Complaint Investigations of Minnesota Health Care Facilities

Report to the Minnesota Legislature explaining the investigative process and summarizing investigations from July 1, 2005 to June 30, 2008 and Information on Deficiencies Issued by OHFC from October 1, 2007 to September 30, 2008

Minnesota Department of Health

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MINNESOTA MDH DEPARTMENT OF HEALTH

Commissioner's Office
625 Robert Street N, Suite 500
P.O. Box 64975
St. Paul, MN 55164-0975
(651) 201-5000
www.health.state.mn.us

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For more information, contact:
Office of Health Facility Complaints
Minnesota Department of Health
P.O. Box 64970
St. Paul, MN 55164-0970
Phone: (651) 201-4201

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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 06 to state FY 08; 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 3 individuals responsible for the intake of complaints and facility reported incidents. There are 3 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
FFY08	12	3	3	3	21	Total Oper. Budget: $2,594,610 Medicare 40.23% Medicaid 30.02 % State Licensure 29.75%
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%

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
FY06, FY07, FY08

Complaints Received	**FY06**	**FY07**	**FY08**
Nursing Home	886	892	979
Hospital	293	278	300
Home Health	313	461	531
Other Licensed Entities	123	141	177
*** Total Complaints Received**	**1615**	**1772**	**1987**
Facility Reported Incidents	**FY06**	**FY07**	**FY08**
Nursing Home	3176	2769	4376
Hospital	131	117	93
Home Health	319	384	554
Other Licensed Entities	49	54	484
**** Total Facility Reported Incidents Received**	**3675**	**3324**	**5507**
***** Grand Total**	**5290**	**5096**	**7494**

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 FY06, FY07 and FY08; 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 FY06, FY07, FY08

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	29	156	26	187	15	241
Physical Abuse	64	227	63	251	58	352
Sexual Abuse	20	78	20	67	32	64
Self Abuse	--	--	--	--	0	20

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	12	69	13	76	15	136
Exploitation by other	7	99	8	113	9	150

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2009	FY 2008
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	385	318	338	223	318	361
Falls	49	766	64	751	59	1174
Medications	52	101	80	119	35	218
Decubiti	21	0	26	3	10	3
Dehydration	3	0	5	9	3	0
Nutrition	10	2	7	3	0	1
Neglect, Failure to notify MD	3	1	2	0	1	0
Neglect of Supervision	28	413	35	363	33	1088
Failure to Report	--	--	--	--	2	0
Entrapment	--	--	--	--	0	2

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	29	829	22	667	20	983

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	142	57	156	39	173	55
Nursing, Infection Control, Medications	120	2	104	4	224	25
Failure to Report	--	--	--	--	2	--
Other	137	6	142	16	205	24

Table 4: Hospital Allegations from Complaints / Facility Reported Incidents
FY06, FY07, FY08

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	2	9	0	9	2	7
Physical Abuse	11	12	4	22	12	10
Sexual Abuse	11	21	8	18	5	26
Accident	0	0	0	1	0	1

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	4	2	1	3	0	1
Exploitation by other	2	0	0	2	0	0

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2009	FY 2008
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	57	5	36	7	32	3
Falls	6	1	6	4	2	7
Medications	6	3	13	0	6	0
Decubiti	11	1	10	1	1	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	0	0	0	0	1	0
Neglect of Supervision	10	67	6	68	9	56

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	4	7	7	2	2	2

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	114	0	110	3	121	4
Nursing, Infection Control, Medications	17	0	31	0	49	1
ER Services	25	3	21	0	31	0
Discharge Planning	13	1	14	0	18	0
EMTALA	17	2	19	1	7	3
Other	19	0	27	1	54	2

Table 5: Home Health Care Allegations from Complaints / Facility Reported Incidents						
FY06, FY07, FY08						
	FY 2006	**FY 2006**	**FY 2007**	**FY 2007**	**FY 2008**	**FY 2008**
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	19	22	24	32	23	30
Physical Abuse	18	20	32	32	28	34
Sexual Abuse	10	15	9	11	11	6
Accident	1	15	0	4	0	1
Self Abuse	--	--	--	--	1	6
	FY 2006	**FY 2006**	**FY 2007**	**FY 2007**	**FY 2008**	**FY 2008**
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	17	55	41	84	44	82
Exploitation by other	8	12	10	28	7	24
	FY 2006	**FY 2006**	**FY 2007**	**FY 2007**	**FY 2008**	**FY 2008**
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	99	28	152	38	175	51
Falls	7	60	17	55	8	152
Medications	24	12	49	20	31	30
Decubiti	9	0	5	1	8	3
Dehydration	1	0	1	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	1	0	2	0	0	0
Neglect of Supervision	20	58	20	88	22	106
	FY 2006	**FY 2006**	**FY 2007**	**FY 2007**	**FY 2008**	**FY 2008**
Allegation : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	8	18	10	48	7	60
	FY 2006	**FY 2006**	**FY 2007**	**FY 2007**	**FY 2008**	**FY 2008**
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	82	12	95	9	130	21
Nursing, Infection Control, Medications, Shortage Staff	42	1	41	2	92	10
Other	21	0	49	2	42	4

Table 6: Other Licensed Entities Allegations from Complaints / Facility Reported Incidents FY06, FY07, FY08

