Annual Quality Improvement Report: The Nursing Home Survey Process

REPORT TO THE MINNESOTA LEGISLATURE FOR FEDERAL FISCAL YEAR 2023

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Executive Summary

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

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

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

This report was prepared by staff of the Health Regulation Division (HRD). This report is the thirteenth annual report on the nursing home survey process and is based on analysis of data representing status of the program during Federal Fiscal Year 2023 (FFY23), which occurred from Oct. 1, 2022, through Sept. 30, 2023.

The development of this report allows the Department to reflect on both successes, as well as areas for improvement. One area noted for improvement for FFY23 is consistency across the state between regional survey teams. In FFY23, a regional comparison within Minnesota reflects difference of almost five deficiencies in the average number of health deficiencies issued per survey (4.8 deficiencies per survey). The average number of health deficiencies across all teams will continue to be reviewed through team meetings, supervisor meetings and quality assurance review of deficiency.

Introduction

Survey Process

General

The Licensing and Certification Program of the Health Regulation Division (HRD) at the Minnesota Department of Health (MDH) surveys nursing homes that are federally certified to provide care to Medicare and Medicaid residents using federal standards. MDH is under contract with the Center for Medicare and Medicaid Services (CMS) to conduct all federal certification inspections. There are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. MDH contracts with the Minnesota State Fire Marshall's (SFM) office to conduct the LSC portion of the inspection, which must be completed within seven days of the health portion of the recertification survey. It is federally mandated that recertification surveys be conducted at least every 15.9 months, and that the statewide average interval between standard surveys of

skilled nursing facilities and nursing facilities not to exceed 12 months[1]. It is typical that a provider receives a recertification survey annually.

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

The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. The LSC, which is revised periodically, is a publication of the National Fire Protection Association (NFPA), which was founded in 1896 to promote the science and improve the methods of fire protection. The basic requirement for facilities participating in the Medicare and Medicaid programs is compliance with the 2012 edition of the LSC.

Surveys are unannounced and are conducted to make sure that the nursing home is meeting state licensing and federal certification standards. The survey review includes but is not limited to, quality of care and quality of life, whether residents' rights are observed, physician and nursing services, freedom from abuse, food and nutritional services, pharmacy services, infection control and whether the facility meets environmental standards of cleanliness[2]. Facilities that do not meet all these standards must correct these deficiencies or they face a variety of federal and/or state sanctions. A deficiency indicates a provider's failure to meet a state licensure or federal certification requirement. Deficiencies range in scope and severity from isolated violations with no actual harm to residents to widespread violations that cause injuries or put residents in immediate jeopardy of harm.

When surveyors find a facility out of compliance with a federal regulatory requirement, the survey team issues a deficiency and corresponding state licensing order, and the facility is then required to correct the deficiency to come into compliance with regulatory requirements. A Statement of Deficiencies (CMS-2567) is provided to the nursing home, which contains the findings of the survey. A written Plan of Correction (PoC) is then required from the facility, and state surveyors conduct a revisit, either by desk review or onsite, to determine whether substantial compliance has been achieved.

The Revisit Process

Since the PoC serves as the facility's allegation of compliance, a post certification revisit (PCR) is conducted to determine whether substantial compliance has been achieved. Substantial compliance cannot be ascertained until facility compliance has been verified. Revisits may be conducted anytime for any level of noncompliance subject to the allowed number of revisits, and both paper/administrative reviews and onsite reviews are

[1] Medicare State Operations Manual Chapter 7 (pdf) (https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107c07pdf.pdf)

[2] For more information about nursing homes see the CMS web page — Nursing Homes - CMS (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Nursing-Homes)

considered to be revisits. Two revisits are permitted at the State's discretion without prior approval from the regional office; a third revisit may be approved only by the CMS Regional Office[3]. See Appendix A for more information regarding the federal revisit policy and timing.

Long Term Care Survey Process (LTCSP)

CMS consolidated Medicare and Medicaid requirements for participation (requirements) for Long Term Care (LTC) facilities in 2016. The requirements for participation were revised to reflect the substantial advances in healthcare that were made over several years in the theory and practices of service delivery and safety. The regulation reform implemented several pieces of legislation from the Affordable Care Act (ACA) and Improving Medicare Post-Acute Care Transformation (IMPACT) Act. This included quality assurance and performance improvement (QAPI), reporting suspicion of a crime, increased discharge planning requirements, and staff training. The revisions were published in a final rule that became effective on November 28, 2016. The implementation of the final rule was implemented in a three-phase process.

The first phase, implemented on Nov. 28, 2016, in which the new regulatory language was uploaded to the federal data base, Automated Survey Processing Environment (ASPEN).

The second phase, implemented on Nov. 28, 2017, included renumbering of the F tags, updating the interpretive guidance and all states implemented the computerized Long Term Care Survey Process (LTCSP) thus changing from the Quality Indicator Survey (QIS) process to the LTCSP.

Minnesota along with less than half of the other states had been using the computerized Quality Indicator Survey (QIS) process for facility evaluations while the remaining states were using the traditional paper-based survey process. On Nov. 28, 2017, CMS required all states to utilize the computer based LTCSP.

The goals of the new process were:

1. Ensure the same survey process for the entire country.
2. Gleam strengths from the traditional and QIS process.
3. Implement a new innovative approach to survey.
4. Ensure an effective and efficient survey process.
5. Ensure the survey process was resident centered.
6. Ensure a balance between structure and surveyor autonomy.

The third phase was scheduled to be implemented on Nov. 28, 2019, was postponed due to the COVID-19 pandemic. Full implementation of the phase three was carried out on Oct. 25, 2022. The phase three requirements included regulatory guidance for trauma informed care, substance abuse and arbitration.

