50	28	856	224	32	81	1	0	16	0	1	1,289
Wisconsin	18	19	432	131	5	110	7	0	40	6	0	768

source: Federal CASPER (Certification and Survey Provider Enhanced Reporting) System

* This table does not include 8 deficiencies included in the Department's count of 77 deficiencies issued in FFY07 as the deficiencies were subject to IDR and IIDRs. See Table 12 for more information.

Division staff have inquired about the complaint processes in the other Region V states. Follow up contact with these states is needed to complete the inventory of information requested so an analysis of why Minnesota is so different can be done. Areas researched include the number of staff in other states assigned to conduct complaint investigations, the types of complaints completed in those states, whether complaint staff in those states have obligations similar to those of OHFC under the VAA; the level of state and federal funding supporting the complaint functions; and any state laws that have different complaint procedures than what is used in Minnesota.

CMS Regional Office personnel visited Minnesota just prior to the close of FFY07, in late September. The purpose of the visit was to ascertain, first hand, how OHFC receives and processes complaints and facility reported incidents. This information is being sought in all states in Region V; CMS opted to start with Minnesota.

As a result of that visit, CMS determined that because of the way Minnesota's Common Entry Point reporting requirement works, nursing homes are not in compliance with the following two federal reporting requirements, federal regulations 483.13(c) (2) and (4). The regulation at (c)(2) requires that "The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." "Immediately" is defined as soon as possible but not to exceed 24 hours (Appendix PP of the State Operations Manual, Transmittal 22, 12-15-06).

The regulation at (c)(4) requires that "the results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate action must be taken".

CMS also stated that there are differences between state and federal definitions of reportable incidents and expressed concern that some federally reportable incidents may not be reported because the state's reporting law (M.S. 626.557) doesn't require reporting.

CMS has required OHFC to develop a process to allow nursing homes to comply with the regulations. The development of an electronic reporting process that complies with both of the federal regulations and state reporting requirements is complete and will be a major area of focus for FFY08 with respect to ensuring compliance with the regulations.

2. Accuracy and Consistency

The additional supervisor OHFC hired has been assisting with managing workflow to improve compliance with state and federal timelines for initiating and completing investigation. Work remains in this area, however. According to CMS' evaluation of FFY07 Performance Standards for OHFC, OHFC did not meet performance standards on prioritizing complaints and incidents and the timeliness of complaint investigations onsite within the required 2 working day threshold. OHFC did meet Performance Standards for the quality of investigations and initiating all of the 10 working day threshold complaints within the required timeframe, which was an area identified as needing work in FFY07.

OHFC has completed its review of the differences between language in the state VAA and the federal regulation relating to the reporting and possible investigation of injuries of unexplained sources. This information will be reviewed with providers in an April 2008 training session on abuse and neglect training.

OHFC has developed a process to enter data in the federal ACTS system on complaints investigated as desk reviews and referred to survey as for inclusion in the survey process. Time spent on this activity will be captured and reflected in the federal data system.

Specific guidelines for writing investigative reports have been developed and revised and are currently being implemented, resulting in improved consistency across investigative reports.

3. Training

As a result of an allocation from monies collected through Civil Money Penalties, OHFC has developed a state wide training program to better assist facilities in identification and reporting of allegations of abuse and neglect; techniques and steps to effectively conduct a facility's internal investigation; to provide information as to the type of allegations that need to be submitted to the state agency under federal and state requirements; and training and resource information on best practices for promoting a safe environment for residents and staff and providing care with dignity and respect. This statewide training was developed following the model used for training sessions conducted during the past year through collaborative efforts between MDH, providers, advocates, and other stakeholders. Survey staff and investigators will participate in the training initiatives. This training will be conducted on April 15 and 29, 2008.

OHFC staff participated in education offerings about culture change in nursing homes.