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Abuse	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Emotional Abuse	1	2	6	9	8	13
Physical Abuse	7	6	9	8	9	24
Sexual Abuse	2	1	1	1	9	3
Accident	0	0	0	1	0	0
Self Abuse	--	--	--	--	0	1

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Exploitation	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Exploitation by staff	1	1	1	1	5	18
Exploitation by other	1	2	0	1	0	11

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2009	FY 2008
Allegations : Neglect	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
General Health Care	22	9	20	4	34	47
Falls	1	1	0	0	3	23
Medications	6	2	3	5	4	24
Decubiti	1	0	0	0	0	0
Dehydration	0	0	0	0	0	0
Nutrition	0	0	0	0	0	0
Neglect, Failure to notify MD	1	0	0	0	0	0
Neglect of Supervision	14	9	4	16	10	81

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : Unexplained Injury	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
	1	9	1	12	10	273

	FY 2006	FY 2006	FY 2007	FY 2007	FY 2008	FY 2008
Allegations : General	**Comp**	**FRI**	**Comp**	**FRI**	**Comp**	**FRI**
Patient Rights	59	1	73	2	66	11
Nursing, Infection Control, Medications	17	0	15	2	23	4
Other	25	0	38	0	35	7

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 Long-term Care 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 Long-term Care 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 FY06, FY07 and FY08 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
SFY06, SFY07, SFY08

	FY06	FY07	FY08
Onsite	442	418	446
Desk	150	165	373
Refer to Survey	206	218	161

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 FY06, FY07, FY08

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 446 onsite investigations assigned in SFY08, 426 were completed in SFY08. 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.

Table 8: Results of Completed Onsite Investigations SFY06, SFY07, SFY08

	SFY06		SFY07		SFY08	
	Number	**Percent**	**Number**	**Percent**	**Number**	**Percent**
Substantiated	164	39.0	187	31.4	137	32.2
Inconclusive	124	30.0	193	32.5	114	26.8
Un-substantiated	129	31.0	215	36.1	175	41.0
Total	417	100	595	100	426	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:

SFY06	SFY07	SFY08
75	68	82

Number of hearings requested:

SFY06	SFY07	SFY08
18	24	19

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

SFY06	SFY07	SFY08
75	41	49

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

[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.

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, 120.2 days for SFY07 and 107.5 days for SFY08. 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 06, 66.6% of the onsite investigations needed to be initiated within 10 days or less. This percentage was 52% in SFY 07 and 65.9% in SFY08. 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:

	SFY06	SFY07	SFY08
Complaint substantiated	51.6 hrs	50.2 hrs	50.6 hrs
Complaint unsubstantiated	30.0 hrs	28.2 hrs	31.3 hrs
Inconclusive	37.7 hrs	37.9 hrs	31.2 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 2008[6] (FFY08) OHFC conducted 455 on-site investigations, of which 299 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, 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.

[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 08 runs from October 1, 2007 to September 30, 2008.

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. 91% of the total number of onsite nursing home investigations (272 of the 299) conducted by OHFC fell within those two categories in FFY08.

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: FFY08 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	299 total	255 of 272	93.8%
Nursing home required within 10 days	236	226	95.8 %
Nursing home required within 2 days	36	29	80.6%

[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 08, OHFC conducted 4 partial extended surveys out of the 299 onsite nursing home investigations. The completion of the partial extended survey was required as the result of the issuance of 4 federal deficiencies. Of the four, 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 FFY08

Nursing Home	Tag and Scope and Severity	Immediate Jeopardy	Substandard Quality of Care
#1	F323J	Yes	Yes
#2	F323J	Yes	Yes
#3	F323K	Yes	Yes
#4	F324J	Yes	Yes

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

[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).

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 FFY08

During FFY08, 38 of 299 onsite nursing home investigations resulted in the issuance of 70 federal certification deficiencies. These deficiencies were issued to 36 separate nursing homes. Two nursing homes were issued deficiencies as the result of more than one OHFC onsite investigation.

A total of 43 state licensing correction orders were issued to 22 different nursing homes during FFY08 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 43 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 FFY08

Note: Deficiencies and Correction Orders do not correspond as listed

Deficiencies:	Correction Orders:
F157 – Failure to Report Significant Change 2-D; 5-G	MN Rule 4658.0085 Notification of Change in Resident Health Status (6) $350 daily
F201 – Transfer/discharge Requirements 1-E	4658.0400 Comprehensive Resident Assessment (1) $300 daily
F202 – Transfer/discharge Documentation 1-E	4658.0405 Comprehensive Plan of Care (3) $300 daily
F203 – Transfer or Discharge 1-D	4658.0450 Clinical Record Contents subp 1A (2) $300 daily
F204 – Orientation for Transfer/discharge 1-D	4658.0520 Adequate and Proper Nursing Care, subp. 1 (12) $350 daily
F223 – Abuse 1-E	4658.0525 Rehabilitation Nursing Care, subp.3B (1) $350 daily, subp.5A (1) $350 daily
F225 – Not Employ Persons Guilty of Abuse 3-D; 2-K	4658.0705 Medical Care & Treatment, subp. 1 (1) $300 daily