[3] Medicare State Operations Manual (cms.gov) Chapter 7

Survey Techniques

There are varieties of techniques surveyors use to document, identify, and support deficiencies. In conducting the survey, surveyors use electronic worksheets or pathways, in conjunction with the Guidance to Surveyors. The Guidance to Surveyors assists in gathering information in order to determine whether the facility has met the requirements.[4]

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

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

Complaint Investigation Process

The Office of Health Facility Complaints (OHFC) was created by the Legislature in 1976 to review and investigate allegations of non-compliance with state regulations. Investigations of federal noncompliance were later added to OHFC's responsibilities to widen the safety net for vulnerable adults in Minnesota who reside in licensed facilities. For several years, complaint investigations were conducted which simultaneously addressed compliance with federal regulations and state statutes, as well as potential maltreatment as defined in the Minnesota vulnerable adult act. In Dec. 2018, at CMS' direction, MDH made changes and aligned responsibility for the federal complaint program to be managed by the HRD Licensing and Certification (Federal) team. This created the current process for nursing home complaints, described below.

Minnesota state and federal laws authorize anyone to file a complaint about licensed health care facilities. Since July 2015, the Minnesota Adult Abuse Reporting Center (MAARC) has served as the centralized reporting system to file a complaint regarding a vulnerable adult in Minnesota. A complaint is an allegation of noncompliance with federal and/or state requirements. The complaint process must ensure that a person who has complained, in good faith, about the quality of care or other issues relating to a licensed or certified health care facility is not retaliated against for making the complaint. The complaint resolution process must include procedures to assure accurate tracking of complaints received, including notification to the complainant that a complaint has been received; procedures to determine the likely severity of a complaint and for the investigation of the complaint and procedures to ensure that the identity of the complainant will be kept confidential. All complaints are reviewed and triaged to achieve the best outcome for vulnerable adults.

[4] See Appendix PP: Nursing Homes | CMS (https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsandRegulations/Nursing-Homes)

A nursing home also needs to self-report incidents. The CMS State Operations Manual (SOM) Chapter 5[5] outlines the types of incidents a nursing home needs to self-report to the State Agency:

- All alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property.
- The results of all facility investigations involving alleged violations of abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property.
- Reasonable suspicions of crimes against nursing home residents.

The CMS SOM also outlines the protocols to be followed by the state survey agency for 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. If an investigation substantiates noncompliance with state and/or federal regulations, deficiencies and/or state orders may be issued against the provider. The provider is responsible to correct violations and assure compliance with applicable regulations within a specific timeframe to avoid further licensing sanctions and/or other penalties. If there would be additional public protection benefits from making a maltreatment determination under the Minnesota vulnerable adults act, the complaint is referred over to a separate team for that additional investigation.

Vulnerable Adults Act

State law also mandates that allegations of maltreatment against a vulnerable adult be reported by the licensed health care entity. The Vulnerable Adults Act (VAA), first adopted in 1981, makes MDH a lead investigative agency for allegations of abuse, neglect, and financial exploitation of residents in licensed health care facilities.

The VAA requires the reporting of abuse, neglect, and financial exploitation which are defined in Minnesota Statutes, section 626.5572. Under federal regulations, Medicaid/Medicare certified facilities are also required to report alleged violations of abuse, neglect, mistreatment, and misappropriation of property. Reports made by providers are referred to as “Facility Self Reports” or “Facility Reported Incidents.”

Under the VAA, a preponderance of evidence is the legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation. If an investigation of maltreatment is conducted, the state VAA allows for one of the three following determinations:

- ***Substantiated*** **—** A substantiated finding means a preponderance of the evidence shows that an act that meets the definition of maltreatment occurred.
- ***False*** **—** False means a preponderance of the evidence shows that an act that meets the definition of maltreatment did not occur.
- ***Inconclusive*** **—** A finding of inconclusive means that there is not a preponderance of evidence to show that maltreatment did or did not occur.

[5] 100-07 | CMS (https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984)

As earlier mentioned, a preponderance of evidence is a legal standard of proof used in maltreatment investigations. In order to substantiate the occurrence of maltreatment, OHFC must have enough evidence from its investigation to support the allegation is true. Findings of maltreatment investigations are available on the MDH website.

If maltreatment is substantiated, MDH must make a further determination of whether the facility, an individual perpetrator, or both, are responsible for the maltreatment. When an individual is held responsible for maltreatment, this impacts their ability to work in regulated health care facilities in the future in several ways. First, the finding is reported to their licensing board, if applicable, such as the Board of Nursing (BON) for nurses or the Board of Executives for Long Term Services and Supports (BELTSS) for licensed nursing home administrators or licensed health services executives. Next, if the individual is on the nurse aide registry, the finding will be placed on the registry. Finally, the maltreatment finding is reported to the DHS background studies unit for possible disqualification under Minnesota Statutes, chapter 245C.

Data Requirements

Minnesota is part of the Center for Medicare and Medicaid Services (CMS) Chicago Region V, which is comprised of six states[6] As mentioned in the previous section, there are two components of a federal certification survey: a health survey and a Life Safety Code (LSC) survey. The following section provides detailed information related to survey results and outcomes in FFY23 within our federal Chicago Region V and regional data within the state. For more data information about Nursing Homes see CMS Quality, Certification and Oversight Reports (QCOR). [7]

Number of Deficiencies — Chicago Region V

Health Deficiencies Issued

In FFY23, Minnesota issued an average of 6.2 deficiencies per health recertification survey, which is consistent with the FFY22 average of 6.0 deficiencies per survey.

Table 1 reflects the average number of health deficiencies per recertification survey in FFY23 for all states comprising CMS Chicago Region V. The average for Chicago Region V was 7.5 health deficiencies per survey.