Areas of Focus for FFY 08

1. CEP incident reporting and compliance with federal regulations and expansion of complaint investigations to ICFsMR.

CMS has identified a need to revise the process of receiving facility reported incidents so that nursing facilities can comply with federal regulations 483.13 (c) (2) and (4). A complying process has been developed and is scheduled to be implemented in April 2008. OHFC, along with survey and compliance, will focus attention on making sure that this reporting system works and that facilities are reporting as required and completing and submitting facility investigations within the required time frame.

Investigation of complaints in Intermediate Care Facilities for the Mentally Retarded (ICFsMR) has historically been conducted by the Minnesota Department of Human Services as that department is the lead agency per Minnesota's Vulnerable Adult law. CMS has recently questioned this process due to the federal certification of those facilities. Coordination of reviews with the Department of Human Services is being worked on. Staff has completed training and orientation to conduct complaint investigations in these federally certified facilities and investigations in ICFsMR will be an area of expansion for OHFC in FFY08 and beyond

2. Accuracy and Consistency

As part of its 2008 Quality Improvement Plan, OHFC will continue its focus on ensuring the accuracy and consistency of the investigative process, ensuring compliance with state and federal requirements for triaging complaints and facility reported incidents and improving communications and coordination with internal and external stakeholders.

An additional supervisor was added to OHFC's staff in August of 2006. This position was added to assist with improving and maintaining consistency and quality in investigator orientation and training, the review of documents, to reduce the completion time of reports, and as a resource for guidance of staff. Ongoing staff training in survey and enforcement of federal regulations and education offerings such as culture change will continue.

The CMS evaluation of FFY07 Performance Standards for OHFC, included as Appendix C, indicates OHFC did not meet performance standards on prioritizing complaints and incidents and the timeliness of complaint investigations onsite within the required 2 working day threshold. A corrective action plan is required.

OHFC now has a process to enter data in the federal ACTS system on complaints investigated as desk reviews and referred to survey as areas of concern. A considerable amount of staff time is spent on these activities and will be captured and reflected in the federal data system, once the process is fully implemented in April, 2008.

OHFC staff is also involved in background study reconsideration reviews. Individuals who seek employment in licensed health care facilities and home care agencies must undergo background checks. When an individual is disqualified from employment due to a previous criminal conviction or finding of maltreatment or neglect against a vulnerable adult or minor child, the person may request a reconsideration for employment in settings licensed by the Department of Health. The nature and complexity of the disqualifications has expanded considerably in recent years, resulting in more review time per reconsideration and creating a significant backlog in the timeliness of completing reviews. An additional position added to the Background Study Unit in April 2007 has improved the timeliness of reconsideration reviews.

3. Transition Planning

The current OHFC Director, who has considerable longevity in this position, has announced he will retire just prior to the end of FFY08. The Assistant Director, who also has longevity in that position, will be eligible to retire in FFY09. Significant institutional memory and experience will be lost with those retirements. Workforce retirement of the baby boom generation is a concern for employers nationally in both the public and private sectors. With transition planning, there may be an opportunity to rethink how OHFC is structured, but there is definitely a need to find candidates with requisite experience and expertise to oversee a program as complex as OHFC.

4. Monitoring a Trend Increase in Home Care Complaints

OHFC has identified an upward trend in the number of home care complaints it receives. With assisted living alternative care continuing to grow, and more consumers receiving these services, and licensed home care necessary in order to provide health-related services, it stands to reason that more complaints may be generated.

MDH is responsible for assuring that home care providers meet standards in the delivery of care to their clients. OHFC will need to prepare to meet expected increases in complaints, however, with current and foreseeable investigative resources, the ability to conduct more complaint investigations is limited. A more positive and cost effective strategy is for OHFC to provide input to Division management on necessary home care regulation to protect the health and safety of clients based on the nature, number and breadth of complaints the Office receives. OHFC will also support Division efforts to work with stakeholder groups to encourage industry sponsored training in areas where training is needed due to increases in correction orders and deficiencies issued and complaints received.