Deficiencies:	Correction Orders:
F226 – Abuse; intent: facility policies and implementation 1-E	4658.1005 Social Services subp. 5 (1) $350 daily
F241 – Dignity 2-D; 1-E	4658.1310 Drug Regimen Review AB (1) $300 daily
F242 – Self-Determination & Participation 1-F	4658.1315 Unnecessary Drugs A (1) $300 daily
F246 – Accommodation of Need 1-E	4658.1320 Med Errors AB (1) $500 daily
F250 – Social Services 1-D; 1-E	4658.1415 Housekeeping, subp. 2 (1), subp. 4 (1) $200 daily
F253 – Housekeeping; maintenance 1-E	4658.5000 Bedroom Design Existing Construction subp. 2 (1)$150 daily
F272 – Comprehensive Assessment 2-D	MS 144.651 Health Care Bill of Rights, subd. 5 (3) $250, subd 6 (1) $250,
F279 – Dev Comprehensive Care Plans 2-D; 1E	MS 626.557 Reporting of Vulnerable Adults, subd 3 (2) $250, subd 4A (1) $100
F282 – Services Provided in Accordance with Care Plan 2-D	
F309 – Fail to Provide Necessary Care 5-D; 4-G	
F314 – Proper Treatment for Pressure Sores, 1-G	
F315 – Urinary Incontinence, 3-D	
F323 – Accident 2-D; 4-G; 3-J; 1-K	
F329 – Unnecessary Medications, 2-D	
F333 – Medication Errors 2-D; 1-G	
F354 – Use of Charge Nurse & Registered Nurse, 1-F	
F385 – Physician Services, 1-D	
F428 – Res Drug Regimen Reviewed Monthly by Pharmacist, 1-D; 1-G	
F442 – Preventing Spread of Infection, 1-E	
F458 – Sq Footage of Resident Bedrooms, 1-D	
F465 – Other Environmental Conditions, 1-E	
F469- Effective Pest Control Program, 1-E	
F490 – Administration, 1-D	
F514 – Clinical Records Meet Appropriate Stnds 1-E	

38 post certification revisits were conducted by OHFC during FFY 08. These revisits were generally conducted onsite. A phone or written verification of compliance occurs rarely, if at all.

During FFY 08, 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 08, 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 08, 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 08, 53 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 38 sets of federal deficiencies issued in FFY08, 35 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 2008 Annual Quality Improvement Report on the Nursing Home Survey Process. Twenty-eight revisits were identified as not complying with the statutory provision; 2 of those were revisits conducted by OHFC. A summary of these 2 situations follows:

- In one facility, MDH scheduling issues did result in the late PCR. The facility was found to be in compliance at the time of the PCR. The timing of this revisit did not result in the facility having increased financial loss. Because the facility was designated a special focus facility and a Level G deficiency was found at the time of an OHFC abbreviated standard survey, it was subject to more severe enforcement sanctions and CMS imposed Category 2 remedies.

- In one facility, MDH scheduling issues did result in the late PCR. The facility was found to be in compliance at the time of the PCR. The timing of this revisit did not result in the facility having increased financial loss. CMS imposed a Category 2 remedy because the facility's

Immediate Jeopardy deficiency met the criterion for no opportunity to correct and mandated imposition of a Category 2 remedy.

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 FFY08, 8 of the 70 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 FFY08

	IDR	IIDR
Total requested	12	14
# of tags disputed	24	30
# that involved OHFC	2	4
# of OHFC tags disputed	3	5
Scope and severity of OHFC tags	1 D, 2 G	1 D, 4 G
Resolution of OHFC tags	all tags valid	3 ALJ reviews involving 4 tags completed: 4 tags valid: 1 @ s/sD; 3 @ s/s G no ALJ reviews pending 1 review withdrawn by nursing home prior to IIDR involving 1 tag @ s/s G

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 08, 12 hearings were requested as the result of 105 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 08, findings of neglect, abuse, or financial exploitation for 53 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 FFY08, 2 requests were made for these reviews.

Areas of Focus in FFY08

Minnesota remains an outlier in terms of the number of deficiencies issued on complaint investigations, despite a change this FFY in how OHFC reports and records actions on complaint activity. 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 FFY08 by states in Region V and the number of deficiencies that have been issued as the result of these investigations.

Table 13: FFY08 Complaint Surveys in Region V by State & Nursing Home Count as of 9/30-08

Illinois	2,675 surveys (805 nursing homes)
Indiana	1,447 surveys (517 nursing homes)
Michigan	615 surveys (433 nursing homes)
Minnesota	469 surveys (394 nursing homes)
Ohio	2,451 surveys (962 nursing homes)
Wisconsin	853 surveys (401 nursing homes)
Region V	8,510 surveys (3512 nursing homes)

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

Table 14: FFY08 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	129	103	4,043	829	82	892	18	1	200	50	11	6,358
Illinois	74	43	864	119	21	330	7	0	73	18	6	1,555
Indiana	7	3	1286	227	6	268	4	0	28	15	2	1,846
Michigan	4	1	341	98	6	106	4	0	40	5	2	607
Minnesota	0	1	53	15	2	10	0	0	3	1	0	85*
Ohio	36	41	1109	288	38	91	0	0	27	4	0	1,364
Wisconsin	8	14	390	82	9	87	3	1	29	7	1	631

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

* This table includes 15 deficiencies issued as a result of a recertification survey in conjunction with a complaint referral from OHFC.