TABLE 1: Average # of Health Deficiencies by States within CMS Chicago Region V

State	Surveys	Deficiencies Issued	Average # of Deficiencies per Survey
Illinois	675	4876	7.2

[6] Region V states include Illinois, Indiana, Michigan, Minnesota, Ohio, and Wisconsin

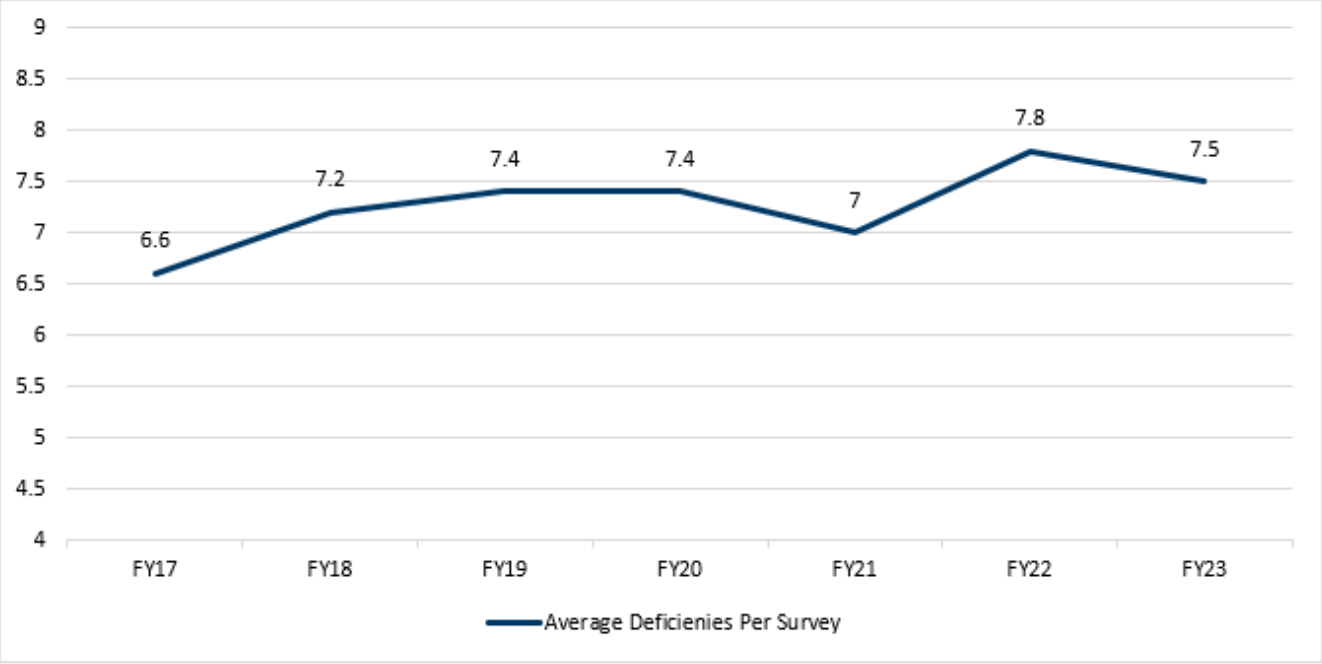
[7] S&C QCOR Home Page (cms.gov)

State	Surveys	Deficiencies Issued	Average # of Deficiencies per Survey
Indiana	445	3080	6.9
Michigan	363	3434	9.5
Minnesota	275	1713	6.2
Ohio	396	3381	8.5
Wisconsin	258	1510	5.9

Source: Federal Casper Data System FFY23

Figure 1 reflects the trend of the average number of health deficiencies issued per health recertification survey over a seven-year period for CMS Region V. The average for Region V was 7.5 health deficiencies per survey.

FIGURE 1: Average Number of Health Deficiencies Issued per Survey



Source: Federal Casper Data System FFY23

Life Safety Code Deficiencies Issued

LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire. It covers construction, protection, and operational features designed to provide safety from fire, smoke, and panic. A recertification survey for a nursing home contains both a health and a LSC portion of the survey.

Table 2 below shows the average number of LSC deficiencies per recertification survey in FFY23 for all states comprising CMS Chicago Region V. Minnesota continues to issue the fewest number of LSC deficiencies within our federal region, with the average number being 4.7 per LSC survey in FFY23.

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

State	LSC Surveys	LSC Deficiencies Issued	Average # of LSC Deficiencies per Survey
Illinois	679	5267	7.8
Indiana	434	2723	6.3
Michigan	344	2032	5.9
Minnesota	255	1202	4.7
Ohio	422	2717	6.4
Wisconsin	291	1764	6.1

Source: Federal Casper Data System, Quality Certification and Oversight Reports (QCOR) FFY23

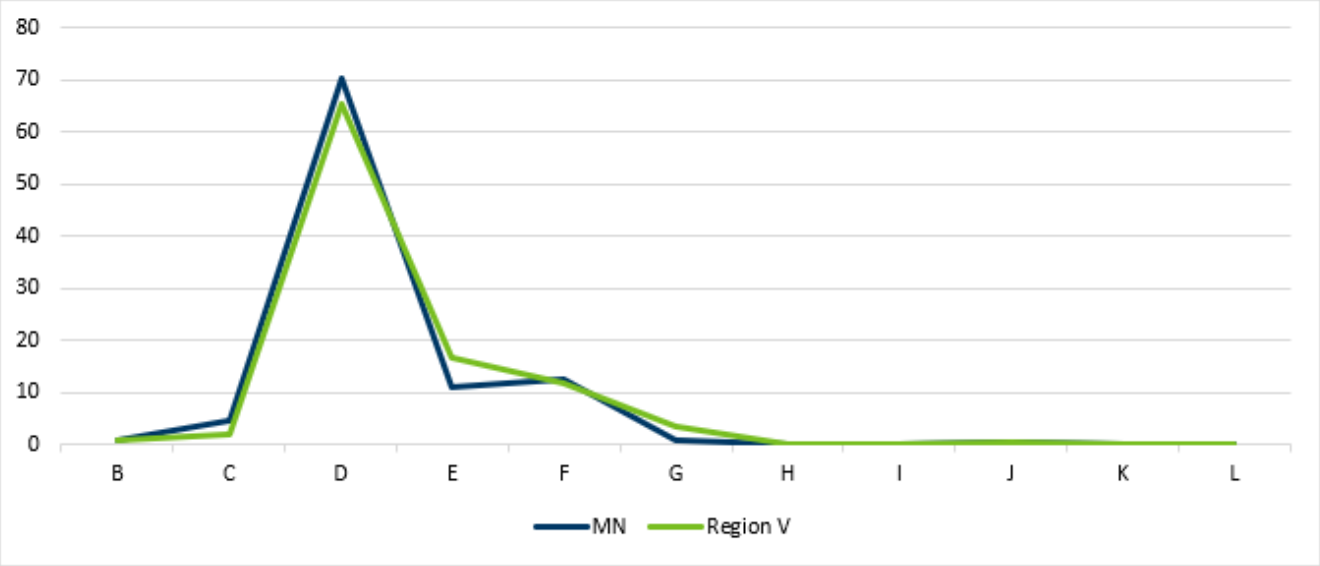
Scope and Severity of Citations — Chicago Region V