A copy of OHFC's Quality Improvement Plan for 2008 is included as Appendix B.

Appendix A: OHFC Policy and Procedures

MINNESOTA OFFICE OF HEALTH FACILITY COMPLAINTS

Policy and Procedures

_____

Arnold Rosenthal, Director

SUBJECT:

Prioritization of complaints/reports

I. The Office of Health Facility Complaints will prioritize all complaints and reports of maltreatment related to possible violation of the rules, regulations and statues in order to insure appropriate response and to manage the workload.

II. Procedures

A. Investigation of complaints which allege immediate jeopardy will be initiated within two working days of receipt of the allegation. Immediate jeopardy are those situation which are present and on-going and are life threatening or have the potential to be life threatening; could result in potentially severe temporary or permanent injury, disability or death; present a serious safety hazard to patient; creates a condition which needs immediate attention. (If the immediate jeopardy has been removed, a two day investigation is not required.

1. Neglect which is life-threatening

2. Physical plant problems which could be life-threatening

3. Inadequate temperature which may be life-threatening

4. Physical or sexual abuse when the perpetrator is still working in the facility and no action has been taken to protect patient/resident

B. Investigation of complaints, which allege a higher level of actual harm, will be initiated within ten working days of receipt of the allegation. Actual harm situations are those that result in serious adverse consequences to patient health and safety but do not constitute an immediate crisis. To delay an investigation would not increase the risk of harm or injury.

1. Neglect which results in actual harm to the resident/patient, i.e., fractures, dehydration, decubitus, and significant weight loss which are avoidable; death; laceration requiring medical treatment; inadequate pain management; inappropriate use of restraints resulting in serious injury,

failure to obtain appropriate medical intervention, medication errors resulting in the need for medical attention

2. Physical abuse

3. Mental abuse resulting in the patient/resident feeling intimidated/threatened

4. Inadequate staffing which has a negative impact on resident health and safety

5. Resident to resident abuse in which no action has been taken to protect resident

C. Investigation of complaints which have not resulted in a higher level of actual harm but which have the potential to do so will be initiated within 45 days of receipt of the complaint or will be referred to survey as an "Area of Concern" if a survey will be initiated with 180 days.

1. Resident care issues

2. Inadequate staffing which has a negative impact on resident health and safety

3. Patient rights issues

D. Investigation of complaints which will be referred to L & C as "Areas of Concern" for consideration during the survey.

1. Neglect issues which do not result in actual harm or which are not recurring, i.e., medication errors in which no adverse consequences occur

2. Verbal or mental abuse which does not result in resident feeling frightened or threatened

3. Patient rights issues

4. Physical plant complaints which do not pose immediate threat to welfare of patients

5. Dietary complaints

6. General complaints which do not govern care of patient and which do not fall within category A or B

7. Housekeeping complaints

E. Complaints for which no determination may be made.

1. Complaints which do not provide enough information
2. Complaints which are not a violation of the rules and regulations
3. Self investigations done by the facility
4. Too much time evolved since incident or situation occurred
5. Cases in which further investigation is not necessary (medical record review does not reveal problems

P:HFC001
1/12/00
Revised 4/7/03
Revised 1/25/05

Appendix B: OHFC Quality Improvement Plan

2008 Quality Improvement Plan for
Office of Health Facility Complaints

Vision of Minnesota Department of Health:

Keeping All Minnesotans Healthy

Mission of Office of Health Facility Complaints 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.

This mission is accomplished through:

1. Investigating complaints by or on behalf of patients, residents, and clients of federally certified and state licensed health care providers;

2. Investigating facility reported incidents made by federally certified and state licensed health care providers;

3. Enforcing compliance with federal and state statutes, regulations and guidelines.

Purpose of the Ongoing OHFC Quality Improvement Plan:

To ensure that activities carried out by OHFC staff are performed accurately and consistently over time and by all staff in accordance with established state and federal requirements to protect patient, resident, and client health, well-being, safety and comfort; to identify areas for improvement in performance and in systems, and to make those improvements.