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

CMS required OHFC to develop a process to allow nursing homes to comply with federal regulations 483.13 (c) (2) and (4) governing federally reportable incidents. The development of an electronic

reporting process that complies with both of the federal regulations and state reporting requirements became operational April 14, 2008, and has been a major area of focus for FFY08 with respect to ensuring compliance with the regulations. OHFC experienced a large influx in facility reported incidents and has spent considerable time working with facilities to correct over reporting, especially in the areas of falls and resident to resident abuse. This will remain an area of focus for FFY09.

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 questioned this process due to the federal certification of those facilities and required OHFC to be the lead department on those complaints investigations. OHFC began conducting complaint investigations in ICFsMR in FFY07 and activity in this area has increased. In FFY07 OHFC received 23 complaints on ICFsMR and conducted 4 onsite investigations; in FFY08 81 ICFMR complaints were received, and 16 onsite investigations were done.

2. Accuracy and Consistency

Managing workflow to improve compliance with state and federal timelines for initiating and completing investigations has been especially challenging for OHFC in FFY08. A large number of unexpected staff turnovers and extended medical leaves resulted in a reduced staff of investigators (5) and significantly affected the Office's ability to expand complaint investigations beyond only the most pressing and highest priority of triaged complaints. According to CMS' evaluation of FFY08 Performance Standards for OHFC, OHFC fell below performance standards on prioritizing complaints and incidents and the timeliness of complaint investigations onsite within the required 2 working day threshold. However, 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 worked closely with an MDH licensing and certification assistant manager, who is a member of the CMS Region V Immediate Jeopardy (IJ) Workgroup. The group meets weekly via telephone conference with representatives from other states in Region V. Each week the group debriefs actual IJ situations, sharing information and ideas to provide guidance on achieving consistency in IJ identification during complaint investigations.

Consistency in enforcement activities between OHFC and the Licensing and Certification Program has been a goal of supervisory staff in both programs. OHFC has worked collaboratively to increase awareness of enforcement activity and now uses the Program Assurance team in the Licensing and Certification Program to process federal deficiencies at Long-Term care Facilities. This practice has resulted in increasing the timeliness, accuracy and consistency of enforcement activities.

Some supervisory and intake staff has participated in root cause analysis training and education. Root cause analysis is a process that focuses on the actual cause of a problem and then directs corrective measures at the cause (root) instead of continuing to address symptoms. Training in this approach will allow new insight into identifying systemic problems at long-term care establishments, as well as an opportunity to work collaboratively with stakeholders to develop solutions to these systemic problems. OHFC's goal is to train all investigators in root cause analysis by the end of calendar year 2012.

OHFC has also been represented as a stakeholder member on the Elder Abuse Justice Project, an outgrowth of a statewide group of individuals that was looking at ways to revise Minnesota's Vulnerable Adult Act. The Elder Abuse Justice Project is comprised of a number of organizations that share a common goal of improved identification and prevention of elder abuse through an informational campaign to increase public awareness and early reporting of elder neglect, abuse and financial exploitation; legislative changes to laws designed to protect all vulnerable adults; and increased training for caregivers and providers regarding identification of abuse, effective law enforcement and resources for those who have been harmed.

OHFC's presence on this group is important because collaborating with community and health care providers to advance the identification and prevention of elder abuse is in our interest as regulators - to ultimately end abuse in all settings, and alternatively, to have effective means of redress when violations occur.

OHFC has implemented 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 that is spent on these activities will now be captured and reflected in the federal data system; the process was fully implemented in April, 2008.

As part of its 2009 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.

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. An additional position added to the Background Study Unit in April 2007 has improved the timeliness of reconsideration reviews.

3. Transition Planning to Transition Implementation

The previous OHFC Director, who had considerable longevity in this position, retired just prior to the end of FFY08. The Assistant Director, who also had longevity in that position, retired in April 2009. Significant institutional memory and experience was lost with those retirements. After 9 months of significant investigator reduction due to turnover and medical leaves, the Office is currently staffed to the full investigator complement of 14 investigators. However, since many of these investigators are new hires, it will take at least 6 months to provide these RNs with the requisite knowledge and mentoring experiences to become proficient investigators. Nine of the full complement of 14 investigators have attained SMQT status, with 2 slated for this federal training in July 2009 and the remaining 3 trained before the close of calendar year 2009.

In addition to hiring new investigators, the OHFC management staff is being rebuilt. A new director was hired in FFY09 and the Assistant Director position will be filled by June 2009. While this rebuilding phase requires a lot of hard work it also offers new opportunity to review and reorganize the work of OHFC. New staff bring new perspectives on how work is assigned, reviewed and processed. OHFC will use this transition time to evaluate how OHFC functions and identify and implement any changes that will improve and strengthen the services provided by OHFC.

4. Monitoring a Trend Increase in Home Care Complaints

OHFC continues to note 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 has begun working with MDH's Case Mix Program to assist in complaint investigations as well as ensure consistency of enforcement between the two programs. OHFC has provided 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 has supported 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.