Scope and severity is a system of rating the seriousness of deficiencies. Every federal deficiency issued as a result of a survey or complaint investigation is assigned a scope and severity level, ranging from A through L. The highest scope and severity level of deficiencies found determine the overall scope and severity of the survey. [8]

Figure 2 reflects the highest overall scope and severity percentages by health survey for Minnesota as compared to Chicago Region V.

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

FIGURE 2: Percentage of Highest Health Scope and Severity

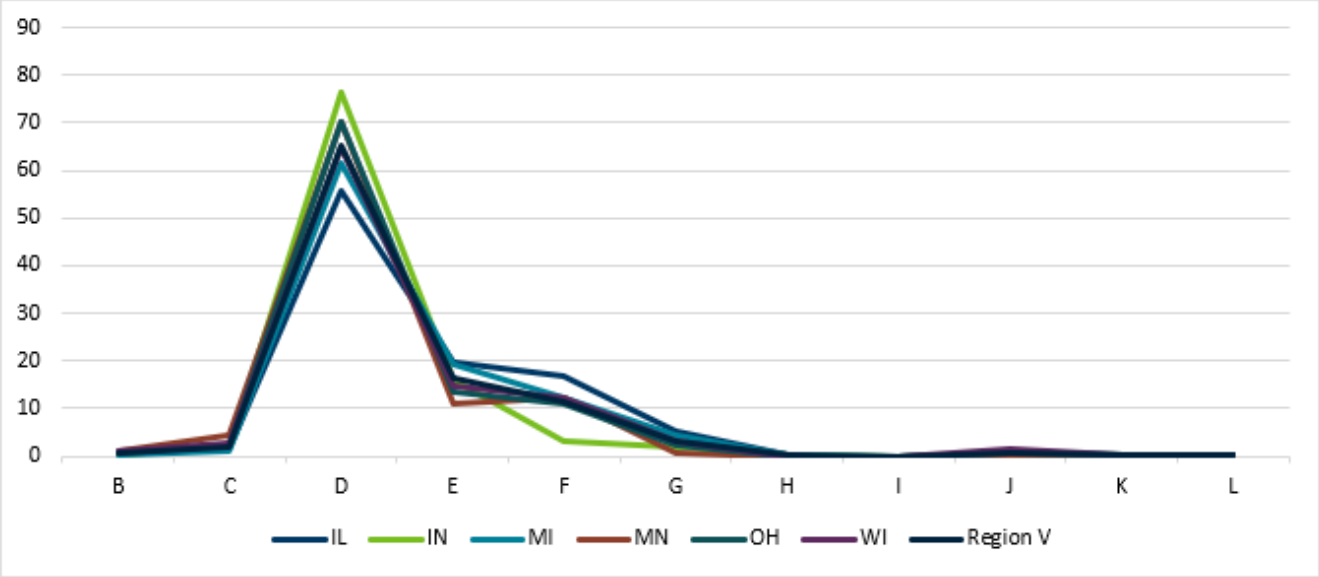


Source: Federal Casper Data System, Quality Certification and Oversight Reports (QCOR) FFY23

Area	B	C	D	E	F	G	H	I	J	K	L
MN	0.9	4.4	70.1	10.8	12.4	0.6	0.0	0.0	0.4	0.1	0.2
Region V	0.6	2.0	65.2	16.5	11.6	3.3	0.02	0.0	0.5	0.1	0.1

The graph and table above reflected the highest overall scope and severity percentages by health survey for Minnesota as compared to Region V, and Figure 3 below contains a greater breakdown of the information found in Figure 2. Figure 3 provides overall scope and severity percentages, but also includes this information for each state in Region V. In addition to the highest overall scope and severity percentages by state, Table 3 reflects the total counts of health surveys by the highest overall scope and severity level. See Appendix B for a further breakdown of Scope and Severity. Scope of isolated and severity of no actual harm with potential for more than minimal harm that is not immediate jeopardy (D level deficiency) is the most frequent deficiency issued.