Intent of the OHFC Quality Improvement Process:

Identify and correct known, suspected or potential problems with the investigative, intake, communication, and other processes and identify opportunities for further improvements.

Goal 1. Ensure accuracy and consistency of the investigation process.

Objective 1. Identify acceptable outcome measures of investigative performance, analyze information and develop methods to reduce variation.

Expected Outcome: Investigative techniques and decision-making process will be applied in a timely, accurate and consistent manner by OHFC investigators.

Actions:
A. Investigators will participate in state and federal training.

B. Investigators will receive onsite mentoring and coaching from experienced investigators and/or supervisors approximately every 2 weeks.
C. OHFC policies and procedures will be reviewed annually and updated as appropriate.
D. Supervisory/management review of substantiated maltreatment and 2567s prior to being issued: (i) will continue to be used to identify variations in investigative processes and documentation, with individual mentoring and coaching provided to investigators; (ii) will be shared with investigators as a group through staff meetings, in-service training, and updating of policies and procedures, as appropriate.
E. Investigators will participate in monthly staff meetings.
F. Timeline requirements for initiation and completion of investigations will be reviewed with investigators at a staff meeting. Reports on timeline compliance will be provided to program manager/supervisory staff and investigators on a monthly basis, and action plans will be developed as needed to ensure timely initiation and completion of investigations.

Data/measurement:
A. Staff participation in training will be documented.
B. Supervisory/management staff will document coaching and mentoring of investigative staff.
C. Supervisory/management staff will document policy & procedure review.
D. Variances will be noted by OHFC supervisory/management staff and will be communicated to OHFC staff, division management, training staff, etc. as appropriate.
E. Attendance at staff meetings will be documented. Occurrence of staff meetings will be documented in Groupwise.
F. Reports from federal data bases will be reviewed on a monthly and quarterly basis to track compliance with timeline requirements.
G. Meet CMS Performance Standards.

Goal 2. Ensure compliance with state and federal requirements for triaging complaints and facility reported incidents.

Objective 2. Identify acceptable outcome measures of intake performance, analyze information and develop methods to improve performance.

Expected Outcome: Intake procedures, triage process/procedures and decision making process will be applied in a timely, accurate and consistent manner by OHFC intake staff.

Actions:
A. Intake policies and procedures will be reviewed annually and updated as appropriate.
B. OHFC will provide training to intake staff to assure they are up to date on state and federal regulations, procedures, processes, systems (e.g., ACTS), etc.
C. Intake staff will participate in staff meetings.
D. Supervisory staff will continue to conduct ongoing review of a portion of all complaints and facility reported incidents to assure proper review and provide necessary direction and assistance to Intake staff.

Data/measurement:
A. Supervisory/management staff will document policy & procedure review.

B. Staff participation in training will be documented.
C. Attendance at staff meetings will be documented. (Or Occurrence of staff meetings will be documented in Groupwise)
D. Variances in intake and triage procedures will be noted by OHFC supervisory/management staff and will be communicated to OHFC staff, division management, training staff, etc. as appropriate.
E. Meet CMS Performance Standards.

Goal 3. Improve communication and coordination with internal and external stakeholders.

Objective 3: Ensure integration and coordination of quality improvement findings and activities with pertinent staff and external stakeholders as appropriate.

Expected Outcome: Informal and formal information collection methods will demonstrate improvements in stakeholder satisfaction with OHFC communication and quality improvement activities.