Areas of Focus for FFY 09

Facility Reported Incidents

OHFC needs to analyze the Facility Reported Incidents (FRIs) it receives as a result of the web based Incident Report System (IRS) which was developed in 2008. Data show that the number of FRIs received from long-term care facilities has doubled in numbers since the inception of the IRS. OHFC needs to analyze this information to ensure the reported incidents meet the federal requirements for reporting maltreatment; the results of the analysis will be used to further educate and train providers who utilize this reporting system. In addition, OHFC will continually update the IRS to better meet the needs of the reporters and try and limit the amount of duplication between state and federal reporting requirements.

OHFC is currently working with the Department of Human Services (DHS) to tie the Intake Process for non-long-term care facilities into the current SSIS (Social Services Information System) state system used by County Common Entry Points (CEP). When completed, it is expected that the Intake Process between the CEP and OHFC will be streamlined and more accurate. OHFC will continue its work with DHS and the state's Elder Abuse Justice Project to develop a centralized CEP that all Minnesota residents can access through one telephone number.

Increase Investigations Initiated and Timeliness of Conclusion

During this time of rebuilding, OHFC needs to take an extensive look at its current practices involved in complaint investigations. Federal figures show that MN historically issues a significantly lower number of federal deficiencies on complaint investigations compared to other states in Region V. OHFC must interpret this data to ensure that all investigation protocols and timelines are being observed and that all investigation activities are being properly captured in the federal reporting system (ACTS). This will include expanding the number of complaint referrals to the Licensing and Certification and Case Mix Programs.

Moreover, OHFC plans to initiate a project that will consider streamlining the current maltreatment public reports to allow more time for onsite investigations as well as analyze increases in licensed only facility complaints to review the possibility of hiring an additional investigator to meet this growing need.

Data Recovery for this Annual Report and Other Data Requests

Retrieving data for this report has historically been time intensive and often involved manual extraction and significant review for accuracy. OHFC will work with MDH Information Systems and Technology Management staff to develop a comprehensive process for accessing data that can be used not only for this report, but as an ongoing management tool to monitor performance functions and preparing quarterly reports for the Centers for Medicare and Medicaid Services. Fully automating the collection and dissemination of data is a priority.

A copy of OHFC's Quality Improvement Plan for 2009 is included as Appendix B.

Appendix A: OHFC Policy and Procedures

MINNESOTA OFFICE OF HEALTH FACILITY COMPLAINTS

Policy and Procedures

_____

Stella French, Director

SUBJECT:

Prioritization of complaints/reports

I. It is the policy of the Office of Health Facility Complaints (OHFC) to enter the following into the Aspen Complaint Tracking System (ACTS):

1. Complaints alleging maltreatment and/or possible violation of the rules, regulations and statutes, which occur in federally certified facilities.

2. Complaints or facility reported incidents in which a fire in the facility has resulted in serious injury or death. These complaints/incidents will be entered into ACTS within one day of receipt.

3. In addition to entering the information into ACTS, an e-mail message will be sent to the Regional Office when complaints allege immediate jeopardy, serious injury, or death from a fire.

4. Facility reported incidents in which an on-site investigation is conducted.

It is also the policy of OHFC to prioritize all complaints in accordance with the federal State Operations Manual and ACTS guidelines in order to insure appropriate response and management of the workload.

II. Procedures

A. **Immediate Jeopardy**: Investigation of complaints alleging immediate jeopardy will be initiated within two working days of receipt of the allegation. Immediate jeopardy is a situation in which non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident/patient. Assign this priority if the alleged noncompliance indicates immediate corrective action is necessary. (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

5. Fires resulting in serious injury or death

B. **Non-immediate jeopardy - high:** Investigation of complaints, which allege non-immediate jeopardy - high, will be initiated within ten working days of receipt of the allegation. Non-immediate jeopardy-high situations are those that allege noncompliance with one or more requirements or conditions may have caused harm that negatively impacts the individual's mental, physical and/or psychosocial status and is of such consequence to the person's well being that a rapid response is indicated. 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 – spitting/slapping/sticking with sharp objects/pushing/pinching

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

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

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

6. Sexual assault/sexual harassment/coercion when the perpetrator has been suspended or is no longer working in the facility

7. Inappropriate use of restraints resulting in injury

8. Failure to obtain appropriate care or medical interventions, i.e., failure to respond to a significant change in condition

C. **Non-immediate jeopardy – medium**: Investigation of complaints that allege non-immediate jeopardy-medium will be initiated within 45 calendar days of receipt. Non-immediate jeopardy-medium are situations in which non-compliance with one or more requirements or conditions has caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical and/or psychosocial status to function.

1. Resident/patient care issues

2. Inadequate staffing which may have a negative impact on resident/patient health and safety

D. **Non-immediate jeopardy – low:** Situations in which the allegation alleges that noncompliance with one or more requirements or conditions may have caused physical, mental and/or psychosocial discomfort that does not constitute injury or damage.

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. Resident/patient rights issues

3. Physical plant complaints which do not pose immediate threat to welfare of residents/patients

4. Dietary complaints

5. General complaints, which do not govern care of residents/patients and which do not fall within category A, B, or C.

6. Housekeeping complaints

E. **Administrative Review/Offsite investigations** are those situations in which an onsite investigation is not necessary. The SA conducts an offsite administrative review (written/verbal communication or documentation) to determine if further action is necessary. The SA may review the information at the next onsite survey.