FIGURE 3: Highest Scope and Severity Level by Percentage



Source: Federal Casper Data System, Quality Certification and Oversight Reports (QCOR) FFY23

State	B	C	D	E	F	G	H	I	J	K	L	Total
IL	0.7	1.4	55.8	19.7	16.6	5.3	0.04	0.0	0.2	0.1	0.1	100%
IN	0.4	1.9	76.2	15.9	3.3	1.8	0.03	0.0	0.4	0.03	0.0	100%
MI	0.4	1.1	61.7	19.4	12.2	4.3	0.03	0.0	0.6	0.1	0.1	100%
MN	0.9	4.4	70.1	10.8	12.4	0.6	0.0	0.0	0.4	0.1	0.2	100%
OH	0.5	2.1	70.2	13.4	10.8	2.3	0.0	0.0	0.5	0.1	0.1	100%
WI	0.9	2.5	64.8	14.8	12.2	3.0	0.0	0.0	1.6	0.1	0.1	100%
Region V	0.6	2.0	65.2	16.5	11.6	3.3	0.02	0.0	0.5	0.1	0.1	100%

TABLE 3: Highest Scope and Severity Level by Number

State	B	C	D	E	F	G	H	I	J	K	L	Total
IL	32	70	2719	961	810	260	20	0	12	6	4	4876
IN	11	60	2348	490	101	56	1	0	12	1	0	3080
MI	14	39	2119	665	419	148	1	0	22	4	3	3434
MN	16	76	1201	665	419	148	1	0	22	2	4	1713
OH	18	71	2374	452	366	79	0	0	16	2	3	3381
WI	14	38	979	223	184	46	0	0	24	1	1	1510
Region V	105	354	11,740	2976	2092	599	4	0	93	16	15	17,994

Source: Federal Casper Data System, Quality Certification and Oversight Reports (QCOR) FFY23

Survey Outcomes and Remedies

Survey Outcomes by Region Within the State — Number of Deficiencies

Minnesota Statutes, section 144A.10, subdivision 17, requires the reporting of the number, scope, and severity of citations by region within the state. Minnesota has twelve survey teams that cover the different areas across the state. In order to create regions within the state, these survey teams were grouped together to create North, Central, Metro and South "regions".[9] The surveys completed within each region are compared for the purposes of regional analysis.

Table 4 reflects the number of surveys completed within each region, the number of deficiencies issued within each region, and the average number of deficiencies issued per health recertification survey by region in FFY23.

[9] Bemidji, Duluth, Fergus Falls teams comprise the North region, two St. Cloud teams comprise the Central region, three metro teams comprise the Metro region; and Marshall, Mankato and Rochester comprise the South region.

TABLE 4: Number of Health Recertification Surveys and Deficiencies Issued by Region

Region	Number of Surveys	Number of Deficiencies	Average Number of Deficiencies per Survey
North	80	411	5.13
Central	57	215	3.77
Metro	92	789	8.57
South	78	505	6.47

The largest regional difference of the average number of health deficiencies issued per recertification survey is almost five deficiencies, or 4.8 deficiencies per survey.

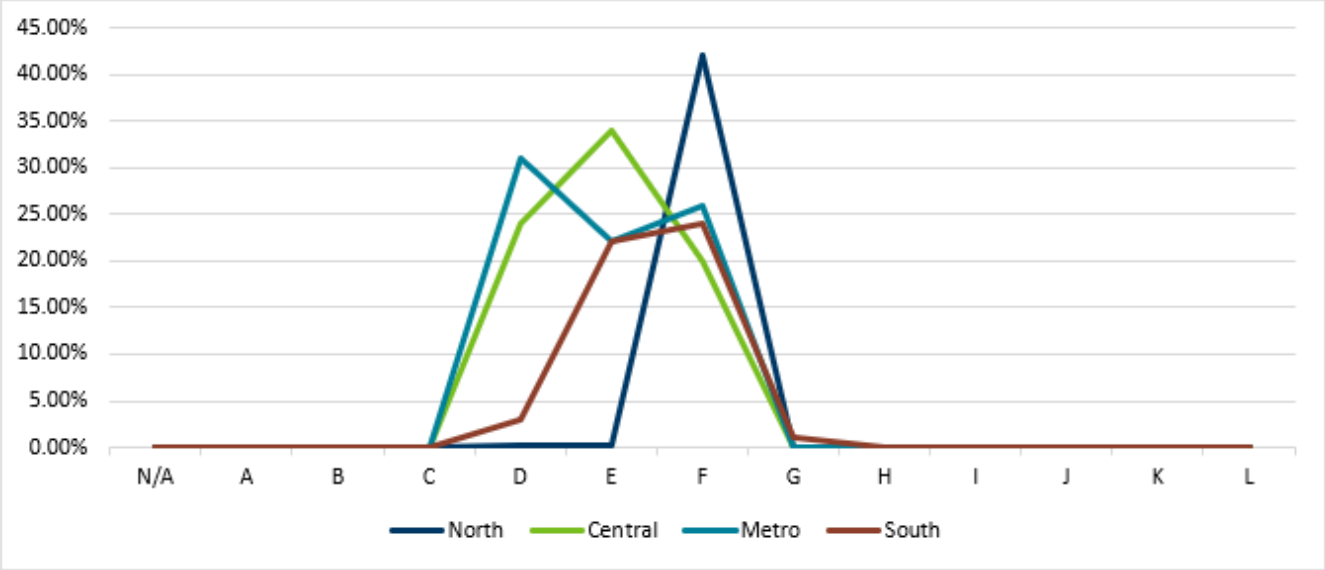
Survey Outcomes by Region Within the State — Scope and Severity

As mentioned previously, every federal deficiency issued is assigned a scope and severity level ranging from A through L. Scope and severity is a system of rating the seriousness of deficiencies. Scope ranges from isolated findings to widespread findings of a deficient practice. Severity ranges from a potential for minimal harm if the deficient practice is not corrected, to immediate jeopardy to resident health or safety.[10] The highest scope and severity levels of deficiencies found determine the overall scope and severity of the survey. See Appendix B for the CMS grid used to determine scope and severity.

Figure 4 reflects the highest overall scope and severity percentages per health recertification survey by region in FFY23.

[10] Scope/severity levels of “G”, “H” and “I” or above represent deficiencies of actual harm. Scope/severity of “J”, “K” and “L” represent deficiencies that are an immediate jeopardy to resident health or safety.