Actions:
A. OHFC staff will participate in videoconferences, in-service programs, and all other available training.
B. OHFC supervisor/manager (and staff) will review form letters used to communicate with providers, licensed and unlicensed health care provider staff, and consumers, and update content of form letters as appropriate.
C. OHFC supervisor/manager will provide prompt review of requests for reconsideration.
D. OHFC will work with division / MDH staff to develop a satisfaction survey for providers and consumers.
E. OHFC will provide prompt follow-up of provider /consumer concerns by reviewing any pertinent findings with all staff.
F. OHFC will continue its participation on the Commissioner's Long-term Care Committee

Data/measurement:
A. Staff participation in training will be documented.
B. OHFC supervisor/manager will document review and updating of form letters.
C. OHFC supervisor & manager will monitor compliance with 15 day time frame (Minnesota Statutes 626.557, Subdivision 9d(b)) and will identify targets for improvement (which may be stated as a quality improvement initiative).
D. Once developed and collected, satisfaction survey results will be reviewed on an on-going basis and will be tabulated on a quarterly and annual basis.
E. Feedback from providers/consumers during follow-up after concerns have been addressed, and results of satisfaction survey, will be monitored by program supervisor/manager.

Appendix C: FFY07 State Performance Measures Review Report

Q6 – Prioritizing Complaints and Incidents – Not Met

Threshold Criteria:

1. **Nursing Homes:** The SA follows CMS guidelines governing the prioritization for 90% of sampled Federal complaints, regardless of whether an onsite survey is conducted, and those incidents that require a Federal onsite survey for nursing homes – **Not Met**
2. **Non-Deemed Hospitals, Non-Deemed Home Health Agencies and ESRD Facilities:** The SA follows CMS guidelines governing the prioritization for 90% of sampled Federal complaints, regardless of whether an onsite survey is conducted, and those incidents that require a Federal onsite survey for non-deemed hospitals, non-deemed home health agencies and ESRD facilities - **Met**

Findings

T/C 1 - Nursing Homes: Forty complaints and incidents that were received by the SA between October 1, 2006 and August 27, 2007 were reviewed. Of these, 33 or 82.5% were triaged correctly. The RO determined that the following seven complaints were not triaged correctly:

Augustana Health Care of Minneapolis – 245242; Intake # MN00012705.
The SA triaged this complaint as "No Action Necessary." The RO triaged the complaint as a "Non IJ-Medium" as the allegations indicate potential abuse. The allegations suggest that the resident may have suffered harm while at the nursing home, including a significant hematoma and diffuse ecchymosis after a staff person performed a diaper change in a rough manner. An onsite investigation would determine whether the facility staff follow standards of practice when changing resident diapers and providing incontinence care.

Cerenity Care Center – 245255; Intake # MN00013132
The SA triaged this complaint as "No Action Necessary." The RO revised its triage of this complaint from "Non IJ-Medium" to "Non IJ-Low." The complaint alleged that staff was not knowledgeable about the administration of nebulizer treatments, that oxygen tanks were not routinely checked, that on several occasions the resident did not receive oxygen as ordered, and that the accuracy of medication administration was questionable. An onsite survey is warranted to investigate facility practices that may result in harm, if confirmed.

Lake Minnetonka Care Center – 245606; Intake # MN00013318

The SA triaged this complaint as "No Action Necessary." The RO triaged the complaint as "Non IJ-Medium." The allegations stated that a resident communicated that she had been abused by an unknown person. An onsite investigation is warranted to determine whether the facility investigated the alleged abuse.

Edina Care and Rehab – 245275; Intake # MN00013603
The SA triaged this complaint as "No Action Necessary." The RO triaged the complaint as "Non IJ-Low." The allegations concern the adequacy of care and should have been triaged to be investigated at the next onsite survey.

Viewcrest Health Center – 245414; Intake # MN00013367
The SA triaged this complaint as "No Action Necessary." The RO triaged as "Non IJ-Low." The allegations concerned the quality of nursing care and should have been triaged to be investigated at the next onsite survey.
Crest View Lutheran Home – 245018; Intake # MN00013272
The SA triaged as "No Action Necessary." The RO triaged as "Non IJ-Low." The complaint related to the quality of dietary services and should have been triaged to be investigated at the next onsite survey.