F. **Referral – Immediate:** Complaints are assigned this priority if the seriousness of a complaint requires referral or reporting to another agency, board, or network without delay for investigation.

G. **Referral –other**: Complaints are assigned this priority when referred to another agency, board, or network for investigation or for informational purposes.

H. No Action Necessary: **Complaints are assigned this priority if the SA determines with certainty that no further investigation, analysis, or action is necessary.**

P:HFC001
1/12/00
Revised 4/7/03
Revised 1/25/05
Revised 10/31/05
Revised 6/22/07
Revised 9/13/07

Appendix B: OHFC Quality Improvement Plan

2009 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: FFY08 State Performance Measures Review Report

Q6 – Prioritizing Complaints and Incidents –Not Met

Threshold Criteria:
Criterion 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.

Criterion 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.

Findings
T/C 1: LTC – Forty complaints and incidents that were received by the State Agency between October 1, 2007 and August 22, 2008 were reviewed. The list of the Q6 LTC sample is enclosed. Of the 40, 23 or 58% were triaged correctly. The following 17 complaints and incidents were not triaged correctly:

Golden Living Center, CCN-245319, Complaint # - 00014587, Date Complaint Received - 03/03/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged it as an "Immediate Jeopardy." The complaint alleges unexplained bruising to a resident's forearms. Since the bruising may represent rough handling by staff during cares, i.e., abuse, neglect or mistreatment by staff, a survey was warranted.

Littlefork Medical Center, CCN-245542, Complaint # - 00014145, Date Complaint Received – 11/14/07: The State Agency triaged this complaint as an "Administrative Review." The Regional Office triaged this complaint as "Non IJ-Medium." In order to investigate the allegation that the resident was not provided adequate hygiene, resulting in the resident smelling like urine and feces, an onsite investigation would have to be conducted.

Good Samaritan Society, CCN-245500, Complaint # - 00014314, Date Complaint Received – 12/26/07: The State Agency triaged this complaint as "Non IJ-High." The Regional Office triaged this complaint as an "Immediate Jeopardy." The allegation is that a resident died from a head injury after falling off the toilet where she was left unattended. The resident was not supposed to be left alone on the toilet.

Renvilla Health Center, CCN-245554, Complaint # - 00014027, Date Complaint Received – 10/15/07: The State Agency triaged this complaint as an "Administrative Review." The Regional Office triaged this complaint as "Non IJ-Low." The complaint alleges that a resident is not provided with timely assistance with toileting and is not allowed to wear incontinence briefs, which puts the resident at greater risk for skin breakdown.

Good Samaritan Society-Mountain Lake, CCN- 245549, Complaint # - 00014552, Date Complaint Received – 02/27/08: The State Agency triaged this complaint as an "Administrative Review." The Regional Office triaged this complaint as "Non IJ-High." The complaint alleges that a resident fell while being transferred by one staff person, when a two-person transfer was required. The resident fractured her left leg.

Golden Living Center, Lynnhurst, CCN-245394, Complaint # - 00014374, Date Complaint Received – 01/16/08: The State Agency triaged this complaint as a "Non IJ-High." The Regional Office triaged the complaint as an "Immediate Jeopardy." The self-reported incident concerns a resident who jumped from a second floor window of a locked unit and suffered multiple fractures. An immediate response by the State Agency was necessary to determine if other residents were at risk, if supervision was being provided in accordance with care plans, and whether this resident was trying to elope or commit suicide.

Southside Care Center, CCN- 24E507, Complaint # 00014864, Date Complaint Received – 05/14/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Non IJ-High" since the resident was admitted to the hospital with multiple bruises of unknown origin and admitted to being hit on the head. These injuries may represent abuse or neglect.

Viewcrest Health Center, CCN – 245414, Complaint # 00014894, Date Complaint Received – 05/12/08: The State Agency triaged this complaint as "Administrative Review." The Regional Office triaged this complaint as "Non IJ-High" due to the facility's failure to send a resident to the hospital on two occasions when his/her condition deteriorated. Based on the intake information, an onsite visit should have been conducted to determine if the facility has a system in place to provide timely intervention for residents with deteriorating medical conditions.

Prairie Manor Care Center, CCN – 245482, Complaint # 00014808, Date Complaint Received – 04/25/08: The State Agency triaged this complaint as "Non IJ-High." The Regional Office triaged this complaint as "Immediate Jeopardy" since there was a delay by the facility in sending a resident to the hospital when his/her condition deteriorated and due to facility's failure to initiate CPR when the same resident suffered a cardiac arrest. An immediate onsite survey was necessary to ensure that other residents were not at risk in the event of a sudden decline in condition.

Golden Valley Rehabilitation Center CCN – 245186, Complaint # 00014873, Date Complaint Received – 05/14/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Immediate Jeopardy" since the complaint alleges physical abuse of a resident. An onsite investigation was warranted to determine if abuse was still occurring and if other residents were at risk.

Ebenezer Care Center, CCN – 245587, Complaint # 00014977, Date Complaint Received – 06/06/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Administrative Review." Through an administrative review, it could have been determined whether additional follow-up was necessary to ensure that the aide in question had not mistreated other residents.