FIGURE 4: Scope and Severity per Health Recertification



Region	N/A	A	B	C	D	E	F	G	H	I	J	K	L
North	0.08%	0%	0.01%	0%	33%	20%	26%	0.03%	0%	0%	0.03%	0%	0.02%
Central	19%	0%	0.02%	0.04%	37%	19%	14%	0.4%	0%	0%	0.02%	0%	0%
Metro	10%	0%	0%	0%	33%	18%	32%	0.02%	0%	0%	0.02%	0.02%	0%
South	.004%	0%	0.01%	0.01%	27%	10%	54%	0.01%	0%	0%	0.01%	0%	0%

Table 5 below reflects the counts of the highest overall health scope and severity level per recertification survey, by region in FFY23. Figure 4 contains percentages based on the total number of overall scope and severity level of the survey divided by the total number of surveys conducted in that region, whereas Table 5 simply contains raw counts. Please note that while similar, the number of surveys conducted within each region varies slightly making percentages a better tool for comparisons.

TABLE 5: Health Scope and Severity Level per Recertification by Region

Region	N/A	A	B	C	D	E	F	G	H	I	J	K	L
North	7	0	1	0	27	16	21	3	0	0	3	0	2
Central	11	0	1	2	21	11	8	2	0	0	1	0	0
Metro	10	0	0	0	30	17	29	2	0	0	2	2	0
South	3	0	1	1	21	8	42	1	0	0	1	0	0

Remedies

As explained in the previous section, the highest levels of deficiencies of the survey determine the overall scope and severity of the survey. If the scope and severity of the survey met the criteria for no opportunity to correct, then immediate sanctions (or remedies) are required to be imposed. If imposed, it is in accordance with the scope and severity matrix in Appendix B.[11]

A complete listing of remedy categories follows. MDH typically recommends only a few of these options for imposition, which was the case in FFY23 and in recent years past. Many factors are used to determine which and how many remedies to impose within the available remedy categories for levels of noncompliance.

TABLE 6: Remedy Categories

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

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

While the overall scope and severity level of a survey may result in immediate remedies, there are other situations where remedies may be triggered during the survey process. One example of this would include a facility not correcting previously issued deficiencies at the time of an onsite revisit, which would result in finding the facility in continued non-compliance. The survey in this example may have started out without remedies, but now has remedies imposed due to the uncorrected revisit.

In FFY23 a total of 294 remedies were imposed for recertification or complaint surveys – it is important to note that multiple kinds of remedies may be imposed during one "survey process" or "enforcement case". For example, a survey resulting in remedies imposed may involve two civil money penalties (CMP), one for each "G" or above deficiency, and directed plan of correction. This would be reflected in Table 7 as one count of imposed (CMP) and as one count of imposed directed plan of correction.

Table 7 below illustrates the total types of all remedies imposed in Minnesota for all enforcement cases (both recertification and complaint surveys) over a three-year period FFY21- FFY23.

TABLE 7: Total Number of Remedies Imposed

Type of Remedy	FFY21	FFY22	FFY23
Imposed Directed Plan of Correction	182	98	51
Imposed CMPs	503	346	203
Imposed DOPNA	67	60	40
Total Remedies Imposed	752	504	294

Source: Federal Casper Data System, Quality Certification and Oversight Reports (QCOR) FFY23

Timelines in Relation to Imposed Remedies

Survey Revisits

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

During FFY23, there were 21 recertification surveys where CMS imposed federal Category 2 or 3 remedies. Eighteen of these 21 cases received on site revisits within the 15-calendar day requirement. Therefore, on site revisits were conducted within the 15-day requirement for 85% of the applicable surveys.

Time Requirements for Statement of Deficiencies

15 Working Day Requirement

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

In FFY23, there were a total of 307 recertification surveys completed for nursing facilities. Of those 307 surveys, the average working days to meet the requirement for delivering final Statement of Deficiencies within 15 days of exit was 12.57 days.

Appeals, Informal Dispute Resolutions (IDR) and Independent Informal Dispute Resolutions (IIDR)

Federal Level: Appeals

Facilities have the right to formally appeal any Civil Money Penalties (CMP's) imposed by CMS. The appeal process is a federal process, where facilities communicate directly with the CMS Region V Office in Chicago. In FFY23, there were seven appeals initiated at the federal level from facilities in Minnesota.

State Level: IDR and IIRDs

The federal regulations require each state to develop and offer IDR and IIDR process to facilities wishing to dispute survey findings.[12] Minnesota Statutes, Section 144A.10, subdivisions 15 and 16, are the statutory provisions governing the two processes. Although the federal regulations require the IIDR process only following the issuance of a CMP, the Minnesota statutes afford this process upon the issuance of any deficiency.

The purpose of the informal process is to give providers an opportunity to refute cited deficiencies after a survey. The IDR process entails a review of the challenged deficiencies by a supervisor who was not involved in the original survey or complaint investigation. Depending on the desire of the facility, the supervisor may facilitate a meeting where they receive the facility's challenges verbally. The supervisor will also review any written submissions and the survey or investigation record.

The IIDR process involves the facility's challenge being heard by an Administrative Law Judge (ALJ) from the Minnesota Office of Administrative Hearings (OAH). In an IIDR, both the facility and MDH Health Regulation Division (HRD) present their positions to the ALJ in a proceeding resembling a court hearing. Following the proceeding, the ALJ makes an advisory recommendation to the Commissioner of Health. The Commissioner's MDH designee reviews the recommendation and makes the final agency recommendation to CMS. CMS reviews the record and issues the final decision on the challenged deficiency.

[12] 42 C.F.R. §§ 488.331 and 488.431.