Southside Care Center – 24E507; Intake # MN00013140
The SA triaged this complaint as "No Action Necessary." The RO triaged this case as "Non IJ-Low." The allegation concerns the living conditions at the facility which are described by the complainant as "abominable." The intake also alleges drug use and dealing at the facility. A survey is warranted to determine whether these allegations represent violations of Federal regulations.

The SA and RO agreed on the triage of the following complaints/incidents:

Facility Name	**CCN**	**Intake Number**
Green Acres Country Center	245370	MN00012907
Grandview Christian Home	245432	MN00013096
Golden Valley Rehab	245186	MN00012854
Three Links Care Center	245450	MN00012803
Good Shepherd Lutheran Home	245269	MN00013021
Golden Valley	245186	MN00012795
Golden Living Center Greeley	245342	MN00013035
New Brighton Health	245164	MN00012701
Minnesota Manor	245496	MN00013007
Park Crest Baptist	245544	MN00012712

Golden Living Center Lynwood	245201	MN00012696
Crossroads Care	245395	MN00013034
Fairmont Medical Center	245274	MN00012806
Golden Living Center Hillcrest	245084	MN00013123
Barnesville Good Samaritan	245281	MN00012778
McIntosh Manor	245356	MN00013296
Madison Lutheran	245382	MN00013385
Woodland Good Samaritan	245488	MN00013197
Southview Acres	245189	MN00013609
Park Health	245083	MN00013220
Bethel Care	245295	MN00013326
Edina Care	245275	MN00013158
Infinia at Fairbault	245097	MN00013608
Benedictine Health	245310	MN00013353
Good Samaritan Society	245246	MN00013244
New Brighton Health	245164	MN00013473
Mapleton Community	245362	MN00013297
Southview Acres	245189	MN00013695
Pierz Villa	245286	MN00013319
Park Health	245083	MN00013310
Robbinsdale Rehab	245417	MN00012894
Bryn Mawr	245203	MN00012789
Prairie View	245371	MN00013508

The score for this Criterion is 82.5%

T/C 2 – NLTC: A sample of six complaints and incidents that were received by the State between October 1, 2006 and August 27, 2007 were reviewed. All six were triaged correctly.

Safety Care, Inc. 248047	Prairie River Home, 248056
Complaint # MN00012841	Complaint # MN00013280
FMC Dialysis Services, 242523	Bridges Medical, 241313
Complaint # MN00012985	Complaint # MN00013649

Redwood Area Hospital, 247229
Complaint # MN00013154

TRC-St. Paul, 242513
Complaint # 00013649

The score for this Criterion is 100%.

Action Plan
The State must develop and implement an action plan that addresses the issues not met in this Measure and that includes a monitoring component. The plan must be submitted to the CMS Regional Office by May 9, 2008.

Q7 – Timeliness of Complaint and Incident Investigations – Not Met

Threshold Criterion 1: Immediate Jeopardy (non-deemed providers)
For nursing homes, ESRD facilities, non-deemed HHAs, and non-deemed hospitals (excluding EMTALA cases), the SA initiates an investigation within two working days of receipt for 100% of all complaints, and those incidents that require an onsite survey, where the intake is prioritized as "IJ." **Not Met**

Findings
NLTC: There were no ESRD, non-deemed HHA and non-deemed hospital immediate jeopardy complaints or incidents to review for the period of October 1, 2006 through September 30, 2007.

LTC: Twenty incidents and complaints received by the State between October 1, 2006 and September 30, 2007 and triaged as immediate jeopardy by the State were reviewed to determine if the onsite investigation began within two working days from the received start date for complaints and the received end date for incidents. For 19 or 95% of the cases, the State met the two-working day requirement for initiating an investigation. For the following one case, the two-working day timeframe was not met:

Ebenezer Care Center, 245587
Complaint # MN00013339
Received start date – 04/30/07; Survey start date – 05/04/07
Interval = 4 days

The score for this Criterion is 95%.