Woodbury Health Care Center, CCN – 245235, Complaint # 00014921, Date Complaint Received – 05/28/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Non IJ-Low." The allegations concern over-medicating residents. Even though the State conducted a survey at the facility a month prior to the allegation which resulted in a deficiency at F329 – unnecessary drugs (unrelated to the over-medication of residents), the allegation also alleges understaffing on weekends and evenings and a lack of activities. These areas need to be addressed by an onsite investigation.

Southview Acres Health Care Center, CCN – 245189, Complaint # 00014845, Date Complaint Received – 05/07/08: The State Agency triaged this complaint as "Administrative Review." The Regional Office triaged this complaint as "Non IJ-Low" because in order to investigate the allegations related to call lights and not meeting resident needs, observations and interviews need to be conducted. It is not clear what the SA did as part of its administrative review.

Golden Living Center – Otter Tail Lake, CCN – 245541, Complaint # 00014763, Date Complaint Received – 04/23/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Administrative Review." The complaint concerns one resident's allegations of neglect, not being fed, and not being taken out of bed. The State should have contacted the facility to conduct interviews with staff and review documentation to ensure that additional onsite follow-up was not necessary.

Walker Methodist Health Center, CCN – 245055, Complaint # 00014964, Date Complaint Received – 06/04/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Administrative Review." The allegation is that a resident walked away from the facility and according to facility protocol, staff had to wait until the following day to inform the nursing supervisor of the situation. An "Administrative Review" would have provided more information as to whether further action was necessary.

Lyngblomsten Care Center, CCN – 245347, Complaint # 00015118, Date Complaint Received – 07/09/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Immediate Jeopardy." An immediate onsite investigation was warranted to investigate the incident that was reported, to check whether the staff person in question is providing care to other residents and to determine what other corrective actions the facility had taken.

Riverview Hospital & Nursing Home, CCN- 245251, Complaint # 00015095, Date Complaint Received – 06/27/08: The State Agency triaged this complaint as "Administrative Review." The Regional Office triaged this complaint as "Immediate Jeopardy." An immediate onsite investigation was warranted to determine if the facility was using the hoyer lift safely and if the facility was following physician orders for neuro-checks following a head injury. Other residents being transferred with a hoyer lift were at risk.

Threshold Criterion 1 is not met.

T/C 2: NLTC – Ten complaints or incidents that were received by the State Agency between October 1, 2007 and August 22, 2008 were reviewed. The list of the Q6 NLTC sample is enclosed. Of the 10 complaints, 8 or 80% were triaged correctly. The following two complaints were not triaged correctly.

Comfort Home Health Care, CCN-247161, Complaint # - 00014611, Date Complaint Received – 02/22/08: The State Agency triaged this complaint as "No Action Necessary." The Regional Office triaged this complaint as "Non IJ-Medium," since an onsite investigation would determine whether the agency nurses are ensuring that patients are following physician medication orders.

St. Paul Dialysis, 242513, Complaint # 00015142, Date Complaint Received – 07/16/08
The State Agency triaged this complaint as "Non IJ-Low." The Regional Office triaged this complaint as "Non IJ-Medium," because facility staff was unable to locate emergency equipment for 20 minutes when needed by a patient.

Threshold Criterion 2 is not met.

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 action plan should address how and under what circumstances the State will use the triage categories of "No Action Necessary" and "Administrative Review" and what criteria it uses to determine if a complaint or incident should be triaged as immediate jeopardy, non IJ-high, non IJ-medium or non IJ-low. The plan must be submitted to the CMS Regional Office by April 24, 2009.

Q7 – Timeliness of Complaint and Incident Investigations –Not Met

Threshold Criterion 1 - *Immediate Jeopardy within two working days*: 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 95% of all complaints and incidents where the intake is prioritized as "IJ."

Findings
LTC: Based on the enclosed ACTS reports, 29 complaints and incidents received from October 1, 2007 through September 30, 2008 and triaged as immediate jeopardy were reviewed. These intakes were reviewed to determine if the onsite investigation began within two working days from the received start date for complaints and within two working days from the received end date for incidents. For 24 intakes or 82.8%, the State met the two working requirement for initiating the investigation. For the following complaint intakes, the State did not meet the two-working day requirement:

Colonial Manor of Balaton, 245552, Intake # 00015240
Rec'd start date – 08/01/08; Survey start date – 08/11/08

Interval = 6 days

Colonial Manor of Balaton, 245552, Intake # 00015241
Rec'd start date – 08/04/08; Survey start date – 08/11/08
Interval = 5 days

North Ridge Care Center, 245183, Intake # 00015163
Rec'd start date – 07/16/08; Survey start date – 07/21/08
Interval – 3 days
Ramsey County Care Center, 245352, Intake # 00015186
Rec'd start date – 07/18/08; Survey start date – 07/23/08
Interval = 3 days

Valley View Nursing Home, 245566, Intake # 00014847
Rec'd start date – 05/02/08; Survey start date – 05/12/08
Interval = 6 days

NLTC: There were no immediate jeopardy complaints or incidents in the review period of October 1, 2007 through September 30, 2008 for the following provider types: ESRD facilities, non-deemed HHAs and non-deemed hospitals.

The score for this Threshold Criterion is 82.8% and it is not met.