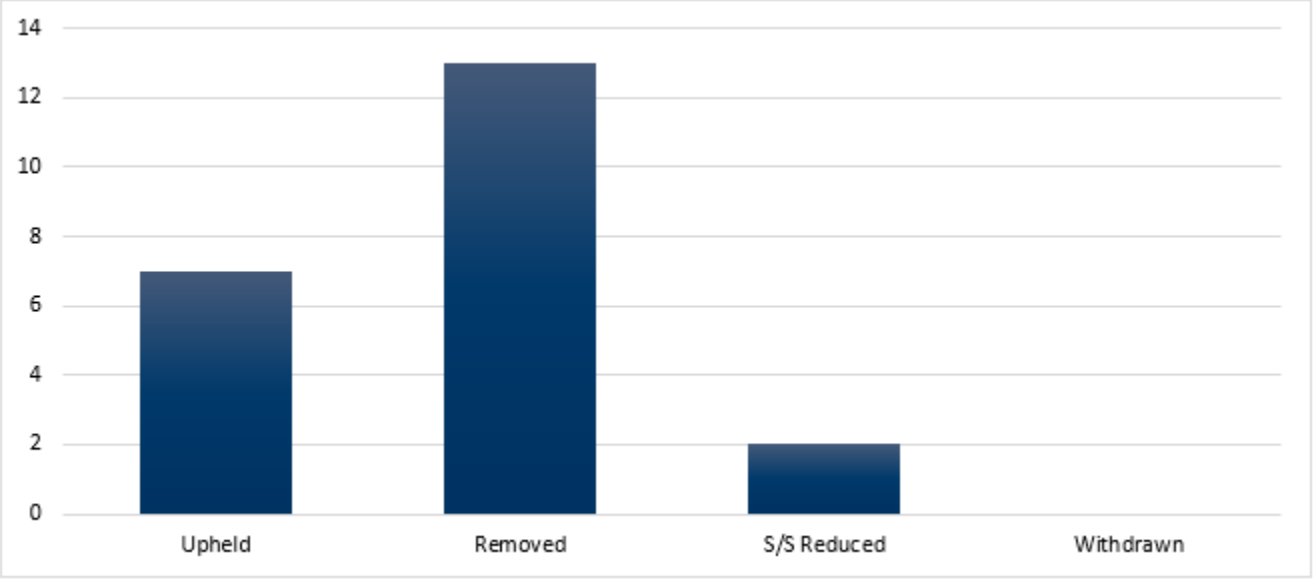
As a result of the review, a variety of outcomes may occur. If found fully supported, the deficiency will be upheld as written. If the findings are found unsupported, the deficiency will be removed. The deficiency may be found supported, but not at the issued scope and severity. In that case, the scope and severity will be reduced. In some cases, it may be found that MDH issued the deficiency at the wrong citation. This results in the tag being modified to the correct citation. Finally, if the deficiency was issued at an immediate jeopardy, the review may find that the period MDH found the facility placed residents in immediate jeopardy for a shorter period than cited in the deficiency. In such cases, the length of the immediate jeopardy will be reduced.

IDR Outcomes

During FFY23, MDH received IDR requests on 22 deficiencies.

Of the challenged deficiencies, seven were upheld as written with no modifications, 13 deficiencies were removed, and two had the scope and severity reduced as a result of the MDH review.

FIGURE 5: IDR Outcomes – FFY23

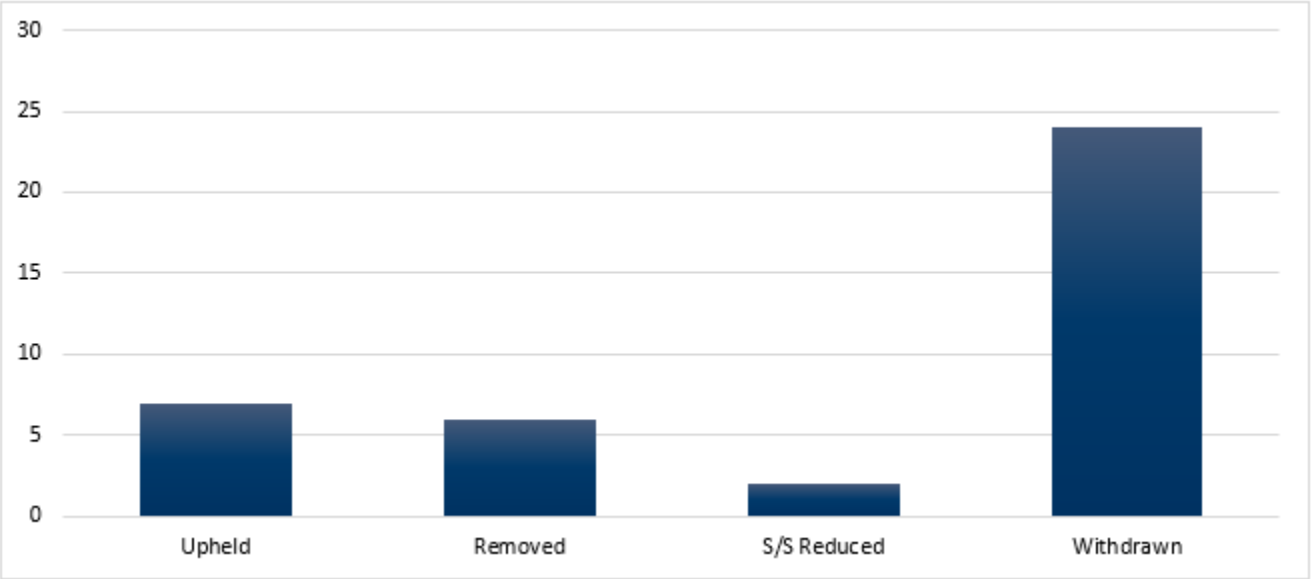


IIDR Outcomes

During FFY23, MDH received IIDR requests challenging 39 deficiencies. Of those, 24 challenges were withdrawn and 15 received a full review and determination.

In total, seven of the 15 reviewed deficiencies were upheld as written. As for changed deficiencies, six were removed and two had the scope and severity reduced.