Threshold Criterion 2: Immediate jeopardy (deemed providers)
For deemed hospitals (excluding EMTALA cases) and deemed HHAs, the SA initiates an investigation within two working days of authorization from the RO for 100% of all complaints and those incidents that require an onsite survey where the intake is prioritized as "IJ." **Met**

Findings
Deemed Hospitals:
Based on review of the ACTS Reports, two complaints triaged as immediate jeopardy were reviewed to determine if the onsite investigation began within two working days from the date it was authorized by the RO. The State met the two-working day timeframe for initiating the investigation for both cases. There are two additional complaints listed on one of the reports, but these two complaints were not triaged as immediate jeopardy, and therefore, were not reviewed under this Threshold Criterion.

Deemed HHAs:
There were no deemed HHA immediate jeopardy complaints and incidents to review.

The score for this Criterion is 100%.

Threshold Criterion 3: Non-immediate jeopardy within 10 working days for nursing homes - For nursing homes, the SA initiates an investigation within 10 working days of prioritization for 95% of all complaints and those incidents that require an onsite survey where the SA prioritizes the intake as "Non-IJ High." **Met**

Findings
Based on a review of ACTS Reports, the SA received and triaged 221 complaints and incidents as non-immediate jeopardy-high. The State met the 10 working day requirement, i.e., Federal intakes where received end dates and survey start dates are no more than 10 working days after taking into account State holidays. For 221 or 100% of the intakes, the SA initiated its investigation within 10 working days of prioritization.

The score for this Criterion is 100%.

Threshold Criterion 4: Non-immediate jeopardy within 45 calendar days for deemed hospitals – For deemed hospitals, the SA initiates an investigation within 45 calendar days of receipt of authorization from the RO for 95% of all complaints and those incidents that require an onsite survey where the intake is prioritized as "Non-IJ." **Met**

Findings
Based on review of the ACTS Reports, there were 25 intakes where the RO authorized an investigation and an investigation was conducted. For all 25 cases or 100%, the SA initiated its investigation within 45 days of the RO authorization.

The score for this Criterion is 100%.

Action Plan
The State must develop and implement an action plan that addresses the issues not met in Threshold Criterion 1 and that includes a monitoring component. The plan must be submitted to the CMS Regional Office by May 9, 2008.

Action plans are not required for Threshold Criteria 2, 3 and 4.

Q8 – Timeliness of EMTALA Investigations - Met

Threshold Criterion: EMTALA Investigations – No less than 80% of approved, sampled complaints are investigated according to CMS policy.

Findings
Six EMTALA investigations out of 15 that were conducted between October 1, 2006 and September 30, 2007 were reviewed. An investigation was conducted according to CMS policy if it had no more than two review requirements that it did not meet. All six investigations reviewed were investigated according to CMS policy.

The score for this Measure is 100%.

Action Plan
Not required

Q9 – Quality of Complaint/Incident Investigations for Nursing Homes - Met

Threshold Criterion: Nursing Home Investigations – The SA investigates no less than 80% of sampled complaints and incidents that require a Federal onsite survey for nursing homes, according to CMS policy for complaint/incident handling.

Findings

Forty complaint/incident investigations that were conducted at Medicare and Medicaid certified nursing homes between October 1, 2006 and August 27, 2007 were reviewed for this Measure. For an investigation or case to be counted as "met," no more than two criteria can be rated as "no."

All complaint/incident investigations that were reviewed were investigated according to CMS policy.

While all cases or investigations are considered met, five cases had criterion #1 scored as "no." Criterion #1 evaluates whether an appropriate sample was chosen based on the allegations.

It should also be noted that due to the large number of "No Action Necessary" cases reviewed at Q6, more than half of the Q9 cases reviewed are not in the Q6 sample.

Action Plan

Not Required