Threshold Criterion 2 - *Immediate jeopardy within two working days for deemed hospitals and deemed HHAs*: For deemed hospitals (excluding EMTALA cases) and deemed HHAs, the SA initiates an investigation within two working days of authorization from the RO for 95% of all complaints and incidents where the intake is prioritized as "IJ."

Findings
Deemed Hospitals**:** Based on the review of the enclosed ACTS Reports, four complaints were received and triaged as "immediate jeopardy" for the review period of October 1, 2007 through September 30, 2008. These complaints were reviewed to determine if an onsite investigation began within two working days from the date authorized by the Regional Office. For all four intakes or 100%, the State met the two working day timeframe for initiating the investigation.

Deemed HHAs**:** There were no deemed HHA immediate jeopardy complaints to review for the review period of October 1, 2007 through September 30, 2008.

The score for this Threshold Criterion is 100% and it is met.

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 incidents where the SA prioritizes the intake as "Non-IJ High."

Findings

Based on the enclosed ACTS report, there were 232 complaints and incidents that were received and triaged by the State as "non-immediate jeopardy-high" for the review period of October 1, 2007 through September 30, 2008. For 229 or 98.7% of the cases, the State initiated the investigation within 10 working days of prioritization. The State did meet the 10-working day requirement for these 229 cases. State holidays are considered in the calculation of this threshold criterion. The following three cases are error cases:

Intake # 00014453, Walker Methodist Health Center, 245055
Rec'd End Date – 01/16/2008
Survey Start Date – 02/04/2008
Interval = 12 days
Intake # 00014377, Elim Home – Milaca, 245422
Rec'd End Date – 01/16/2008
Investigation Due Date – 01/25/2008
Investigation overdue by 124 days

Intake # 00015009, Fairview Care Center, 245344
Rec'd End Date – 06/16/08
Investigation Due Date – 06/27/08
Investigation overdue by 143 days

The score for this Threshold Criterion is 98.7% and it is met.

Threshold Criterion 4 - *Non-immediate jeopardy within 45 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 incidents where the intake is prioritized as "Non-IJ."

Findings

Based on the enclosed ACTS Reports, there were 34 intakes where the Regional Office authorized an investigation and an investigation was conducted during the review period of October 1, 2007 through September 30, 2008. For these 34 intakes or 100%, the State initiated its investigation within 45 days of the RO authorization.

The score for this Threshold Criterion is 100% and it is met.

The ACTS reports used to evaluate this Measure are enclosed.

Action Plan
The State must develop and implement an action plan that addresses the issues not met in Threshold Criterion 1 of this Measure and that includes a monitoring component. The action plan must be submitted to the CMS Regional Office by April 24, 2009.

E1 – Timeliness of Processing Immediate Jeopardy Cases – Met

Threshold Criterion - *IJ processing*: In 95% of the SA's determinations that there is an IJ to resident and/or patient health and safety that was not removed onsite prior to the end of the survey of a provider/supplier, the SA adheres to the 23-day termination process. This would exclude cases involving Medicaid-only providers and suppliers and EMTALA.

Findings
LTC: There were no LTC IJ cases in the review period of October 1, 2007 through September 30, 2008 where the IJ was not removed onsite prior to the end of the survey.

NLTC: There was one NLTC IJ case for the review period of October 1, 2007 through September 30, 2008 where the IJ was not removed onsite prior to the end of the survey. For this one case, which is identified below, the State followed the 23-day termination process.

Phillips Eye Institute, 240196
IJ survey date – 01/31/2008
IJ notification to RO – 02/04/2008
Termination date – 02/23/2008
Removal alleged – 02/20/2008
Revisit date – 02/22/2008
IJ removal notice/call to RO – 02/22/2008

The score for the Measure is 100%.

Action Plan
Not required.

E2 – Timeliness of Mandatory Denial of Payment for New Admissions (DPNA) Notification for Nursing Homes-Met

Threshold Criterion – *Mandatory DPNA processing*: The SA adheres to the enforcement processing timeframes so that DPNA is imposed when a nursing home is not in substantial compliance three months after the date of the original survey. In 80% of the cases, the SA transfers the enforcement case to CMS by the 70th day or the imposition notice is sent by the SA to the provider by the 70th day. This excludes cases involving Medicaid-only nursing homes.

Findings

There were 64 LTC enforcement cases opened between July 23, 2007 and June 30, 2008 in which the compliance status on the 70th day following the original survey was either unknown (the revisit had not occurred and the State agency had not verified compliance) or was not in substantial compliance (as verified by a revisit occurring on or before day 70). This number is comprised of both opportunity to correct and no opportunity to correct case types. Sixty of the 64 cases, or 93.8%, were processed within the required 70 day timeframe, i.e., timely notification of the imposition of DPNA by the SA to the facility, or timely transfer to the RO. (Last year's review period ended July 22, 2007; the review of this Measure straddles fiscal years.)

Enclosed is a list of all the cases in the universe. The following four cases did not meet the criteria for being processed timely:

CCN	Name	First Visit
245393	Good Shepherd Lutheran Home	08/09/07
245024	Interfaith Care Center	08/23/07
245460	Jones Harrison Residence	02/01/08
245414	Viewcrest Health	05/08/08