FIGURE 6: IIDR Outcomes – FFY23



Areas of Special Focus

MDH strives to continuously improve both internal and external processes. Below are a few areas of focus and highlights from FFY23.

MDH/HRD Feedback Questionnaire

HRD developed a feedback questionnaire to give to providers at the beginning and end of a recertification survey and complaint investigation. The feedback from the providers is anonymous unless a provider would like to share their name. The feedback provides information to HRD on customer service and survey/investigation areas that can be improved. This questionnaire supports MDH'S culture of learning and collaborative safety by providing opportunities for facilities and providers to give MDH their perspectives about MDH's procedures, how MDH representatives communicated and whether the facilities and providers felt heard. The responses have been positive, and providers have been very open to share about their experiences. Any critical feedback is given immediately to the supervisor. If a provider shares an HRD staff name, that is shared with the supervisor as well.

Collaborative Systems Change

In December 2020, HRD contracted with Collaborative Safety LLC (Contractor) to introduce the concepts of "safety science" to enhance the HRD's capacity to improve health and safety of Minnesotans in long term care, assisted living and home care facilities. HRD was interested in exploring the Contractor's collaborative learning model to implement a nonregulatory approach to prevent health and safety violations. Rooted in safety science, the Contractor's unique process uses a blame-free, collaborative approach to engage providers, regulators, consumer advocates, non-profit and profit organizations, and state agencies in reviewing critical incidents through a "systemic mapping" process. The idea is to create a shared and collaborative learning space to study recurring issues and trends, identify systemic influences, collect, and analyze qualitative and quantitative data.

Results are then shared with leaders, regulators, providers, and partners to recommend solutions. This contract gave HRD the opportunity to explore how the Department of Human Services was using the model to broaden their regulatory lens.

From Oct. 2022 through Oct. 2023, HRD held 10 systemic mapping sessions. To determine areas to study in our pilot year, the Systemic Critical Incident Review (SCIR) Team evaluated the aggregate trends, or correction orders, with a focus on the top 10 areas cited by survey staff. One area of study included learning about the systemic barriers to comply with the tuberculosis prevention and control requirements for assisted living and home care providers. The point of study was to identify how barriers to tuberculosis prevention and control screening impacts provider staffing and subsequently, client cares. Five systemic mapping sessions were held to reveal systemic barriers that influence provider compliance. A second area of study was to understand the systemic features of developing an individual abuse prevention plan. Five systemic mapping sessions were held related to understanding the barriers providers had when completing individual abuse prevention plans, and intervention strategies. The systemic mapping team consisted of HRD staff facilitating the process along with the Contractor, assisted living and home care providers, for profit and not for profit provider advocates, the Ombudsman for Long Term Care, Ombudsman for Mental Health, and Development Disabilities, the Board of Executives for Long Term Services and Supports, and the Board of Nursing.

The qualitative data was evaluated as well as emerging themes learned through the systemic mapping process. HRD will evaluate the top takeaways from the systemic mappings to categorize areas where HRD, as the regulating agency, can recommend and design both short-term and long-term strategies to support improvements. This method supports efforts to understand barriers to health and racial equity and illuminates barriers to compliance requirements by listening to the perspectives of persons who are most affected by the regulatory system.

Appendices

APPENDIX A: CMS Revisit/Date of Compliance Policy
APPENDIX B: Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix

Appendix A: CMS Revisit/Date of Compliance Policy

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F (SQC), harm or IJ	Noncompliance continues	Any noncompliance
1st Revisit	Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the 1st onsite revisit, or correction occurred sooner than the latest correction date on the PoC.	1. A 2nd onsite revisit is discretionary if acceptable evidence is provided. When evidence is accepted with no 2nd onsite revisit, compliance is certified as of the date confirmed by the evidence. 2. When a 2nd onsite revisit is conducted, acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered for the compliance date.	1. A 2nd onsite revisit is required. 2. Acceptable evidence is required if the facility wants a date earlier than that of the 2nd onsite revisit to be considered as the compliance date.	
2nd Revisit	Compliance is certified as of the date of the 2nd onsite revisit or the date confirmed by				1. A remedy must be imposed if not already imposed. 2. Either conduct a 3rd onsite revisit

Revisit #	Substantial Compliance	Old deficiencies corrected but continuing noncompliance at F (no SQC) or below	Old deficiencies corrected but continuing noncompliance at F (SQC), harm or IJ	Noncompliance continues	Any noncompliance
	the acceptable evidence, whichever is sooner.				or proceed to termination.
3rd Revisit (A 3rd revisit is not assured and must be approved by the RO)	Compliance is certified as of the date of the 3rd onsite revisit.				Proceed to termination.

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

- An invoice or receipt verifying purchases, repairs, etc.
- Sign-in sheets verifying attendance of staff at in-services training.
- Interviews with more than 1 training participant about training.
- Contact with resident council, e.g., when dignity issues are involved.

Givens:

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

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

Scope	Isolated	Pattern	Widespread
Immediate jeopardy to resident health or safety	J = **SQC**, PoC Required	K = **SQC**, PoC Required	L = **SQC**, PoC Required
Actual harm that is not immediate	G= PoC Required	H = **SQC**, PoC Required	I = **SQC**, PoC Required
No actual harm with potential for more than minimal harm that is not immediate jeopardy	D= PoC Required	E= PoC Required	F = **SQC**, PoC Required
No actual harm with potential for minimal harm	A = **Substantial Compliance**, No PoC	B = **Substantial Compliance**, PoC Required	C = **Substantial Compliance**, PoC Required

Substandard Quality of Care (SQC) is defined in Centers for Medicare & Medicaid Services Nursing Homes State Operations Manual, Chapter 7 as one or more deficiencies which constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm, related to certain participation requirements.

Substantial compliance means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm. Substantial compliance constitutes compliance with participation requirements Centers for Medicare & Medicaid Services Nursing Homes State Operations Manual, Chapter 7.